DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER LOVE HOME SERVICES LLC	7895 BROADWAY STE L, MERRILLVILLE, IN, 46410

(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	This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 2/10/2022 to 2/15/2022. Due to low patient census and patient refusals of home visits due to the Covid pandemic, 2 home visits were completed for this survey. Facility ID: 012817 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. Quality Review Completed 02/23/2022	G0000		2022-02-24
N0000	Initial Comments This visit was a re-licensure survey of a home health agency. The survey visit took place from 2/10/2022 to 2/15/2022. Due to low patient census and patient refusals of home visits due to the Covid pandemic, 2 home visits were completed for this survey. Facility ID: 012817	N0000		2022-02-24
E0000	Initial Comments	E0000		2022-02-24

	This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 2/10/2022 to 2/15/2022. Facility ID: 012817 At this Emergency Preparedness survey, Tender Love Home Services LLC was found to be in compliance with 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.			
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. (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	G0574	Correction for G0574: Clinical Supervisor faxed new medication addendum orders for all 7 active client's charts to clarify all medications to be added to the plan of care. A complete medication order containing name of drug, dosage, route, frequency and usage if used for PRN administration. It will be signed by the physician and faxed back to the agency to be immediately placed in the client's charts. Prevention for G0574: Clinical Supervisor will ensure complete medication orders contain Drug name, dosage, route, frequency and for PRN orders medications will include the indication for use. All eye drops orders will indicate which eye. The Administrator, will ensure 100% that all active charts will be reviewed bi-weekly to ensure that all the medication orders are completed and containing, the following: drugs name, dosage, route, frequency and usage if used for prn administration.	2022-02-24

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 the plan of care contained complete medication orders for all patient medications in 7 of 7 records reviewed (#1, #2, #3, #4, #5, #6, #7).

The findings include:

1. Record review on 2/15/2022, evidenced an agency policy titled, "Care Planning, coordination, quality of care Policy", reviewed 4/2/2021, which stated, " ... The plan of care ... covers all pertinent Diagnoses, including mental status, types of services and equipment required ... medications and treatments ... Plan of care must include the following: ... All medications and treatments...."

2. Clinical record review for patient #1 on 2/11/2022, start of care 6/25/2018, certification period 2/4/2022 to 4/4/2022, primary diagnosis of Cerebral Vascular Accident (stroke), evidenced an untitled agency document identified by the clinical supervisor as the plan of care, signed by the physician on 2/4/2022. The plan of care had a subsection titled, "Medications;", which stated, " ... Prostat Liquid [a liquid protein] 30 ml (tues, thurs, sat) ... Probiotic 1 per peg tube [feeding tube] BID [twice a day], Miralax [a laxative] 30 mL [milliliter] Q [every] (tues, thurs, sun), Tylenol [a pain and fever reducing medication] 5 ml PRN [as needed] Q 6 hrs. ... Silvadene [a topical antibiotic used to treat burns] 1% cream topically prn, Tinactin [a topical anti-fungal] 1% powder under breast prn ... Multivitamin 10 mLs (Tue, Th, Sat) ... Guaifenesin [a cough and cold medication] 100 mg [milligram] / 5mL per peg tube q6hrs prn ... Flexeril [a muscle relaxant] 10 mg per peg tube BID prn ... Nystatin [an anti-fungal] ointment top [topical] prn, Prep H [preparation H] [a hemorrhoid treatment] rectally prn, Loperamide [an anti-diarrheal] 2 mg per peg tube QID [four times a day] prn, Zofran [an anti-nausea medication] 5 mL per peg tube q8hr [every 8 hours] prn...."

Review of the plan of care failed to evidence a

Multivitamin. Review of the plan of care failed to evidence a frequency for taking Silvadene, Tinactin, Nystatin, and Preparation H. Review of the plan of care failed to evidence an amount/dosage for the Probiotic. Review of the plan of care failed to evidence the indication for use of the as needed medications: Tylenol, Silvadene, Guaifenesin, Flexeril, Nystatin, Preparation H, Loperamide, and Zofran.

3. Clinical record review for patient #2 on 2/11/2022, start of care 8/12/2014, certification period 1/2/2022 to 3/2/2022, primary diagnosis of Paraplegia (paralysis effecting the lower half of the body), evidenced an untitled agency document identified by the clinical supervisor as the plan of care, signed by the physician on 12/28/2022. The plan of care had a subsection titled, "Medications;", which stated, " ... Oxycodone [a narcotic pain reliever] 7.5 mg PO [by mouth] q 4 hrs prn ... Senna Lax [a laxative] 8.6 mg 2 tabs PO prn ... Zofran 4 mg PO Q 8 hr prn...."

