STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200829700A	A. BUILDING B. WING	04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND HOMECARE INC	1304 MAIN STREET, ANDERSON, IN, 46016

(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
N0000	Initial Comments This visit was for a State Licensure Survey. Survey Dates: 3/29, 3/30, 3/31, and 4/1/2022. Census: 96 Quality Reviewed x2 on 5/13/22	N0000		2022-04-29
G0000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. The survey was announced as partially extended on 3/31/2022 at 11:33 AM and was announced as fully extended on 4/1/2022 at 2:46 PM. Survey Dates: 3/29, 3/30, 3/31, and 4/1/2022. Census: 96	G0000		2022-04-29

	These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State findings. Quality Review x2 completed on 5/13/22			
E0000	Initial Comments This visit was for a federal Recertification and State Licensure Survey. Survey Dates: 3/29, 3/30, 3/31, and 4/1/2022. Above and Beyond Home Care was found to be in compliance with Emergency Preparedness at 42 CFR 484.102.	E0000		2022-04-29
N0458	Home health agency administration/management 410 IAC 17-12-1(f) 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	N0458	**1. Describe what the Agency did to correct the deficient practice for eachclient cited:** The Agency addressed all TB Screens that fall outside of theannual timeline for a TB Evaluation. AllAgency employees, staff members, persons providing care on behalf of theagency, and contractors having direct patient contact have received an annualTB evaluation. **2. Describe how the Agency reviewed all clients in the**	2022-04-29

registration.

(5) Annual performance evaluations.

Based on record review and interview, the administrator failed to ensure all health records were current and complete for 1 of 1 clinical director file reviewed.

The findings include:

The agency policy, with adoption date 01/08/2021, titled "Tuberculosis Evaluation Policy" stated, "The agency shall ensure all persons providing care on behalf of the agency, who will have direct patient contact, are evaluated for tuberculosis upon hire and annually thereafter as required by the Indiana and Federal Laws for home health, and PSA [personal service agency] Agencies."

The health file of the clinical supervisor was conducted on 3/31/2022 and failed to evidence an annual risk assessment. The most recent risk assessment was dated 01/21/2021.

During an interview on 3/31/22 at 4 PM, Employee F, the human resource representative, relayed the health file provided was the original and complete file.

agency that could beaffected by the same deficient practice and actions the agency to address thedeficiency for any client the agency identified as being affected.

The Agency audited 100% of all employees, staff members,persons providing care on behalf of the agency, and contractors having directpatient contact. The goal is to identifyany of those listed above as out of compliance with an outdated annual TBevaluation.

3. Describe the steps or the systemicchanges the agency has made to ensure the deficient practice does not recur.

The Administrator re-educated HumanResources on the tracking method for TB evaluation to be performed annual byuse of the EMR systems tracking application.

4. Describe how the corrective action will be monitored to ensure ongoingcompliance.

The Administrator will ensure thatthe Human Resources

			Officer prints a report weekly to show those individualswho need to receive an annual TB evaluation before expiration. **5. Date of corrective action: 04/29/2021.** **6. Employee position responsible for ensuring ongoing compliance with N0458.** The Administrator is responsible forensuring ongoing compliance with N0458.	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the home health agency failed to ensure the registered nurse [RN] accurately assessed blindness as a sensory loss, in 1 of 5 active clinical records reviewed (Patient #2). Findings include: An agency policy titled Clinical Documentation, undated, indicated but was not limited to &to ensure there is an accurate record of all services provided &.	G0528	**1. Describe what the Agency did to correct thedeficient practice for each client cited:** The Clinical Manager instructed the RN Case Manager to writean addendum to the comprehensive assessment documenting that the patient's legalblindness was not a neurological sensory loss but a visual impairment. **2. Describe how the Agency reviewed allclients in the agency that could be**	2022-04-29

