STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300008080	A. BUILDING B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYADA PEDIATRICS	6351 CONSTITUTION DRIVE, FORT WAYNE, IN, 46804

(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 Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: 9/28, 9/29, 10/3, 10/4, and 10/5/2022 Census: 30 At this Emergency Preparedness survey, Bayada Pediatrics was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102 QR: Area 2 10/06/22	E0000		2022-11-18
G0000	INITIAL COMMENTS This visit was for Federal Recertification and State Re-licensure survey of a home	G0000		2022-11-18

	health agency provider in conjunction with a Federal complaint. A fully Extended Survey was announced to the Alternate Administrator on 10/04/2022 at 3:43PM. Facility ID: 014153 Survey Dates: 09/28/2022, 09/29/2022, 10/03/2022, 10/04/2022, and 10/05/2022 Complaint #: 93745 - Substantiated. Federal deficiencies related to the allegation were cited. Census: 30 QR: Area 2, 10/07/22			
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on record review and interview, the agency failed to ensure they provided patients with the current administrator's name	G0414	**G0414** **HHA administrator contactinformation** Based on an analysis of thespecific deficiencies cited, the corrective plan and actions taken are toaddress the lack of demonstrated knowledge resulting in failure to identify thecorrect/current administrator	2022-11-01

	and contact information in order to receive complaints, with the potential to affect all current patients. Findings include: During the entrance conference, on 9/28/2022, the Alternate Administrator indicated Person #1's last date as administrator was July 29, 22 and Corporate Person 1 was the current administrator. Review of the patient admission packet, provided by the agency on 9/28/22, failed to evidence the current administrator's name to receive complaints. The admission packet included a document titled "Client Comment Form with Hotline," dated 10/2018, and listed Person 1 as the administrator. A separate page in the patient admission binder was titled "Office Information Sheet" and identified Corporate Person 1 as the Administrator. Review of the agency information in the Internet Quality Improvement and Evaluation System (iQIES) identified Person 1 as the current administrator. During an interview on 10/5/22		with name and contact information. The plan ofcorrection will be completed through comprehensive focused education. The client comment form wasupdated with the Administrator and approved by the Governing Body on 10/06/2022. The office information sheet wasupdated on 10/25/2022 to include the name and contact information of thecurrent Administrator. The appointment of the Administratorwas submitted to the state on 10/28/2022. On 10/14/2022, the Manager ofRegulatory Support and Guidance provided education for all office staff onfollowing: · Office responsibility for maintainingkey designations and communicating to the appropriate entities when there	

	at 9 AM, Administrative Staff 2 indicated the "Office Information Sheet" was a "sample" and Corporate Person 1 must have placed the information sheet in the front of the binder.		is avacancy/change in designations, · The role of the Regulatory Support andGuidance office to review the resumes for all personnel being considered for akey designation to ensure qualifications are sufficient, · The appointment process for designatedroles, i.e. Administrator / Alternate Administrator, including the Agencies GoverningBody (Board of Trustees) approval and submission of persons for approval viathe Regulatory Support and Guidance office and Credentialing Office, Education also included a reviewof the role of the administrator as per *Administrator Position DescriptionSupplement – Indiana, 0-9625* as well as the Agency specific organizationalchart. Effective 11/1/2022, the Regional Director/Designeewill review monthly the organization structure of the office to ensure theappropriate personnel are in	

			Administrator,Alternate Administrator, Supervising RN, and Alternate Supervising RN. Anydiscrepancies i.e., vacancies/potential vacancies, will be identified and theappropriate communication to the State and the Organization Credentialing andRegulatory office and the process to fill the vacancy will be initiated. The Regional Director has overallresponsibility for the implementation and oversight of the plan.	
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure all patients received a complete comprehensive assessment which included the patient's strengths, care preferences, and goals with measurable outcomes for 7 of 10	G0530	**G530** **Strengths, goals, and care preferences** Based on an analysis of the specific deficiencies cited,the corrective plan and actions taken are to address the lack of demonstratedknowledge resulting in failure to complete a comprehensive assessment whichincluded the client's strengths and care preferences as well asprogress towards goals and measurable	2022-11-18

	patient records reviewed (Patient #1, 2, 3, 4, 5, 7, 8). Findings include: Clinical record review for Patient #1, start of care [SOC] date 7/2/2018, included a plan of care [POC] for the certification period 8/11/22 to 10/09/22, that included a "Pediatric Nursing Assessment" dated 8/5/22. That section included instructions "Client strengths, care preferences, including goals …." The assessment identified strengths and goals but failed to identify any care preferences. Review of the clinical record for Patient #5, start of care date 4/30/2020, certification period 8/18/2022 – 10/16/2022, evidenced a "Pediatric Nursing Assessment" with an assessment date of 9/9/2022. The assessment evidenced a section for client goals, strengths, and care preferences. That section included instructions "Client strengths, care preferences, including goals …." The assessment		outcomes. The plan of correction will becompleted through comprehensive focused education. Patient #1 – The plan of care associated with patientrecord #1 will be reviewed and updated as needed at the nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes the client'sstrengths and care preferences as identified by the Agency and client, as wellas goals with measurable outcomes. Patient #2 - The plan of care associated with patientrecord #2 will be reviewed and updated as needed at the nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes theclient's strengths and care preferences as identified by the Agency and client,as well as goals with measurable outcomes.	

