STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K005	A. BUILDING B. WING	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OHIO VALLEY HOME CARE	204 PEARL STREET STE 201, NEW ALBANY, IN, 47150

(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 This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Provider. Survey Dates: 1/24/2023 to 1/27/2023 Active Census: 156 The survey was partially extended on 01/26/2023 at 10:00 a.m. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G0000		2023-03-01
G0562	Discharge Planning 484.58(a)	G0562	Ohio Valley is in the process of developing a Discharge Planning Policy. This policy will be written by the Administrator and approved by the governing body no later than 3/1/2023. The Discharge Planning Policy will include	2023-03-01

	Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Based on record review and interview, the agency failed to develop and implement an effective discharge planning process for 5 of 5 active records reviewed (Patient 1, 2, 3, 4, & 5). Findings include: 1. A policy titled "Discharge/Transfer of Patient Policy" was provided by the administrator on 1/26/2023. The document indicated but was not limited to; "Ohio Valley Home Health seeks to improve post-home health care and reduce avoidable hospitalizations by developing a patient discharge plan within 24 hours of a patient's admission."		measures to begin discharge planning during patient admission, on recertification and upon transfer to other agencies/facilities. It will also include discharge planning education for the family and provide for documentation of discharge planning goals to be included on the POC. 100% of staff will be educated on the new policy and 100% of client Plans of Care will include discharge planning by 5/1/23. This time frame will allow a complete 60 day recertification period for each client to enact the changes after the policy is approved. Staff education will be provided through our electronic continuing education system. Client charts will be reviewed quarterly by the Administrator, DON, or selected RN to ensure compliance with this measure.	

	2. The clinical record of patient #1 was reviewed on 1/25/2023 and evidenced the following: A plan of care for the certification dates of 11/25/2022 through 1/23/2023 that failed to include discharge planning. A comprehensive assessment dated 1/19/2023 indicated but was not limited to; "Discharge Plans ... Client requires ongoing care. No discharge plans at this time." 3. The clinical record of patient #2 was reviewed on 1/25/2023 and evidenced the following: A plan of care for the certification dates 12/09/2022 through 2/06/2023 that indicated but was not limited to; "No plans to discharge services at this time." The plan of care failed to show evidence of discharge planning. 4. The clinical record of patient #3 was reviewed on 1/25/2023 and evidenced the following: A plan of care for the certification dates 12/07/2022 through 2/04/2023 that			

	"No plans to discharge, the client requires ongoing assistance due to medical diagnoses and limited assistance available." The plan of care failed to show evidence of discharge planning. 5. The clinical record of patient #4 was reviewed on 1/25/2023 and evidenced the following: A plan of care for the certification dates 11/08/2022 through 1/06/2023 that indicated but was not limited to; "No plans to discharge; patient requires ongoing care why [sic] mom works." The plan of care failed to show evidence of discharge planning. 6. The clinical record of patient #5 was reviewed on 1/25/2023 and evidenced the following: A plan of care for the certification dates 11/28/2022 through 1/26/2023 that indicated but was not limited to; "No plans to discharge; patient requires ongoing care due to need for 24-hour supervision related to cognitive delay and seizures." The plan of care failed to show evidence of discharge planning.			

	7. During an interview on 1/26/2023 at 10:54 p.m. the administrator stated they did not have a specific discharge policy plan only what is included in their discharge/transfer policy. The administrator stated they were not aware of the discharge planning requirement. During a home visit on 1/26/2023 at 10:30 a.m. Home Health Aide (HHA1) was asked if the agency talked about discharge planning for patient 1. HHA1 indicated there were no plans in place to discharge the patient and would remain on services for life. During a home visit on 1/26/2023 at 12:00 p.m. Registered Nurse (RN1) was asked if the agency talked about discharge planning for patient 2. RN1 indicated there were no plans to discharge patient 2. During a home visit on 1/26/2023 at 1:00 p.m. Licensed Practical Nurse (LPN1) was asked if the agency talked about discharge planning for			