	The clinical record of Patient #2, with start of care of 9/09/2020, was reviewed on 3/30/22. The comprehensive assessment dated 2/28/22, indicated Neuro Assessment & WNL [within normal limits] / PERRLA [pupils, equal, round, reactive to light and accommodation] /: Yes & Motor / Gait: Unsteady gait, Loss of balance coordination & Other Neuro &Seizures & Sensory loss: No &. The plan of care for the certification period 3/3/22 to 5/1/22 included the diagnoses, but not limited to, bipolar disorder and legal blindness. During an interview on 4/01/22 at 3:00 PM, RN #2 relayed, after review of the recertification assessment, I guess I just never put two and two together on that one. A skilled nurse visit note, dated 3/14/22, indicated & Neuro - Progress & WNL / PERRLA / A&O [alert and oriented]: Yes & Cognitive / Emotional Status: Forgetful &Motor / Gait: Unsteady gait, Loss of balance / coordination &Other Neuro: Seizures & A skilled nurse visit note dated 3/28/22, indicated ... Neuro - Progress & WNL / PRRLA / A&O: Yes & Cognitive / Emotional Status: Forgetful & Motor / Gait: Unsteady gait, Loss of balance/ coordination & Other Neuro: Headaches, Seizures &. During an interview on 4/1/22 beginning at 3:00 PM, RN #2 indicated they interpreted WNL as what was normal for the patient and indicated they struggled to answer that question in the assessment.		**affected by the same deficient practice andactions the agency to address the deficiency for any client the agencyidentified as being affected.** The Clinical Manager and the QAPI Nurse identified allpatients with impaired vision and reviewed their comprehensive assessment toensure correct documentation of their impairment as a sensory deprivation andhow it impacted their daily life. **3. Describe the steps or the systemicchanges the agency has made to ensure the deficient practice does not recur.** The Clinical Manager has met with all RN Case Managers tore-educate them to include blindness or impaired vision as a sensory losspertaining to a neurological visual impairment. **4. Describe how the corrective actionwill be monitored to ensure ongoing compliance.** The Clinical Manager/designee	

			will audit all comprehensiveassessments at certification timepoints and will monitor for ongoingcompliance. **5. Date of corrective action: 4/29/2022.** **6. Employee position responsible forensuring ongoing compliance with G528:** The Clinical Manager will be responsible for ensuring ongoingcompliance with G528.	
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 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 clinical record review and interview, the agency failed to ensure home health aide services were provided as ordered and services were not reduced or placed	G0572	**1. Describe what the Agency did to correct the deficient practice for eachclient cited:** The Agency Governing Body met to discuss the problem ofpatients who place their services in an “on-hold” status. The Governing Body agreed that this would nolonger be allowed except in the rare circumstance of the patient taking avacation or having family members or friends visiting them. The time allowed would be fourteen days orless and the physician must be aware of the “on-hold” status.	2022-04-29

	on hold due to lack of staffing in 3 of 5 active records reviewed with orders for home health aide services only (#7, 10, and 11). Findings include: Clinical record review occurred on 3/31/2022, for Patient #10 for certification period 3/31/2022 to 5/29/2022. The agency s electronic medical record revealed that Patient #10 was on hold and with an active certification period of 3/31/2022 to 5/29/22. Review of the assessment, completed on 3/28/2022 by Employee D a registered nurse, revealed the diagnoses / symptoms of lupus (the immune system attacks healthy tissue in many parts of the body), lymphedema (inability of the body to drain fluid which is normally drained through the lymphatic system) repeated falls, systemic involvement of connective tissue (damage to the connective tissue that holds the body structure together), fracture of the right ring finger, and chronic pain. The assessment revealed the associated symptoms were controlled with difficulty, affected daily functioning, and the need for ongoing monitoring. On the 4/01/2022, it was requested, of the clinical director, to provide the most recent home health aide visit notes. The clinical director provided, on 4/01/22 at 3 PM, home health aide visit notes which revealed Patient #10's last aide visit was completed on 02/07/2022. The clinical director confirmed, verbally, the last aide visit was provided on 02/07/22 and relayed they [the agency] was following the plan of care [POC] because the agency notified the physician and they had a physician order to place the patient's services on hold.		Upon return from vacation or upon leave offamily or friends the RN Case Manager will make a home visit to the patient toassess their health status for any changes. 2. **Describe how the Agency reviewed all clients in the agency that could beaffected by the same deficient practice and actions the agency to address thedeficiency for any client the agency identified as being affected.** The Clinical Manager and the QAPI Nurse audited all clinicalrecords to identify any additional patients who have placed their services onhold. No other patients were identifiedas being “on-hold”. **3. Describe the steps or the systemic changes the agency has made to ensurethe deficient practice does not recur.** The Clinical Manager has met with all RN Case Managers andSchedulers to educate all staff members on the above process.	

The record evidenced a physician order, dated 02/08/22 to place the service on hold.

Review of the record failed to evidence services were provided from 02/07/2022 through the end of the prior certification period ending 3/30/2022 nor were any services provided during the current certification period, which began on 3/31/2022, the patient remained "on hold."

