STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157644	A. BUILDING B. WING	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVEANNA HEALTHCARE	111 EAST LUDWIG RD STE 109, FORT WAYNE, IN, 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
E0000	Initial Comments An Emergency Preparedness Revisit Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: May 29, 30, 31, June 3, 2004 Active Census: 35 At this Emergency Preparedness Revisit survey, Aveanna Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		

G0000	INITIAL COMMENTS	G0000		
	This was a Post-Condition revisit, Federal and State Licensure complaint survey for Complaint #107064 for the Home Health Provider complaint survey conducted on 04/17/2024. An Immediate Jeopardy related to 42 CFR 484.50 was identified on 4/9/2024 The IJ remained unabated at exit on 4/17/2024. An IJ removal revisit was conducted on 4/25/2024 and the IJ was abated during this visit. During this Post-Condition revisit Complaint IN105493 was investigated with related findings. Survey Dates: 5/29, 5/30, 5/31, and 6/3/2024. Unduplicated Skilled Admissions last 12 months: 9 Two previous conditions were corrected. Fourteen previous deficiencies were corrected, and one deficiency was re-cited. QR 6/10/24 A2			

G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the home health agency failed to ensure patients received services as ordered in the plan of care (POC) for 4 of 6 active records reviewed (Patient #4, 10, 12 and 13). Findings include: 1. The agency policy "Back-Up Services" indicated in the event that the provider is not available to deliver the required care, the company will seek the resource through shared staff from another location, subcontract for service or internal clinical staff. 2. The agency policy "Missed Services" indicated patients/caregivers should be consulted in advance regarding scheduling of services, so the patient receives the ordered services and indicated when scheduled services, visits or shifts are not provided for any reason, the MD must be notified	G0436	It was identified there was a lack of education provided and/or lack of understanding of staff regarding patients are to receive all services as ordered in the plan of care. Plan of Correcting the specific deficiency 1. Correction will be completed through mandatory staff in services to 100% of Internal Staff the Administrator and/or the Regional VP of Operations regarding:a. The requirement that patients are to receive all services as ordered in the planof care.b. The agency's process for tracking & evaluation the services ordered, and services provided.c. Coordination with the patient and physician regarding the need to revise and update the plan of care as applicable 2. A sign in sheet along with an acknowledgment form will be completed once education has been provided 3. Inservice education will be incorporated into the orientation process for all new hire internal staff regarding: a. The requirement that patients are to receive all services as ordered in the plan of care.	2024-07-03

	notification must be in the patient's record to reflect the alteration of the plan of care. 3. The agency "Patient Packet" indicated the patient has the right to receive services as outlined in the plan of care. 4. The agency policy "Physician Order / Plan of Care" indicated the physician must be promptly alerted to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or the POC should be altered and the POC must include the frequency, duration of each treatment, service, shifts and/or visits. 5. Patient #4's clinical record included a POC for the certification period 5/21/24 to 7/19/24. The POC indicated the patient was to receive Home Health Aide (HHA) services 8-10 hours a day, 6-7 days a week. The record evidenced HHA Visits were performed on 5/21/24 and 5/22/24. The record failed to evidence Patient #4 received any HHA visits after 5/22/24 and failed to evidence Patient #4 received the HHA visits as ordered in the		b. The agency's process for tracking & evaluation the services ordered, and services provided. c. Coordination with the patient and physician regarding the need to revise and update the plan of care as applicable 4. Patient #4 services ordered, and services provided will be evaluated, reviewed with the patient/family and physician, and the plan of care will be revised by 7/03/24. 5. Patient #12 services ordered, and services provided will be evaluated, reviewed with the patient/family and physician, and the plan of care will be revised by 7/03/24. 6. Patient #13 services ordered, and services provided will be evaluated, reviewed with the patient/family and physician, and the plan of care will be revised by 7/03/24. 7. 100% of active patient records will be evaluated for services ordered vs. services provided to evaluate the effectiveness of services and identify any trends. In the event trends are identified, coordination of care with the physician and patient family will be conducted to determine if revision of the plan of care is	