	were no plans to discharge patient 5.			
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 directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.	G0574	On 2/6/23 Ohio Valley's Administrator updated the template for the POC to include all of the current COP's. There is a Supervisory Nurse meeting scheduled for 2/23/23 to train the supervisory nurses on the new template for the POC and what measures need to be included in each section. The POC now includes but is not limited to: diagnoses, mental/psychosocial and cognitive status, types of services, DME, frequency and duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures, Risk for ER and hospitalization including interventions to prevent, patient and caregiver education regarding discharge planning, patient specific goal, interventions and education with measurable outcomes and goals, advanced directive information. 100% of all client POC's will include this information by 5/1/23 to allow for each of the clients current 60 day certification period to conclude. The new POC template will formulate as each clients recertification becomes due and will include the information noted above. Client charts will be reviewed quarterly by the Administrator, DON, or selected RN to ensure compliance with this measure.	2023-03-01

	Based on observation, record review, and interview, the agency failed to ensure the patient's Plan of Care included an accurate mental, psychosocial, and cognitive status assessment, failed to include discharge planning, failed to include a description of the patient's risk for emergency department visits and hospital re-admissions, and all necessary interventions to address underlying risk factors, and failed to include information related to any advance directives for 5 of 5 active records reviewed. (Patients 1, 2, 3, 4, and 5) Findings include: The clinical record for patient #3, SOC 10/29/2018, certification period 12/07/2022 to 2/04/2023, included a Plan of Care (POC) that failed to evidence the patient's mental status, failed to show evidence of discharge planning, failed to evidence the patient's risk for ER visits or re-hospitalization, and failed to evidence information related to any advance directives for the patient. The clinical record for patient #4, SOC 5/13/2021, certification period 11/08/2022 to 1/06/2023, included a POC			

	status as “Other Alert, Cognitive Delay” The agency failed to indicate on the POC a specific mental status assessment to determine patient #4''s orientation to person, place, and time. The POC failed to indicate patient 4’s psychosocial (interpersonal relationships, financial status, social/transportation problems …) status, and cognitive status (attention, learning/reasoning, decision making) status, failed to show evidence of discharge planning, failed to evidence the patient's risk for ER visits or re-hospitalization, and failed to evidence information related to any advance directives for the patient. 1. A 9/1/2021 policy titled Assessment and Development of the Plan of Care was provided by the Administrator on 1/26/2023 at 10:54 a.m. The policy indicated, but was not limited to, “ … assure appropriate data collection and documentation of assessment findings, …Knowledge, skill, and ability in data collection can affect the quality and quantity of data that is gathered …” 2. During a home visit on			

	1/26/2023 at 10:30 a.m. Home Health Aide (HHA1) was asked what asked to explain patient 1's mental status (person, place, time …). HHA1 indicated patient 1 was fully aware, recognizes faces, non-verbal, and squints eyes. 3. The clinical record for patient 1, Start of Care (SOC) date 8/7/2020, certification period 1/24/2023 to 3/2422023, included a Plan of Care (POC) indicating patient 1's mental status as "Other Alert, Autistic [developmental disability]" The agency failed to indicate on the POC a specific mental status assessment to determine patient 1's orientation to person, place, and time. The POC failed to indicate patient 1's psychosocial (interpersonal relationships, financial status, social/transportation problems …) status, and cognitive status (attention, learning/reasoning, decision making) status. 4. The clinical record for patient 2, SOC date 9/17/2015, certification period 12/9/2022 to 12/6/2023, included a POC indicating patient 2's mental status as "Oriented, Forgetful" The agency failed to indicate on			