The record evidenced a recertification assessment was completed on 3/28/2022. The assessment identified Home Health Aide services of 3 - 5 days per week, for 1 3 hours per visit.

Review of the plan of care for certification period 3/31/2022 5/29/2022, included physician orders for Home Health Aide services 3 5 days per week for 1 3 hours per visit for the assistance with showering, dressing, hair care, hand / foot care, skin care, meal preparation and set up. The plan of care revealed Patient #10 had no primary caregiver.

Notes for Patient #10 s, within the electronic medical record, [EMR] revealed the patient s representative (son / daughter) contacted the agency on 3/1/2022, and requested services to restart, that the patient's request to try to do as much as they could independently had failed, and indicated, & starting up services again &.

4. Describe how the corrective action will be monitored to ensure ongoingcompliance.

The Clinical Manager holds daily staff meetings with the RNCase Managers and Schedulers to discuss patient needs and staffingconcerns. All refusals of service willbe discussed, and potential solutions identified and followed up on.

5. Date of corrective action: 04/29/2022.

6. Employee position responsible for ensuring ongoing compliance with G572.

The Clinical Manager is responsible for ensuring ongoingcompliance with G572.

Another EMR note, dated 3/29/2022, revealed a case conference note, which indicated Patient #10 wanted to try performing tasks on her own to see if he / she could be independent. The document also revealed Patient #10 s needs and deficits as & decreased endurance, tires easily, has decreased participation in activities when [Patient #10 s] pain increases, continues to have increased risk for alteration in skin integrity due to incontinence and [Patient #10] is a fall risk due to unsteady gait with dependence on assistive device. [Patient #10] has no local family available for assistance. The note revealed home health aide services of 3 5 days a week, 1 3 hours per visit. The note concluded Will continue with services as ordered. [Patient #10] will be updated on new hire s availability.

A phone interview was conducted with Patient #10 on 3/31/2022 at 1:05 p.m. Patient #10 confirmed he / she requested services on hold to try to see his / her level of independence, but that was about 6 weeks ago. Patient #10 indicated he / she could not be independent and required continued home health aide services. Patient #10 denied refusing replacement aides, and relayed they don t have anybody.

During an interview on 3/29/2022 at 10:45 a.m., Employee B, Clinical Supervisor, confirmed the agency had difficulty hiring home health aides and had to turn down referrals as the agency did not have available staff.

During an interview on 4/1/2022 at 3:00 p.m., Employee B, asserted the agency was providing services to this patient per the plan of care or physician order.

A clinical record review occurred on 4/1/2022 for Patient #11, for certification period 3/15/2022 5/13/2022. The agency s electronic medical record revealed Patient #11 was on hold.

Review of the assessment for the certification period 3/15/2022 to 5/13/2022, completed on 3/11/2022 by Employee D, Registered Nurse, revealed the diagnoses / symptoms of Multiple Sclerosis (damage to the insulating covers of nerve cells in the brain and spinal cord, disrupting in nerve damage that disrupts communication between the brain and body), high blood pressure, weakness, hypothyroidism (abnormally low activity of the thyroid gland), depression, and fatigue. The assessment revealed the associated symptoms were controlled with difficulty, affecting daily functioning, and the need for ongoing monitoring.

The EMR evidenced the last date service were provided to patient 11 was on 02/15/2022; a recertification assessment was completed on 3/11/2022.

Review of the plan of care for certification period 3/15/2022 to 5/13/2022, revealed the need for Home Health Aide services 1 3 days per week for 3 5 hours per visit. The plan of care revealed patient needed & assistance with showering, dressing, skin care, and meal prep. [Patient #11] has started having difficulty with standing unassisted. The plan of

caregiver (other than the agency).

Review of a document titled Aide Care Plan for certification period 3/15/2022 5/13/2022, revealed aide tasks for assistance with shower, hair care, mouth care, hand/ foot care, skin care, shave, assist with clothing, toileting, mobility, use of a walker, wheelchair, or cane; getting in or out of bed or chair, meal preparation, medication reminder, change bed linens, laundry, clean up area, and offering fluids.

When the last week of home health aide notes were requested, the agency provided notes which revealed Patient #11 s last aide visit was 2/15/2022.

Review of the record revealed notification of missed visits on the following dates and included comments regarding the missed visits:

1/26/2022, 1/27/2022: Aide called off; client did not want a replacement sent.

