

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157213	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
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NAME OF PROVIDER OR SUPPLIER INTREPID USA HEALTHCARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3333 FOUNDERS RD STE 100 INDIANAPOLIS, IN 46268
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G000000	<p>This was a federal home health recertification survey. This survey was partial extended.</p> <p>Facility #: 5374</p> <p>Survey Dates: April 14-16, 2014</p> <p>Medicaid vendor #: 2004860080</p> <p>Surveyors: Tonya Tucker, RN, PHNS and Bridget Boston, RN, PHNS</p> <p>Census: 353 skilled unduplicated patients in last 12 months</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 21, 2014</p>	G000000		
G000159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record review and</p>	G000159	The Administrator or designee will	05/16/2014

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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G000332	<p>interview, the agency failed to ensure a plan of care was developed for 1 of 13 clinical records reviewed creating the potential to affect all the patients of the agency. (#7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 7, start of care 4/3/14, included a comprehensive assessment dated 4/3/14 performed by the registered nurse. The record failed to evidence a plan of care for the certification period beginning 4/3/14. 2. On 4/16/14 at 3:40 PM, employee A (administrator) indicated the plan of care is completed from information documented in the comprehensive assessment and the plan of care had not been finished at time of survey. <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p>		<p>ensure that the medical plan of care shall be developed in consultation with the home health agency staff, including all services providing skilled services, and covering all pertinent diagnoses. The Administrator will in-servicing all clinical staff on the following: Policy 2.022 Plan of Care to ensure the POC will be documented within the time frame determined by federal/state regulations. In-service also on: How to write an effective Plan of Care that is individualized for the patient, reflective of their needs and reviewed by the patient's physician, as well as how to develop the plan of care in consultation with all staff involved in patient's care. The Administrator or designee will monitor for compliance by weekly reviews of all current episode Plans of Care to assure they are complete and accurate in meeting the patient's needs for a period of 30 days, then at that time, the Administrator or designee will then re-evaluate the need for continued weekly review. Ongoing monitoring by the Administrator or designee will be accomplished by reviewing 10% of current episode Plans.</p>	

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G000341	<p>Based on clinical record review, policy review, and interview, the agency failed to ensure the initial assessment visit was held within 48 hours of referral in 1 of 13 clinical records reviewed creating the potential to affect all new patients of the agency. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #2, start of care 2/26/14, evidenced a referral to home care dated 2/19/14 and a comprehensive assessment on 2/26/14. The record failed to evidence an initial assessment was completed within 48 hours of the referral to identify immediate care needs. <p>On 4/14/14 at 2:30 PM, employee A (administrator) indicated the initial assessment was not conducted within 48 hours of referral.</p> <ol style="list-style-type: none"> The agency policy with a revision date of February 2013 titled "Admission" states, "Criteria for admission: ... 4. Upon receipt of the referral, the client will be admitted within 48 hours unless otherwise directed by the physician, referral source, client, or payor." <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be</p>	G000332	<p>The Administrator or designee will assure that an initial assessment visit will be made within 48 hours of referral or patient's return home or on the physician-ordered start of care date by providing education to all admitting clinicians on Policy 2.001 Admission to ensure that the client be admitted within 48 hours unless otherwise directed by the physician referral source, client or payor. The Administrator or designee will review all referrals and scheduling of admissions on a daily basis. Ongoing monitoring for compliance will be accomplished by reviewing 10% of current episode census monthly.</p>	05/16/2014

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N000000	<p>updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the comprehensive assessment was updated and revised at discharge in 1 of 2 discharged records reviewed creating the potential to affect all discharged patients. (#1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, discharge date 3/20/14, failed to evidence a discharge assessment had been completed. <p>On 4/14/14 at 2:48 PM, employee A (administrator) indicated there was no discharge assessment completed on the patient.</p> <ol style="list-style-type: none"> The agency policy with a revision date of November 2012 titled "Discharge" states, "Guidelines/Procedures: ... 9. Discharge from the agency ... d. The clinician completes comprehensive discharge assessment, which includes OASIS data elements for appropriate patients as required by regulations." <p>This was a state home health relicensure survey.</p>	G000341	The Administrator or designee will ensure that the comprehensive assessment must be updated and revised at discharge by reviewing with all clinical staff, Policy 2.011 Discharge, that all skilled clinical staff complete the comprehensive discharge assessment, which includes OASIS data elements for appropriate patients as required by federal regulations and Policy 2.032 Reporting of OASIS to ensure the clinician collects the required OASIS data at the time of discharge. The Administrator or designee will monitor 10% of all Discharge OASIS comprehensive assessments to assure they are accurate in meeting the OASIS discharge requirement for correct and complete documentation for a period of 30 days then will review 10% of all discharge OASIS records quarterly.	05/28/2014	
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N000524	<p>Facility #: 5374</p> <p>Survey Dates: April 14-16, 2014</p> <p>Medicaid vendor #: 2004860080</p> <p>Surveyors: Tonya Tucker, RN, PHNS and Bridget Boston, RN, PHNS</p> <p>Census: 353 skilled unduplicated patients in last 12 months</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 21, 2014</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p>			

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	<p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review and interview, the agency failed to ensure a plan of care was developed for 1 of 13 clinical records reviewed creating the potential to affect all the patients of the agency. (#7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record 7, start of care 4/3/14, included a comprehensive assessment dated 4/3/14 performed by the registered nurse. The record failed to evidence a plan of care for the certification period beginning 4/3/14. On 4/16/14 at 3:40 PM, employee A (administrator) indicated the plan of care is completed from information documented in the comprehensive assessment and the plan of care had not been finished at time of survey. 	N000524	<p>The Administrator or designee will ensure that the medical plan of care shall be developed in consultation with the home health agency staff, including all services providing skilled services, and covering all pertinent diagnoses. The Administrator will in-servicing all clinical staff on the following: Policy 2.022 Plan of Care to ensure the POC will be documented within the time frame determined by federal/state regulations. In-service also on: How to write an effective Plan of Care that is individualized for the patient, reflective of their needs and reviewed by the patient's physician, as well as how to develop the plan of care in consultation with all staff involved in patient's care. The Administrator or designee will monitor for compliance by weekly reviews of all current episode Plans of Care to assure they are complete and accurate in meeting the patient's needs for a period of 30 days, then at that time, the Administrator or designee will then re-evaluate the need for continued weekly review. Ongoing monitoring by the Administrator or designee will be accomplished by reviewing 10% of current episode Plans.</p>	05/16/2014