STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVEANNA HEALTHCARE	**111 EAST LUDWIG RD STE 109 , FORT WAYNE, Indiana, 46825**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	INITIAL COMMENTS This visit was for a complaint investigation survey of a Deemed Home Health Agency. Complaint #: IN105493 with related findings Survey Dates: April 4, 5, 8, 9, 15, 16, and 17, 2024. Unduplicated 12 Month Census: 14 Current Census: 50 The administrator was notified of the Immediate Jeopardy on 4/9/24, at 5 PM at 42 CFR 484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect, and misappropriation of property. The Immediate Jeopardy was not removed prior to exit on 4/17/2024. Based on the Condition-level deficiencies identified during the 4-17-2024, survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, on 4/17/2020 at 5:00 PM. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for two years beginning 4/17/2024 and continuing through 4/16/2026.	G0000		
G0430	Be free from abuse CFR(s): 484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; This ELEMENT is NOT MET as evidenced by: Based on record review, observation and interview, the agency failed to ensure the home health aide (HHA)	G0430		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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G0430	Continued from page 1 reported changes in skin condition to the registered nurse (RN), and the RN failed to complete a comprehensive assessment that reflected patients current skin condition for 1 active record reviewed that resulted in untreated alteration in skin integrity (Patient #1) and for 1 discharged record reviewed of a patient hospitalized with a Stage IV pressure wound (a wound that penetrates all three layers of skin, exposing muscles, tendons and bones) and septic shock (serious condition that occurs when a body-wide infection leads to dangerously low blood pressure) (Patient #7). Findings include: Based on record review, observation, and interview, the agency failed to ensure the home health aide (HHA) reported changes in skin condition to the registered nurse (RN), and the RN failed to complete a comprehensive assessment that reflected the patient current skin condition for 1 active record reviewed that resulted in untreated alteration in skin integrity (Patient #1) and for 1 discharged record reviewed of a patient hospitalized with a Stage IV pressure wound (a wound that penetrates all three layers of skin, exposing muscles, tendons and bones) and septic shock (serious condition that occurs when a body-wide infection leads to dangerously low blood pressure) (Patient #7). 1. A review of an agency document titled “Patient Packet” indicated the patient’s right to be free from neglect. A review of an agency policy titled “Wound Care Management” indicated wound care management includes a thorough assessment of the wound, wounds will be assessed every visit and includes documentation regarding the wound assessment, wound care, and treatment. A review of the HHA job description indicated the HHA is to report changes in Patient’s condition to an RN. 2. A review of the clinical record of Patient #7, start of care date 12/19/22, included plans of care (POCs) for certification periods 12/14/23 – 02/11/24 and 02/12/24 – 04/11/24. The plans of care identified the following diagnoses, but not limited to, radiculopathy lumbar region (range of symptoms produced by the pinching of a nerve root in the spinal column), post-laminectomy syndrome (pain that continues after undergoing back surgery), muscle weakness and included a new diagnosis on 12/11/23 of an unstaged pressure	G0430		

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G0430	Continued from page 2 ulcer (full-thickness pressure wound in which the wound bed is obscured by slough, tissue formed when dead cells and/or bacteria accumulate in a wound, and/or eschar, a collection of dry, dead tissue in the wound bed) of sacral region (between the lower back and tailbone). The plan of care included frequency orders for a home health aide to visit Patient 2-6 hours a day, for 5-7 days a week: up to 42 hours a week. Review of a document titled “Patient Assessment Resumption of Care (ROC) Form” completed on 12/10/23 by RN 1 indicated a coccyx (tailbone) wound was covered with a dressing, was infected, and unstageable. Documentation failed to evidence the RN performed an assessment of the wound and failed to evidence the RN contacted the physician regarding the wound. Review of the case supervisor/interim assessment dated 1/10/24 by RN 1, indicated the patient went to the ER on 1/9/24 due to a laceration to the left knee. When the patient went to the ER in January, they thought the dressing to the sacrum got changed there because the wound was covered. and they were not supposed to remove it to assess it. Review of orders effective 02/08/24 evidenced Collagenase (enzyme used to clean pressure ulcers) was to be applied to the affected skin once a day at bedtime. Orders effective 02/26/24 included the application of a mepilex dressing (foam dressing that shields the wound and contains silver that helps to kill bacteria) to the sacral wound and to be changed every 3 days. Review of an agency document titled “Patient Assessment ROC Form” completed on 02/26/24 by RN 2 indicated Other A recommended placement of a mepilex dressing on the sacral area that should be changed every 3 days. Documentation indicated RN 2 did not assess the sacral wound because the agency home health aide would not change Patient’s brief while a maintenance person was in patient’s home. Documentation failed to evidence the RN performed an assessment of the wound and failed to evidence the RN contacted the physician regarding the wound. Review of a Visit Record completed by Home Health Aide 3 on 03/18/24 indicated Patient #7 had a wound infection and left the home by ambulance. Review of an agency document titled “Care Coordination Note” completed on 03/18/24 by RN 2 indicated Patient #7 was taken to the emergency room by ambulance due to increased sacral wound pain and pus-like drainage from	G0430		