2/3/2022, 2/4/2022: Client cancelled visit for the day due to weather conditions.

2/16/2022, 2/17/2022, 2/18/2022: Aide requested out; client stated she is okay while looking for a different caregiver.

2/21/2022, 2/22/2022, 2/23/2022, 2/24/2022, 2/25/2022: Aide requested out; client states she does not need replacement until permanent aide placed.

2/28/2022, 3/2/2022, 3/2/2022, 3/4/2022, 3/4/2022: Regular aide not available and client refused replacement.

An additional physician order effective 2/28/2022, revealed Physician Orders for Services Addendum. The home health aide order was reduced to 1 3 days a week, 1 visit per day for 3 5 hours.

The agency failed to provide physician ordered services, based on the patient assessed needs and functional deficits.

During an interview on 4/1/2022 at 3:00 p.m., Employee B, Clinical Supervisor, asserted the agency was providing services to this patient per the plan of care or physician order.

410 IAC 17 - 13 - 1(a)

The clinical record of Patient #7, with start of care 6/08/2021, was reviewed on 3/30/22. The record included a plan of care [POC] for the certification period 02/3/22 - 4/3/22 with patient diagnoses that included, but not limited to, autistic disorder, pervasive developmental disorder, attention deficit hyperactivity disorder, and urinary incontinence. The POC included the physician orders for home health aide (HHA) 3 visits per

	week for 1 week effective 02/03/22 and then 5-7 visits per week, 2-5 hours per visit (up to 24 hours per week) for 8 weeks. The home health agency failed to provide the minimum number of home health aide visits for first 8 weeks of the certification period. Week 1, the patient received 1 HHA visit for a total of 5 hours. Week 2, the patient received 3 visits for a total of 13 hours. Week 3, the patient received 3 visits for a total of 12 hours. Week 4, the patient received 3 visits for a total of 13.75 hours. Week 5, the patient received 4 visits for a total of 15.75 hours. Week 6, the patient received 4 visits for a total of 14 hours. Week 7, the patient received 4 visits for a total of 14.75 hours.			

	Week 8, the patient received 3 visits for a total of 11.5 hours. An interview was conducted on 4/1/22 at 3:30 pm with the Clinical Manager. During the interview the Clinical Manager confirmed that when 5-7 home health aide visits per week are ordered in the plan of care, the agency should provide home health aide services for at least 5 visits per week unless there is an interim order written specifying otherwise.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, agency document review, and interview, the home health agency failed to direct their staff on specific products to use in the home for the decontamination of reusable tools and equipment and failed to follow accepted standards of practice and their own policies to prevent the transmission of infections and communicable diseases for 2 of 2 skilled nursing visits observed [Registered nurse # 1 with patients # 7 and 8). Findings include: During an interview at the daily conference on 3/31/2022, Employee B, the alternate administrator / clinical supervisor, relayed that reusable disinfected equipment, should be dry, before returned to the nurse's supply bag. When asked which product was to be used for the decontamination of the agency staff's	G0682	**1. Describe what the Agency did tocorrect the deficient practice for each client cited:** The Agency Governing Body hasapproved a revised infection control policy that addresses bag technique,handwashing, and equipment sanitation. The Agency Clinical Manager has heldan in-service for nursing staff to re-educate clinicians on the appropriatesteps to take when sanitizing equipment utilized during the home visitassessments. The Agency will be providing all cliniciansand field staff with Clorox wipes to have a uniform dwell time requirement.	2022-04-29

	employee B relayed that the staff may use any product of their choosing, the agency does not provide the product, the product the staff choose to use is to be labeled to kill 99%. When asked if they have directions for the use of the products the staff are using, employee B relayed the agency did not as every product would be different. 410 IAC 17 - 12 - 1(m) An undated agency policy titled Bag Technique, indicated, but not limited to, & following care & soiled reusable items must be cleaned and disinfected prior to returning to the bag, per agency protocol & once reusable items are cleaned, place them on a clean surface & perform hand hygiene & replace items into bag &. An undated agency policy titled Bag Technique In-Service, indicated, but not limited to &,there exists the risk for transmission of infection from one patient to another via contaminated nursing bags & preventing transmission through bag technique &. During a home visit observation, conducted on 3/30/2022 at 9:32 AM, with Patient #7 (start of care 6/08/21) and Registered Nurse [RN] #1, after the nurse used a disposable wipe on the items / tools she used during the home visit assessment, RN #1 failed to place the items on a clean surface and allow to dry and failed to perform hand hygiene prior to returning the items to her nurse bag. During a home visit observation, conducted on 3/30/22 at 11:03 AM with Patient #8 (start of care 9/20/21) and RN #1, after the nurse used a disposable wipe on the items / tools she used during the home visit assessment, RN #1 failed to place the items on a clean surface and		**2. Describe how the Agency reviewed all clients in the agency that could beaffected by the same deficient practice and actions the agency to address thedeficiency for any client the agency identified as being affected.** Agency management staff have made random unannounced visits allRN Case managers while they are making their home visits to evaluate and ensurecompliance with the agency's infection control processes. This includes observations of handwashing,bag technique, and equipment sanitization. **3. Describe the steps or the systemic changes the agency has made to ensurethe deficient practice does not recur.**	