Review of the plan of care failed to evidence an indication for use of Oxycodone, Senna Lax, and Zofran.

4. Clinical record review for patient #3 on 2/11/2022, start of care 4/10/2013, certification period 12/24/2021 to 2/21/2022, primary diagnosis of Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), evidenced an untitled agency document identified by the clinical supervisor as the plan of care, signed by the physician on 12/21/2022. The plan of care had a subsection titled, "Medications;", which stated, " ... Mucinex [a cough and cold medication] 600 mg PO BID PRN...."

Review of the plan of care failed to evidence an indication for use of Mucinex.

5. Clinical record review for patient #4 on 2/11/2022, start of care 11/20/2019, certification period 1/8/2022 to 3/8/2022, primary diagnosis of Degenerative Joint Disease (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), evidenced an untitled agency document identified by the clinical supervisor as the plan of care, signed by the physician on 1/19/2022. The plan of care had a

subsection titled, "Medications;", which stated, " ... Vit [vitamin] B6 PO Daily, Multivitamin PO Daily, Bisacodyl [a laxative] PO Daily ... Loperamide [an anti-diarrheal] 2 mg PO PRN, Cyclobenzaprine [a muscle relaxant] 5 mg PO TID [three times a day] PRN ... Sennosides [a laxative] 15 mg 2 tabs PO 1-2x Daily [one to two times per day] PRN ... Hydrocodone / Acetaminophen [a narcotic pain medication] 5/325 mg PO PRN...."

Review of the plan of care failed to evidence a dosage / amount for Vitamin B6, Multivitamin, and Bisacodyl. Review of the plan of care failed to evidence an indication for use of Loperamide, Cyclobenzaprine, Sennosides, and Hydrocodone / Acetaminophen.

6. Clinical record review for patient #5 on 2/11/2022, start of care 5/17/2015, certification period 12/10/2021 to 2/7/2022, primary diagnosis of Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves), evidenced an untitled agency document identified by the clinical supervisor as the plan of care, signed by the physician on 12/7/2021. The plan of care had a subsection titled, "Medications;", which stated, " ... Proventil HFA [a medication used for wheezing and shortness of breath] 108 mcg / ACT [micrograms per actuation] 2 puffs QID [four times a day] prn...."

Review of the plan of care failed to evidence an indication for use of Proventil HFA.

7. Clinical record review for patient #6 on 2/11/2022, start of care 5/21/2021, certification period 1/16/2022 to 3/16/2022, primary diagnosis of Multiple Sclerosis, evidenced an untitled agency document identified by the clinical supervisor as the plan of care. The plan of care had a subsection titled, "Medications;", which stated, " ... Tylenol 325 mg PO Q4hrs [every 4 hours] prn ... Miralax [a laxative] 17 gm [grams] PO Daily prn."

Review of the plan of care failed to evidence an indication for use of Tylenol and Miralax.

8. Clinical record review for patient #7 on 2/11/2022, start of care 10/17/2018, certification

	period 6/3/2021 to 8/1/2022, primary diagnosis of Multiple Sclerosis, evidenced an untitled agency document identified by the clinical supervisor as the plan of care, signed by the physician on 6/2/2021. The plan of care had a subsection titled, "Medications;", which stated, " ... Latanoprost Sol [a glaucoma medication] 0.005% 1 gtt [drop] HS [at bedtime], Alprazolam [an anti-anxiety medication] 0.25 mg PO BID [twice a day] prn, Clonazepam [a medication used to treat seizures, panic disorder, and anxiety] 0.5 mg PO BID prn...." Review of the plan of care failed to evidence in which eye(s) the Latanoprost was used. Review of the plan of care failed to evidence an indication for use of Alprazolam and Clonazepam. 9. During an interview on 2/14/2022, at 9:40 a.m., the clinical supervisor indicated the plan of care should contain complete orders for all medications taken by the patient. The clinical supervisor indicated a complete medication order contains the name of the drug, dosage, route, and frequency. When queried, the clinical supervisor indicated orders for PRN (as needed) medications should include the indication for use of the medication, and orders for eye drops should indicate in which eye(s) the drops are used. 17-13-1(a)(1)(D)(ix)			
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, record review, and interview, the agency failed to ensure all staff followed standard precautions to prevent the transmission of infections and communicable diseases in 1 of 2 home visits observed (#6). The findings include: Record review on 2/15/2022 evidenced an	G0682	Administrator/ClinicalSupervisor called HHA E into the office and reviewed infectioncontrol/handwashing policy and bag technique. Clinical supervisor reviewed withHHA E verbally and reviewed handwashing should be performed after removinggloves and before applying new gloves, before patient contact and afterhandling patient bodily fluids. Handwashing should be done in between changinggloves. Also, verbally instructing that handwashing should be done before goinginto nursing bag and that any equipment used on the patient should bedisinfected before and after patient use and before returning items to the bag. Preventionfor G0682:	2022-02-24

