

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
G 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure, and a Complaint Survey.</p> <p>A partially extended survey was announced on 12/19/19.</p> <p>A fully extended survey was announced on 12/20/19.</p> <p>Complaint IN00314881 - Substantiated with findings</p> <p>Survey Dates: December 18, 19, 20, and 31, 2019</p> <p>Facility: IN006094 Medicaid Vendor: 200097860A Provider: 15K005</p> <p>Unduplicated Census: 26 skilled 135 home health aide only 16 personal service only 177 total</p> <p>Current Census: 26 skilled 89 home health aide only 16 personal service only 131 total</p> <p>Sample Selection: Home Visits: 3 Total clinical records reviewed: 9</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings.</p> <p>Ohio Valley Home Health is precluded from</p>			G 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 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.

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0374  Bldg. 00	<p>providing its own home health aide training and competency evaluation program for a period of 2 years beginning December 31, 2019. The cumulative effect of this systemic problem resulted in the agency being out of compliance with §484.60 Condition of participation: Care planning, coordination of services, and quality of care, and §484.100 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients, and §484.80 Condition of participation: Home health aide services.</p> <p>Quality Review Completed: 01/27/20 by Area 1</p> <p>484.45(b) Accuracy of encoded OASIS data Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the agency failed to ensure patient's OASIS (Outcome Assessment and Information Set) were completed in their entirety to reflect patient status for 4 of 4 patients reviewed with OASIS assessments. (Patients 2, 10, 7, 6)</p> <p>Findings included:</p> <p>1. A policy, revised 2/27/14, titled, "Documentation," was provided by the Administrator on 12/27/19 at 8:37 a.m. The policy indicated, but was not limited to, "Documentation reflects the quality of care and provides evidence of each health care team member's responsibility in giving care. Documentation will be: 1. Clear and neat; 2. Dated with month/day/year; 3. Timed when applicable."</p>			G 0374	<p>January 12, 2020 Ohio Valley Home Health (OVHH) began implementation of a new state approved home care system Sandata. This system allows for complete paperless environment as well as complete monitoring for untimely and/or incomplete documentation (including Oasis). Any time a document is opened for patient record use it is time and date stamped. Prior to any document be listed as "completed" and then logged into the patient chart all fields must be addressed and not left blank or unacknowledged. The system will not allow close out without completion in its entirety. The</p>		02/24/2020

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>2. An undated job description, titled, "Staff Registered Nurse/Clinical Manager," was provided by the Administrator on 12/31/19 at 1:30 p.m. The job description indicated, but was not limited to, "Duties: 1. Demonstrate familiarity with and abide by all agency policies, procedures, state and federal rules. 17. Responsible for completion and accuracy of charts including, assessments, SN visits....."</p> <p>3. Patient 2's clinical record was reviewed on 12/18/19 at 2:20 p.m., and included a Recertification OASIS, dated 11/19/19, which lacked documentation of the following: staff time in and time out, patient's name on each page, current number of unhealed pressure ulcers, care plan update, medication status, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>Patient's 2's clinical record included a Resumption of Care OASIS, dated 10/27/19, lacked documentation of the following: staff time in and time out, patient's name on each page, start of care date, resumption of care date, date/time person completed the form, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>4. Patient 10's clinical record was reviewed on 12/19/19 at 1:10 p.m., and included a Recertification OASIS, dated 12/4/19, which lacked documentation of the following: staff time in and time out, patient's name on each page, start of care date, current number of unhealed pressure ulcers, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>Patient 10's Recertification OASIS, dated 10/18/19, lacked documentation of the following: staff time in and time out, patient's name on each page, start of care date, current number of unhealed pressure</p>				<p>supervisory nurse, Clinical Manager and Administrator will be monitoring these documents daily to ensure nothing is left uncompleted.</p> <p>As of 01/28/2020 all home health aides are using this system for EVV and completed tasks done during visits. SN staff have been orientated to the new system and will "go live" beginning 2/10/2020. All staff will be using full system capabilities by 02/24/2020. This will ensure compliance with document completion as well as timeliness. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned in and prior to being filed in the patient's chart by the ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice.</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>ulcers, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>5. Patient 7's clinical record was reviewed on 12/19/19 at 2:20 p.m., and included a Recertification OASIS, dated 6/26/19, which lacked documentation of the following: staff time in and time out, patient's name on each page, current number of unhealed pressure ulcers, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>Patient 7's Recertification OASIS, dated 8/26/19, lacked documentation of the following: staff time in and time out, patient's name on each page, current number of unhealed pressure ulcers, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>Patient 7's Recertification OASIS, dated 10/24/19, lacked documentation of the following: staff time in and time out, patient's name on each page, current number of unhealed pressure ulcers, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>6. Patient 6's clinical record was reviewed on 12/19/19 at 2:50 p.m., and included a Recertification OASIS, dated 11/4/19, which lacked documentation of the following: staff time in and time out, patient's name on each page, Resumption of Care Date or N/A, certification period, current number of unhealed pressure ulcers, or OASIS date reviewed, entered, locked, or transmitted.</p> <p>7. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated visits should be dated, timed, and signed, and the staff know they should fill out the pertinent information, especially what</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0528  Bldg. 00	<p>goes into jHAVEN. During an interview at the same time, the Director of Nursing indicated the nurses put their time on their time sheets, but not on the OASIS forms.</p> <p>484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status;</p> <p>Based on record review and interview, the home health agency failed to ensure the comprehensive assessment reflected the patient's current health status in 3 of 3 active clinical records with nursing, reviewed. (Patients 2, 3, 10)</p> <p>Findings included:</p> <p>1. A policy, revised 2/27/14, titled, "Documentation," was provided by the Administrator on 12/27/19 at 8:37 a.m. The policy indicated, but was not limited to, "Documentation reflects the quality of care and provides evidence of each health care team member's responsibility in giving care. Documentation will be: 1. Clear and neat; 2. Dated with month/day/year; 3. Timed when applicable."</p> <p>2. An undated job description, titled, "Staff Registered Nurse/Clinical Manager," was provided by the Administrator on 12/31/19 at 1:30 p.m. The job description indicated, but was not limited to, "Duties: 1. Demonstrate familiarity with and abide by all agency policies, procedures, state and federal rules. ... 17. Responsible for completion and accuracy of charts including, assessments, SN [skilled nurse] visits....."</p> <p>3. Patient 2's clinical record was reviewed on 12/18/19 at 2:20 p.m., and included a Home Health</p>			G 0528	<p>All staff have been in-serviced on following patient plan of treatment to include following all physician ordered care. All staff have been trained on the new home care system Sandata. Sandata will be fully implemented for skilled and non-skilled staff as of 02/24/2020. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed care. Examples include but are not limited to: G-tube residual check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care, and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation and / or patient care trends in order to</p>		02/07/2020

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>Certification and Plan of Care, dated 11/23/2019 to 1/21/2020. The Plan of Care indicated, but was not limited to, SN 8 (eight) hours per day, 6 (six) days per week to provide medication administration, mini nebulizer treatments, assess respiratory status, tracheostomy care, ventilator monitoring, assist with feedings, assess pulmonary/heart rate and assist with all ADLs/IADLs (Activities of Daily Living and Instrumental Activities of Daily Living).</p> <p>Nursing Assessment Forms, dated 11/24/19, 11/25/19, 11/27/19, 11/29/19, 12/1/19, 12/2/19, 12/4/19, 12/5/19, 12/6/19, and 12/13/19, indicated, but were not limited to, trach (tracheostomy) care done. The Assessments failed to evidence documentation of what specific trach care was provided.</p> <p>4. Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Home Health Certification and Plan of Care, dated 10/9/19 to 12/7/19. The Plan of Care included, but was not limited to the following: HHA (Home Health Aide) 7-8 hour visits, 5 days a week to assist with bathing, grooming, transfers, incontinent care, meal prep, light house keeping, and all other ADLs/IADLs. The Plan of Care indicated the patient had undergone a recent heart by-pass, required assistance with ADLs/IADLs, was unable to ambulate more than a couple of steps due to weakness and being short of air, was on fall precautions, experienced dizziness at times, stated she had pain at all times, was incontinent of bowel, was confused at times, and was on bleeding precautions.</p> <p>A Comprehensive Adult Nursing Start of Care Assessment, dated 10/9/18 (dated incorrectly), failed to evidence documentation of the following:</p>				maintain the most up to date health status of the patient. Follow up will be completed daily as well as follow up of trends during quarterly QAPI.		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>vital signs (blood pressure, temperature, pulse, respirations), primary caregiver information, assessment of nose, throat, mouth, or ears, pain assessment, endocrine assessment, integumentary status, cardiopulmonary status, mental status, psychosocial status, musculoskeletal assessment, mobility status, drug regimen review, medication follow up, and patient/caregiver high risk drug education. The assessment failed to evidence a time in, time out, patient signature, or person completing the form signature/date/time.</p> <p>A Comprehensive Adult Nursing Start of Care Assessment, dated 11/19/19, with "re-assessment for SOC" written on top, failed to evidence documentation of the following: height, weight, vital signs (blood pressure, temperature, pulse, respirations), primary caregiver information, assessment of nose, throat, mouth, or ears, pain assessment, endocrine assessment, integumentary status, cardiopulmonary status, nutritional status, mental status, psychosocial status, or musculoskeletal assessment. The assessment failed to evidence a time in or time out.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated the first assessment was completed on 10/9/19, not 2018, then another was completed on 11/19/19 to re-assess. The 10/9/19 assessment was to see if they could get the Prior Authorization hours and they could not get this without a completed plan of care.</p> <p>5. Patient 10's clinical record was reviewed on 12/19/19 at 1:10 p.m., and included a Home Health Certification and Plan of Care, dated 12/5/19 to 2/2/20. The Plan of Care included, but was not limited to, Nursing 5-6 times per week for 8-10</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
G 0570  Bldg. 00	<p>hour visits to provide...administer ordered medications via g-tube, provide g-tube care, administer ordered feeds via g-tube....Hold feed for 60 milliliters of residual. Flush with 30-60 milliliters of water after feeds and medication administration.</p> <p>Nursing Assessment Forms, dated 12/5/19, 12/6/19, 12/9/19, 12/10/19, 12/11/19, 12/11/19, 12/12/19, 12/13/19, and 12/13/19, failed to evidence documentation of g-tube residual amount or g-tube site care being completed.</p> <p>During an interview on 12/20/19 at 12:38 p.m., Employee E indicated Patient 10's g-tube site is cleaned with soap and water daily in the shower. Employee E indicated feedings did not usually need to be held, and did not usually document residual amount.</p> <p>During an interview on 12/20/19 at 12:48 p.m., the Director of Nursing indicated nursing staff should have been checking and documenting g-tube residual, as well as documenting g-tube site care daily.</p> <p>6. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated staff should have been following the plan of care and documenting what they were doing.</p> <p>17-14-1(a)(1)(C) 17-15-1(a)(1)</p> <p>484.60 Care planning, coordination, quality of care Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can</p>						