	identified strengths and goals but failed to identify any care preferences. Review of the clinical record for Patient #7, start of care date 12/6/2021, certification period 6/4/2022 – 8/2/2022, evidenced a "Pediatric Nursing Assessment" with an assessment date of 5/31/2022. The assessment evidenced a section for client goals, strengths, and care preferences. That section included instructions "Client strengths, care preferences, including goals …." The assessment identified a goal but did not address strengths or preferences. During an interview on 10/4/2022 at 3:17 PM, when queried about the location of patient preferences in the assessment, the Alternate Administrator indicated the preferences are on the last page of the assessment. The		Patient #3 - The plan of care associated with patientrecord #3 will be reviewed and updated as needed at the nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes theclient's strengths and care preferences as identified by the Agency and client,as well as goals with measurable outcomes. Patient #4 - The plan of care associated with patientrecord #4 will be reviewed and updated as needed at the nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes theclient's strengths and care preferences as identified by the Agency and client,as well as goals with measurable outcomes. Patient #5 - The plan of care associated with patientrecord #5 will be reviewed and updated as needed at the	

	assessments did not contain care preferences. Clinical record review for Patient #2, start of care date 02/02/2021, for certification period 07/27/2022 – 09/24/2022, included an agency document titled "Pediatric Nursing Assessment 802" dated 07/26/2022 that indicated "… reason for assessment … reassessment … client goals … and measurable outcomes … tracheostomy decannulation (removal of an opening created at the front of the neck so a tube can be inserted into the windpipe to help with breathing) and once healed work more toward overcoming oral aversion (strongly dislikes or is afraid of anything touching the mouth) … work on eating by mouth …." The assessment failed to evidence goals with measurable outcomes that include details on how to measure progress. During an interview on 10/04/2022 at 3:17PM, when asked if the goal outcome was		nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes theclient's strengths and care preferences as identified by the Agency and client,as well as goals with measurable outcomes. Patient #7 - The plan of care associated with patientrecord #7 will be reviewed and updated as needed at the nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes theclient's strengths and care preferences as identified by the Agency and client,as well as goals with measurable outcomes. Patient #8 - The plan of care associated with patientrecord #8 will be reviewed and updated as needed at the nextassessment/reassessment or within 30 days of receipt of the statement ofdeficiencies, which is November 18th , to ensure it includes theclient's strengths and care preferences	

	administrator / clinical supervisor indicated it was measurable with wound healing and with eating by mouth. Clinical record review for Patient #3, start of care date 02/27/2018, for certification period 08/05/2022 – 10/03/2022, included an agency document titled "Pediatric Nursing Assessment 802" dated 08/01/2022 that indicated "… reason for assessment … reassessment … client goals … and measurable outcomes … mechanical lift in home environment by next certification period …." The assessment failed to evidence goals with measurable outcomes that include details on how to measure progress. During an interview on 10/04/2022 at 3:17PM, when asked if the goal outcome was measurable, the alternate administrator / clinical supervisor indicated in the next certification period would follow up to see if the lift is in patient's home.		as identified by the Agency and client,as well as goals with measurable outcomes. By 11/18/2022, the remainder of the active clients forthis Agency will have their plan of care reviewed by the Manager of ClinicalOperations/designee and updated as needed to include the client's strengths andcare preferences as identified by the Agency and client, as well as goals withmeasurable outcomes. On 11/2/2022, policy *Client Assessment andReassessment, 0-988* was reviewed by the Director of Policy Development and Accreditation Support/designee andthe Director of Regulatory Support and Guidance. It was determined the policyreflects Condition of Participation 484.55(c)(2) and the required contents ofthe comprehensive assessment, including information that may be used todemonstrate the patient's progress toward achievement of the goals identifiedby the	