	the POC a specific mental status assessment to determine patient 2's orientation to person, place, and time. The POC failed to indicate patient 2's psychosocial (interpersonal relationships, financial status, social/transportation problems ...) status, and cognitive status (attention, learning/reasoning, decision making) status. 5. The clinical record for patient 5, SOC date 2/12/2020, certification period 11/28/2022 to 1/26/2023, included a Plan of Care (POC) indicating patient 5's mental status as "Oriented, Other intellectual impairment" The agency failed to indicate on the POC a specific mental status assessment to determine patient 5's orientation to person, place, and time. The POC failed to indicate patient 5's psychosocial (interpersonal relationships, financial status, social/transportation problems ...) status, and cognitive status (attention, learning/reasoning, decision making) status. 6. During an interview on 1/27/2023 at 10:10 a.m. the Administrator indicated they do not know why the employee			

	mental status and agreed that Autistic was a diagnosis, not a mental status. 17-13-1(a)(1)(D)(i-xiii)			
G0586	Review and revision of the plan of care 484.60(c) Standard: Review and revision of the plan of care. Based on record review and interview the agency failed to review and revise the patient's plan of care to ensure all medications include the correct dosage and all nutrition requirements were adequately documented for 4 of 5 active records reviewed. (Patients 1, 2, 4, and 5) Findings include: 1. A 9/1/2021 policy titled Administration of Medications: General Guidelines was provided by the Administrator on 1/26/2023 at 10:54 a.m. The policy indicated but was not limited to, "Procedure: 1. ...	G0586	As of 2/9/23, education materials are being formulated by the Administrator and DON and will be provided to 100% of the nursing staff by 3/1/23 regarding Physician Orders and ensuring that medications are entered correctly on the POC and MAR to include correct medication, dosage, route, duration and frequency of administration. This education will also include ensuring that tube feedings are correctly documented to include amount of feed, duration, rate and route. A supervisory nurse meeting is scheduled for 2/23/23 to ensure that the supervisory nurses are reviewing all medications at each recertification and ensuring that orders are entered correctly on the POC and MAR. 100% of client charts will be reviewed and updated by 3/1/23 by each client's supervisory nurse to ensure accuracy of orders and that all components above are included on the MAR and POC. Client charts will be reviewed quarterly by the Administrator, DON, or selected RN to ensure compliance with this measure.	2023-03-01

	physician's order for the patient's medication. It should include ... Medication dose, route, duration, and frequency of administration ... Documentation Guidelines: ... Document the medication's name, dosage, route, and frequency of administration ... on the medical record. 2. The clinical record for patient #2, Start of Care 9/17/2015, was reviewed for the certification period 12/09/2022 to 02/6/2023 and included a Plan of Care (POC) indicating patient #2 takes Sulfamethoxazole-Trimethoprim (antibiotic) twice daily. The POC failed to include a dosage for the Sulfamethoxazole-Trimethoprim . 3. The clinical record for patient #4, Start of Care 5/3/2021, was reviewed for the certification period 11/08/2022 to 01/06/2023 and included a Plan of Care (POC) indicating patient #4 receives Nourish formula 210mL/hour every for 4 hours. The POC failed to indicate the total amount of formula patient #4 is to receive at each feeding			

	duration of each of the feedings every 4 hours. 4. During a home visit on 1/26/2023 at 1:00 p.m. patient #5's Medication profile/physician order was reviewed along with Licensed Practical Nurse (LPN1). The agency failed to include a dosage for Folic Acid (vitamin B supplement). 5. During a home visit on 1/26/2023 at 10:30 a.m. patient #1's Medication profile was reviewed. The Medication profile listed Dilantin (seizure medication) as a capsule. At that time, Home Health Aide (HHA1) indicated patient #1 takes Dilantin chewable instead of the capsule form. The agency failed to include a dosage (amount) for Miralax (laxative medication) and Melatonin (sleep medication). 6. During an interview on 1/27/2023 at 10:00 a.m. the administrator stated they did not realize the duration or total amount of feeding was not included on the POC for patient #4 and indicated that all medications on the POC should include the dose, route, and			

