STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157606	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVEANNA HEALTHCARE	**2629 WATERFRONT PKWY E DR STE 150 , INDIANAPOLIS, Indiana, 46214**

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G0000	INITIAL COMMENTS This visit was for a Federal complaint survey of a Deemed Home Health Provider. Survey Dates: 1/22/2024, 1/23/2024, and 1/24/2024 Complaint: 103870 with related deficiencies cited. 12-Month Unduplicated Skilled Admission: 63 QR on 01/29/2024 by A4	G0000		
G0436	Receive all services in plan of care CFR(s): 484.50(c)(5) Receive all services outlined in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patients received all home health aide visits as ordered, and failed to ensure all interventions were provided as ordered on the plan of care for 2 of 5 active clinical records reviewed. (Patients #1, 7) Findings include: 1. A review of agency policy 04.40.05 "Staffing and Scheduling," last revised 02/22/23, indicated "Care and services will be rendered based on ... physician orders ... 2. A review of agency policy 4.27.04 "Physician Orders/Plan of Care," last revised 12/07/23, indicated "Care and services will be provided in accordance with physician's (or authorized prescriber's) orders ... " 3. A review of the comprehensive assessment for Patient #1, dated 01/11/24, indicated a primary diagnosis of post laminectomy syndrome (a condition where the individual continues to feel pain after undergoing a laminectomy, or removal of vertebrae to reduce pressure on the spinal cord) and secondary diagnoses of encounter for attention to tracheostomy (an artificial opening into the windpipe through the neck), cerebral	G0436		

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G0436	Continued from page 1 palsy (a group of disorders affecting the ability to move and maintain balance), neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord, or nerve problems), microcephaly (smaller than normal head at birth or due to growth failure of the head after birth), other deforming dorsopathies (a group of diseases of the spine caused by impaired blood supply or shock/trauma to the spine), vascular myelopathies (damage to the spinal cord due to impaired blood supply), paralytic syndrome (symmetric, ascending weakness that progresses over days), convulsions (rapid, involuntary muscle contractions and twitching, often seen during a seizure), encounter for attention to gastrostomy tube (G-tube, a tube placed through an artificial opening from the abdomen to the stomach and used to provide nutrition, medication, and hydration), and dependence on supplemental oxygen. The assessment indicated Patient #1 was dependent on the ventilator (breathing machine), required frequent trach tube suctioning, required intermittent in and out catheterization (insertion of a tube via the urethra into the bladder to drain urine) every 3 hours and as needed, and required placement of a Foley catheter (a type of tube placed into the bladder to drain urine and stabilized with an inflated balloon tip to prevent dislodgement) at bedtime and removal of the Foley catheter the next morning. The patient received all nutrition and hydration, except peanut butter crackers, via G-tube, was bedfast and totally dependent for all needs, required repositioning every 2 hours, required incontinence care for bowel movements, required a specialized vest to assist with coughing up to 4 times per day, utilized orthotics, braces, and splints applied for various contracted extremities, and was dependent for all care and medications. A review of the plan of care for certification period 01/16/24 - 03/15/24 indicated a history of a wound which was healed as of 11/12/23. Skilled Nurse interventions included, but were not limited to, completing a comprehensive assessment with pain assessment every (q) shift and as needed, turn q 2 hours, G-tube feedings and water flushes 3x/day, oximetry spot checks q shift, medication administration via G-tube multiple times per day, intermittent urinary catheterization every 3 hours and as needed, placement of a Foley catheter at bedtime and removal of the catheter in the morning, assessment and monitoring of migraine, seizure activity, and spastic behavior, application of braces, orthotics, and splints to contracted limbs daily as tolerated, verification of ventilator and oximeter (non-invasive device for monitoring oxygen levels) settings and alarms, trach care q shift including change of trach ties and trach	G0436		