	Clinical record review for Patient #4, start of care date 01/25/2022, for certification period 09/22/2022 – 11/20/2022, included an agency document titled "Pediatric Nursing Assessment 802" dated 09/12/2022 that indicated "… reason for assessment … reassessment … client goals … and measurable outcomes … continue to increase rate of formula with a long-term goal of working off of HS (bedtime) feed …." The assessment failed to evidence goals with measurable outcomes that include details on how to measure progress. During an interview on 10/04/2022 at 3:17PM, when asked if the goal outcome was measurable, the alternate administrator / clinical supervisor indicated it was measurable by comparing the bedtime feeding from this visit to the last visit to see if it decreases. Clinical record review for Patient #8, start of care date		patient and the measurable outcomes identified by the Agency. By 11/11/2022, all office staffwill be educated by the Director of Clinical Operations on the requiredcomponents of the comprehensive assessment and completing it as per policy *ClientAssessment and Reassessment, 0-988,* which includes the requirement for patient'sstrengths, care preferences, and goals with measurable outcomes to bedocumented. Effective 11/14/22 for 3 months, the Director of ClinicalOperations/Designee will review weekly the records of 100% new admissions andclients due for recertification to ensure the plan of care includes client'sstrengths, care preferences, and goals with measurable outcomes identified bythe Agency and client. The expected compliance threshold will be 100%. Failureto achieve 100% will be addressed through focused education with the individualstaff members by the Director/designee. Sustained improvement will be monitoredthrough quarterly clinical record reviews conducted as a required component ofthe Organization's Quality	

	period 08/27/2022 – 10/25/2022, included an agency document titled "Pediatric Nursing Assessment 802" dated 08/18/2022 that indicated "… reason for assessment … reassessment … client goals … and measurable outcomes … increase PO (by mouth) food and decrease GT (gastrostomy tube into the stomach) feedings …." The assessment failed to evidence goals with measurable outcomes that include details on how to measure progress. During an interview on 10/04/2022 at 3:17PM, when asked if the goal outcome was measurable, the alternate administrator / clinical supervisor indicated in the 30 day period of time would evaluate whether to increase or decrease GT feedings.		Assurance and Performance Improvement program. The Director has overall responsibility for theimplementation and oversight of the plan.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed	G0572	**G0572** **Plan of Care (care provided by a nurse instead of theprimary caregiver)** Based on an analysis of the specific deficiencies cited,the corrective plan and actions	2022-11-14

	by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the patient received the services ordered on the Plan of Care in 1 of 5 active patient records reviewed (#1). Findings include: 1. Review of an agency policy "0-945 Client Care Plan" revised on 7/5/2021, indicated the plan of care content include, but not limited to "... statement of individualized client needs ... notation of specific services to be provided ..." and "... level and frequency of care to be delivered ...." 2. Review of an agency policy "0-6277 Missed Visits/ Hours" revised 8/2/2021, indicated the agency standard was to "... consistently deliver expected services." 3. Review of the clinical record for Patient #1, identified diagnoses including, but not limited to, a chronic respiratory disorder which required a		taken are to address the lack of demonstratedknowledge resulting in failure to ensure the patient received services asordered on the plan of care. The plan of correction will be completed throughfocused education. In an effort to meet thecontinuing care needs of client #1, the following actions were taking/are inprocess: · Two qualified nurses were hired– one was declined by the family and the second found employment elsewhere and discontinuedworking with this Agency. · The Agency has been activelyrecruiting, utilizing all strategies including the Nurse Residency Program and payincentives (i.e., sign-on bonus). · Continuing efforts including employmentads posted regularly to various media sites to find qualified, licensed staff. · Weekly discussions with Agencystaff and status updates	

	tracheostomy and ventilator (an opening in the trachea with tubes attached to a machine to breathe for the patient) and Prader – Willi syndrome (a genetic condition with symptoms of weak muscles, poor feeding, slow development, and a feeling of constant hunger), which required tube feedings (liquid nutrition supplied through a tube placed into the stomach). The record evidenced a plan of care for certification period 8/11/22 to 10/09/22, with orders for skilled nursing services 8 – 10 hours per day, 3 – 5 days per week and an additional 20 hours per month of respite nursing (care provided by a nurse instead of the primary caregiver). Review of the nurse visits for Patient #1's for the time frame of 8/11 to 9/23/22, identified missed skilled nurse visits on 9/6, 9/7, 9/9, 9/13, 9/14, 9/15, 9/16, 9/19, 9/20, 9/21, 9/22, and 9/23/2022. The minimal number of visits, 3 per week, were not provided during the weeks of 9/4 through 9/10, 9/11 through 9/17, and 9/18 through 9/23/2022.		related to current staffing needs and open shifts, · Offer to the client's mother topursue alternate staffing options. The above recruiting effortsdemonstrate a comprehensive approach to continuously address all staffing needsidentified in the Agency. By 11/18/2022, the plans of carefor all active clients will be reviewed by the Manager of ClinicalOperations/designee to ensure care is being provided at the appropriate levelbased on client need and physician orders. For any client identified whosestaffing frequency is not being met, a case conference will be conducted toidentify all alternative options for staffing. By 11/11/22, the Director ofClinical Operations/Designee will educate all Clinical Managers on client careplan with emphasis on writing orders that accurately document the	