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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.</p> <p>Based on record review and interview, the agency failed to ensure they were able to meet a patient's needs by failing to provide timely care ordered by the physician following a hospitalization in 1 of 7 active patients. (Patient 3)</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with §484.60 Condition of participation: Care planning, coordination of services, and quality of care.</p> <p>Findings included:</p> <p>A policy, revised 5/3/12, titled, "Patient Admission," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "There must be a reasonable expectation that the patient's medical, nursing and psychosocial needs can be adequately and safely met in the patient's place of residence."</p>			G 0570	<p>Ohio Valley Home Health began utilizing Sandata home care system on 01/12/2020. This system is one of the state approved sites for HHA to use in order to maintain best care for patients as well as maintain federal and state compliance. Going forward OVHH is using Sandata's referral tracking in order to achieve prior authorization requests for potential clients without having to put them in the system as active as the previous system OVHH used did. This means we will be able to receive MD orders so as to gain approval for PA hours without having leaving the potential patient as active yet not providing care. This tracking system will be monitored daily by the Clinical Manager, ADON, and</p>		01/12/2020

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>An undated job description, titled, "Staff Registered Nurse/Clinical Manager," was provided by the Administrator on 12/31/19 at 1:30 p.m. The job description indicated, but was not limited to, "Duties: 1. Demonstrate familiarity with and abide by all agency policies, procedures, state and federal rules. 17. Responsible for completion and accuracy of charts including, assessments, SN visits....."</p> <p>Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Start of Care Nursing Assessment, dated 10/9/18.</p> <p>The Start of Care Nursing Assessment included, but was not limited to, the following:</p> <p>Patient lives alone, around the clock. The assessment primary caregiver section was blank.</p> <p>Patient has pain all the time, but the location, onset, worst pain gets, best pain gets, and pain description were all blank.</p> <p>Integumentary status (skin) section was blank, with the exception of an indication there were no pressure ulcers.</p> <p>Cardiopulmonary status section was blank.</p> <p>Functional limitations included, bowel/bladder (incontinence), endurance, dizziness at times.</p> <p>Patient had a Fall Risk Assessment Score of 7. A score of 4 or more is considered at risk for falling.</p> <p>ADL/IADLs section indicated patient needed assistance to groom self, dress upper body, dress lower body, bathing,</p>				<p>Administrator. This will avoid failing to provide timely care to patients. OVHH has also implemented a policy on following POC as well as Physician Orders to ensure future compliance.</p>		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>Functional abilities and goals and mobility sections were blank.</p> <p>Drug regimen review, medication follow-up, and patient/caregiver high risk drug education sections were all blank.</p> <p>Types and Sources of Assistance - Assistance needed, but no non-agency caregiver available.</p> <p>Rehabilitation/potential goals section was blank.</p> <p>The Assessment lacked a patient signature and person completing the form signature, as well as date/time.</p> <p>Patient 3's Plan of Care, dated 10/9/19 to 12/7/19, included the following:</p> <p>Diagnoses included, but were not limited to, Heart Triple Bypass, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disorder.</p> <p>An order for a HHA (Home Health Aide) 7-8 hour visits, 5 days per week to assist with bathing, grooming, transfers, incontinent care, meal prep, light house keeping, and all other ADLs/IADLs (Activities of Daily Living/Instrumental Activities of Daily Living).</p> <p>A nursing note which indicated patient had undergone a recent heart by-pass, required assistance with ADLs/IADLs, was unable to ambulate more than a couple of steps due to weakness and being short of air, was on fall precautions, experienced dizziness at times, stated she had pain at all times, was incontinent of bowel, was confused at times, and was on bleeding precautions.</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
G 0572  Bldg. 00	<p>Goals included, but were not limited to, patient's caregiver would verbalize understanding of seizure precautions and safety measures, skin and mucous membranes would remain intact, and hygiene and personal care needs would be met.</p> <p>Patient 3's Home Health Aide Care Plan was created on 11/19/19, and HHA visits also started on 11/19/19.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated the year was written incorrectly on the Start of Care Nursing Assessment and the correct date should have been 10/9/19. The Administrator indicated after the initial start of care assessment, another re-assessment was completed on 11/19/19 after they received approval for Medicaid PA (prior authorization) hours. The Administrator indicated they could not get approved Medicaid PA hours without a plan of care, and they could not see the patient until they received the approval.</p> <p>17-13-1(a)</p> <p>484.60(a)(1) Plan of care</p> <p>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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Based on record review and interview, the agency failed to ensure patients received the services in their plan of care for 3 of 7 active patients. (Patients 3, 10, 7)</p> <p>Findings included:</p> <p>1. Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Home Health Certification and Plan of Care, dated 10/9/19 to 12/7/19. The Plan of Care included, but was not limited to, HHA (Home Health Aide) 7-8 hour visits, 5 days per week to assist with bathing, grooming, transfers, incontinent care, meal preparation, light house keeping, and all other ADLs/IADLs (Activities of Daily Living/Instrumental Activities of Daily Living).</p> <p>Patient 3's Home Health Aide Care Plan was created on 11/19/19.</p> <p>Patient 3's Home Health Aide Visits began on 11/19/19. The clinical record failed to evidence any HHA visits prior to 11/19/19.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated Patient 3's first nursing assessment was completed on 10/9/19, then another was completed on 11/19/19 to re-assess. The 10/9/19 assessment was to see if they could get the Prior Authorization hours and they could not get this without a completed plan of care.</p> <p>2. Patient 10's clinical record was reviewed on 12/19/19 at 1:10 p.m., and included a Home Health Certification and Plan of Care, dated 12/5/19 to 2/2/20. The Plan of Care included, but was not limited to, Nursing 5-6 times per week for 8-10 hour visits to provide....administer ordered medications via g-tube, provide g-tube care,</p>			G 0572	<p><b>All staff have been in-serviced on following patient plan of treatment to include following all physician ordered care. All staff have been trained on the new home care system Sandata as of 01/28/2020. Sandata will be fully implemented for skilled and non-skilled staff as of 02/24/2020. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed care. Examples include but are not limited to: G-tube residual check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care, and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation in order to maintain the most up to date health status of the patient. All SN will be undergoing a skills check off covering care of G-Tube, Trach, Implanted</b></p>		02/24/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>administer ordered feeds via g-tube....Hold feed for 60 milliliters of residual. Flush with 30-60 milliliters of water after feeds and medication administration. Skilled nurse to provide g-tube site care daily. Clean with warm soapy water, pat dry, apply clean 2x2 (dressing).</p> <p>Nursing Assessment Forms, dated 12/5/19, 12/6/19, 12/9/19, 12/10/19, 12/11/19, 12/11/19, 12/12/19, 12/13/19, and 12/13/19, failed to evidence documentation of g-tube residual amount or g-tube site care being completed.</p> <p>During an interview on 12/20/19 at 12:38 p.m., Employee E indicated Patient 10's g-tube site is cleaned with soap and water daily in the shower. Employee E indicated feedings did not usually need to be held, and did not usually document residual amount.</p> <p>During an interview on 12/20/19 at 12:48 p.m., the Director of Nursing indicated nursing staff should have been checking and documenting g-tube residual, as well as documenting g-tube site care daily.</p> <p>3. Patient 7's clinical record was reviewed on 12/19/19 at 2:20 p.m., and included a Home Health Certification and Plan of Care, dated 10/26/19 to 12/24/19. The Plan of Care included, but was not limited to, Home Health Aide 6-7 hour visits, 4-5 days per week while mom is at work to assist with personal care, and Skilled Nursing 3 hour visits, 4-5 days per week while mom is at work.</p> <p>Patient 7's Home Health Aide Visit Records indicated HHA visits outside of the hours ordered on the following dates:</p> <p>10/28/19, 10/31/19, 11/1/19, 11/4/19, 11/7/19,</p>				<p><b>Pumps, Suprapubic Catheters to ensure proper care and documentation going forward.</b> In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned in by the ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice.</p>		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
G 0574  Bldg. 00	<p>11/8/19, 11/11/19, 11/14/19, 11/15/19, 11/18/19, 11/21/19, 12/2/19, 12/5/19, 12/6/19, 12/9/19, 12/12/19, and 12/13/19 from 5:30 a.m. to 3:00 p.m. - 9.5 hours per day</p> <p>11/5/19, 11/12/19, 11/19/19, and 12/10/19 from 5:30 a.m. to 12:45 p.m. and 12:45 p.m. to 3:00 p.m. - 9.5 hours</p> <p>11/6/19 from 5:40 a.m. to 12:00 p.m. and 12:01 p.m. to 2:59 p.m. - 9 hours and 18 minutes</p> <p>11/13/19 from 5:30 a.m. to 12:00 p.m. and 12:00 p.m. to 3:02 p.m. - 9 hours and 32 minutes</p> <p>11/20/19 from 5:30 a.m. to 12:00 p.m. and 12:01 p.m. to 3:00 p.m. - 9 hours and 29 minutes</p> <p>12/3/19 from 5:30 a.m. to 3:00 p.m. and 12:45 p.m. to 3:00 p.m. - 11.75 hours</p> <p>12/4/19 from 5:30 a.m. to 12:00 p.m. and 12:06 p.m. to 3:00 p.m. - 9 hours and 24 minutes</p> <p>12/11/19 from 5:30 a.m. to 12:00 p.m. and 11:47 a.m. to 2:57 p.m. - 9.5 hours</p> <p>4. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated staff should have been following the plan of care and documenting what they were doing. The Administrator indicated the staff must follow the plan of care.</p> <p>5. On 12/31/19 at 12:03 p.m., the Director of Nursing was unable to provide a policy regarding following the plan of care.</p> <p>17-13-1(a)</p> <p>484.60(a)(2)(i-xvi)</p> <p>Plan of care must include the following</p> <p>The individualized plan of care must include the following:</p> <p>(i) All pertinent diagnoses;</p> <p>(ii) The patient's mental, psychosocial, and cognitive status;</p> <p>(iii) The types of services, supplies, and</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>equipment required;</p> <p>(iv) The frequency and duration of visits to be made;</p> <p>(v) Prognosis;</p> <p>(vi) Rehabilitation potential;</p> <p>(vii) Functional limitations;</p> <p>(viii) Activities permitted;</p> <p>(ix) Nutritional requirements;</p> <p>(x) All medications and treatments;</p> <p>(xi) Safety measures to protect against injury;</p> <p>(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.</p> <p>(xiii) Patient and caregiver education and training to facilitate timely discharge;</p> <p>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;</p> <p>(xv) Information related to any advanced directives; and</p> <p>(xvi) Any additional items the HHA or physician may choose to include.</p> <p>Based on record review and interview, the agency failed to ensure the plan of care was individualized and included all pertinent orders for 1 of 4 active patients (Patient 2) with skilled nursing and 1 of 2 discharged patients reviewed. (Patients 5)</p> <p>Findings included:</p> <p>1. Patient 5's clinical record was reviewed on 12/18/19 at 12:09 p.m., and included a Home Health Certification and Plan of Care, dated 10/17/19 to 12/16/19. The Plan of Care included, but was not limited to, Nursing 3 times per week, 1-2 hours visits to provide and oversee ... change suprapubic catheter monthly and PRN (as needed) ....provide wound care as ordered...</p>			G 0574	<p>January 12, 2020 Ohio Valley Home Health (OVHH) began implementation of a new state approved home care system Sandata. This system allows for complete paperless environment as well as complete monitoring for untimely and/or incomplete documentation. All SN staff have been orientated to Sandata as of 01/31/2020 and are aware they must document and/or acknowledge all areas of patient specific care prior to the system allowing the document to be completed. Any time a document</p>		02/24/2020