agency policy titled, "Infection prevention and control policy", reviewed 4/2/2021, which stated, "TLHS [Tender Love Home Services] will follow accepted standards of practice, including the use of standard precautions to prevent the transmission of infections and communicable diseases ... Staff should follow the organization's standards precautions, including: A. Hand hygiene: Wash hands before and after patient contact, after contact with any potentially infectious material, and before and after donning protective equipment, including gloves and masks...."

Record review on 2/15/2021, evidenced an agency document titled, "HOME HEALTH AIDE SKILLS CHECKLIST", dated 5/21/2021, signed by the clinical supervisor and HHA E. The evaluation indicated HHA could safely perform basic infection control procedures without supervision.

Observation of a home visit for patient #6 took place on 2/11/2022, at 8:53 a.m. At 8:58 a.m., HHA [home health aide] E was observed removing a stethoscope and blood pressure cuff from their bag, then removing the patient's folder from a dresser drawer. At 8:59 a.m., HHA E was observed placing the blood pressure cuff on the patient's left arm, then checking the patient's blood pressure using their stethoscope on the patient's arm. At 9:00 a.m., HHA E was observed removing the blood pressure cuff from the patient's arm, placing it back in their bag, and removing their gloves. HHA E then placed the stethoscope in their bag. HHA E failed to clean the blood pressure cuff and stethoscope before returning them to their bag. At 9:04 a.m., HHA was observed applying new gloves. HHA E failed to perform hand hygiene after removing used gloves and before applying new gloves. At 9:05 a.m., HHA E was observed emptying the urine collection bag. After emptying & cleaning the basin used, HHA E was observed removing their gloves and applying new gloves. HHA E failed to perform hand hygiene after removing used gloves and before applying new gloves.

During an interview on 2/14/2022, at 9:52 a.m., the clinical supervisor indicated hand hygiene should be performed after removing gloves and before applying new gloves. The clinical supervisor indicated only clean items and clean hands should enter the supply bag. When queried, the clinical supervisor indicated the HHA infection control training included hand hygiene and bag technique. When informed of

ClinicalSupervisor held an in-service on handwashing and bag technique for all HHA's.The in-service included standard precautions: handwashing/hygiene, washinghands before and after patient contact, after contact with any possibleinfectious body fluids, before and after gloving. After vitals are taken,instruction was given to wash hands and then clean equipment prior to returningto bag.

Bagtechnique included washing hands before reaching into the bag. Only clean handsshould be place into the bag. Disinfect equipment before and after use andbefore returning to the bag.

The Administrator and Clinical Supervisor are both responsible for ensuring that it does not reoccur. We will be requiring each HHA to do a return handwashing demonstration/bag technique every other month during their required in-service. We will ensure 100% that this will not reoccur.