	4. During an interview on 9/29/22 at 9 AM, the Clinical Supervisor indicated Patient #1 was transported to / from and attended school Monday through Friday, when a nurse was available; the nurse went to school, with the patient, and remained throughout the day. Patient #1 did not attend school on 9/6, 9/7, 9/9, 9/13, 9/14, 9/15, 9/16, 9/19, 9/20, 9/21, 9/22, and 9/23/22; there was no nurse available for the visits. 5. During an interview on 10/3/22 at 12:20 PM, the Alternate Administrator confirmed Patient #1 had missed visits due to no staff available and therefore Patient #1 did not attend school. The Alternate Administrator indicated the agency had recruited a nurse to provide care to Patient #1, however, the services had not yet started. 410 IAC 17 - 13 - 1(a)		frequency andduration of services. By 11/11/22, the Director ofClinical Operations/Designee will educate all Clinical Managers on thefollowing: · Policy *Admission Criteria andProcedure – Medicare Certified Offices, 0-672* with emphasis on therequirement to only accept client whose staffing needs can be met. · Policy *Client Assessment andReassessment, 0-988* and the process to develop an individualized plan ofcare in conjunction with the physician that reflects the care and servicesneeded by the client based on the comprehensive assessment. · Policy *Client Care Plan,0-945* with emphasis on the requirement for all actions and interventions tobe consistent with the plan of care and physician orders. · The need to routinely reviewcare and services provided to each client as part	

			tocommunicate and document in a timely fashion with the client/family andphysician when services are not provided as indicated on the plan of care,including when there are missed shifts/hours. Effective 11/14/2022, the Director/designee will reviewweekly the effectiveness of recruitment and staffing strategies. Also effective11/14/2022, the Director/designee will review weekly the records of all clientswith missed shifts/hours to ensure the client/family and the physician havebeen notified when care/services are not provided in accordance as indicated onthe plan of care, and to pursue alternative staffing options. The expectedcompliance threshold will be 100%. Failure to achieve 100% will be addressedthrough focused education with the individual staff members by theDirector/designee. Sustained improvement will be monitored through quarterlyclinical record reviews conducted as a required component of the Organization'sQuality Assurance	

			and Performance Improvement program. The Director has overall responsibility for theimplementation and oversight of the plan.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.	G0574	**G0574** **Plan of Care must include the following** Basedon an analysis of the specific deficiencies cited, the corrective plan andactions taken are to address the lack of demonstrated knowledge resulting infailure to complete required components of the client care plan, specifically relatedto nutrition orders. Theplan of correction will be completed through comprehensive focused education. Patient #1 - The plan of care associated with clientrecord #1 was updated. The nutrition orders were clarified on	2022-11-14

	(xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure patients' plan of care included (but not limited to) nutrition orders for 3 of 7 active records reviewed (Patient's #1, 2, and 4). Findings include: Review of the clinical record for Patient #1 included a Plan of Care [POC] for certification period 8/11/22 to 10/09/22, that included a nutritional requirement section that stated "... Honey thick all liquids [use of a thickening agent to a consistency of honey]." The POC stated, "... Feeding orders: nectar thickened liquids [slightly less thick than honey] to be utilized PRN [as needed] only for S/S [signs/ symptoms] of aspiration [food or liquid gets into the airway]." During an interview on 10/4/2022, the Alternate Administrator confirmed the instructions were contradictory and nectar thickened liquids		10/7/2022. Patient #2 - The plan of care associated with clientrecord #2 was updated. The nutrition orders were clarified on 10/4/2022. Patient#4 - The plan of care associated with client record #4 was updated. Thenutrition orders were clarified on 10/4/2022. By 11/18/2022, the remainder of the active clients withnutrition orders will have their orders reviewed by the Manager of ClinicalOperations/designee to ensure they contain all required components. By11/11/2022, the Director of Clinical Operations/Designee will re-educate alllicensed clinicians who are responsible for developing client care plans on theelements of a complete care plan and policies *Client Care Plan 0-945* and*Physician*	