	hygiene prior to returning the items to her nurse bag. 410 IAC 17-12-1(m)		Agency management staff will continue to make randomunannounced visits of clinicians while they are making their home visits toensure that appropriate infection control measures continue to be performed perpolicy guidelines by all field staff. **4. Describe how the corrective action will be monitored to ensure ongoing compliance.** The Clinical Manager will perform routine supervisory visitsof all RN Case Managers to evaluate their compliance with agency infectioncontrol practices. The RN Case Managers will perform routine supervisory visitsof all Home Health Aides to evaluate their compliance with agency infectioncontrol practices. **5. Date of corrective action: 4/29/2022.**	

			6. Employee position responsible for ensuring ongoing compliance with G682 The Administrator and ClinicalManager are responsible for ensuring ongoing compliance with G682.	
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other	G0687	**1. Describe what the Agency did to correct the deficient practice for eachclient cited:** The Administrator and Governing Body has approved a revisedpolicy regarding CMS requirements r/t Covid-19 vaccination. This policy has been communicated to allagency staff. The HR department will beresponsible for tracking COVID-19 immunization records. Staff who are not vaccinated must show proof of weeklytesting evidencing their lack of infection. The testing results are to be maintained by the HR department. **2. Describe how the Agency reviewedall clients in**	2022-04-29

	arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination		**the agency that could be affected by the same deficient practiceand actions the agency to address the deficiency for any client the agencyidentified as being affected.** The Agency Management staff has metwith all employees to explain the CMS requirements for additional precautionsfor unvaccinated staff require the use of a NIOSH N95 mask. Agency has also amended COVID Vaccine Policyrequiring those that receive an exemption to use an N95 mask which will bemonitored by unannounced visits and RN Case Manager Supervisory Visits. Staff will sign a confirmation that theyreceived the appropriate number of N95 masks per there schedule and receivedinstructions on proper use. **3. Describe the steps or the systemic changes the agency has made to ensurethe deficient practice does not recur.** The HR Department Manager will be responsible for allemployee tracking processes	

	recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically		and will report their findings monthly to the AgencyAdministrator. **4. Describe how the corrective action will be monitored to ensure ongoingcompliance.** The corrective actions will also be reported to the QAPIcommittee on a quarterly basis. Anyincrease in COVID-19 infections will be evaluated and addressed to identify measuresadditional improvement. **5. Date of corrective action: 04/29/2022.** **6. Employee position responsible for ensuring ongoing compliance with G687** The agency Administrator isresponsible for ensuring ongoing compliance with G687.	

contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Based on observation, record review, and interview, the agency failed to ensure the safety of ALL patients and employees in regards to the lack of enforcement of the additional precautions intended to mitigate the transmission and spread of COVID-19.

Findings include:

During an interview on 3/30/2022 which began at 10 AM, the administrator relayed relayed he provided a N95 mask to each staff member. When asked, if the agency's unvaccinated staff were to be wearing the N95 mask during all patient contact and / or when in the office, the administrator relayed that they may remove the mask, if they have difficulty breathing, and wear a well fitting mask. When asked if the

agency is tracking or monitoring their unvaccinated staff to determine or identify which unvaccinated staff are wearing which type of mask, the administrator relayed they were not monitoring. The administrator indicated verbally, several times during the conversation, that their unvaccinated staff may choose to wear a well fitting mask as mitigation for the spread of SARS CoV2 [COVID-19].