	the findings, the clinical supervisor indicated HHA E was a seasoned HHA who knew better, but was nervous being observed during the visit. 17-12-1(m)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health aide failed to provide services as ordered in the aide care plan in 5 of 7 clinical records reviewed with home health aide services (#3, #4, #5, #6, #7). The findings include: 1. Record review on 2/15/2022, evidenced an agency policy titled, "Home Health Aide Services", reviewed 4/2/2021, which stated, " ... A HHA [home health aide] provides services that are: ... Ordered by the physician ... Included in the plan of care ... Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including ... Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional...." 2. Clinical record review for patient #3 on 2/11/2022, start of care 4/10/2013, certification period 12/24/2021 to 2/21/2022, primary diagnosis of Dementia (loss of memory,	G0800	Correctionfor G0800: Administrator/ClinicalSupervisor reviewed all active clinical records with the HHA's that failed toprovided care as ordered in the aide care plan. The HHA's corrected the recordby checking all boxes for care provided and was verified by the ClinicalSupervisor that care assigned matched the aide care plan. New Care planswere done to correct the deficiency that were noted on the current care plans.The Clinical supervisor went over the care plan with the HHAs to ensure thatthey understood they are only to check for care rendered that matches the aidecare plan. Preventionfor G0800: Clinical Supervisor will create the individualized HHA care plan foreach client with the family/caregiver to ensure that the chosen servicesrequested are rendered by HHA. Each care plan will be reviewed verbally and inwriting by the Clinical Supervisor and Admitting RN. The Clinical supervisor willreview each note when turned into the office by the HHA to ensure all taskperformed are correctly marked as indicated on the weekly note that must matchthe care plan. The Administrator will ensure 100% that all Care Plans, created by the admitting RN/Clinical Supervisor will be reviewed to ensure that all task chosen by the client/caregiver will be performed.	2022-02-24

abilities that are severe enough to interfere with daily life), evidenced a group of agency documents titled, "HHA / CNA [certified nurse's assistant] WEEKLY NOTE", which stated, " ... CHECK ALL BOXES FOR CARE PROVIDED ... VERIFY THAT CARE HAS BEEN ASSIGNED PER AIDE CARE PLAN....". Review of the HHA notes indicated mouth / denture care was performed by HHA F on 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/27/2021, 12/28/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/10/2022, 1/11/2022, 1/12/2022, 1/13/2022, and 1/14/2022.

Clinical record review evidenced an agency document titled, "HHA / CNA ASSIGNMENT SHEET", identified by the clinical supervisor as the aide care plan, reviewed and signed by the clinical supervisor on 12/21/2021. Review of the aide care plan failed to evidence the HHA was assigned to provide mouth / denture care to the patient.

3. Clinical record review for patient #4 on 2/11/2022, start of care 11/20/2019, certification period 1/8/2022 to 3/8/2022, primary diagnosis of Degenerative Joint Disease (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), evidenced a group of agency documents titled, "HHA / CNA [certified nurse's assistant] WEEKLY NOTE", which stated, " ... CHECK ALL BOXES FOR CARE PROVIDED ... VERIFY THAT CARE HAS BEEN ASSIGNED PER AIDE CARE PLAN....". Review of the HHA notes indicated, "Assist In and out of bed" was performed by HHA G on 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/8/2022, 1/9/2022, 1/10/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/22/2022, 1/23/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/27/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022.

Clinical record review evidenced an agency document titled, "HHA / CNA ASSIGNMENT SHEET", identified by the clinical supervisor as the aide care plan, reviewed and signed by the clinical supervisor on 11/4/2021 and 1/7/2022. Review of the aide care plan failed to evidence the HHA was assigned to assist the patient in and out of bed.

4. Clinical record review for patient #5 on 2/11/2022, start of care 5/17/2015, certification period 12/10/2021 to 2/7/2022, primary diagnosis of Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves), evidenced an agency document titled, "HHA / CNA ASSIGNMENT SHEET", identified by the clinical supervisor as the aide care plan, reviewed and signed by the clinical supervisor on 12/6/2022. Review of the care plan evidenced a list of tasks assigned for the aide to complete at each visit. The list included, but was not limited to: hair care, mouth care, skin care, assist with ambulation, passive range of motion (stretching or movement of a part of the body, done by another person), and empty catheter bag (urine collection bag).

Clinical record review evidenced a group of agency documents titled, "HHA / CNA [certified nurse's assistant] WEEKLY NOTE", which stated, " ... CHECK ALL BOXES FOR CARE PROVIDED ... VERIFY THAT CARE HAS BEEN ASSIGNED PER AIDE CARE PLAN....". Review of the HHA notes failed to evidence the HHA provided hair care on 12/13/2021, 12/14/2021, 12/15/2021, 12/16/2021, 12/17/2021, 12/18/2021, 12/19/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/10/2022, 1/11/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA provided mouth care on 12/13/2021, 12/14/2021, 12/15/2021, 12/16/2021, 12/17/2021, 12/18/2021, 12/19/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/10/2022, 1/11/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA provided skin care on 12/13/2021, 12/14/2021, 12/15/2021, 12/16/2021, 12/17/2021, 12/18/2021, 12/19/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/10/2022, 1/11/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022,

1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA assisted with ambulation on 12/13/2021, 12/14/2021, 12/15/2021, 12/16/2021, 12/17/2021, 12/18/2021, 12/19/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/10/2022, 1/11/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA provided passive range of motion on 12/12/2021, 12/13/2021, 12/14/2021, 12/15/2021, 12/16/2021, 12/17/2021, 12/18/2021, 12/19/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/26/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/8/2022, 1/9/2022, 1/10/2022, 1/11/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/22/2022, 1/23/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA emptied the catheter bag on 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/10/2022, 1/11/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, and 2/1/2022.