	PRN was Patient #1 correct information. 410 IAC 17 - 13 - 1(viii) Review of an agency policy with revised date of 07/05/2021 and titled "0-945 Client Care Plan" indicated "… the client plan of care includes … nutritional requirements …." Record review for Patient #2 for certification periods 07/27/2022 – 09/24/2022 and 09/25/2022 – 11/23/2022 contained an agency documents titled "Home Health Certification and Plan of Care" that indicated "… Nutritional req (requirement) … NPO (takes nothing by mouth) … alteration in nutritional status R/T (related to) gastrostomy (tube inserted through the belly that brings nutrition directly to the stomach) status and feeding difficulties … feeding orders: PO (eats by mouth) bites/tastings/sips … as tolerated …." Record review for Patient #4 for certification period 07/24/2022 – 09/21/2022 contained an		*Orders, 0-983* with emphasis on required components of a nutritionorder. Effective 11/14/2022 for 3 months, the Director of ClinicalOperations/Designee will review weekly the records of 100% new admissions andclients due for recertification to ensure care plans with nutrition orders includethe required components. The expected compliance threshold will be 100%.Failure to achieve 100% will be addressed through focused education with theindividual staff members by the Director/Designee. Sustained improvement willbe monitored through quarterly clinical record reviews conducted as a requiredcomponent of the Organization's Quality Assurance and Performance Improvementprogram. TheDirector has overall responsibility for the implementation and oversight of theplan	

	agency document titled "Home Health Certification and Plan of Care" that indicated "... Nutritional req ... NPO ... alteration in nutritional status R/T dysphagia (difficulty swallowing) and feeding difficulties with GT (gastrostomy tube) dependence ... feeding orders: start PO tastes as tolerated during the day ... give 1-3 tsp per setting ... no max amount ...." Record review for certification period 09/22/2022 – 11/20/2022 contained an agency document titled "Home Health Certification and Plan of Care" that indicated "... Nutritional req ... NPO ... alteration in nutritional status R/T dysphagia and feeding difficulties with GT dependence ... feeding orders: may provide feedings pureed baby food ... may remove 90 mls (milliters) for each 4-ounce PO feed ...." During an interview on 10/03/2022 at 12:20PM, when asked if NPO is the correct nutrition plan of care order for Patient #2, the alternate			

	administrator / clinical supervisor indicated no because the feeding orders clarify what patient can have by mouth. When asked if NPO is the correct nutrition plan of care order for Patient #4, the alternate administrator / clinical supervisor indicated NPO is an error.			
G0856	Officer, a director, agent, managing employee 484.100(a)(2) The name and address of each person who is an officer, a director, an agent, or a managing employee of the HHA as defined in §420.20l, §420.202, and §420.206 of this chapter. Based on record review and interview, the agency failed to notify the state agency, Indiana Department of Health [IDOH] of the vacancy position of the Administrator position, on or about the time of the departure from the position on 7/29/22, for 1 of 1 vacancy of an agency's management position. Findings include: During the entrance conference on 9/28/22, the Alternate Administrator identified Corporate Person 1 was the Administrator; the alternate	G0856	**G0856** **Officer, a director agent, managingemployee** Based on an analysis of thespecific deficiencies cited, the corrective plan and actions taken are toaddress the lack of demonstrated knowledge resulting in failure to notify thestate on the vacancy of the Administrator position. The plan of correction willbe completed through comprehensive focused education.	2022-11-01

	#1's last day as the administrator was 7/29/22. The agency was asked for evidence that they relayed the change in the administrator position to the IDOH; the agency failed to provide evidence, by survey exit, that the IDOH was notified of the administrator vacancy, nor that Corporate Person #1 was the current administrator. Review of the agency information in the Internet Quality Improvement and Evaluation System (iQIES) identified Person 1 as the current administrator. Review of the patient admission folder identified Person 1 as the administrator. Review of the "Office Information Sheet," provided to patients as part of the admission binder, identified Corporate Person 1 as the current administrator. Review of Governing Body meeting minutes failed to evidence the appointment of an administrator, other than Person 1 in 2018. During an interview on		The appointment of the new Administratorwas approved by the Governing Body on 10/6/2022 and notification submitted tothe state agency, Indiana Department of Health, on 10/28/2022. The office information sheet wasupdated to include the name and contact information for the current Administratoron 10/25/2022.	

	Alternate Administrator and Client Services Manager identified Corporate Person 1 as the alternate administrator. During an interview on 10/4/2022 at 3:17 PM, the Alternate Administrator indicated Corporate Person 1 was not the Administrator for the agency. The Alternate Administrator confirmed the Governing Body did not designate an Administrator in writing, but will do so at the next meeting. 410 IAC 17 - 10 - 1(d)(2)(D)		On 10/14/2022, the Manager of RegulatorySupport and Guidance provided education for all office staff on the role of theCredentialing office in reporting changes in designated administration and theneed to notify the Credentialing office if/when there is vacancy or change inthe Administrator position in order for the state agency to be notified of the vacancyor change. Education also included review of Indiana State regulation 410 IAC17 - 10 - 1(d)(2)(D) and the requirement for the state agency to be notifiedwhen there is a vacancy or change in Administrator. Effective 11/1/2022, the RegionalDirector/Designee will review monthly the organization structure of the officeto ensure the appropriate personnel are in the designated roles, i.e.,Administrator, Alternate Administrator, Supervising RN, and AlternateSupervising RN. Any discrepancies i.e., vacancies/potential vacancies, will beidentified and the appropriate communication to	