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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Patient 5's Plan of Care included DME (Durable Medical Equipment) and Supplies - ...baclofen pump...wound pump...</p> <p>Patient 5's Plan of Care, 60 Day Summary indicated patient had a Stage 4 pressure ulcer on the left buttock as well as Stage 2 pressure sores to the left knee. Patient 5 had a wound pump to be utilized continuously for the wound on the left buttock. Dressing changes were on Mondays, Wednesdays, and Fridays. Patient 5 received skilled nursing services 3 times per week for wound care.</p> <p>Patient 5's Plan of Care failed to evidence documentation of specific baclofen pump orders, specific wound vac orders, specific suprapubic catheter size orders, or specific wound care orders for the left knee.</p> <p>2. Patient 2's clinical record was reviewed on 12/18/19 at 2:20 p.m., and included a Home Health Certification and Plan of Care, dated 11/23/19 to 1/21/20. The Plan of Care included, but was not limited to, G-tube 20 french. The 60 day summary indicated patient had a 20 french g-tube and received flushes and nutrition as needed. The Plan of Care failed to evidence specific g-tube orders regarding flushes, feeding, amounts, time frame, and parameters.</p> <p>3. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated the plan of care should have specific g-tube orders with a size and flush. The Administrator indicated they did not do anything with the baclofen pumps but the plan of care should say baclofen pump care completed by whomever and there should be a summary note of when it was filled last or went to see the doctor</p>				<p>is opened for patient record use it is time and date stamped. Prior to any document be listed as "completed" and then logged into the patient chart all fields must be addressed and not left blank or unacknowledged. The system will not allow close out without completion in its entirety. This includes but is not limited to: equipment sizes and care, as well as other medical supplies that may be used by the patient such as for baclofen pump care. The supervisory nurse, ADON, Clinical Manager and Administrator will be monitoring these documents daily to ensure nothing is left uncompleted. SN will all be undergoing a skills check off for G-Tube care/ Baclofen Pump Care and/or knowledge/Trach Care/Suprapubic Cath Care by 2/24/2020 then will be assessed at least yearly. The ADON and DON will track any hospitalizations or re-hospitalizations regarding these specific items with our QAPI quarterly and with combined Sandata System hospitalizations tracking use. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned in and prior to being filed in the patient's chart, by the ADON and the Clinical Manager for completion, timeliness, and to ensure staff are</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0578  Bldg. 00	<p>about it. The Administrator indicated they have tried not to take patient's with wound pumps because it is too hard to send nursing out all the time. The wound pump orders should be specific regarding wound vac care. The Administrator indicated the plan of care should have suprapubic catheter orders, size, when to flush, what to look for, how to monitor, and how often to change.</p> <p>4. On 12/31/19 at 12:03 p.m., the Director of Nursing was unable to provide a policy regarding following the plan of care.</p> <p>17-13-1(a)(1)(B) 17-13-1(a)(1)(D)(ix) 17-13-1(a)(1)(D)(xiii)</p> <p>484.60(b) Conformance with physician orders Standard: Conformance with physician orders. Based on record review and interview, the agency failed to ensure physician's orders were followed for 3 of 7 active records reviewed. (Patients 3, 10, 7)</p> <p>Findings included:</p> <p>1. A policy, revised 5/3/12, titled, "Patient Admission," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "There must be a reasonable expectation that the patient's medical, nursing and psychosocial needs can be adequately and safely met in the patient's place of residence."</p> <p>2. An undated job description, titled, "Staff Registered Nurse/Clinical Manager," was provided by the Administrator on 12/31/19 at 1:30 p.m. The job description indicated, but was not</p>			G 0578	<p>following POC according to their scope of practice. ="" span=""&gt;</p> <p>All staff have been in-serviced on following patient plan of treatment to include following all physician ordered care and patient scheduling. All staff have been trained on the new home care system Sandata. The system will be fully implemented for skilled and non-skilled staff as of 02/24/2020. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed care. Examples include but are not limited to: G-tube residual</p>		01/28/2020

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>limited to, "Duties: 1. Demonstrate familiarity with and abide by all agency policies, procedures, state and federal rules. 17. Responsible for completion and accuracy of charts including, assessments, SN visits....."</p> <p>3. Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Plan of Care, dated 10/9/19 to 12/7/19, which included the following: An order for a HHA (Home Health Aide) 7-8 hour visits 5 days per week to assist with bathing, grooming, transfers, incontinent care, meal prep, light house keeping, and all other ADLs/IADLs (Activities of Daily Living/Instrumental Activities of Daily Living).</p> <p>Patient 3's Home Health Aide Care Plan was created on 11/19/19, and HHA visits also started on 11/19/19. The clinical record failed to evidence HHA visits prior to this date.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated the year was written incorrectly on the Start of Care Nursing Assessment and the correct date should have been 10/9/19. The Administrator indicated after the initial start of care assessment, another re-assessment was completed on 11/19/19 after they received approval for Medicaid PA (prior authorization) hours. The Administrator indicated they could not get approved Medicaid PA hours without a plan of care, and they could not see the patient until they received the approval.</p> <p>2. Patient 10's clinical record was reviewed on 12/19/19 at 1:10 p.m., and included a Home Health Certification and Plan of Care, dated 12/5/19 to 2/2/20. The Plan of Care included, but was not limited to, Nursing 5-6 times per week for 8-10 hour visits to provide....administer ordered</p>				<p>check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care, and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation in order to maintain the most up to date health status of the patient. We will also monitor daily to ensure scheduling is according to POT orders as they are inputted into Sandata upon approval by MD and state payors. This enables scheduling to not happen against the plan of care orders without necessary documentation and approval. OVHH has also implemented new policies on Following POC and Physician Orders to ensure future compliance. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned in by the ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice.</p> <p>="" p=""&gt;</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>medications via g-tube, provide g-tube care, administer ordered feeds via g-tube....Hold feed for 60 milliliters of residual. Flush with 30-60 milliliters of water after feeds and medication administration. Skilled nurse to provide g-tube site care daily. Clean with warm soapy water, pat dry, apply clean 2x2 (dressing).</p> <p>Nursing Assessment Forms, dated 12/5/19, 12/6/19, 12/9/19, 12/10/19, 12/11/19, 12/11/19, 12/12/19, 12/13/19, and 12/13/19, failed to evidence documentation of g-tube residual amount or g-tube site care being completed.</p> <p>During an interview on 12/20/19 at 12:38 p.m., Employee E indicated Patient 10's g-tube site is cleaned with soap and water daily in the shower. Employee E indicated feedings did not usually need to be held, and did not usually document residual amount.</p> <p>During an interview on 12/20/19 at 12:48 p.m., the Director of Nursing indicated nursing staff should have been checking and documenting g-tube residual, as well as documenting g-tube site care daily.</p> <p>3. Patient 7's clinical record was reviewed on 12/19/19 at 2:20 p.m., and included a Home Health Certification and Plan of Care, dated 10/26/19 to 12/24/19. The Plan of Care included, but was not limited to, Home Health Aide 6-7 hour visits, 4-5 days per week while mom is at work to assist with personal care, and Skilled Nursing 3 hour visits, 4-5 days per week while mom is at work.</p> <p>Patient 7's Home Health Aide Visit Records indicated HHA visits outside of the hours ordered on the following dates:</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
G 0580  Bldg. 00	<p>10/28/19, 10/31/19, 11/1/19, 11/4/19, 11/7/19, 11/8/19, 11/11/19, 11/14/19, 11/15/19, 11/18/19, 11/21/19, 12/2/19, 12/5/19, 12/6/19, 12/9/19, 12/12/19, and 12/13/19 from 5:30 a.m. to 3:00 p.m. - 9.5 hours per day</p> <p>11/5/19, 11/12/19, 11/19/19, and 12/10/19 from 5:30 a.m. to 12:45 p.m. and 12:45 p.m. to 3:00 p.m. - 9.5 hours</p> <p>11/6/19 from 5:40 a.m. to 12:00 p.m. and 12:01 p.m. to 2:59 p.m. - 9 hours and 18 minutes</p> <p>11/13/19 from 5:30 a.m. to 12:00 p.m. and 12:00 p.m. to 3:02 p.m. - 9 hours and 32 minutes</p> <p>11/20/19 from 5:30 a.m. to 12:00 p.m. and 12:01 p.m. to 3:00 p.m. - 9 hours and 29 minutes</p> <p>12/3/19 from 5:30 a.m. to 3:00 p.m. and 12:45 p.m. to 3:00 p.m. - 11.75 hours</p> <p>12/4/19 from 5:30 a.m. to 12:00 p.m. and 12:06 p.m. to 3:00 p.m. - 9 hours and 24 minutes</p> <p>12/11/19 from 5:30 a.m. to 12:00 p.m. and 11:47 a.m. to 2:57 p.m. - 9.5 hours</p> <p>4. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated staff should have been following the plan of care and documenting what they were doing. The Administrator indicated the staff must follow the plan of care.</p> <p>5. On 12/31/19 at 12:03 p.m., the Director of Nursing was unable to provide a policy regarding following physician's orders.</p> <p>17-14-1(a)(1)(H)</p> <p>484.60(b)(1)</p> <p>Only as ordered by a physician</p> <p>Drugs, services, and treatments are administered only as ordered by a physician. Based on record review and interview, the agency failed to ensure a wound care treatment was administered only as ordered by a physician for 1</p>			G 0580	<p>="" spancare="" span="" examples="" include="" but="" not="" limited="" to="" aide=""</p>		02/24/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>of 2 discharged records reviewed. (Patient 11)</p> <p>Findings included:</p> <p>A policy, revised 1/18/18, titled, "Wound Treatment," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "Wound care must be performed by a Licensed Practical Nurse or a Registered Nurse ... Home Health Aides/CNAs should not perform wound care..."</p> <p>An undated job description, titled, "Certified Nursing Assistant," was provided by the Administrator on 12/31/19 at 1:30 p.m. The Job Description indicated, but was not limited to, "Duties: ... 2. Functions within the limits of own experience and knowledge and practices safely and competently within the job description. 3. Performs total care or assists in all activities of daily living/personal care, such as, but not limited to, bathing, dressing, hair and skin care, oral hygiene, elimination activities, meal prep, feeding and linen changes. Job Limitations: 4. May not perform procedures requiring the knowledge, training and skill of a licensed nurse."</p> <p>Patient 11's clinical record was reviewed on 12/19/19 at 3:46 p.m., and included a Home Health Certification and Plan of Care, dated 7/28/19 to 9/25/19.</p> <p>The Plan of Care included, but was not limited to, Home Health Aide 4-5 times per week, 3 hour visits to assist with bathing, grooming, personal care, transfers, meal prep and all other ADLs (activities of daily living) as needed.</p> <p>An Aide Care Plan, dated 5/28/19, and reviewed on 7/25/19, included assignments of: tub/shower,</p>				<p>allowed="" them="" practice="" and="" any="" patient="" refusals="" care. &lt;="" span=""&gt; The Supervisory nurses, ADON, DON, and Administrator will be monitoring all staff's documentation daily through use of Sandata for any incomplete documentation, patient refusal trends, and any other concerns that may arise that needs attention. Sandata allows for real time access, specific patient centered tasks and optimal delivery of care. All staff have been in serviced regarding scope of practice. New policies are in place for following physician orders as well as POC in order to aid in future care of patients. Staff have started being inserviced on scope of practice and following proper procedures in order to maintain patient care going forward. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned in and at supervisory visits by the supervisory nurses, ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice. ="" spancare="" span="" examples="" include="" but="" not="" limited="" to="" aide="" allowed="" them="" practice="" and="" any="" patient=""</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
G 0590  Bldg. 00	<p>personal care, assist with dressing, hair care, shampoo, skin care, nail care, oral care, assist with elimination, assist with ambulation, mobility assist, ROM (range of motion) active, meal preparation, wash clothes, and light housekeeping.</p> <p>Home Health Aide Visit Records, dated 7/28/19, 7/30/19, 8/1/19, 8/11/19, 8/12/19, 8/13/19, and 8/18/19, indicated the home health aide performed and documented wound care.</p> <p>During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated home health aides are not allowed to perform wound care or document wound care.</p> <p>17-14-1(a)(1)(H)</p> <p>484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to ensure the physician was notified that</p>	G 0590	<p>refusals="" care. &lt;="" span=""&gt; ="" b=""&gt; ="" b=""&gt; ="" b=""&gt; ="" b=""&gt; ="" b=""&gt; ="" b=""&gt; ="" b=""&gt; ="" span=""&gt; ="" spancare="" span="" examples="" include="" but="" not="" limited="" to="" aide="" allowed="" them="" practice="" and="" any="" patient="" refusals="" care. &lt;="" span="" assigned="" caregivers="" through="" use="" sandata="" this="" ensures="" proper="" care="" is="" being="" completed="" supervisory="" nurses,="" adon,="" don,="" administrator="" following="" real="" time="" activity="" completed="" state="" ensure="" compliance="" practice.&lt;=""&gt; ="" b=""&gt; ="" span=""&gt; ="" span=""&gt; ="" b=""&gt;</p> <p>Ohio Valley Home Health began utilizing Sandata home care</p>	01/31/2020	