	POC. During an interview on 5/31/24 beginning at 3:26 PM, the Clinical Manager relayed Patient #4 has not received any HHA visits after 5/22/24 and indicated they were unsure if the caregiver had been notified of a hold in HHA services. They also relayed the physician had not been contacted by the home health agency for POC changes. 7. Patient #12's clinical record included a POC for the certification period 5/13/24 to 7/11/24. The POC indicated the patient was to receive Skilled Nurse (SN) services 9-11 hours per day and 8-10 hours per night, 6-7 days a week. The record evidenced daytime SN Visits were not performed on 5/17/24, 5/19/24, 5/20/24, 5/24/24, 5/25/24, 5/26/24, 5/27/24, 5/31/24, 6/01/24 and 6/02/24. The record failed to evidence documentation the caregiver for Patient #12 was notified regarding the above visits not being performed and failed to evidence Patient #12 received the SN visits as ordered in the POC.		required. Date the corrective action will be completed: 07/03/2024 Person responsible to implement the plan of correction: The Administrator Monitoring Process: A quality improvement indicator has been developed to track the process and progress will be monitored through location QAPI meetings and reported up through the Corporate QAPI Committee and the governing body. Effective compliance with this standard is evidenced by a compliance threshold of 100%. Methodology: The agency's tracking report will be reviewed by the Administrator weekly x2 weeks to ensure services ordered and services provided are being tracked/evaluated, care coordination with the patient/family and physician is documented, and the plan of care is revised/updated as applicable. To ensure ongoing compliance, 10% of patient records (services ordered/services provided) and/or tracking reports will be reviewed on a quarterly basis as part of the ongoing QAPI process to ensure patients are receiving all services ordered. If	

	During a home visit observation on 5/30/24 beginning at 8:05 AM, LPN 2 indicated they usually notify the caregivers for Patient #12 in advance when they are unable to complete a shift. LPN 2 indicated this is not usually documented in the clinical record. During an interview on 5/30/24 beginning at 3:46 PM, the Clinical Manager relayed the clinical record for Patient #12 failed to evidence any documentation the caregiver was notified regarding the above missed shifts and the clinical record failed to include documentation that the physician had been contacted. 8. Patient #13's clinical record included a POC for the certification period 5/18/24 to 7/16/24. The POC indicated the patient was to receive Skilled Nurse (SN) services 6-8 hours per day 4-5 days a week and 6-8 hours per night, 1-4 nights a week. The record evidenced day SN visits were performed on 5/20/24, 5/21/24 and 5/22/24. The record failed to evidence Patient #13 received any daytime SN visits after 5/22/24 and failed to evidence		at any point compliance falls below the threshold, then all appropriate internal staff will be reeducated to ensure there is not a knowledge deficit.	

	Patient #13 received the SN daytime visits as ordered in the POC. During an interview on 5/30/24 beginning at 3:46 PM, the Clinical Manager relayed the SN attended school with Patient #13 during the day and verified Patient #13 had not received any daytime SN visits after 5/22/24. They relayed the clinical record failed to evidence collaboration with the caregiver or physician regarding changes in POC frequencies for SN services.			
N0000	Initial Comments This visit was a Re-visit for a State Re-licensure Survey of a Home Health provider. Survey Dates: May 29, 30, 31, June 3, 2004 12-month Unduplicated Skilled Admissions: 9	N0000		

	During this revisit, two deficiencies were re-cited and three new deficiencies were cited.			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the home health agency failed to ensure the agency's organizational chart depicted only the home health agency's personnel and failed to ensure the required lines of authority for 1 of 1 agency. Findings include: 1. A review of an agency document titled "Aveanna Healthcare Organizational Chart" included positions that were not staff of the agency nor members of the governing body, including but not limited	N0440	It was identified there was a lack of education provided and/or lack of understanding of staff regarding The Agency's Organizational chart must include lines of authority, including the Governing Body, the Administrator, the Alternate Administrator, Clinical Manager/Supervising nurse, and Alternate Clinical Manager/Supervising Nurse, Nursing supervisors, and field staff providing care to the patients: Plan of Correcting the specific deficiency 1. Correction was completed through re-education to the Administrator by the Associate VP of Clinical Practice and Compliance on 6/03/2024 regarding: a. The requirements of the Organizational chart, clearly depicting all lines of authority, in writing and readily identifiable. 2. Correction was completed through re-education to the Alternate Administrator by the Administrator on 6/21/2024 regarding: a. The requirements of the Organizational chart, clearly depicting all lines of authority, in writing and readily identifiable. 3. A sign in sheet along with an acknowledgment form will be completed once education has been provided 4. Inservice education of the Organizational Chart requirements will be incorporated into the orientation process for any new appointments of Administrator/Alternate Administrator. 5. The Organizational Chart was updated by the Administrator on 6/03/2024 and presented to the surveyors prior to exit, depicting all lines	2024-07-03