			OrganizationCredentialing and Regulatory office and the process to fill the vacancy will beinitiated. The Regional Director has overallresponsibility for the implementation and oversight of the plan.	
G0946	Administrator appointed by governing body 484.105(b)(1)(i) (i) Be appointed by and report to the governing body; Based on record review and interview, the agency failed to ensure the administrator was appointed by and reported to the governing body for 1 of 1 agency. Findings include: During the entrance conference on 9/28/22, the Alternate Administrator identified Corporate Person 1 was the Administrator; relayed Person #1's last day as the administrator was 7/29/22. The	G0946	**G0946** **Administrator appointed by governingbody** Based on an analysis of thespecific deficiencies cited, the corrective plan and actions taken are toaddress the lack of demonstrated knowledge resulting in the failure to appointthe Administrator by the Governing Body. The plan of correction will becompleted through comprehensive focused education. The appointment of the newAdministrator was approved by the Governing Body on	2022-11-01

	agency was asked for evidence that they relayed the change in administrator position to the IDOH; the agency failed to provide this evidence, by survey exit. Review of the agency information in the Internet Quality Improvement and Evaluation System (iQIES) identified Person 1 as the current administrator. Review of the patient admission folder identified Person 1 as the administrator. Review of the "Office Information Sheet," provided to patients as part of the admission binder, identified Corporate Person 1 as the current administrator. Review of Governing Body meeting minutes failed to evidence the appointment of an administrator, other than Person 1 in 2018. During an interview on 10/3/2022 at 9:40 AM with the Alternate Administrator and Client Services Manager		notificationsubmitted to the state agency, Indiana Department of Health, on 10/28/2022. The office information sheet wasupdated to include the name and contact information for the currentAdministrator on 10/25/2022. On 10/14/2022, the Manager ofRegulatory Support and Guidance provided education for all office staff onfollowing: · Office responsibility for maintainingkey designations and communicating to the appropriate entities when there is avacancy/change in designations, · The role of the Regulatory Support andGuidance office to review the resumes for all personnel being considered for akey designation to ensure qualifications are sufficient, · The appointment process for designatedroles, i.e. Administrator / Alternate Administrator, including the	

	the alternate administrator. During an interview on 10/4/2022 at 3:17 PM, the Alternate Administrator indicated Corporate Person 1 was not the Administrator for this agency and the Governing Body did not designate an Administrator in writing, as of this date. Review of an undated and untitled document, submitted on 09/28/2022 by the client services manager, who indicated it was the agency's organizational chart. The top center box indicated the board of trustees followed below by the following positions with names of personnel outside of the agency as president/CEO, group president, practice president, regional director, and division director. The box below division director, indicated the alternate administrator / clinical supervisor was the agency's administrator. The document indicated the administrator reports to corporate staff 1. The document failed to evidence the administrator reported to the governing body.		AgenciesGoverning Body (Board of Trustees) approval and submission of persons forapproval via the Regulatory Support and Guidance office and CredentialingOffice, · Indiana regulations 410 IAC 17-9-2 and410 IAC 17-12-1 and Medicare Condition of Participation 484.105 with emphasison Administrator requirements and Governing Body approval. Education also included a reviewof the role of the administrator as per *Administrator Position DescriptionSupplement – Indiana, 0-9625* as well as the Agency specific organizationalchart. Effective 11/1/2022, the RegionalDirector/Designee will review monthly the organization structure of the officeto ensure the appropriate personnel are in the designated roles, i.e.,Administrator, Alternate Administrator, Supervising RN, and AlternateSupervising RN. Any discrepancies i.e., vacancies/potential vacancies,	

	Review of an agency policy with revised date of 08/15/2022 and titled "0-523 Ownership, Governance, and Administration" indicated "... the governing body (board of trustees) is responsible for ... appointing a qualified administrator and designated back-up administrator (Medicare Certified Offices) ... the board of trustees has established the appointment committee of the organization to make interim or time-sensitive appointments of qualified administrators, alternate administrators ... with counter-approval by the Board ...." Review of the alternate administrator / clinical supervisor personnel file on 10/03/2022, indicated agency job description documents titled "Clinical Manager I and II Home Care / Clinical Educator" signed and dated 05/10/2021 and "Alternate Administrator" signed and dated 10/24/2018. Alternate administrator / clinical		appropriate communication to the State and the OrganizationCredentialing and Regulatory office and the process to fill the vacancy will beinitiated. The Regional Director has overallresponsibility for the implementation and oversight of the plan.	