5. Clinical record review for patient #6 on 2/11/2022, start of care 5/21/2021, certification period 1/16/2022 to 3/16/2022, primary diagnosis of Multiple Sclerosis, evidenced an agency document titled, "HHA / CNA ASSIGNMENT SHEET", identified by the clinical supervisor as the aide care plan, reviewed and signed by the clinical supervisor on 11/12/2021 and 1/11/2022. Review of the care plan evidenced a list of tasks assigned for the aide to complete at each visit. The list included, but was not limited to: hair care, mouth care, assist with transfer, assist in and out of bed, and encourage fluids.

Clinical record review evidenced a group of agency documents titled, "HHA / CNA [certified nurse's assistant] WEEKLY NOTE", which

PROVIDED ... VERIFY THAT CARE HAS BEEN ASSIGNED PER AIDE CARE PLAN....". Review of the HHA notes failed to evidence the HHA provided hair care on 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/27/2022, 1/28/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA provided mouth care on 1/24/2022, 1/25/2022, 1/26/2022, 1/27/2022, 1/28/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA assisted the patient to transfer on 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/25/2022, 1/27/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA assisted the patient in and out of bed on 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/27/2022, 1/28/2022, 1/31/2022, and 2/1/2022. Review of the HHA notes failed to evidence the HHA encouraged the patient to drink fluids on 1/31/2022, and 2/1/2022.

6. Clinical record review for patient #7 on 2/11/2022, start of care10/17/2018, certification period 6/3/2021 to 8/1/2022, primary diagnosis of Multiple Sclerosis, evidenced an agency document titled, "HHA / CNA ASSIGNMENT SHEET", identified by the clinical supervisor as the aide care plan, reviewed and signed by the clinical supervisor on 3/30/2021. Review of the care plan evidenced a list of tasks assigned for the aide to complete at each visit. The list included, but was not limited to: record vital signs, hair care, mouth care, skin care, assist with transfer, assist in and out of bed, and encourage fluids.

Clinical record review evidenced a group of agency documents titled, "HHA / CNA [certified nurse's assistant] WEEKLY NOTE", which stated, " ... CHECK ALL BOXES FOR CARE PROVIDED ... VERIFY THAT CARE HAS BEEN ASSIGNED PER AIDE CARE PLAN....". Review of the HHA notes failed to evidence vital signs recorded on 6/17/2021, 6/18/2021, and 6/21/2021. Review of the HHA notes failed to evidence the HHA provided hair care on 6/17/2021, 6/18/2021, 6/21/2021, 6/22/2021 and 6/25/2021. Review of the HHA notes failed to evidence the HHA provided mouth care on 6/21/2021, 6/22/2021 and 6/25/2021. Review of the HHA notes failed to evidence the HHA provided skin care on 7/3/2021. Review of the HHA notes failed to evidence the HHA provided hair care on 6/17/2021, 6/18/2021, 6/21/2021, 6/22/2021 and 6/25/2021. Review of the HHA notes failed to evidence the HHA assisted the patient to transfer on 6/5/2021, 6/21/2021,

6/22/2021, 6/25/2021, 6/26/2021, 7/3/2021, and 7/10/2021. Review of the HHA notes failed to evidence the HHA assisted the patient in and out of bed on 6/5/2021, 6/21/2021, 6/22/2021, 6/25/2021 and 7/3/2021. Review of the HHA notes failed to evidence the HHA encouraged the patient to drink fluids on 6/5/2021, 6/21/2021, 6/22/2021 and 6/25/2021.

7. During an interview on 2/14/2022, at 9:43 a.m., the clinical supervisor indicated the nurse created the individualized HHA care plan for each patient and reviewed it with the HHA verbally as well as in writing. The clinical supervisor indicated the HHA should perform assigned tasks at each visit and document them on the HHA weekly note.

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