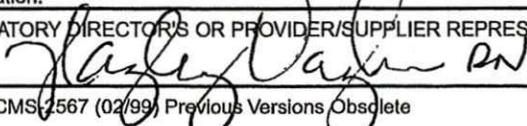


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 437051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER AVEANNA HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 101 S Reid St Ste 201A , SIOUX FALLS, South Dakota, 57103	
(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 A complaint health survey for compliance with 42 CFR Part 484, Subpart G, Subsections 484, Subparts B-C, requirements for Home Health Agencies, was conducted from 1/7/26 through 1/8/26. Areas surveyed included therapy services initiated, timely and skilled nurse assessments. Aveanna Home Health was found not in compliance with the following requirement, G510.	G0000		
G0510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This CONDITION is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that complete vital signs were documented in the electronic medical record (EMR) in the Skilled Nurse Initial Comprehensive Assessment, the second skilled nurse visit note, and the physical therapy evaluation for one of three patient (1) records reviewed. Findings include: 1. Record Review of patient #1's EMR on 1/8/26 revealed: *The patient was admitted to home health services on 12/23/25 after being discharged home from a rehabilitation stay for hemiplegia following cerebral infarction (inability to move affected muscles voluntarily after a stroke where blood flow to part of the brain is blocked).	G0510	Action: Re-education will be done to clinicians that each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Focus of education to include that vital signs are taken as part of the comprehensive assessment and any delays in care will have coordination of care with the patient and the provider. Who is responsible: Executive Director/Clinical Manager Monitoring Plan: A quality improvement indicator has been developed to track this process, and progress will be monitored through location QAPI meetings. Effective compliance with this standard is evidenced by a compliance threshold of 100%. Methodology: 100% of all new admissions will be reviewed for timely initiation of services and a comprehensive assessment performed including vital signs for 4 weeks. 100 % of subsequent visits will be reviewed for continued vital sign assessments x 4 weeks. Then 10% on a quarterly basis x 2 as part of the ongoing QAPI process to ensure ongoing compliance. If at any point compliance falls below the threshold for vital sign assessments or timely initiation of services, then all appropriate clinical staff will be reeducated to ensure there is not a knowledge deficit, and they understand the standard for assessments and timely care. In addition, the frequency of audits monitoring will be increased as above until compliance is sustained.	2/9/2026

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 Executive Director	(X6) DATE 2/2/2026
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G0510	<p>Continued from page 1</p> <p>*There were no vital signs recorded in the skilled nurse's initial comprehensive assessment completed on 12/23/25, the patient's home health start of care date.</p> <p>*There were no vital signs documented in the skilled nurse visit note dated 12/30/25, the second home health visit made with the patient.</p> <p>*The patient's respirations were the only vital sign documented in the initial physical therapy evaluation completed on 12/30/25, the third home health visit with the patient.</p> <p>*The patient was prescribed and took Lisinopril and Metoprolol medications for high blood pressure.</p> <p>*The initial plan of care, developed on 12/23/25 at the start of care and signed by the patient's physician on 1/5/26, listed the intervention that licensed professionals were to report vital signs falling outside established parameters.</p> <p>2. Interview with Area Executive Director B on 1/8/26 at 9:00 a.m. regarding missing vital signs documentation in the EMR revealed that he:</p> <p>*Confirmed there were no vital signs documented in the EMR for the skilled nurse's initial comprehensive assessment completed on 12/23/25 at patient 1's home health start of care visit, the second skilled nurse visit on 12/30/25, and respirations were the only vital sign documented in the physical therapy initial evaluation completed on 1/25 for patient 1.</p> <p>*Agreed that an assessment is not comprehensive without the patient's vital signs being completed.</p> <p>*Stated that the agency's process was for vital signs to be completed by the home health nurse and therapy staff for patients at every skilled nursing and physical therapy visit.</p> <p>3. Interview on 1/8/26 at 10:00 a.m. with registered nurse E revealed he:</p> <p>*Agreed vital signs are required and part of a patient's comprehensive assessment.</p> <p>*Stated vital signs were to be completed for patients at every skilled nurse visit.</p> <p>*Confirmed there was no documentation of vital signs in</p>	G0510		

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G0510	<p>Continued from page 2 the EMR for the skilled nurse's initial comprehensive assessment completed on 12/23/25 at patient 1's home health start of care visit, the second skilled nurse visit on 12/30/25, for which he was the nurse, and respirations were the only vital sign documented in the physical therapy initial evaluation completed on 1/25 for patient 1.</p> <p>4. Interview on 1/8/26 at 10:45 a.m. with patient 1 and the patient's spouse revealed:</p> <p>*The nurse who completed the patient's first and second home health visits on 12/23/25 and 12/30/25 did not take the patient's vital signs.</p> <p>*The physical therapist who completed the patient's third home health visit on 12/30/25 reviewed the blood pressure that was taken with the patient's own wrist blood pressure cuff and stated it was normal.</p> <p>*The patient had a wrist blood pressure cuff; She and her husband would take her blood pressure daily, document it in a notebook, were aware of normal blood pressure parameters, and stated that they would call the doctor if the blood pressure were high.</p> <p>5. Interview on 1/8/26 at 2:00 p.m. with physical therapist F revealed:</p> <p>*It is the agency's therapy services process that vital signs are to be completed for all patients at every physical therapy visit and documented in the patient's EMR.</p> <p>6. Review of the provider's "Admission and Acceptance to Service" policy dated 3/11/25 revealed:</p> <p>**"Once a patient is admitted to service, the organization is responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations."</p> <p>**If the patient is accepted for care, an initial plan of care will be developed in consultation with the physician and the patient, then submitted to the physician for signature."</p> <p>*The comprehensive assessment must be completed within (5) calendar days of the patient's start of care, inclusive of weekends, holidays, and weekday admissions."</p>	G0510		

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G0510	Continued from page 3 7. Review of the provider's "Therapy Services" policy dated 5/19/25 revealed: **4. Therapy evaluations will be completed, timely in accordance with federal/state regulations, accreditation standards and/or payor requirements." **Therapy evaluations may include but is not limited to:" -c. Relevant systems review -d. Functional tests, standardized testing, and objective measurements."	G0510		