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G0436	Continued from page 2 dressing, stoma cleaning, and changing/cleaning of the inner cannula (daily), G-tube care twice daily, output monitoring q shift, passive range of motion (PROM) every shift if patient did not perform active range of motion during the shift, bathing, dressing, and personal care, and incontinence care as needed. Review of the active feeding orders indicated a daily feeding plan of Kate Farms (a brand of G-tube feeding) 375 milliliters (ml), 4 packages of peanut butter crackers, and 2 packages of Prosource Water 960ml (see interview with patient caregiver concerning Prosource Protein vs Prosource Water) divided up to 3 meals/day via gravity bolus, and may have oral diet per patient or patient caregiver request for comfort or taste. Skilled nurse to give 5-8 ounces of cranberry juice with 8 ounces of water per G-tube daily for signs/symptoms of urinary tract infection including fever, cloudy urine, foul-smelling urine, pain, or agitation. Ordered safety measures included, but were not limited to, aspiration precautions, equipment safety, seizure precautions, and side rails up. A review of a skilled nursing flow sheet, dated 01/17/23, evidenced RN 3 clocked in at 8 AM and clocked out at 5 PM. The flow sheet indicated the following were checked: emergency equipment, go bag, infection control kit, O2 tank, all alarms on and audible, ambu bag/extra trach on site, safety precautions, fall precautions, aspirations precautions, standard precautions, and respiratory precautions. No time was indicated. Vital signs were obtained at 8:20 AM and 4:25 PM and an untimed comprehensive assessment was documented on the flow sheet. The record failed to evidence the patient's blood pressure was obtained during the shift. The patient received 150 ml juice and crackers at 9 AM, 150 ml of water and crackers at 12 PM, 250 ml of formula mixture and crackers at 12:15 PM, 200 ml water and crackers at 12:55 PM, 170 ml water and crackers at 2 PM, and 170 ml water and crackers at 5 PM. The record failed to evidence the amount of crackers consumed, failed to evidence they were divided into 3 meals, failed to evidence the patient received 960 ml Prosource Protein packets vs water (see interview below concerning Prosource Protein vs water), failed to evidence the patient received Kate Farms feedings of 375 ml divided into 3 feedings (125 ml each feeding), failed to evidence the type of juice given, and failed to evidence signs and symptoms of urinary tract infection indicating the need for juice. The patient was turned at 9 AM, 11 AM, and 3 PM. The record failed to evidence the patient was turned q 2 hours, failed to evidence G-tube care was done, failed to evidence active or passive range of motion was completed, failed to evidence orthotics, braces, or	G0436		

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G0436	Continued from page 3 splints were applied or why they were not applied, failed to evidence trach care was completed or the inner cannula was changed/cleaned. The flow sheet indicated the patient was intermittently catheterized at 12 PM and a Foley catheter was inserted at 3 PM. The record failed to evidence the patient was intermittently catheterized every 3 hours and a Foley was placed at bedtime. The record failed to evidence ventilator settings and alarms were assessed and documented throughout the shift. On 01/24/24 at 3:44 PM, Person K, a relative and primary caregiver for Patient #1, indicated the patient received feedings of Kate Farms Regular which comes in an 11.5 ounce (oz.) per container. Mix 375 ml, about 1 1/2 containers, with tap water to equal 32 oz. and divide to be given in 3 separate meals. Person K indicated Prosource is not water but is a liquid protein supplement. The patient receives a 30 ml packet of Prosource Protein supplement at 9 AM and another at 9 PM, flushed before and after with tap water because the Prosource Protein supplement curdles the Kate Farms formula if they come in contact. Person K indicated the peanut butter crackers were figured into the patient's calories and nutrition plan by a dietician to increase protein and promote healing of a now-healed pressure ulcer caused by the patient's cough assist vest and the crackers, which come 6/package, were required nutritional intake for the patient. On 01/23/24, the Nursing Director indicated all skilled nurse's caring for patients receiving mechanical ventilation should document using a skilled nurse flow sheet and an invasive ventilation flow sheet. The Nursing Director indicated RN 3 did not submit an invasive ventilation flow sheet on 01/17/24. On 01/24/24 at 3:10 PM, RN 3 indicated the ventilator and alarm settings should be documented at least every hour and the patient's interventions and treatments should all be documented on the nursing flow sheet as ordered on the plan of care. RN 3 indicated she gets busy and doesn't document things if they are going as they should. 4. A review of a complaint dated 01/18/24 indicated Person L, a relative and primary caregiver for Patient #7, spoke with RN 1 on 01/17/24 to ask if any other available HHAs were available to cover upcoming open shifts. A review of a care plan assessment for Patient #7, dated 01/08/24, indicated home health aide services were ordered for 4 hours/day, 7 days/week not to exceed	G0436		