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>the plan of care was not being fulfilled as ordered for 1 of 1 active home health aide only patient. (Patient 3)</p> <p>Findings included:</p> <p>A policy, revised 5/3/12, titled, "Patient Admission," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "There must be a reasonable expectation that the patient's medical, nursing and psychosocial needs can be adequately and safely met in the patient's place of residence."</p> <p>Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Start of Care Nursing Assessment, dated 10/9/18.</p> <p>Patient 3's Plan of Care, dated 10/9/19 to 12/7/19, included the following:</p> <p>Diagnoses included, but were not limited to, Heart Triple Bypass, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disorder.</p> <p>An order for a HHA (Home Health Aide) 7-8 hour visits 5 days per week to assist with bathing, grooming, transfers, incontinent care, meal prep, light house keeping, and all other ADLs/IADLs (Activities of Daily Living/Instrumental Activities of Daily Living).</p> <p>A nursing note which indicated patient had undergone a recent heart by-pass, required assistance with ADLs/IADLs, was unable to ambulate more than a couple of steps due to weakness and being short of air, was on fall precautions, experienced dizziness at times, stated she had pain at all times, was incontinent of bowel, was confused at times, and was on</p>				<p>system on 01/12/2020. This system is one of the state approved sites for HHA to use in order to maintain best care for patients as well as maintain federal and state compliance. Going forward OVHH is using Sandata's referral tracking in order to achieve prior authorization requests for potential clients without having to put them in the system as active as the previous system OVHH used did. This means we will be able to receive MD orders so as to gain approval for PA hours without having leaving the potential patient as active yet not providing care. This tracking system will be monitored daily in coordination with the state CMS Prior Authorization site, by the Clinical Manager, ADON, and Administrator. This will avoid failing to provide timely care to patients while awaiting PA approval.</p>		



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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>bleeding precautions.</p> <p>Goals included, but were not limited to, patient's caregiver would verbalize understanding of seizure precautions and safety measures, skin and mucous membranes would remain intact, and hygiene and personal care needs would be met.</p> <p>Patient 3's Home Health Aide (HHA) Care Plan was created on 11/19/19, and HHA visits also started on 11/19/19.</p> <p>Copies of Patient 3's entire clinical record was provided by the Director of Nursing on 12/19/19 at 11:49 a.m.</p> <p>Patient 3's clinical record failed to evidence any HHA visits prior to 11/19/19.</p> <p>Patient 3's clinical record failed to evidence an updated Plan of Care or physician notification of delay in care.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated the year was written incorrectly on the Start of Care Nursing Assessment and the correct date should have been 10/9/19, not 2018. The Administrator indicated after the initial start of care assessment, another re-assessment was completed on 11/19/19 after they received approval for Medicaid PA (prior authorization) hours. The Administrator indicated they could not get approved Medicaid PA hours without a plan of care, and they could not see the patient until they received the approval.</p> <p>17-13-1(a)(2) 17-13-1(d)</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0682  Bldg. 00	<p>484.70(a) Infection Prevention 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 infection control practices were maintained at 3 of 3 home visits. (Patients 9, 7, 10)</p> <p>Findings included:</p> <p>1. A policy, dated 7/16/19, titled, "Ohio Valley Handwashing Policy," was provided by the Administrator on 12/27/19 at 8:37 a.m. The policy indicated, but was not limited to, "When to wash hands: Upon arrival in patient home, whenever preparing food, after touching contaminated areas, before putting on gloves and after glove removal, before and after patient care, after sneezing/coughing, after toilet use."</p> <p>2. A policy, revised 1/1/18, titled, "OVHH Infection Control Education/Training," was provided by the Administrator on 12/27/19 at 8:37 a.m. The policy indicated, but was not limited to, "1. Infection control training during OVHH orientation will include the following information....c. Infection control policies; f. Aseptic technique...g. Standard precautions: Hand washing techniques and personal protective equipment; j. Cleaning and sterilization of equipment and devices, Disinfecting reusable equipment..."</p> <p>3. During a home visit with Patient 9 on 12/19/19 at 8:25 a.m., Employee H was observed washing her hands and applied gloves to assist the patient</p>			G 0682	<p>All staff (skilled and non-skilled) have started being in serviced on infection control precautions and proper procedures specific to their scope of care. In services included but were not limited to basic infection control, standard precautions, barriers, glove changes, cleaning of shared medical equipment and proper cleaning and care of patient medical equipment. Going forward supervisory nurses and/or ADON and Clinical Manager will monitor staff at least yearly for all clinical skills within staff scope of practice as well as when conducting mandatory supervisory visits. Any problems or concerns found during staff review will result in the staff being retrained and then required to show return the skill. All current staff are inputted into the new Sandata home care system used by OVHH in order to track due dates for clinical skills check off dates. These will be followed by the ADON and DON for compliance and tracked during QAPI quarterly meetings going forward. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all</p>		02/24/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>with a shower. Employee H washed the patient's hair, face, upper body, arms, both legs, back, peri area, and buttocks. Employee H rinsed out the washcloth, closed the shower curtain, then rinsed off the patient from the other end of the shower with a removable shower head. Employee H turned off the water, opened the curtain, removed a towel from the bathroom counter, and dried patient off from head to toe, then dried peri area and buttocks. Employee H walked to patient's bedroom to retrieve clothes from the drawers and closet, and deodorant from a drawer. Employee H assisted Patient 9 to dress. Employee H then removed gloves and washed hands. Employee H was not observed to remove gloves and/or perform hand hygiene until this point.</p> <p>4. During a home visit with Patient 7 on 12/20/19 at 8:00 a.m., Employee G was observed to wash hands then sit at the kitchen table with the patient. Employee G removed vital sign equipment from her bag, then placed directly on the kitchen table with no barrier. Employee G assessed the patient's temperature under the arm, then checked a manual blood pressure with a cuff and stethoscope. Employee G placed the vital sign equipment back in the bag without performing hand hygiene. Employee G checked the patient's pulse, then reached back into the bag without performing hand hygiene to retrieve her stethoscope. Employee G listened to Patient 7's lung sounds, abdomen, and heart, then placed the stethoscope back in the bag without sanitizing.</p> <p>5. During a home visit with Patient 10 on 12/20/19 at 12:15 p.m., Employee E was observed to administer feeding without wearing gloves, then placed all feeding supplies in the patient's bathroom sink. Employee E then rinsed the supplies off and placed on a towel to dry.</p>				<p>paperwork/documentation will be audited upon being turned in and during any supervisory visits by the supervisory nurses, ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice.</p>		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
G 0710  Bldg. 00	<p>6. During an interview on 12/20/19 at 12:48 p.m., the Director of Nursing indicated home health aides should change gloves after assisting a patient with a shower and should also wash hands before donning new gloves. The Director of Nursing indicated they do not use a barrier in the home between their equipment and the home, but they have been talking about doing this since they are wanting to be a Medicare agency. The Director of Nursing indicated the staff should sanitize their vital sign equipment between patients and before placing it back in their bag. The Director of Nursing indicated g-tube feeding supplies should not be placed in a dirty sink after use if being reused.</p> <p>17-12-1(m)</p> <p>484.75(b)(3)</p> <p>Provide services in the plan of care</p> <p>Providing services that are ordered by the physician as indicated in the plan of care; Based on record review and interview, the agency failed to ensure patients received the services in their plan of care for 1 of 4 patients reviewed with skilled nursing services. (Patient 10)</p> <p>Findings included:</p> <p>Patient 10's clinical record was reviewed on 12/19/19 at 1:10 p.m., and included a Home Health Certification and Plan of Care, dated 12/5/19 to 2/2/20. The Plan of Care included, but was not limited to, Nursing 5-6 times per week for 8-10 hour visits to provide....administer ordered medications via g-tube, provide g-tube care, administer ordered feeds via g-tube....Hold feed for 60 milliliters of residual. Flush with 30-60 milliliters of water after feeds and medication</p>			G 0710	<p>="" span=""&gt;</p> <p>All staff have been in-serviced on following patient plan of treatment to include following all physician ordered care. All staff have been trained on the new home care system Sandata. Sandata will be fully implemented for skilled and non-skilled staff as of 02/24/2020. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed</p>		01/31/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>administration. Skilled nurse to provide g-tube site care daily. Clean with warm soapy water, pat dry, apply clean 2x2 (dressing).</p> <p>Nursing Assessment Forms, dated 12/5/19, 12/6/19, 12/9/19, 12/10/19, 12/11/19, 12/11/19, 12/12/19, 12/13/19, and 12/13/19, failed to evidence documentation of g-tube residual amount or g-tube site care being completed.</p> <p>During an interview on 12/20/19 at 12:38 p.m., Employee E indicated Patient 10's g-tube site is cleaned with soap and water daily in the shower. Employee E indicated feedings did not usually need to be held, and did not usually document residual amount.</p> <p>During an interview on 12/20/19 at 12:48 p.m., the Director of Nursing indicated nursing staff should have been checking and documenting g-tube residual, as well as documenting g-tube site care daily.</p> <p>During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated staff should have been following the plan of care and documenting what they were doing. The Administrator indicated the staff must follow the plan of care.</p> <p>During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated staff should have been following the plan of care and documenting what they were doing. The Administrator indicated the staff must follow the plan of care.</p> <p>On 12/31/19 at 12:03 p.m., the Director of Nursing was unable to provide a policy regarding following the plan of care.</p> <p>17-14-1(a)(1)(H)</p>				<p>care. Examples include but are not limited to: G-tube residual check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care, and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation and / or trends for QAPI in order to maintain the most up to date health status of the patient.</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0716  Bldg. 00	<p>484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on record review and interview, the agency failed to ensure nurses documented what specific medications they administered at visits for 2 of 4 active records with nursing. (Patients 2, 10)</p> <p>Findings included:</p> <p>1. A policy, revised 5/2/12, titled, "Pharmaceutical Administration," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "Oral/Rectal medications will be dealt with as follows: 2. Clinical notes reflect the route, date and time of all medications administered by the RN [registered nurse] and/or LPN [licensed practical nurse] employees. Clinical notes shall also reflect any medications not given as ordered and the reason why."</p> <p>2. Patient 2's clinical record was reviewed on 12/18/19 at 2:20 p.m., and included a Home Health Certification and Plan of Care, dated 11/23/2019 to 1/21/2020. The Plan of Care indicated, but was not limited to, SN (Skilled Nurse) 8 (eight) hours per day, 6 (six) days per week to provide medication administration....</p> <p>Nursing Assessment Forms, dated 11/25/19, 11/27/19, 11/29/19, 12/1/19, 12/2/19, 12/5/19, and 12/13/19, indicated, but were not limited to, oral meds given. The Assessments failed to evidence documentation of what specific medications were administered.</p> <p>3. Patient 10's clinical record was reviewed on 2/19/19 at 1:10 p.m., and included a Home Health Certification and Plan of Care, dated 12/5/19 to</p>			G 0716	<p>Beginning January 12, 2020 OVHH has begun using the Sandata State approved home care site in replacement of Generations Home Care system as we believe Sandata will aid in maintaining our compliance and growth in much better standards. Sandata will allow us to become paperless and follow our patient's care in real time. They have MAR capability which we have already begun utilizing. SN has been orientated to the new system however we will not be fully live until 02/24/2020. We will enter meds given at time of visits by our skilled staff using a shared form so the office can follow and make changes in real time according to MD orders. This will provide a much more efficient patient care process as well as better coordination between all involved in the patient's care. The system will not allow a visit to closeout without being totally completed, including documentation of medications given. The supervisory nurses, ADON, DON, as well as the Administrator will monitor daily for incomplete charting r/t medications, patient care, and or MD orders changing. OVHH has also implemented new policies for following POC and Physician orders to aid in</p>		02/24/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0750  Bldg. 00	<p>2/2/20. The Plan of Care indicated, but was not limited to, Nursing 5-6 times per week for 8-10 hours to....administered ordered medications via g-tube.</p> <p>Nursing Assessment Forms, dated 12/12/19, indicated but were not limited to, gave client his afternoon meds (medications).</p> <p>Nursing Assessment Forms, dated 12/6/19, 12/9/19, 12/10/19, 12/11/19, 12/11/19, 12/12/19, 12/13/19, indicated, but were not limited to, medications and feeding given as ordered.</p> <p>Nursing Assessment Forms, dated 12/9/19, 12/12/19, 12/13/19, 12/14/19, indicated, but were not limited to, gave client his late afternoon meds.</p> <p>4. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated some of the nursing staff document meds given per orders and that is an easy way out. The Administrator indicated the staff should document what medications were given, and the nurses should be more specific.</p> <p>17-14-1(a)(1)(E)</p> <p>484.80 Home health aide services Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) ensured the home health aide (HHA) care plan was individualized with specific tasks to be completed and how often for 4 of 4 active records</p>			G 0750	<p>maintaining compliance going forward. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned in by the ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice. All staff will also be monitored by supervisory nurses, ADON, Clinical Manager during supervisory/home visits.</p> <p>="" span=""&gt; All supervisory nurses (RN) and the ADON have been in serviced on following policy and procedures on conducting supervisory visits</p>		01/31/2020