	to evidence a signed job description for administrator. Review of governing body minutes dated 09/01/2022 and 08/04/2022 indicated "... motions / action items ... upon motion and seconded, the appointment of the individuals recommended to serve as Administrators, Alternate Administrators ... was unanimously approved ...." These documents failed to evidence the approval for appointment of an administrator for this agency. During the entrance conference on 09/28/2022 at 9:40AM, when asked who the administrator of the agency was, the alternate administrator / clinical supervisor indicated it was corporate staff 1. When asked who the alternate administrator of the agency was, the alternate administrator / clinical supervisor indicated it was herself / himself. During an interview on			

	10/03/2022 at 9:40AM, when asked who the administrator of the agency was, the alternate administrator / clinical supervisor and the client services manager indicated it was the alternate administrator / clinical supervisor. When asked who the alternate administrator of the agency was, the alternate administrator / clinical supervisor and the client services manager indicated it was corporate staff 1. During an interview on 10/03/2022 at 12:20PM, when asked why the alternate administrator / clinical supervisor and client services manager indicated corporate staff 1 was alternate administrator, the client services manager indicated the last date of work for person 1 as administrator was 07/29/2022 and had spoken with the corporate policy department and person 1 was listed as administrator and the alternate administrator / clinical supervisor was listed as alternate administrator. Client			

	alternate administrator / clinical supervisor was acting as administrator because the administrator was not available. During an interview on 10/04/2022 at 3:17PM, when asked why on 09/28/2022 at the entrance conference the agency indicated the administrator was corporate staff 1 and the alternate administrator was the alternate administrator / clinical supervisor and on 10/03/2022 when asked the same question, the agency indicated the administrator was the alternate administrator / clinical supervisor and the alternate administrator was corporate staff 1, the client services manager indicated had clarified that point and person 1 was listed as administrator, the alternate administrator / clinical supervisor was the acting administrator and corporate staff 1 was never the administrator. When asked for the governing body written appointment and approval of the alternate administrator / clinical supervisor as administrator, the alternate administrator / clinical			

	supervisor indicated was the acting administrator so was automatically the administrator. IAC 17-12-1(b)(1)			
G0954	Ensures qualified pre-designated person 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview, the agency failed to ensure there was a qualified, pre-designated individual appointed in writing by the governing body to act in the administrator's absence for 1 of 1 agency. The findings include: Review of an agency policy with revised date of 08/15/2022 and titled "0-523 Ownership,	G0954	**G0954** **Ensures qualified pre-designated person** Based on an analysis of thespecific deficiencies cited, the corrective plan and actions taken are to addressthe lack of demonstrated knowledge resulting in failure to ensure there was aqualified pre-designated individual appointed in writing by the governing bodyto act in the Administrator's absence. The plan of correction will be completedthrough comprehensive focused education. On 10/14/2022, the Manager	2022-11-01

	Governance, and Administration" indicated "... the governing body (board of trustees) is responsible for ... appointing a qualified administrator and designated back-up administrator (Medicare Certified Offices) ... the board of trustees has established the appointment committee of the organization to make interim or time-sensitive appointments of qualified administrators, alternate administrators ... administrator ... must be appointed by and report to the governing body." Review of governing body minutes, dated 09/01/2022 and 08/04/2022, indicated failed to evidence the approval for appointment of an administrator for this agency. During an interview on 10/04/2022 at 3:17 PM, when asked why on 09/28/2022 at the entrance conference the agency indicated the administrator was corporate staff 1 and the alternate administrator was the alternate administrator / clinical supervisor and on 10/03/2022 when asked the same question, the agency indicated the		ofRegulatory Support and Guidance provided education for all office staff onfollowing: · Office responsibility for maintainingkey designations and communicating to the appropriate entities when there is avacancy/change in designations, · The role of the Regulatory Support andGuidance office to review the resumes for all personnel being considered for akey designation to ensure qualifications are sufficient, · The appointment process for designatedroles, i.e. Administrator / Alternate Administrator, including the AgenciesGoverning Body (Board of Trustees) approval and submission of persons forapproval via the Regulatory Support and Guidance office and CredentialingOffice, · Indiana regulations 410 IAC 17-9-2 and410 IAC 17-12-1, Medicare Condition of Participation 484.105 and agency policy,*Ownership, Governance, and Administration: BAYADA Home Health Care, 0-523* withemphasis on Administrator requirements and	

	administrator was the alternate administrator / clinical supervisor and the alternate administrator was corporate staff 1, the client services manager indicated had clarified that point and person 1 was listed as administrator, the alternate administrator / clinical supervisor was the acting administrator and corporate staff 1 was never the administrator. When asked for the governing body written appointment and approval of the alternate administrator / clinical supervisor as administrator, the alternate administrator / clinical supervisor indicated was the acting administrator so was automatically the administrator. 410 IAC 17-12-1(d)(8)		Governing Body approval of theAdministrator. · The following designations wereappointed, approved by the Board of Trustees (Governing Body), and communicatedto the Indiana Department of Health on the following dates: o Administrator:appointed and approved on 10/06/2022 by the governing body and communicated tothe Indiana Department of Health of 10/28/2022. o AlternateAdministrator: appointed and approved on 10/06/2022 by the governing body andcommunicated to the Indiana Department of Health of 10/28/2022. o SupervisingRN: appointed and approved on 10/06/2022 by the governing body and communicatedto the Indiana Department of Health of 10/28/2022.	