	to Entity I office staff. The organizational chart failed to include the governing body, failed to list the Administrator overseeing all staff. The organizational chart failed to include the Alternate Administrator and Alternate Clinical Manager and failed to evidence the agency's current lines of authority beyond the Nursing Supervisors to the registered nurses (RN), licensed practical nurses (LPN), and home health aides (HHA) who provided direct care to the patients. 2. During an interview on 6/03/24 beginning at 10:03 AM, the Administrator relayed the home health agency does not have an organizational chart specific to the Fort Wayne office and indicated the organizational chart probably needed revised to include the governing body, Alternate Administrator, Alternate Clinical Manager and field staff.		of authority, including the Governing Body, the Administrator, the Alternate Administrator, Clinical Manager/Supervising nurse, and Alternate Clinical Manager/Supervising Nurse, Nursing supervisors, and field staff providing care to the patients. Date the corrective action was implemented: 6/21/2024 Person responsible to implement the plan of correction: Administrator Monitoring Process: A quality improvement indicator has been developed to track this process and progress will be monitored through location QAPI meetings and reported through the Corporate QAPI Committee and the Governing Body. Effective compliance of this standard is evidenced by a compliance threshold of 100%. Methodology: The Administrator or Clinical Director will review the organizational chart to ensure current and accurate lines of authority on a quarterly basis as part of the QAPI process to ensure compliance. If at any point compliance falls below the threshold, then all appropriate administrative staff will be re-educated to ensure there is not a knowledge deficit and they understand the policy and standard. In addition, the frequency of audits will be increased as above until compliance is sustained.	
N0458	Home health agency administration/management 410 IAC 17-12-1(f)	N0458	It was identified there was a lack of education provided and/or lack of understanding by the internal staff regarding all staff are to receive an annual performance evaluation. The annual performance evaluation is filed in the individual’s personnel file.:	2024-07-03

	Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to include an annual performance evaluation for 4 of 5 home health aide (HHA) personnel files reviewed (HHA 2, HHA 6, HHA 7 and HHA 8) and 1 of 1 licensed practical nurse (LPN) personnel file reviewed (LPN 2). Findings include: 1. The review of the employee record for HHA 2 evidenced a hire date of 11/18/22. The personnel file failed to evidence an annual performance		Plan of Correcting the specific deficiency 1. Correction will be completed through mandatory staff in services to 100% of the internal staff by the Administrator and/or the Clinical Director regarding: a. All staff are to receive an annual performance evaluation. The annual performance evaluation is filed in the individual's personnel file. 2. A sign in sheet along with an acknowledgment form will be completed once education has been provided 3. Inservice education regarding all staff are to receive an annual performance evaluation. The annual performance evaluation is filed in the individual's personnel file and will be incorporated into the orientation process for all new hire internal staff. 4. The Administrator and/or the Area Support Manager will review 100% of personnel file /reports to ensure compliance with annual performance reviews. Any missing annual performance evaluations will be completed and filed in the individual's personnel file. 5. Home Health Aide #2: A performance Evaluation will be completed by 6/27/24 and filed in the Home Health Aide's personnel file. 6. Home Health Aide #6: A performance Evaluation will be completed by 6/27/24 and filed in the Home Health Aide's personnel file. 7. Home Health Aide #7: A performance Evaluation will be completed by 6/27/24 and filed in the Home Health Aide's personnel file. 8. Home Health Aide #8: A performance Evaluation will be completed by 6/27/24 and filed in the Home Health Aide's personnel file. 9. Licensed Practical Nurse #2: A performance Evaluation will be completed by 6/27/24 and filed in the Licensed Practical Nurse's personnel file. Date the corrective action will be completed	