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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	
	<p>reviewed with a HHA, and failed to ensure the HHA followed the care plan as ordered or notified the nurse of deviations for 4 of 4 active records reviewed with a HHA (See G798); the agency failed to ensure the Home Health Aide provided services that were ordered by the physician and within their scope of practice for 2 of 2 closed records reviewed. (See G800); agency failed to ensure a nurse supervised the home health aide to ensure they furnished care in a safe manner within their scope of practice for 1 of 2 closed records reviewed. (See G818).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with §484.80 Condition of participation: Home health aide services.</p>		<p>timely and ensuring the staff member is following the patient's plan of treatment. OVHH now is utilizing Sandata for its home care system. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed care. Examples include but are not limited to: home health aide tasks, G-tube residual check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care, and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation in order to maintain the most up to date health status of the patient. Supervisory nurses will also be utilizing the sup visit tracking part of Sandata's system in order to maintain timely supervisory visits. This will be monitored by the ADON and the DON daily in order to maintain compliance and optimal patient care.</p>		



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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0798  Bldg. 00	<p>484.80(g)(1) Home health aide assignments and duties 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, the agency failed to ensure the Registered Nurse (RN) ensured the home health aide (HHA) care plan was individualized with specific tasks to be completed and how often for 4 of 5 active records reviewed with a HHA, and failed to ensure the HHA followed the care plan as ordered or notified the nurse of deviations for 4 of 4 active records reviewed with a HHA. (Patients 3, 4, 9, 6)</p> <p>Findings included:</p> <p>1. An undated job description, titled, "Certified Nursing Assistant," was provided by the Administrator on 12/31/19 at 1:30 p.m. The Job Description indicated, but was not limited to, "Duties: 2. Functions within the limits of own experience and knowledge and practices safely and competently within the job description. 3. Performs total care or assists in all activities of daily living/personal care, such as, but not limited to, bathing, dressing, hair and skin care, oral hygiene, elimination activities, meal prep, feeding and linen changes. ... 12. Takes and records accurately vital signs (temperature, pulse, respirations, and blood pressure) and reports changes to the Supervisory RN. 13. Completes records accurately and carries out all assignments</p>			G 0798	<p><b>All supervisory nurses (RN) and the ADON have been in serviced on following policy and procedures on conducting supervisory visits timely and ensuring the staff member is following the patient's plan of treatment. OVHH now is utilizing Sandata for its home care system. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed care. Examples include but are not limited to:home health aide tasks, G-tube residual check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care,</b></p>		01/31/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>as requested. 14. Observes general condition and reports changes to the Supervisory RN."</p> <p>2. An undated job description, titled, "Staff Registered Nurse/Clinical Manager," was provided by the Administrator on 12/31/19 at 1:30 p.m. The Job Description indicated, but was not limited to, "Duties: 1. Demonstrate familiarity with and abide by all agency policies, procedures, state and federal rules."</p> <p>3. Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Home Care Aide Care Plan, dated 11/19/19. The Home Care Aide Care Plan included, but was not limited to: Temperature, Pulse, Respirations, and Blood Pressure - weekly, Personal Care every visit, Assist with Dressing every visit, Shampoo every visit - as requested, Assist with Elimination every visit, Assist with Ambulation every visit, Meal Preparation every visit, Wash Clothes every visit - as requested, Light Housekeeping every visit - as requested.</p> <p>The Home Care Aide Care Plan failed to assign specific tasks either at each visit or on specific days for the home health aide to perform, and the vital sign parameters to notify care manager was left blank.</p> <p>The Home Health Aide Visit Records failed to evidence the HHA followed the care plan as ordered or notified the nurse of deviations for the following dates: Week of 11/19/19 to 11/23/19 - no vital signs were recorded 11/19/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, assist with ambulation, meal preparation, laundry, or housekeeping.</p>				<p><b>and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation in order to maintain the most up to date health status of the patient. Supervisory nurses will also be utilizing the sup visit tracking part of Sandata's system in order to maintain timely supervisory visits. This will be monitored by the ADON and the DON daily in order to maintain compliance and optimal patient care.</b></p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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		
	<p>11/20/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, or assist with ambulation.</p> <p>11/21/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, meal preparation, or housekeeping.</p> <p>11/22/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, assist with ambulation, meal preparation, or laundry.</p> <p>11/23/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, or assist with ambulation.</p> <p>Week of 11/24/19 to 11/30/19 - no vital signs were recorded</p> <p>11/24/19 - HHA was present for 4 hours with no documentation of any duties completed.</p> <p>11/25/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, assist with ambulation, or laundry. Grocery shopping completed without being assigned.</p> <p>11/26/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, assist with ambulation, or laundry.</p> <p>11/27/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, assist with ambulation, or laundry. Grocery shopping completed without being assigned.</p> <p>11/29/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, assist with ambulation, or laundry. Grocery shopping completed without being assigned.</p> <p>11/30/19 - no documentation of personal care, assist with dressing, shampoo, assist with elimination, or assist with ambulation.</p> <p>Week of 12/1/19 to 12/7/19 - no vital signs were recorded</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>12/1/19 - no documentation of assist with elimination, assist with ambulation, or laundry. Grocery shopping completed without being assigned.</p> <p>12/2/19 - no documentation of assist with elimination. Tub/shower, nail care, assist with mobility, and grocery shopping completed without being assigned.</p> <p>12/3/19 - no documentation of assist with elimination and assist with ambulation. Grocery shopping completed without being assigned.</p> <p>12/4/19 - no documentation of assist with elimination or laundry. Tub/shower, nail care, and assist with mobility completed without being assigned.</p> <p>12/5/19 - no documentation of assist with elimination, assist with ambulation, or laundry.</p> <p>12/6/19 - no documentation of assist with elimination or laundry. Tub/shower, nail care, and assist with mobility completed without being assigned.</p> <p>12/7/19 - no documentation of assist with elimination, assist with ambulation, or laundry.</p> <p>Patient 3's Supervisory Note was completed by the Director of Nursing on 12/9/19, and indicated the home health aide followed the assignment sheet.</p> <p>4. Patient 4's clinical record was reviewed on 12/19/19 at 11:50 a.m., and included a Home Care Aide Care Plan, dated 10/29/19. The Home Care Aide Care Plan included, but was not limited to, Temperature, Pulse, Respirations, Blood Pressure, Weight, and Pain Rating - As Requested Per Client, Shower every visit - Upon Request, Hair Care, Shampoo, Skin Care, Foot Care, Check Pressure Areas, Nail Care, and Circulation - every visit, Assist with Ambulation - every visit, Mobility Assist - every visit, Meal Preparation,</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>Encourage Fluids, Grocery Shopping, Wash Clothes, Light Housekeeping, Errands, and Appointments - every visit</p> <p>The Home Care Aide Care Plan failed to assign specific tasks either at each visit or on specific days for the home health aide to perform, and the vital sign parameters to notify care manager was left blank.</p> <p>The Home Health Aide Visit Records failed to evidence the HHA followed the care plan as ordered or notified the nurse of deviations for the following dates:</p> <p>10/29/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, or Laundry.</p> <p>10/30/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, or Laundry.</p> <p>10/31/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, or Grocery Shopping.</p> <p>11/1/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, or Laundry.</p> <p>11/2/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Meal Preparation, or Grocery Shopping.</p> <p>11/5/19 - no documentation of Temperature, Blood</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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		
	<p>Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, or Laundry.</p> <p>11/6/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, or Foot Care.</p> <p>11/7/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, or Laundry.</p> <p>11/8/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, or Laundry.</p> <p>11/9/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, or Grocery Shopping.</p> <p>11/11/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Mobility, Grocery Shopping, and Laundry. Partial Bed Bath, Oral Care, Range of Motion, and Positioning completed without being assigned.</p> <p>11/12/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>11/13/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>11/14/19 - no documentation of Temperature,</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, and Assist with Mobility.</p> <p>11/15/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Mobility, and Laundry.</p> <p>11/16/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Meal Preparation, Grocery Shopping, and Laundry.</p> <p>11/19/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Skin Care, Nail Care, Foot Care, Assist with Mobility, and Laundry.</p> <p>11/20/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, and Assist with Mobility.</p> <p>11/21/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Skin Care, Nail Care, Assist with Mobility, and Grocery Shopping.</p> <p>11/22/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Mobility, or Laundry.</p> <p>11/23/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>11/25/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>11/26/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, and Assist with Mobility. Personal care and oral care completed without being assigned.</p> <p>11/27/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>11/29/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, and Laundry.</p> <p>11/30/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, and Grocery Shopping.</p> <p>12/2/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, and Grocery Shopping.</p> <p>12/3/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Mobility, and Laundry.</p> <p>12/4/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, and Assist with Mobility.</p> <p>12/5/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>12/6/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care,</p>						



