STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR HEALTHCARE	9102 N MERIDIAN STREET STE 100, INDIANAPOLIS, IN, 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This visit was for a Federal and State complaint survey of a Home Health Agency. Survey dates: 1/3, 1/4, 1/5, and 1/6/2022 Complaint #: 61442; Substantiated with findings These deficiencies reflect State findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State findings. QR by Area 3 on 1-17-2022	G0000	POC accepted on 2-8-2022 Deborah Franco	2022-02-21
G0462	Before discharge for cause HHA must: 484.50(d)(5) The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(i) through (d)(5)(iii) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired. The HHA must do the following before it discharges a patient for cause: Based on record review and interview, the agency failed to implement their policy that required a series of actions were taken prior to discharging a patient for cause, for 1 of 1 policies reviewed, which affected 1 (Patient #3) of 4 patients whose closed clinical record was reviewed. Findings include: 1. Review of an undated Policy titled Section	G0462	· The Administrator and Director ofNursing (Clinical Manager) will review the current Discharge Policy and presentchanges required to the Governing Body for approval of policy change by 2.18.22. · Discharge process checklist will bedeveloped to follow the Discharge Policy by the Director of Nursing andapproved by Governing Body by 2.18.22. · The Director of Nursing will in-serviceall RN Case Managers on the proper discharge process and use of the dischargechecklist by 2.21.22.	2022-02-21

	02.23 Discharge stated, 6. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan. 10. To avoid charges of abandonment at the time of discharge, agency documentation should include the following (not meant to be all-inclusive): - Evidence that the decision was not made unilaterally. The patient, family and physician participated in the decision to discharge the patient from the agency. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary care physician ... 13. The physician will be informed of the change in status and an order will be sent to the physician for confirmation of discharge. 2. A review of the clinical record for patient #3, evidenced home health aide orders for care, 7 days a week, 14 hours per day. Patient #3's diagnoses included Multiple Sclerosis (MS - disease in which the immune system eats away the protective covering of the nerves), Cerebrovascular Accident (CVA - damage to the brain from interruption of its blood supply), early onset dementia, dysphagia (difficulty swallowing), gastrostomy-tube with enteral feedings (tube inserted through the belly to bring nutrition directly to the stomach), indwelling urinary catheter (tube inserted into urethra to drain urine from the bladder), and wound to coccyx (tailbone area). The date of the last care visit was 11/17/2021. The date of discharge was 11/17/2021. A review of the clinical record failed to evidence the agency had not made the decision to discharge patient #3 for cause unilaterally. The clinical record failed to evidence documentation the patient, family and physician participated in the decision to discharge patient #3 from the agency. The clinical record failed to evidence how patient #3's needs were met in the absence of agency services. The record failed to evidence documentation that demonstrated appropriate notice was given (verbal and written) and referrals were made to obtain necessary care. The clinical record failed to evidence documentation of		· 100% of potential discharges will bereviewed by care management team during case conferences to ensure entiredischarge process is followed. Discharge process checklist will be utilized forevery discharge and kept with all discharge records in QAPI binder. · 100%of all discharges will be audited within 5 days of discharge by DON to ensureall steps were followed. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

	the communication with the patient/patient's caregiver, to include the rationale for discharge, and failed to evidence compliance with agency policy to keep documentation in the patient's file with copies sent to the primary care physician. Review of the record failed to evidence the physician was informed of the change in status and failed to evidence an order was obtained from the physician for confirmation of discharge. 3. The Complaint binder was submitted for review on 1/4/2022 at 10:00 AM. A review of the entry for patient 3 consisted of printed out emails and copies of cell phone text messages between the person F (a member of patient #3's family and main caregiver) and the administrator. The headers of the pages revealed print dates of 1/3/2022 and 1/4/2022 respectively, although the pertinent dates of the entries ranged from 10/21/2021 to 11/23/2021. The contents of the binder failed to evidence further documentation pertaining to patient #3. 4. During an interview on 1/05/2022 at 1:40 PM, employee D, alternate clinical manager, stated the ordering physician had not been contacted in relation to concerns regarding patient 3 and caregiver, nor was the physician contacted regarding patient #3's impending discharge. 5. On 1/5/2022 at 11:29 AM, the surveyor left a message with the provider s office inquiring if this home health agency had contacted the provider s office regarding the anticipated discharge of patient 3, for cause, who still required ongoing services. On 1/6/2022 at 12:48 PM, nurse K for Dr. J (the ordering provider for patient 3) returned the telephone call and left a voicemail which stated, I don t see where anybody from Brightstar Home Care has contacted us (regarding patient 3) & I don t see anything in here &.			
G0464	Advise the patient of discharge for cause	G0464	· The Administrator and	2022-02-21