			o AlternateSupervising RN: appointed and approved on 10/06/2022 by the governing body andcommunicated to the Indiana Department of Health of 10/28/2022. Effective 11/1/2022, the RegionalDirector/Designee will review monthly the organization structure of the officeto ensure the appropriate personnel are in the designated roles, i.e.,Administrator, Alternate Administrator, Supervising RN, and AlternateSupervising RN. Any discrepancies i.e., vacancies/potential vacancies, will beidentified and the appropriate communication to the State and the OrganizationCredentialing and Regulatory office and the process to fill the vacancy will beinitiated. The Regional Director has overallresponsibility for the implementation and oversight of the plan.	
G0982	Skilled services furnished 484.105(f)	G0982	G0982 **Skilled Services furnished**	2022-11-11

	Standard: Services furnished. Skilled nursing services and at least one other therapeutic service (physical therapy, speech-language pathology, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the services described in this subsection directly, but may provide the second service and additional services under arrangement with another agency or organization. Based on record review and interview, the agency failed to provide another therapeutic service in addition to skilled nursing for patients with therapy needs for 1 of 1 agency. Findings include: An agency document, revision date of 12/07/2020 and titled "Admission Booklet for Medicare-Certified Pediatric Services," indicated the agency mission was to provide nursing, rehabilitative, therapeutic and assistive care to children and adults. On 09/29/2022, the agency's services manager provided a letter, addressed to the administrator of the agency, received from the Department of Health & Human Services		Based on an analysis of the specificdeficiencies cited, the corrective plan and actions taken are to address thelack of demonstrated knowledge resulting in failure to provide therapeuticservices in addition to skilled nursing for patients with therapy needs. By 11/11/2022, the Director of ClinicalOperations/designee will educate all office staff on appropriate physicaltherapy intervention for clients and not refusing service to a client withMedicare as their payor if the Agency can appropriately meet their needs. The Agency will not refuse service to aclient with Medicare as their payor if the needs of the client can be appropriatelymet.	

	indicated the agency was approved to provide skilled nurse and physical therapy services. During the entrance conference on 09/28/2022, when asked what services the facility provided, the alternate administrator / clinical supervisor indicated the agency provided skilled nursing and that physical therapy services were provided through a contract with Other 4. During an interview on 09/29/2022 at 11:30AM, when asked for the documentation of coordination of services with therapy, the alternate administrator / clinical supervisor indicated the agency had a contract for physical therapy with Other 4, but Other 4 had never provided therapy services because the agency did not provide nor bill for therapy services; the agency only provided and billed for skilled nurse services. On 09/29/2022 at 11:55AM, alternate administrator / clinical supervisor was notified that the Center for Medicare and Medicaid Services was notified		By 11/18/2022, the Manager of ClinicalOperations/designee will review all active clients who are not currentlyreceiving therapy services to evaluate their need for physical therapy. Effective 11/18/2022, all newadmissions will be evaluated by the Clinical Manager for their need forphysical therapy services. The Director has overall responsibilityfor the implementation and oversight of the plan**.**	

	that this Medicare certified agency did not nor does provide, offer, nor arrange for an additional skilled or therapeutic service to their patients, other than skilled nursing services. The alternate administrator / clinical supervisor indicated they would not rescind and no changes would be made by the agency. During an interview, on 09/29/2022 at 3:00 PM, the alternate administrator / clinical supervisor indicated the agency will consider rescinding their Medicare certification when a specific patient changes their payor source from managed care Medicaid to traditional Medicaid. During an interview on 10/03/2022 at 12:20 PM, the alternate administrator / clinical supervisor indicated therapists are listed in the agency's organizational chart because their Medicare certification indicated physical therapy was provided, therefore they obtained a contract, though the contracted service was not used since obtained. During an interview on			

	10/03/2022 at 2:20 PM the alternate administrator / clinical supervisor indicated the agency had a contract to provide therapy services but had never provided therapy services to their patients. During an interview on 10/04/2022 at 3:17 PM, the alternate administrator / clinical supervisor indicated the agency has not ever provided their patients with home health aide services.			

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
Sarah Zamarripa	Associate Director	11/3/2022 5:15:05 PM