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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>12/7/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, Grocery Shopping, and Laundry.</p> <p>12/9/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, Assist with Ambulation, Assist with Mobility, and Grocery Shopping.</p> <p>12/14/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, Shower, Hair Care, Shampoo, Skin Care, Nail Care, Foot Care, and Assist with Mobility. Bed bath, assist with dressing, oral care, range of motion, and positioning documented without being assigned.</p> <p>The following items are assigned on the Home Care Aide Care Plan, but are not available to be documented on the Home Health Aide Visit Record, and therefore were not documented at any visit: Weight, Pain Rating, Check Pressure Areas, Circulation, Encourage Fluids, Errands, and Appointments.</p> <p>5. Patient 9's clinical record was reviewed on 12/19/19 at 12:30 p.m., and included a Home Care Aide Care Plan, dated 11/4/19. The Home Care Aide Care Plan included, but was not limited to, Temperature, Pulse, Respirations, Blood Pressure weekly - As Patient Allows, Shower every visit - Upon Request, Personal Care, Assist with Dressing, Hair Care, Shampoo, Skin Care, Foot Care, Check Pressure Areas, Nail Care, and Oral Care - every visit, Meal Preparation - per request, Light Housekeeping.</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>The Home Care Aide Care Plan failed to assign specific tasks either at each visit or on specific days for the home health aide to perform, and the vital sign parameters to notify care manager was left blank.</p> <p>The Home Health Aide Visit Records failed to evidence the HHA followed the care plan as ordered or notified the nurse of deviations for the following dates:</p> <p>11/4/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and Shower.</p> <p>11/6/19 - no documentation of Temperature, Blood Pressure, Respirations, and Pulse.</p> <p>11/8/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, nail care, oral care, foot care, and meal preparation.</p> <p>11/9/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, nail care, and meal preparation. Assist with ambulation was documented without being assigned.</p> <p>11/11/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower.</p> <p>11/12/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, shower, personal care, hair care, nail care, oral care, and meal preparation. Bed bath was documented without being assigned.</p> <p>11/13/19 - no documentation of Temperature, Blood Pressure, Respirations, and Pulse. Assist/chair was documented without being assigned.</p> <p>11/14/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower.</p> <p>11/15/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, nail care, and meal preparation.</p> <p>11/16/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, skin care, mail care, and meal preparation.</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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		
	<p>11/18/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower. Laundry was documented without being assigned.</p> <p>11/20/19 - no documentation of Temperature, Blood Pressure, Respirations, and Pulse. Laundry was documented without being assigned.</p> <p>11/21/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower. Laundry was documented without being assigned.</p> <p>11/22/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, personal care, nail care, foot care, and meal preparation. Assist/chair was documented without being assigned.</p> <p>11/23/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, skin care, nail care, and meal preparation.</p> <p>11/25/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower.</p> <p>11/26/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, personal care, nail care, foot care, and meal preparation. Assist/chair was documented without being assigned.</p> <p>11/27/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower.</p> <p>11/29/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, personal care, nail care, oral care, foot care, and meal preparation. Assist/chair was documented without being assigned.</p> <p>12/2/19 - no documentation of Temperature, Blood Pressure, Respirations, and Pulse. Assist/chair and Range of Motion were documented without being assigned.</p> <p>12/3/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, personal care, nail care, foot care, and meal preparation. Assist/chair</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>was documented without being assigned.</p> <p>12/4/19 - no documentation of Temperature, Blood Pressure, Respirations, and Pulse. Assist/chair and Range of Motion were documented without being assigned.</p> <p>12/5/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower. Assist/chair and Range of Motion were documented without being assigned.</p> <p>12/9/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower. Assist/chair was documented without being assigned.</p> <p>12/10/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, personal care, assist with dressing, hair care, skin care, nail care, oral care, foot care, and meal preparation.</p> <p>12/11/19 - no documentation of Temperature, Blood Pressure, Respirations, and Pulse. Assist/chair was documented without being assigned.</p> <p>12/12/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, and shower. Assist/chair was documented without being assigned.</p> <p>12/13/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, personal care, assist with dressing, hair care, skin care, nail care, oral care, foot care, and meal preparation. Range of Motion was documented without being assigned.</p> <p>12/14/19 - no documentation of Temperature, Blood Pressure, Respirations, Pulse, nail care, and meal preparation.</p> <p>The following items are assigned on the Home Care Aide Care Plan, but are not available to be documented on the Home Health Aide Visit Record, and therefore were not documented at any visit: Check Pressure Areas.</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>6. Patient 6's clinical record was reviewed on 12/19/19 at 2:50 p.m., and included a Home Care Aide Care Plan, dated 11/4/19. The Home Care Aide Care Plan included, but was not limited to, Pulse, Respirations, Blood Pressure weekly - If Requested by Patient, Assist Bath/Chair, Personal Care, and Assist with Dressing every visit - As Request by patient, Assist with Ambulation - every visit, Meal Preparation - every visit, Grocery shopping - every visit, Wash Clothes - every visit, and Light Housekeeping - every visit.</p> <p>The Home Care Aide Care Plan failed to assign specific tasks either at each visit or on specific days for the home health aide to perform, and the vital sign parameters to notify care manager was left blank.</p> <p>The Home Health Aide Visit Records failed to evidence the HHA followed the care plan as ordered or notified the nurse of deviations for the following dates:</p> <p>11/4/19 - no documentation of Assist Bath/Chair, personal care, assist with dressing, assist with ambulation and laundry. Temperature, Tub/Shower, Foot Care, and Range of Motion were documented without being assigned.</p> <p>11/5/19 - no documentation of assist bath/chair, assist with dressing, assist with ambulation, grocery shopping, and laundry. Range of Motion was documented without being assigned.</p> <p>11/6/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, and laundry. Tub/shower, foot care, and range of motion were documented without being assigned.</p> <p>11/7/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, grocery shopping, and laundry.</p>						

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>Range of motion was documented without being assigned.</p> <p>11/8/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, grocery shopping, laundry, and housekeeping. Tub/shower, foot care, and range of motion were documented without being assigned.</p> <p>11/11/19 - no documentation of assist bath/chair, personal care, assist with dressing, and assist with ambulation. Tub/shower, foot care, and range of motion were documented without being assigned.</p> <p>11/12/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, and laundry. Range of motion was documented without being assigned.</p> <p>11/13/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, and laundry. Tub/shower, foot care, and range of motion were documented without being assigned.</p> <p>11/14/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, and laundry. Range of motion was documented without being assigned.</p> <p>11/15/19 - no documentation of assist bath/chair, personal care, assist with dressing, and assist with ambulation. Tub/shower, foot care, and range of motion were documented without being assigned.</p> <p>11/18/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, grocery shopping, and laundry. Tub/shower, foot care, and range of motion were documented without being assigned.</p> <p>11/19/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, grocery shopping, laundry, and housekeeping. Range of motion was documented</p>						

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0800  Bldg. 00	<p>without being assigned.</p> <p>11/20/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, grocery shopping, laundry, and housekeeping. Tub/shower, foot care, and range of motion was documented without being assigned.</p> <p>11/21/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, and grocery shopping. Range of motion was documented without being assigned.</p> <p>11/22/19 - no documentation of assist bath/chair, personal care, assist with dressing, assist with ambulation, grocery shopping, laundry, and housekeeping. Tub/shower and range of motion was documented without being assigned.</p> <p>7. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated home health aide care plans should be specific, and if something is refused there should be a note written that it is refused, and they should initial and circle. The home health aides must follow aide orders and if not they must notify the office.</p> <p>17-14-1(m)</p> <p>484.80(g)(2)</p> <p>Services provided by HH aide</p> <p>A home health aide provides services that are:</p> <p>(i) Ordered by the physician;</p> <p>(ii) Included in the plan of care;</p> <p>(iii) Permitted to be performed under state law; and</p> <p>(iv) Consistent with the home health aide training.</p> <p>Based on record review and interview, the agency failed to ensure the Home Health Aide provided services that were ordered by the physician and</p>			G 0800	All aides have been in serviced on staying within their own scope of practice. To report any changes in		01/31/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>within their scope of practice for 2 of 5 active records reviewed with a Home Health Aide (Patients 3, 7) and 2 of 2 closed records reviewed with a Home Health Aide. (Patients 5, 11)</p> <p>Findings included:</p> <p>1. A policy, revised 1/18/18, titled, "Wound Treatment," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "Wound care must be performed by a Licensed Practical Nurse or a Registered Nurse .... Home Health Aides/CNAs should not perform wound care..."</p> <p>2. An undated job description, titled, "Certified Nursing Assistant," was provided by the Administrator on 12/31/19 at 1:30 p.m. The Job Description indicated, but was not limited to, "Duties: 2. Functions within the limits of own experience and knowledge and practices safely and competently within the job description. 3. Performs total care or assists in all activities of daily living/personal care, such as, but not limited to, bathing, dressing, hair and skin care, oral hygiene, elimination activities, meal prep, feeding and linen changes. Job Limitations: 4. May not perform procedures requiring the knowledge, training and skill of a licensed nurse."</p> <p>3. Patient 3's clinical record was reviewed on 12/19/19 at 11:30 a.m., and included a Home Health Certification and Plan of Care, dated 10/9/19 to 12/7/19. The Plan of Care included, but was not limited to, HHA (Home Health Aide) 7-8 hour visits, 5 days per week to assist with bathing, grooming, transfers incontinent care, meal preparation, light house keeping, and all other ADLs/IADLs (Activities of Daily Living/Instrumental Activities of Daily Living).</p>				<p>patient condition and not to provide care they are not licensed for. OVHH is using Sandata to input only tasks for which the home health aides are allowed to be doing on the patients POT. This will be monitored by the supervisory nurse, ADON and Clinical Manager for compliance going forward to avoid non-compliance.</p> <p>="" span=""&gt; ="" b=""&gt; ="" b=""&gt; ="" span=""&gt; ball="" supervisory="" nurses="" (rn)="" and="" the="" adon="" have="" been="" in="" serviced="" on="" following="" policy="" procedures="" conducting="" visits="" timely="" ensuring="" staff="" member="" is="" patient's="" plan="" of="" treatment.="" ovhh="" now="" utilizing="" sandata="" for="" its="" home="" care="" system.="" allows="" specific="" tasks="" to="" be="" inputted="" record="" that="" needs="" addressed="" by="" during="" care.="" will="" unable="" complete="" their="" daily="" documentation="" without="" completely="" addressing="" all="" needed="" examples="" include="" but="" are="" not="" limited="" t="" health="" aide="" tasks,="" g-tube="" residual="" check="" with="" amount,="" refusals="" any="" particular=""</p>		