	484.50(d)(5)(i) (i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s), issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered; Based on record review and interview, the agency failed to ensure the patient's ordering provider was notified of the Home Health Agency's intention to discharge a patient for cause in 1 (patient 3) of 4 closed clinical records reviewed. Findings include: 1. Review of Policy titled Section 2.39 Reporting patient s condition to Physician dated 05/2010, stated &Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient. 3. The patient s physician will be contacted when there are significant changes in the patient s condition, such as &. changes in the expectations of treatments or goals. 4. All conferences or attempts to communicate with physician will be documented in the clinical record ... A. Documentation of physician notification will include: 1. Date and time contacted 2. Patient name 3. Name of physician notified or his/her representative 4. Reason for notification 5. Physician response 6. Action taken or orders obtained 7. Professional signature or title. B. Documentation of attempted physician notification will include: 1. Date and time 2. Patient name 3. Name of physician attempting to notify 4. Reason for notification 5. Name of person taking message. 2. Review of an undated Policy titled Section 02.23 Discharge stated 6. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan. 10. To avoid charges of abandonment at the time of discharge, agency documentation should include the following (not meant to be all-inclusive): - Evidence that the decision was not made unilaterally. The patient, family, and physician participated in the decision to discharge the patient from the agency. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as		Director ofNursing (Clinical Manager) will review the current Discharge Policy, DocumentationPolicy, and Physician Notification Policy and present changes required to theGoverning Body for approval of policy change by 2.18.22. · Physician Notification form will bereviewed and required changes will be made with approval of Governing Body by2.18.22. · The Director of Nursing will in-serviceall RN Case Managers on the updated policies by 2.21.22 to ensure all RN CaseManagers follow the proper process of notifying the physician of patientchanges and how to properly document all changes and notifications. · 100% of all discharges will be auditedwithin 5 days of discharge by DON to ensure all steps were followed. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with these standards. · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary care physician ... 13. The physician will be informed of the change in status and an order will be sent to the physician for confirmation of discharge.

3. A review of the clinical record for patient 3, evidenced home health aide orders for care, 7 days a week, 14 hours per day. Patient 3's diagnoses included Multiple Sclerosis (MS - a disease in which the immune system eats away the protective covering of the nerves), Cerebrovascular Accident (CVA - damage to the brain from interruption of its blood supply), early-onset dementia, dysphagia (difficulty swallowing), gastrostomy-tube with enteral feedings (a tube inserted through the belly to bring nutrition directly to the stomach), an indwelling urinary catheter (a tube inserted into the urethra to drain urine from the bladder), and wound to the coccyx (tailbone area). The date of the last care visit was 11/17/2021. The date of discharge was 11/17/2021. A review of the clinical record failed to evidence documentation of notification of patient, family representative, and physician that discharge for cause was being considered. The clinical record failed to evidence documentation of ongoing communication with the ordering physician to ensure safe and appropriate care for patient #3. The clinical record failed to evidence documentation of all conferences or attempts to communicate with the physician. The clinical record failed to evidence documentation physician was involved in the discharge plan. Further review of the clinical record failed to evidence the agency had not made the decision to discharge patient #3 for cause unilaterally. The clinical record failed to evidence documentation the patient, family, and physician participated in the decision to discharge patient #3 from the agency. The clinical record failed to evidence compliance with agency policy to keep documentation in the patient's file with copies sent to the primary care physician. A review of the record failed to evidence the physician was informed of the change in status and failed to evidence an order was obtained from the physician to discharge for cause.

4. In an interview on 1/03/2022 at 2:52 PM, person F, the caregiver of patient #3, stated the current administrator started pulling away staff

	patient had previously had received regular visits both day and night for over a year without issue. Person F, the caregiver for patient #3, stated the patient was not able to care for self, related to medical diagnoses (CVA and MS), which required position changes every 2 hours while in bed. Person F, the caregiver stated, they [this agency] did not discharge [patient 3], period. They [this agency] just stopped coming. 5. During an interview on 1/5/2022, at 1:40 PM, employee D, alternate clinical manager, stated the ordering provider had not been contacted in relation to concerns regarding patient 3 and caregiver, nor was the physician contacted regarding impending discharge for cause. Employee D stated the agency reached out to and worked with entity L, a community resource agency, regarding the concerns with the behavior a family member of patient #3. 6. On 1/5/2022 at 11:29 AM, the surveyor had left a message with the provider s office to inquire if this agency had contacted the provider s office regarding the impending discharge for cause of patient 3. On 1/6/2022, at 12:48 PM, nurse K for Dr. J (the ordering provider for patient 3) returned a call and left a voicemail which stated, I don t see where anybody from Brightstar Home Care has contacted us [regarding patient 3] &I don t see anything in here &. 410 IAC 17-12-2(i)			
G0468	Provide contact info other services 484.50(d)(5)(iii) (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and Based on record review and interview, the agency failed to implement their policy to ensure the patient's caregiver was provided with the phone numbers	G0468	· The Administrator and Director ofNursing (Clinical Manager) will review the current Discharge Policy and presentchanges required to the Governing Body for approval of policy change by 2.18.22.	2022-02-21