	frequency.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the agency failed to ensure the Medication profile / physician orders included accurate dosages and instructions for 2 of 3 home visit observations. (Patient 1 & 5) Findings include:	G0616	As of 2/9/23, education materials are being formulated by the Administrator and DON and will be provided to 100% of the nursing staff by 3/1/23 regarding Physician Orders and ensuring that medications are entered correctly on the POC and MAR to include correct medication, dosage, route, duration and frequency of administration. This education will also include ensuring that tube feedings are correctly documented to include amount of feed, duration, rate and route. A supervisory nurse meeting is scheduled for 2/23/23 to ensure that the supervisory nurses are reviewing all medications at each recertification and ensuring that orders are entered correctly on the POC and MAR. 100% of client charts will be reviewed and updated by 3/1/23 by each clients superviosry nurse to ensure acuracy of orders and that all components above are included on the MAR and POC. Client charts will be reviewed quarterly by the Administrator, DON, or selected RN to ensure compliance with this measure.	2023-03-01

	1. A 9/1/2021 policy titled Administration of Medications: General Guidelines was provided by the Administrator on 1/26/2023 at 10:54 a.m. The policy indicated, but was not limited to, "Procedure: 1. … physician's order for the patient's medication. It should include … Medication dose, route, duration and frequency of administration … Documentation Guidelines: … Document the medication's name, dosage, route, frequency of administration … on the medical record. 2. During a home visit on 1/26/2023 at 10:30 a.m. patient 1's Medication profile was reviewed. The Medication profile listed Dilantin (seizure medication) as a capsule. At that time, Home Health Aide (HHA1) indicated patient 1 takes Dilantin chewable instead of the capsule form. The agency failed to include a dosage (amount) for Miralax (laxative medication) and Melatonin (sleep medication). 3. During a home visit on 1/26/2023 at 1:00 p.m. patient 5's Medication profile /			

	along with Licensed Practical Nurse (LPN1). The agency failed to include a dosage for Folic Acid (vitamin B supplement).			
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 arrangement. (2) The policies and procedures of this section	G0687	100% of staff will be fully vaccinated or have an approved medical or religious waiver on file by 3/1/23. 3 staff were noted during survey to not have the appropriate documentation on file. Staff L.T. had a religious exemption in her file that was found after the surveyor had left. Staff T.W. was undecided about receiving vaccinations and had started the process of the medical exemption. She is now willing to get the vaccinations and has scheduled her first dose. Staff A.S. had her first vaccination but had failed to get her 2nd dose. She has also scheduled her 2nd dose. Ohio Valley will be in full compliance with this measure by 3/1/23. Staff that do not have the required documentation regarding vaccination will not be allowed to work after 3/1/23. HR will be responsible for reviewing and maintating compliance of employee charts and Vaccination records. Annual audits will be conducted to ensure compliance.	2023-03-01

	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 must be temporarily delayed, as 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 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 record review and interview the agency failed to implement policies and procedures to ensure all agency staff is in compliance with the Center for Medicare and Medicaid Services COVID-19 vaccination mandate for 1 of 1 agency reviewed.

Findings include:

1. A policy titled "Mandatory Covid-19 Vaccine Policy and Procedure" was provided by the administrator on 1/24/2023. The document indicated but was not limited to; "On

	or before, January 4, 2022, all Covered Staff Members must either: a. Provide proof they are fully vaccinated, b. Provide proof of a need for a temporary delay … c. Have a pending request for an exemption … d. Have been granted an exemption … Covered Staff Members who are not in compliance … may not provide any care, treatment, or other services … (Waiver Services are excluded)." 2. The Home Health Agencies (HHAs) State Operations Manual Revision 188, indicates but is not limited to; 2202.3E "If home care is provided by an entity required to meet the Medicare CoPs for any reason, then the entity must apply all the requirements of the CoPs, including the comprehensive assessment and OASIS data reporting requirements, to all patients of the agency, including patients treated under a Medicaid Waiver or state plan."			

3. A review of the agency's employees' vaccine status indicated 3 of 96 employees failed to be fully vaccinated or have a valid exemption on file causing the agency to not meet the 100% vaccine compliance requirement.