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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST 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	
	<p>Patient 3's Home Health Aide Care Plan was created on 11/19/19.</p> <p>Patient 3's Home Health Aide Visits began on 11/19/19. The clinical record failed to evidence any HHA visits prior to 11/19/19.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated Patient 3's first nursing assessment was completed on 10/9/19, then another was completed on 11/19/19 to re-assess. The 10/9/19 assessment was to see if they could get the Prior Authorization hours and they could not get this without a completed plan of care.</p> <p>4. Patient 5's clinical record was reviewed on 12/19/19 at 12:09 p.m., and included a Home Health Certification and Plan of Care, dated 10/17/19 to 12/16/19.</p> <p>The Plan of Care included, but was not limited to, Home Health Aide 2 time per day, 7 days per week, 1-2 hour visits, to assist with personal care including: showering, shampooing hair, dressing, skin care, oral care, cleaning nails, and foot care. Aide in home to assist with meal preparation upon request, as well as light housekeeping. Aide to provide stand-by-assist, and provide for patient's safety at all times.</p> <p>An Aide Care Plan, dated 10/17/19, included, but was not limited to, an assignment to perform Passive Range of Motion as needed to bilateral legs.</p> <p>The Home Health Certification and Plan of Care failed to evidence documentation of an order for Passive Range of Motion.</p>			<p>type="" care,="" medical="" appliance="" coordination="" other="" supply="" dealers="" equipment="" completion="" documentation.="" nurses,="" clinical="" manager="" administrator="" system="" looking="" incomplete="" patient="" or="" missed="" order="" maintain="" visit="" information="" let="" md="" know="" as="" well="" re-schedule.="" also="" sup="" tracking="" part="" sandata's="" visits.="" this="" monitored="" don="" compliance="" optimal="" care.&lt;="" span=""&gt; ball="" (rn)="" serviced="" following="" policy="" procedures="" conducting="" timely="" ensuring="" member="" is="" patient's="" plan="" treatment.="" ovhh="" now="" utilizing="" for="" its="" home="" care="" system.="" allows="" specific="" inputted="" record="" that="" needs="" addressed="" care.="" unable="" complete="" their="" documentation="" without="" completely="" addressing="" all="" needed="" examples="" include="" but="" are="" not="" limited="" t="" health="" aide="" tasks,="" g-tube="" residual="" check="" with="" amount,="" refusals="" any="" particular="" type="" care,="" medical="" appliance="" coordination="" other="" supply="" dealers="" equipment=""</p>			

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST 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
	<p>5. Patient 7's clinical record was reviewed on 12/19/19 at 2:20 p.m., and included a Home Health Certification and Plan of Care, dated 10/26/19 to 12/24/19. The Plan of Care included, but was not limited to, Home Health Aide 6-7 hour visits, 4-5 days per week while mom is at work to assist with personal care, and Skilled Nursing 3 hour visits, 4-5 days per week while mom is at work.</p> <p>Patient 7's Home Health Aide Visit Records indicated HHA visits outside of the hours ordered on the following dates:</p> <p>10/28/19, 10/31/19, 11/1/19, 11/4/19, 11/7/19, 11/8/19, 11/11/19, 11/14/19, 11/15/19, 11/18/19, 11/21/19, 12/2/19, 12/5/19, 12/6/19, 12/9/19, 12/12/19, and 12/13/19 from 5:30 a.m. to 3:00 p.m. - 9.5 hours per day</p> <p>11/5/19, 11/12/19, 11/19/19, and 12/10/19 from 5:30 a.m. to 12:45 p.m. and 12:45 p.m. to 3:00 p.m. - 9.5 hours</p> <p>11/6/19 from 5:40 a.m. to 12:00 p.m. and 12:01 p.m. to 2:59 p.m. - 9 hours and 18 minutes</p> <p>11/13/19 from 5:30 a.m. to 12:00 p.m. and 12:00 p.m. to 3:02 p.m. - 9 hours and 32 minutes</p> <p>11/20/19 from 5:30 a.m. to 12:00 p.m. and 12:01 p.m. to 3:00 p.m. - 9 hours and 29 minutes</p> <p>12/3/19 from 5:30 a.m. to 3:00 p.m. and 12:45 p.m. to 3:00 p.m. - 11.75 hours</p> <p>12/4/19 from 5:30 a.m. to 12:00 p.m. and 12:06 p.m. to 3:00 p.m. - 9 hours and 24 minutes</p> <p>12/11/19 from 5:30 a.m. to 12:00 p.m. and 11:47 a.m. to 2:57 p.m. - 9.5 hours</p> <p>6. Patient 11's clinical record was reviewed on 12/19/19 at 3:46 p.m., and included a Home Health Certification and Plan of Care, dated 7/28/19 to 9/25/19.</p> <p>The Plan of Care included, but was not limited to,</p>				<p>completion="" documentation="" nurses="" clinical="" manager="" administrator="" looking="" incomplete="" patient="" or="" missed="" maintain="" visit="" information="" let="" md="" know="" re-schedule="" also="" sup="" tracking="" part="" sandata's="" visits="" this="" monitored="" compliance="" optimal="" care.&lt;="" span=""&gt;="" p=""&gt;="" b=""&gt;="" span=""&gt;="" b&lt;="" p=""&gt;="" b&lt;="" p=""&gt;="" b&lt;="" p=""&gt;="" b&lt;="" p=""&gt;="" span=""&gt;="" span=""&gt;="" b&lt;="" p=""&gt;="" b&lt;="" p=""&gt;="" span=""&gt;="" spancare&lt;="" span=""&gt;="" examples="" include="" but="" not="" limited="" to="" aide="" allowed="" them="" practice="" and="" any="" patient="" refusals="" care.="" supervisory="" nurses="" adon="" don="" administrator="" monitoring="" staff's="" through="" use="" incomplete="" documentation="" refusal="" trends="" other="" concerns="" may="" arise="" attention="" real="" time="" access="" optimal="" delivery="" care.&lt;="" span=""&gt;="" spancare&lt;="" span=""&gt;="" examples="" include="" but="" not="" limited="" to="" aide=""</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0818  Bldg. 00	<p>Home Health Aide 4-5 times per week, 3 hour visits to assist with bathing, grooming, personal care, transfers, meal prep and all other ADLs (activities of daily living) as needed.</p> <p>An Aide Care Plan, dated 5/28/19, and reviewed on 7/25/19, included assignments of: tub/shower, personal care, assist with dressing, hair care, shampoo, skin care, nail care, oral care, assist with elimination, assist with ambulation, mobility assist, ROM (range of motion) active, meal preparation, wash clothes, and light housekeeping.</p> <p>Home Health Aide Visit Records, dated 7/28/19, 7/30/19, 8/1/19, 8/11/19, 8/12/19, 8/13/19, and 8/18/19, indicated the home health aide performed and documented wound care.</p> <p>During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated home health aides were not allowed to perform wound care or document wound care.</p> <p>7. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated they must have an order for Range of Motion.</p> <p>17-14-1(m)</p> <p>484.80(h)(4)(i-vi) HH aide supervision elements Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home</p>				<p>allowed="" them="" practice="" and="" any="" patient="" refusals="" care.="" supervisory="" nurses,="" adon,="" don,="" administrator="" monitoring="" staff's="" through="" use="" incomplete="" documentation,="" refusal="" trends,="" other="" concerns="" may="" arise="" attention.="" real="" time="" access="" optimal="" delivery="" care.&lt;="" span=""&gt; ="" span=""&gt; ="" spancare&lt;="" span.="" examples="" include="" but="" not="" limited="" to:="" aide="" allowed="" them="" practice="" and="" any="" patient="" refusals="" care.="" supervisory="" nurses,="" adon,="" don,="" administrator="" monitoring="" staff's="" through="" use="" incomplete="" documentation,="" refusal="" trends,="" other="" concerns="" may="" arise="" attention.="" real="" time="" access="" optimal="" delivery="" care.&lt;="" span=""&gt; ="" span=""&gt;</p>		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights.</p> <p>Based on record review and interview, the agency failed to ensure a nurse supervised the home health aide to ensure they furnished care in a safe manner within their scope of practice for 1 of 2 closed records reviewed. (Patient 11)</p> <p>Findings included:</p> <p>1. A policy, revised 1/18/18, titled, "Wound Treatment," was provided by the Administrator on 12/31/19 at 1:30 p.m. The policy indicated, but was not limited to, "Wound care must be performed by a Licensed Practical Nurse or a Registered Nurse....Home Health Aides/CNAs should not perform wound care..."</p> <p>2. An undated job description, titled, "Certified Nursing Assistant," was provided by the Administrator on 12/31/19 at 1:30 p.m. The Job Description indicated, but was not limited to, "Duties: 2. Functions within the limits of own experience and knowledge and practices safely and competently within the job description. 3. Performs total care or assists in all activities of daily living/personal care, such as, but not limited to, bathing, dressing, hair and skin care, oral hygiene, elimination activities, meal prep, feeding and linen changes. Job Limitations: 4. May not</p>			G 0818	<p><b>All supervisory nurses (RN) and the ADON have been in serviced on following policy and procedures on conducting supervisory visits timely and ensuring the staff member is following the patient's plan of treatment. OVHH now is utilizing Sandata for its home care system. Sandata allows for specific tasks to be inputted in the patient's record that needs to be addressed by OVHH staff member during care. OVHH staff will be unable to complete their daily documentation /tasks without completely addressing all needed care. Examples include but are not limited to:home health aide tasks, G-tube residual check with amount, refusals of any particular type of care, specific medical appliance care, coordination of care with other medical supply dealers for patient's equipment/type/care,</b></p>		01/31/2020