	evaluation in the past year for HHA 2. 2. The review of the employee record for HHA 6 evidenced a hire date of 3/20/23. The personnel file failed to evidence an annual performance evaluation in the past year for HHA 6. 3. The review of the employee record for HHA 7 evidenced a hire date of 1/06/23. The personnel file failed to evidence an annual performance evaluation in the past year for HHA 7. 4. The review of the employee record for HHA 8 evidenced a hire date of 10/19/21. The personnel file failed to evidence an annual performance evaluation in the past year for HHA 8. 5. The review of the employee record for LPN 2 evidenced a hire date of 5/23/18. The personnel file failed to evidence an annual performance evaluation in the past year for LPN 2. 6. During an interview on 5/31/24 beginning at 10:58 AM, the Administrator relayed the		by: 07/03/2024 Person responsible to implement the plan of correction: Administrator and/or Clinical Director Monitoring Process: A quality improvement indicator has been developed to track the process and progress will be monitored through location QAPI meetings and reported up through the Corporate QAPI Committee and the governing body. Effective compliance with this standard is evidenced by a compliance threshold of 100%. Methodology: 10% of all personnel files will be reviewed monthly x 2 months to ensure compliance with annual performance evaluations. 10% of personnel files will be reviewed on a quarterly basis as part of the ongoing QAPI process to ensure ongoing compliance with annual performance evaluations. If at any point compliance falls below the threshold, then all appropriate internal operations/ clinical staff will be reeducated to ensure there is not a knowledge deficit.	

	personnel files for HHA 2, HHA 6, HHA 7, HHA 8 and LPN 2 were missing the annual performance evaluations. During an interview on 6/03/24 beginning at 1:45 PM, the Administrator relayed the home health agency did not have any further personnel file documents to submit to surveyor for review.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented:	N0464	Action Taken: It was identified there was a lack of education provided and/or lack of understanding of staff regarding baseline TB screening and TB screening policy and procedures. Plan of Correcting the specific deficiency 1. Correction will be completed through mandatory staff in services to 100% of Internal Staff by the Administrator and/or the AVP of Operations regarding: a. The Agency's Tuberculosis Infection Control Plan policy b. Specifically: All employees	2024-07-03

	(i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the home health agency failed to ensure all employees were screened for tuberculosis (TB, a contagious lung infection) upon hire for 1 of 2 home health aides (HHA) hired within the last year (HHA 9) and failed to ensure		exposure to TB, are screened upon hire and annually; based on state and Federal regulations, the organization's policy and ongoing assessment of TB exposure risk based on the population and/or community served c. A sign in sheet along with an acknowledgment form will be completed once education has been provided 2. Inservice education of All employees at risk for occupational exposure to TB, are screened upon hire and annually; based on state and Federal regulations, the organization's policy and ongoing assessment of TB exposure risk based on the population and/or community served will be incorporated into the orientation process for all new hire internal staff 3. The Area Support Manager will review 100% of active HR files to ensure evidence of TB screening. Any staff member with lack of documented evidence of TB screening, will complete a TB screening. The TB screening will be filed in the staff's personnel file.	

	all employees were screened for tuberculosis annually for 4 of 7 employees employee health files reviewed who have been employed at least 1 year (LPN 2, HHA 2, HHA 7 and HHA 8). Findings include: 1. The personnel health file for HHA 9 indicated a hire date of 7/23/23 and the employee's duties included direct patient contact. The employee's health file included a Tuberculin Skin Test (TST) test dated 7/01/23. The personnel health file for HHA 9 failed to evidence a 2-step TST had been performed upon hire. 2. The personnel health file for LPN 2 indicated a hire date of 5/23/18 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually.		4. Home Health Aide #9: The Home Health Aide had not completed a TB two step done, as this Home Health Aide has never worked and provided patient care for Aveanna and is currently on hold due to inactivity and unresponsiveness. 5. LPN #2: The LPN completed an annual screening for TB on 3/21/24. 6. Home Health Aide #2: The Home Health Aide completed an annual screening for TB on 6/21/24. 7. Home Health Aide #7: The Home Health Aide completed an annual screening for TB on 6/24/24. 8. Home Health Aide #8: The Home Health Aide completed an annual screening for TB on 5/20/24. 9. Home Health Aide #6: The Home Health Aide completed an annual screening for TB on 4/17/24. Date the corrective action will be completed by: 07/03/2024 Person responsible to	

