

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

PRINTED: 03/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/12/2020	
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
{G 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a follow up to a Recertification and State Licensure, and a Complaint Survey.</p> <p>Complaint IN00314881 - Substantiated with findings.</p> <p>Survey Dates: March 11 and 12, 2020</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: 1 Total clinical records reviewed: 10</p> <p>Ohio Valley Home Health is precluded from 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</p>	{G 000}		

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 that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 03/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/12/2020
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
{G 000}	Continued From page 1 and regulations related to the health and safety of patients, and §484.80 Condition of participation: Home health aide services. Quality Review Completed 3/18/2020 A4	{G 000}		