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G0436	Continued from page 4 28 hours per week. A review of the plan of care for certification period 01/12/24 - 03/11/24 indicated home health aide services were ordered 4 hours/day, 7 days/week, not to exceed 28 hours/week. A review of the confirmed visit schedule (visits confirmed as provided based on clock in/clock out and submission of visit notes) indicated missed visits on 01/13/24, 01/14/24, and 01/18/24 - 01/24/24 due to "unassigned." 5. On 01/24/24 at 2:11 PM, HHA 3 indicated Patient #7 received 3 separate HHA shifts each day for an hour in the morning for dressing and toileting, an hour around noon for toileting, and 2 hours from 8 PM - 10 PM for bathing, personal care, and meal prep for the next day. HHA 3 indicated there were only 2 HHAs assigned to the case, and they had difficulty staffing all shifts. HHA 3 indicated they tried to fill in for the night shift but often couldn't and the second aide was currently on vacation with no one to fill the shifts. 6. On 01/23/24 at 4:09 PM, Person L indicated Patient #7 received a 1-hour morning shift, a 1-hour shift around noon, and a 2-hour shift in the evening where most of the personal care occurred. Person L indicated being concern about scheduling because the scheduler worked out of the Indianapolis office and the patient was in the Valparaiso area. Person L indicated the scheduler doesn't return their calls and no one had not called about the unscheduled shifts. 7. On 01/24/24 at 1:31 PM, the Client Services Supervisor indicated RN 1 notified him the patient had been moved to a relative's house due to a flood in the apartment and the relative would provide care. The Client Services Representative also indicated an aide scheduled to fill in starting 01/17/24 was asked not to return and there was no one else to schedule. 8. On 01/24/24 at 4:48 PM, the Nursing Director indicated Patient #7 received 3 visits each day and they were unable to find coverage for all 3 shifts. No further information was available related to care coordination.	G0436		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner.	G0580		

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G0580	Continued from page 5 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all medications were administered according to physician's orders for 1 of 5 active patient records reviewed. (Patient #1) Findings include: A review of agency policy 4.27.04 "Physician's Orders/Plan of Care," last revised 12/07/23, indicated "Care and services will be provided in accordance with physician's … orders … " A review of the plan of care for Patient #1, for the certification period 01/16/24 - 03/15/24, evidenced the patient received Sodium Chloride 0.9% inhalation every 4 hours, Sodium Chloride 3% Inhalation twice daily and as needed every 6 hours for increased secretions, Albuterol Sulfate 2.5mg/3ml inhalation every 3 hours as needed for wheezing/shortness of breath/cough/increased work of breathing (start date 12/03/08), and Tobramycin Sulfate 80 mg via nebulizer twice/day as needed x 28 days for respiratory illness (effective date 09/19/22). The plan of care failed to evidence the Tobramycin Sulfate was discontinued 28 days after the effective date of 09/19/22. A review of a skilled nurse flow sheet, dated 01/22/24, evidenced an entry at 6:30 AM which indicated " 3L [Liters] continuous O2 [oxygen] nebs [refers to inhaled medication delivered via a nebulizer or device used to create a fine spray of an inhaled medication] started per order by mom 0715 started tobi [Tobramycin - an inhaled antibiotic] per order due to psudeomonous [sic pseudomonas - a type of bacteria] smell … " The record failed to evidence a current order for inhaled Tobramycin. On 01/24/24 at 9:08 AM, the Nursing Director indicated a patient's parent may choose to give different medications, treatments, or care but the nurse should verify all medications, care, and treatments against the plan of care or updated physician's order or by speaking with the physician's office.	G0580		
G1012	Required items in clinical record CFR(s): 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care,	G1012		

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G1012	Continued from page 6 and physician or allowed practitioner orders; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the clinical record contained all clinical notes and all documentation of communication with and about patients and their care and services for 2 of 5 active clinical records reviewed. (Patients #1, #2) Findings include: 1. A policy received from the Agency on 01/23/2024 at 12:06 PM titled " General Communication" indicated but was not limited to " Regular communication with physicians, patients, staff, payers, case managers, supervisors or others providing and/or overseeing care or service to patients will be documented . . . Any communication . . . will be documented in the patient's medical record . . . ." 2. During an interview with Registered Nurse (RN) # 1 on 01/23/2024 at 2:30 PM, they reported having a document from 12/19/2023 related to Patient #2 explaining the education and information provided to the caregiver of Patient #2. When queried if this was in the clinical record, they replied, " . . . I do my best but I am checking . . . " The RN failed to include the document in the Patient's clinical record and failed to follow agency policy. 3. A review of the comprehensive assessment for Patient #1, dated 01/11/24, indicated the patient had a tracheostomy (an artificial opening through the neck and windpipe) and was dependent on mechanical ventilation for breathing. Review of the skilled nurse visits evidenced a skilled nurse flow sheet was submitted for 12/06, 12/07, 12/09, 12/16, 12/20, 12/21, 12/24, 12/27, 12/30/23 and 01/03, 01/04, 01/06, 01/11, and 01/13/24. The record failed to evidence an Invasive Ventilation Flow Sheet was submitted with the skilled nurse visit note for the specified days. On 01/23/24 at 2:46 PM, the Nursing Director indicated the nurses document ventilator settings and information on the Invasive Ventilation Flow Sheet and it was expected to be submitted with every visit. On 01/24/24 at 3:10 PM, RN 3 indicated she had not submitted Invasive Ventilation Flow Sheets for Patient #1 but should have done so.	G1012		