	3. The personnel health file for HHA 2 indicated a hire date of 11/18/22 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 4. The personnel health file for HHA 7 indicated a hire date of 1/06/23 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 5. The personnel health file for HHA 8 indicated a hire date of 10/19/21 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 6. During an interview on 6/03/24 beginning at 1:45 PM, the Administrator relayed the employee health files for HHA 2, HHA 6, HHA 7, HHA 8 and LPN 2 were missing the annual TB screening and indicated HHA 9 did not receive the 2-step TB test that was required upon hire.		correction: Administrator and/or the Area Support Manager Monitoring Process: A quality improvement indicator has been developed to track this process and progress will be monitored through location QAPI meetings and reported through the Corporate QAPI Committee and the Governing Body. Effective compliance of this standard is evidenced by a compliance threshold of 100%. Methodology: 100% of personnel files will have documentation of tuberculosis screening. The Administrator and/or the Area Support Manager will review 100% of current personnel files to ensure no further noncompliance. Then all new hire personnel files will be reviewed monthly x2 and then 10% of active employee personnel files will be reviewed on a quarterly basis as part of the QAPI process to ensure compliance. If at any point compliance falls below the threshold, then all appropriate internal staff will be reeducated to ensure there is not a knowledge deficit and they understand the policy and standard. In addition, the	

	During an interview on 6/03/24 beginning at 1:45 PM, the Administrator relayed the home health agency did not have any further personnel file documents to submit to surveyor for review.		frequency of audits will be increased as above until compliance is sustained.	
N0490	Q A and performance improvement 410 IAC 17-12-2(k) Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the agency failed to provide a good faith effort to provide home health aide services during the 15 days prior to discharge for 1 of 1 patient with a 15 day notice of discharge (Patient #8). Findings include: A review of the clinical record for Patient #8, certification	N0490	Action Taken: It was identified there was a lack of education provided and/or lack of understanding of staff regarding the requirement the agency must continue, in good faith, to attempt to provide services during the fifteen (15) day discharge notice. If the agency cannot provide such services during this period, its continuing attempts to provide the services must be documented Plan of Correcting the specific deficiency 1. Correction will be completed through mandatory staff in services to 100% of Internal Staff by the Administrator and/or the RVP of Operations regarding: the agency must continue, in good faith, attempt to provide services during the fifteen (15) day period prior to	2024-06-28

	evidenced a plan of care (POC) which included orders for a home health aide (HHA) 2 – 3 hours per day, 4 -5 days per week to provide bathing, dressing, grooming, and transfers to wheelchair prior to the patient leaving for school. The clinical record evidenced a letter from the Administrator which notified Patient #8's parent that home health aide services would be discontinued on 5/16/2024 as it was determined Patient #8 developed a wound on the back. The letter indicated the agency did not have the ability to provide wound care and the patient would be discharged on 5/30/2024. Patient #8 received no aide services since 5/15/2024. During an interview on 5/30/2024 at 3 PM, the Administrator and Clinical Manager indicated they removed the aide once they discovered Patient #8 had a wound. They indicated Patient #8's family and parent took over the daily care. During an interview on 5/31/2024 at 9:38 AM, Patient		discharge and if the agency cannot provide such services during that time period, the continued attempts to provide the services are documented in the patient's medical record. 2. A sign in sheet along with an acknowledgment form will be completed once education has been provided 3. Inservice education of the agency must continue, in good faith, attempt to provide services during the fifteen (15) day period prior to discharge and if the agency cannot provide such services during that time period, the continued attempts to provide the services are documented in the patient's medical record will be incorporated into the orientation process for all new hire internal staff. 4. The Administrator will review active patient records to identify any patients with a fifteen (15) day discharge notice for documented evidence of attempts to provide continued services during the discharge notice. 5. Patient #8: The patient was discharged on 5/30/2024 and	

	#8's parent indicated they took over the patient's care and it interfered with their work.		we were not able to make corrections. Date the corrective action will be implemented: 6/28/2024 Person responsible to implement the plan of correction: Administrator and/or Clinical Director Monitoring Process: A quality improvement indicator has been developed to track this process and progress will be monitored through location QAPI meetings and reported through the Corporate QAPI Committee and the Governing Body. Effective compliance of this standard is evidenced by a compliance threshold of 100%. Methodology: The Administrator and/or the Area Support Manager will review 100% of any pending discharge patient records to ensure ongoing compliance with a good faith effort to continue to provide services during the fifteen (15) day notice monthly x3 months. Then 10% of discharge patient medical records will be reviewed on a quarterly basis as part of the	

