

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

PRINTED: 03/04/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/21/2019
NAME OF PROVIDER OR SUPPLIER FRIENDS HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 N 15TH ST VINCENNES, IN 47591		
(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 federal home health post certification revisit survey.</p> <p>Survey Date: February 21, 2019.</p> <p>Facility ID: IN009488 Provider # 157483 Medicaid Vendor ID: 200198250</p> <p>Census: 14</p> <p>Sample: 4 records reviewed/ 0 home visits</p> <p>Friends Home Health Care Inc., was found to be in compliance with 42 CFR 484 but continues to be precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 01/07/19 to 01/07/21, for being out of compliance with Condition of Participation 42 CFR 484.75 Skilled professional services.</p>	{G 000}			
{E 000}	<p>Initial Comments</p> <p>An Emergency Preparedness post certification revisit survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102.</p> <p>Survey Date: February 21, 2019.</p> <p>Facility Number: IN009488 Provider Number: 157483</p> <p>Census = 14</p> <p>At this Emergency Preparedness post certification survey, Friends Home Health Care,</p>	{E 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.

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{E 000}	Continued From page 1 INC., was found to be in compliance with the Conditions of Participation 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	{E 000}		