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>perform procedures requiring the knowledge, training and skill of a licensed nurse."</p> <p>3. Patient 11's clinical record was reviewed on 12/19/19 at 3:46 p.m., and included a Home Health Certification and Plan of Care, dated 7/28/19 to 9/25/19.</p> <p>The Plan of Care included, but was not limited to, Home Health Aide 4-5 times per week, 3 hour visits to assist with bathing, grooming, personal care, transfers, meal prep and all other ADLs (activities of daily living) as needed.</p> <p>An Aide Care Plan, dated 5/28/19, and reviewed on 7/25/19, included assignments of: tub/shower, personal care, assist with dressing, hair care, shampoo, skin care, nail care, oral care, assist with elimination, assist with ambulation, mobility assist, ROM (range of motion) active, meal preparation, wash clothes, and light housekeeping.</p> <p>Home Health Aide Visit Records, dated 7/28, 7/30, 8/1, 8/11, 8/12, 8/13, 8/18, indicated the home health aide performed and documented wound care.</p> <p>A supervisory visit was attempted on 5/24/19 by Employee F. The supervisory visit note indicated patient's mother declined a supervisory visit and was going to transfer services. The clinical record failed to evidence any supervisory visits or attempts at a supervisory visit after this date.</p> <p>A Discharge Summary Sheet indicated a discharge date of 8/22/19.</p> <p>4. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated home health aides are not</p>				<p><b>and completion of all documentation. Supervisory nurses, Clinical Manager and Administrator will be following daily on the Sandata system looking for any incomplete patient documentation and/or missed visits in order to maintain the missed visit information to let their MD know as well as to re-schedule. Supervisory nurses will also be utilizing the sup visit tracking part of Sandata's system in order to maintain timely supervisory visits. This will be monitored by the ADON and the DON daily in order to maintain compliance and optimal patient care.</b></p>		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 0848  Bldg. 00	<p>allowed to perform wound care or document wound care. The Administrator indicated home health aide supervisory visits should occur every 30 days.</p> <p>17-14-1(n)</p> <p>484.100</p> <p>Compliance with Federal, State, Local Law</p> <p>Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.</p> <p>The HHA and its staff must operate and furnish services in compliance with all applicable federal, state, and local laws and regulations related to the health and safety of patients. If state or local law provides licensing of HHAs, the HHA must be licensed.</p> <p>Based on record review and interview, the agency failed to ensure they adhered to federal, state, and local laws and regulations related to the safety of patients by hiring a nurse with a Felony Neglect charge on their Background Check for 1 of 8 nurses employee records reviewed. (Employee J)</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with §484.100 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.</p> <p>Findings included:</p> <p>1. A policy, dated 7/1/16, titled, "Ohio Valley Home Health Criminal Background Policy," was provided by the Administrator on 12/31/19 at</p>			G 0848	<p>Ohio Valley Home Health has conducted an internal audit of all current employees to rule out any further infractions on our criminal background policy. We have also spoke with the nurse that had the potential background history and was able to obtain legal documents showing those records were expunged and sealed. We have also ran a current criminal history on this staff member showing no records found. Effective 1/14/2020 OVHH will continue to follow the policies and procedures set forth on July 1, 2016 in accordance with state and federal regulations. We have now conducted a review of all currently</p>		01/14/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>11:05 a.m. The policy indicated, but was not limited to, "The Indiana Code at 16-27-2-5 specifies that a person who operates a home health agency under IC 16-27-1 may not employ a person to provide services in a patient's or client's temporary or permanent resident [sic] if that person's national criminal history check or expanded criminal history check indicates that the person has been convicted of any of the following: .....neglect or exploitation of an endangered adult, or theft. Employees....may not employ a person to provide services in a patient's or client's temporary or permanent residence if that person's national criminal history background check, or expanded criminal history check indicates that the person has been convicted of any of the following:.....5. Theft (IC 35-43-4) if the conviction for the theft occurred less than ten (10) years before the person's employment application date; 6. A felony that is substantially equivalent to a felony listed in:... A. subdivisions (1) through (4); or B. subdivisions (5), if the conviction for the theft occurred less than ten (10) years before the person's employment application date...."</p> <p>2. Employee J's record was reviewed on 12/31/19 at 10:50 a.m., and included a Start Date of 3/20/15 and a First Patient Contact Date of 4/10/15.</p> <p>Employee J's record included a Limited Criminal History, dated 3/19/15, which showed a Neglect of a Dependant, Class D Felony Charge on 4/22/12.</p> <p>Employee J's Limited Criminal History, dated 3/19/15, which showed a Theft, Class D Felony Charge, dropped to a Misdemeanor on 10/31/11.</p> <p>3. During an interview on 12/31/19 at 10:59 a.m., the Administrator indicated they would not hire a</p>				<p>employed staff members to ensure regulations are followed and will continue forward with any new potential staff. We also have begun a two person system to look at all incoming background checks in order to avoid any future errors.</p> <p>="" span=""&gt;</p>		

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
G 1024  Bldg. 00	<p>nurse with a theft charge on their criminal history check. The Administrator indicated the person who received the background check on Employee J was no longer an employee of the agency.</p> <p>484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure documentation was appropriately authenticated with the date, time, signature, and title for 7 of 7 active clinical records reviewed. (Patients 2, 3, 4, 9, 10, 7, 6)</p> <p>Findings included:</p> <p>1. A policy, revised 2/27/14, titled, "Documentation," was provided by the Administrator on 12/27/19 at 8:37 a.m. The policy indicated, but was not limited to, "Documentation will be: 1. Clear and neat; 2. Dated with month/day/year; 3. Timed when applicable..."</p> <p>2. Patient 2's clinical record was reviewed on 12/18/19 at 2:20 p.m., and included a Recertification, dated 11/19/19, with no time in, no time out, and no time of nurse signature.</p> <p>Patient 2's Resumption of Care, dated 10/27/19, had no time in, not time out, and not date or time of nurse signature.</p> <p>3. Patient 3's clinical record was reviewed on</p>			G 1024	<p>January 12, 2020 Ohio Valley Home Health (OVHH) began implementation of a new state approved home care system Sandata. This system allows for complete paperless environment as well as complete monitoring for untimely and/or incomplete documentation. Any time a document is opened for patient record use it is time and date stamped. Prior to any document be listed as "completed" and then logged into the patient chart all fields must be addressed and not left blank or unacknowledged. The system will not allow close out without completion in its entirety. The supervisory nurse, Clinical Manager and Administrator will be monitoring these documents daily to ensure nothing is left uncompleted. Sandata also allows electronic and/or verbal signatures by the patient ensuring they are</p>		02/24/2020



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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST 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
	<p>12/19/19 at 11:30 a.m., and included a Start of Care Assessment, dated 10/9/18, with no time in, no time out, and no nurse signature/time/date.</p> <p>During an interview on 12/19/19 at 11:50 a.m., the Administrator indicated the Start of Care Assessment should have been dated 10/9/19.</p> <p>Patient 3's Re-assessment for Start of Care, dated 11/19/19, had no time in, no time out, and no time of nurse's signature.</p> <p>4. Patient 4's clinical record was reviewed on 12/19/19 at 11:50 a.m., and included a Recertification, dated 10/29/19, with no time in, no time out, and no time of nurse's signature.</p> <p>5. Patient 9's clinical record was reviewed on 12/19/19 at 12:30 p.m., and included a Recertification, dated 7/5/19, with no time in, no time out, and no time of nurse's signature.</p> <p>6. Patient 10's clinical record was reviewed on 12/19/19 at 1:10 p.m., and included a Recertification, dated 12/4/19, with no time in, no time out, and no time of nurse's signature.</p> <p>Patient 10's Resumption of Care, dated 10/18/19, had no time in, no time out, and no time of nurses's signature.</p> <p>7. Patient 7's clinical record was reviewed on 12/19/19 at 2:20 p.m., and included a Recertification, dated 10/24/19, with no time in, no time out, and no time of nurse's signature.</p> <p>8. Patient 6's clinical record was reviewed on 12/19/19 at 2:50 p.m., and included a Recertification, dated 11/4/19, with no time in, no time out, and no time of nurse's signature.</p>				<p>informed of their plan of treatment. As of 01/28/2020 all home health aides are using this system for EVV and completed tasks done during visits. SN staff have been orientated to the new system and will "go live" beginning 2/10/2020. All staff will be using full system capabilities by 02/24/2020. This will ensure compliance with document completion as well as timeliness. In-between now and 2/24/2020 when OVHH will be utilizing Sandata fully all paperwork/documentation will be audited upon being turned and prior to being filed in patient chart by the ADON and the Clinical Manager for completion, timeliness, and to ensure staff are following POC according to their scope of practice.</p>		

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
N 0000  Bldg. 00	<p>9. During an interview on 12/20/19 at 9:43 a.m., the Administrator indicated visits should be dated, timed, and signed. The Director of Nursing indicated the time in and time out is on the employee's time sheet, but not on the OASIS (Outcome and Assessment Information Set) forms.</p> <p>17-15-1(a)(7)</p> <p>This visit was for a State Licensure, and a Complaint Survey.</p> <p>Complaint IN00314881 - Substantiated with findings</p> <p>Survey Dates: December 18, 19, 20, and 31, 2019</p> <p>Facility: IN006094 Medicaid Vendor: 200097860A Provider: 15K005</p> <p>Unduplicated Census: 26 skilled 135 home health aide only 16 personal service only 177 total</p> <p>Current Census: 26 skilled 89 home health aide only 16 personal service only 131 total</p> <p>Sample Selection: Home Visits: 3 Total clinical records reviewed: 9</p>			N 0000			

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

PRINTED: 02/18/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP COD 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
N 0458  Bldg. 00	<p>410 IAC 17-12-1(f) Home health agency administration/management 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 registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure they adhered to federal, state, and local laws and regulations related to the safety of patients by hiring a nurse with a Felony Neglect charge on their Background Check for 1 of 8 nurses employee records reviewed. (Employee J)</p> <p>Findings included:</p> <p>1. A policy, dated 7/1/16, titled, "Ohio Valley Home Health Criminal Background Policy," was provided by the Administrator on 12/31/19 at 11:05 a.m. The policy indicated, but was not limited to, "The Indiana Code at 16-27-2-5 specifies that a person who operates a home health agency under IC 16-27-1 may not employ a person to provide services in a patient's or client's temporary or permanent resident [sic] if that person's national criminal history check or expanded criminal history check indicates that the</p>			N 0458	<p>Ohio Valley Home Health has conducted an internal audit of all current employees to rule out any further infractions on our criminal background policy. We have also spoke with the nurse that had the potential background history and was able to obtain legal documents showing those records were expunged and sealed. We have also ran a current criminal history on this staff member showing no records found. Effective 1/14/2020 OVHH will continue to follow the policies and procedures set forth on July 1, 2016 in accordance with state and federal regulations. We have now conducted a review of all currently employed staff members to ensure</p>		01/14/2020

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/31/2019	
NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>person has been convicted of any of the following: .....neglect or exploitation of an endangered adult, or theft. Employees.....may not employ a person to provide services in a patient's or client's temporary or permanent residence if that person's national criminal history background check, or expanded criminal history check indicates that the person has been convicted of any of the following:.....5. Theft (IC 35-43-4) if the conviction for the theft occurred less than ten (10) years before the person's employment application date; 6. A felony that is substantially equivalent to a felony listed in:.... A. subdivisions (1) through (4); or B. subdivisions (5), if the conviction for the theft occurred less than ten (10) years before the person's employment application date...."</p> <p>2. Employee J's record was reviewed on 12/31/19 at 10:50 a.m., and included a Start Date of 3/20/15 and a First Patient Contact Date of 4/10/15.</p> <p>Employee J's record included a Limited Criminal History, dated 3/19/15, which showed a Neglect of a Dependant, Class D Felony Charge on 4/22/12.</p> <p>Employee J's Limited Criminal History, dated 3/19/15, which showed a Theft, Class D Felony Charge, dropped to a Misdemeanor on 10/31/11.</p> <p>3. During an interview on 12/31/19 at 10:59 a.m., the Administrator indicated they would not hire a nurse with a theft charge on their criminal history check. The Administrator indicated the person who received the background check on Employee J was no longer an employee of the agency.</p>				<p>regulations are followed. OVHH will also conduct a two person review between human resources and either the Clinical Manager or Administrator going forward of all background checks to ensure compliance.</p>		