4. The vaccine record for Registered Nurse (RN) 3, indicated RN 3 received the 1st dose of a 2-dose series vaccine on 9/13/2022. RN 3 failed to receive the 2nd dose of the 2-dose series vaccine.

5. A document titled "Ohio Valley Home Care Mandatory Covid-19 Vaccination Form" was provided by the administrator on 1/26/2023. The document indicated Home Health Aide (HHA) 2 declined the Covid-19 vaccine and provided a medical or religious waiver for review. The agency failed to have a medical or religious

6. The agency was unable to provide a medical or religious exemption for HHA 3 and had no record of vaccination for HHA 3 on file.

7. During an interview on 1/26/2023 at 10:29 a.m. the Administrator stated RN 3 failed to receive the 2nd dose in their vaccine series but would get it by the end of the day. The Administrator stated HHA 2 only provided services to a Medicaid Waiver patient and when the patient wanted more hours with HHA 2 the agency stated they could not request non-waiver hours while HHA 2 remained unvaccinated. The Administrator stated they did not realize the vaccine mandate applied to staff providing care to patients only utilizing waiver hours. The Administrator stated they had requested HHA 2 provide their religious waiver on multiple occasions and HHA 2 failed to provide the

	requested document. The Administrator stated HHA 3 only provided waiver respite services and did not realize they were required to meet the vaccine mandate, they stated HHA 3 has neither proof of vaccination nor a medical exemption on file with the agency.			
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 observation, record review, and interview, the agency failed to ensure specific written patient care instructions and frequencies of each task were included on the aide plan of care for 1 of 1 home health aide observations. (Patient 1) Findings include:	G0798	As of 2/9/23 all supervisory nurses have been notified by the Administrator that the personal care tasks on the Aide Plan of Care must include frequencies. A supervisory nurse meeting is scheduled for 2/23/23 and documentation of frequencies will be discussed at the meeting. The supervisory nurses will add frequencies to personal care tasks on 100% of clients Aide Care Plans by 5/1/23. This time frame will allow a complete 60-day recertification period for each client to enact the changes after the policy is approved. Furthermore, at each of the clients monthly supervisory visits, recertification visits, any ROC visits and upon client/MD request- frequencies will be discussed and adjusted to meet the client's needs as appropriate. Frequencies will be determined by the RN in conjunction with the client/family and MD if necessary. 100% of Home Health Aide staff will be educated to follow the frequency on the Aide Care Plan and to notify the Supervisory RN if changes are warranted or frequency is not met.	2023-03-01

	A 9/1/2021 policy titled Assessment and Development of the Plan of Care was provided by the Administrator on 1/262023 at 10:54 a.m. The policy indicated, but was not limited to, " ...provides an organized structure for identifying patient needs through a comprehensive assessment and for individualizing care to address these needs. Ensures consistent, continuous quality of care ... Statement: A Plan of Care (POC) provides a written document that communicates to all disciplines and can be referred to at any time. It details goals, action steps and appropriate timelines to address patient's medical ... needs An undated document titled Ohio Valley Home Health & Home Care was provided by the Administrator on 1/25/2023 at 10:00 a.m. The document indicated, but was not limited to, "Provide assistance with personal care such as bathing ..." During a home visit on		Home Health Aide documentation will be reviewed quarterly by the Administrator, DON, or selected RN to ensure compliance with frequencies set forth.	

	1's Aide Plan of Care was reviewed along with Home Health Aide (HHA 1). The Aide Plan of Care failed to indicate specific instructions and frequencies (number of occurrences) regarding bathing, shampooing, dressing, nail care, oral care, skin care, incontinent care, and turn/repositioning. At that time, HHA1 indicated patient 1 receives a bath every day and shampoos hair twice a week. HHA1 agreed the Aide Plan of Care instruction section was left blank and did not specify the frequency of each task.			

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
Stephanie Lang	Administrator	2/9/2023 1:15:02 PM