			QAPI process to ensure compliance. If at any point compliance falls below the threshold, then all appropriate internal staff will be reeducated to ensure there is not a knowledge deficit and they understand the policy and standard. In addition, the frequency of audits will be increased as above until compliance is sustained.	
N0586	Scope of Services 410 IAC 17-14-1(h) Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy	N0586	Action Taken: It was identified there was a lack of education provided and/or lack of understanding of staff regarding the requirement that the aides participate in at least 12 hours of in-service training during each 12-month period Plan of Correcting the specific deficiency 1. Correction will be completed through mandatory staff in services to 100% of Internal Staff and Home Health Aides by the Administrator and/or the Clinical Director regarding: a. The requirement that the aides participate in at least 12 hours of in-service training	2024-07-03

environment.

(7) Recognizing emergencies and knowledge of emergency procedures.

(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.

(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:

(A) Bed bath.

(B) Bath; sponge, tub or shower.

(C) Shampoo, sink, tub, or bed.

(D) Nail and skin care.

(E) Oral hygiene.

(F) Toileting and elimination.

(10) Safe transfer techniques and ambulation.

(11) Normal range of motion and positioning.

(12) Adequate nutrition and fluid intake.

(13) Medication assistance.

(14) Any other task that the home health agency may choose to have the home health aide perform.

Based on record review and interview, the home health agency failed to maintain continuing education hours for 2 of 2 home health aide (HHA) personnel files reviewed with a hire date greater than 12 months ago (HHA 6 and HHA 7).

Findings include:

during each 12-month period using the agency's electronic learning platform.

2. A sign in sheet along with an acknowledgment form will be completed once education has been provided

3. Inservice education of the requirement that the aides participate in at least 12 hours of in-service training during each 12-month period using the agency's electronic learning platform will be incorporated into the orientation process for all new hire internal staff and Home Health Aide staff.

4. Home Health Aide #6: The Home Health Aide has been assigned 12 hours of continuing education and completed them on 5/14/2024.

5. Home Health Aide #7: The Home Health Aide has been assigned 12 hours of continuing education and completed them on 6/5/2024.

6. All home health aides were assigned the 12 hours of CEU learning modules in the agency's electronic learning platform. 100% of Home Health Aide personnel files were

	1. The personnel record for HHA 6 evidenced a hire date of 3/20/23. The personnel record failed to evidence continuing education hours. 2. The personnel record for HHA 7 evidenced a hire date of 1/06/23. The personnel record failed to evidence continuing education hours. 3. During an interview on 5/31/24 beginning at 12:02 PM, the Administrator indicated they would contact Entity I to obtain continuing education transcripts. During an interview on 6/03/24 beginning at 1:25 PM, the Administrator indicated they were unable to provide any further continuing education documents for HHA 6 and HHA 7.		reviewed to identify progress towards completion status of the required 12 hours CEUs in a 12-month period. This review will occur monthly through audit of the electronic learning system to ensure progress towards completion by all home health aides. In addition, all Home Health Aides were re-educated of the requirement to complete 12 hours of CEUs in a 12-month period. Date the corrective action will be completed by: 07/03/2024 Person responsible to implement the plan of correction: The Administrator and/or Clinical Director Monitoring Process: A quality improvement indicator has been developed to track the process and progress will be monitored through location QAPI meetings and reported up through the Corporate QAPI Committee and the governing body. Effective compliance with this standard is evidenced by a compliance threshold of 100%. Methodology: 100% of all home	

			and complete at least 12 hours of in- service training on the company platform during each 12-month period. To ensure ongoing compliance, 100% of home health aide training logs will be reviewed on a quarterly basis as part of the ongoing QAPI process to ensure all training is being assigned and completed. If at any point compliance falls below the threshold, then all appropriate internal staff and home health aides will be reeducated to ensure there is not a knowledge deficit.	

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
Clayton Blackwell	Executive Director/Administrator	7/2/2024 8:53:15 AM