On 4/01/2022 at 11:18 AM, when asked, the administrator relayed that the agency did not have a mechanism in place to ensure the implementation of additional precautions, intended for the spread of COVID-19; the administrator relayed the agency did not a process in place for tracking the vaccinate status of staff that obtain a booster, the administrator relayed they did not require their unvaccinated staff to obtain COVID 19 testing; and relayed that their contingency staffing plan for unvaccinated staff was to use their office staff to complete home visits, that the office staff are also home health aides.

During an interview on 3/29/2022 at the entrance conference, Employee B, the Alternate Administrator and Clinical Supervisor, stated he / she would have to check what mitigation the agency had in place for unvaccinated personnel, and that Employee A, the Administrator had the COVID policies.

On 3/29/2022 at 12:04 PM, the alternate administrator provided a list of the agency s vaccinated and unvaccinated staff. The list evidenced of their 106 employees, 44 applied for and were given a religious exemption.

Review of the agency s January 2022 Quality Assessment and Performance Improvement (QAPI) Plan revealed the following objectives

identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation, To meet state and federal regulatory requirements, and To reduce factors that contributes [sic] to unanticipated adverse events and/ or outcomes.

The QAPI January 2022 meeting agenda revealed a section to address each of the objectives in the QAPI plan. This revealed additional objectives of To address hi- risk [sic], hi- volume[sic], or problem prone areas, and Address any identified concerns that lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients.

Review of the Centers for Disease Control and Prevention [CDC] revealed options to reduce the spread of COVID 19 among or by healthcare providers, which include, but not limited to, A NIOSH [National Institute for Occupational Safety and Health] approved N95 or equivalent or higher level respirator or a well fitting facemask. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

During the end of day conference on 3/31/2022, Employee A, Administrator, stated, I understand you don t like it, but that is our policy.

During all interactions with Employee C, the Muncie Branch Manager on 3/29/22, 3/30/22, 3/31/22, and 4/01/22, he / she was observed to wear a cloth mask, while within 6 feet of

	other unvaccinated employees and the surveyors.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the home health agency failed to ensure that orders for home health aides (HHA) on the plan of care were present on the Aide Care Plan for 1 of 7 active records with HHA orders reviewed (Patient #2). Findings include: 410 IAC 17 - 14 - 1(m) The clinical record of Patient #2, with start of care of 9/09/2022, was reviewed on 3/30/22. The record included a plan of care (POC) for the certification period 3/03/22 to 5/01/22 that included the diagnoses, but not limited to, bipolar disorder, bulimia nervosa, and legal blindness. The POC included physician orders for HHA [home health aide] services, 3 to 5 days per week, 3 to 5 hours per visit for 60 days, aide to offer fluids for hydration and to offer 1 to 2 high protein shakes per day. The record included an aide care plan [list of aide tasks] that failed to include the aide task to offer the patient the physician ordered 1 - 2 high protein shakes per day.	G0798	**1. Describe what the Agency did to correct the deficient practice for eachclient cited:** The Agency audited 100% of all patients Medical Plans of Careand their Home Health Aide Care Plans. The goal was to identify any discrepancies between the Hha directionsfor care as written on the Medical Plan of Care and the directions for care aswritten on the Hha Care Plan. Anydiscrepancies in orders were addressed with the patient and physician andcommunicated to the Hha staff. Allchanges were documented in the agency EMR system. **2. Describe how the Agency reviewed all clients in the agency that could beaffected by the same deficient practice and actions the agency to address thedeficiency for any client the agency identified as being affected.** The Agency audited 100% of all patients Medical Plans of Careand their Home Health	2022-04-29

	An interview was conducted on 4/1/22, beginning at 3:00 pm with registered nurse [RN] # 2. /During the interview, the RN confirmed the aide plan of care should include the physician ordered task to offer 1 - 2 high protein shakes per day.		Aide Care Plans. The goal is to identify any discrepancies between the Hha directions forcare as written on the Medical Plan of Care and the directions for care aswritten on the Hha Care Plan. **3. Describe the steps or the systemicchanges the agency has made to ensure the deficient practice does not recur.** The Clinical Manager re-educated allRN Case Managers and the Management Team of the necessity for ensuring the Hhaorders as written and approved by the physicians/designee are written on theHha Care Plan. **4. Describe how the corrective action will be monitored to ensure ongoingcompliance.** All Medical Plans of Care and HomeHealth Aide Care Plans are audited by the Management Team at all certificationtimepoints. **5. Date of corrective action: 04/29/2021.** **6. Employee position**	

			responsible for ensuring ongoing compliance with G798. The Clinical Manager is responsiblefor ensuring ongoing compliance with G798.	

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