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G0430	Continued from page 3 the sacral wound. Review of an agency document titled “Patient Assessment Form” completed on 03/26/24 by RN 2 indicated the assessment data was taken from the 02/26/24 ROC assessment. Documentation indicated the patient would be transferred to a long-term care facility when discharged from the hospital. Review of a document obtained from Other A indicated Patient #7 had a history of paraplegia (paralysis of the lower body) secondary to spinal cord injury from back surgery and indicated Patient #7 was admitted to the hospital from 03/18/24 – 03/28/24 for a worsening sacral ulcer causing septic shock. Review of the clinical record failed evidence Patient #7 received skilled nursing services since the patient developed the wound on December 10, 2023, and per ordered by the wound clinic and failed to coordinate with the wound clinic and patient to ensure treatments are being done. Review of the Discharge Summary completed on 03/26/24 by RN 2 indicated Patient #7 was discharged from home health services and would be transferred from the hospital to a long-term care facility. During an interview on 04/09/24 at 11:45 AM, when asked who was responsible for the wound management of Patient #7, RN 1 indicated was the wound clinic. When asked for the name of the wound clinic and the frequency of wound clinic visits, RN 1 indicated did not know. When asked why a wound assessment was not completed during the ROC assessment on 12/10/23, RN 1 indicated because they didn't think the home health agency was to do anything with wounds that are covered with dressing by the wound clinic. During an interview on 4/9/2024 beginning at 11:45 AM, RN 1 indicated she thought that the affected area was the knee. RN 1 indicated the patient was going to the wound clinic on 2/12/24 so no wound assessment was done. RN 1 indicated she was not sure how the patient could apply the Mepilex dressing to the sacral wound and indicated the patient had a friend that might apply and change the dressing. RN 1 indicated she did not know how often the patient goes to the wound clinic. RN 1 indicated she assumed the wound clinic was responsible for the patient’s wounds. 3. A review of the clinical record of Patient #1, start of care date 08/24/20, included POCs for certification periods 01/26/24 – 03/25/24 and 03/26/24 – 05/24/24.	G0430		

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G0430	Continued from page 4 The plans of care identified the following diagnosis, but not limited to, quadriplegia (paralysis of upper and lower body). The POC included frequency orders for a home health aide to visit Patient 1-2 hours a day, for 4-7 days a week; up to 14 hours a week, and for the home health aide to report any unusual occurrences to the office. Review of an agency document titled “Patient Assessment Recertification Form” completed by RN 1 on 01/24/24 indicated patient reported having a sacral wound, unsure of the size, that had the top layer of the skin off with some bleeding. Documentation evidenced RN 1 asked Patient #1 if going to contact the wound clinic and Patient #1 responded would like to wait a week. Documentation indicated a second wound located on the outer part of the left ankle and end of the fibula, with a length of 1.5 cm and width of 1.5 cm. Documentation failed to evidence RN 1 performed a skin assessment of the sacral wound and failed to contact the physician to obtain orders or interventions to manage the wounds. Review of home health aide visit records for dates 01/01/24 through 02/09/24 and 03/22/24 indicated alteration in skin integrity. Documentation failed to evidence the home health aides communicated the skin condition of Patient #1 to the home health office or an RN. During a home visit with Patient #1 on 04/08/24 between 9:00 AM and 9:45 AM, during a skilled nurse assessment, RN 1 placed the stethoscope on Patient’s back to listen to breath sounds. Patient #1 reported had placed a dressing to lower back area to cover dead skin. RN 1 failed to remove the dressing to observe the skin and failed to transfer Patient from the wheelchair to the bed to perform a skin assessment. During an interview on 04/08/24 at 10:15 AM, when asked why a skin assessment was not performed during the home visit with Patient #1, RN 1 indicated she does not assess the skin of patients when they are dressed and sitting in chair and does assess the skin if performing home health aide care. During an interview on 04/05/24 at 10:25 AM, when asked if notified by a HHA about skin issues for Patient #1, RN 1 indicated had been notified and because Patient #1 frequently had skin breakdown, would either speak with the patient or the physician and the patient would put a dressing on the skin and take care of skin himself/herself.	G0430		

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G0430	Continued from page 5 During an interview on 04/09/24 at 11:45 AM, when asked who is responsible for the management of Patient #1's wound, RN 1 indicated the patient likes to take care of himself/herself or go to the wound clinic. When asked if Patient #1 would be able to apply a wound dressing to the sacral area, RN 1 indicated had never seen Patient apply a dressing. 4. During an interview on 04/04/24 at 4:10 PM, when asked to describe the process a HHA should follow when observes skin issues, the clinical supervisor indicated the HHA should notify the RN, who would go out to assess skin and if needs to be addressed by the physician, the RN would contact the physician and follow physician orders. When asked if the nurse would measure the wound, the clinical supervisor indicated would expect the RN to observe and not necessarily measure.	G0430		