	agencies when the agency determined to discharge a patient for cause in 1 (patient 3) of 4 closed clinical records reviewed. Findings include: 1. Review of an undated Policy titled Section 02.23 Discharge evidenced the policy stated, 10. To avoid charges of abandonment at the time of discharge, agency documentation should include the following (not meant to be all-inclusive): - If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. 2. A review of the clinical record for patient #3, evidenced home health aide orders for care, 7 days a week, 14 hours per day. Patient #3's diagnoses included Multiple Sclerosis (MS - disease in which the immune system eats away the protective covering of the nerves), Cerebrovascular Accident (CVA - damage to the brain from interruption of its blood supply), early onset dementia, dysphagia (difficulty swallowing), gastrostomy-tube with enteral feedings (tube inserted through the belly to bring nutrition directly to the stomach), indwelling urinary catheter (tube inserted into urethra to drain urine from the bladder), and wound to coccyx (tailbone area). The date of the last care visit was 11/17/2021. The date of discharge was 11/17/2021. The clinical record failed to evidence how patient #3's needs were met in the absence of agency services. The record failed to evidence documentation that demonstrated appropriate notice was given (verbal and written) and referrals were made to obtain necessary care. The agency failed to document the patient/caregiver/family member were provided with contact information of other home health agencies. 3. In an interview on 1/3/2022 at 2:52 PM, person F, the caregiver/family member for patient #3, stated the reason for the complaint was, neglect of [patient 3] , and the current administrator started pulling away staff from the patient s case without explanation. The patient had previously been receiving regular visits both day and night for over a year without issue, and that patient was not able to care for self, related		· Discharge process checklist will bedeveloped by Director of Nursing and approved by Governing Body by 2.18.22. · The Director of Nursing will in-serviceall RN Case Managers on the discharge process by 2.21.22 to ensureunderstanding of the notification process to family/patient and physician and requirementfor providing resources/referrals to family/patient. · 100% of potential discharges will bereviewed by care management team during case conferences to ensure entiredischarge process is followed. Discharge process checklist will be utilized forevery discharge and kept with all discharge records in QAPI binder. · 100% of all discharges will beaudited within 5 days of discharge by DON to ensure all steps werefollowed. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

	to medical diagnoses (CVA and MS), which included the requirement of position changes every 2 hours while in bed, they [this agency] did not discharge [patient 3], period; they [this agency] just stopped coming. Person F, further stated that names and numbers of alternate Home Health agencies were not provided by the agency.			
G0562	Discharge Planning 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Based on record review and interview, the agency failed to ensure an effective discharge planning process, to include coordination of care and assistance to patients and their caregivers in the procurement of another provider's service appropriate for the patient, for 1 of 4 closed records reviewed. (Patients #6) Findings Include: 1. Review of a undated Policy titled, Discharge Policy 02.23, &stated, &4. Patient s needs for continuing care to meet physical and psychological needs are identified and patients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. 5. Patients are informed of the reason for discharge &6. The physician will be involved in the discharge plan &8. A discharge plan shall be developed that is documented in writing and includes written/verbal instruction regarding the patient s ongoing care needs &10. &if there are unmet needs and the agency is no longer &documentation will demonstrate that appropriate notice was given (verbal and written) and referrals are made &Patients and/or their legal representative or other individual responsible &at least five (5) calendar days &Documentation of all communication with the	G0562	· The Administrator and Director ofNursing (Clinical Manager) will review the current Discharge Policy andTransfer policy and present changes required to the Governing Body for approvalof policy change by 2.18.22. · Discharge process (including Transfers)checklist will be developed by Director of Nursing and approved by GoverningBody by 2.18.22. · The Director of Nursing will in-serviceall RN Case Managers on the discharge and transfer process by 2.21.22. · 100% of potential discharges will bereviewed by care management team during case conferences to ensure entiredischarge process is followed. Discharge/Transfer process checklist will beutilized for every discharge and kept with all discharge records in QAPIbinder. · 100% of all discharges will beaudited within 5 days of discharge by DON to ensure all steps werefollowed.	2022-02-21

	client, including the rationale for discharge will be kept in the client file with copies sent to the primary physician...13. The physician will be informed of the change &and an order will be sent & 2. Review of an undated Policy titled, Transfer 02.24 , stated & 1. Patient transfer may be needed, hospitalization occurs &transferred to another service provider &2. A written summary, including the patient s discharge &will indicate &has transferred and will be documented and kept in the patient s clinical record. 3. The patient s physician will be notified and an order obtained & 3. A review of the clinical record for patient #6 revealed a comprehensive assessment dated 6/20/21, for the recertification period of 6/24/21 - 8/22/21. The comprehensive assessment evidenced a section labeled "Other goals to include:" which indicated "Son thinking about LTAC (Long Term Acute Care) for pt. [patient]. Will notify office of decision." The document failed to evidence the patient's physician was notified of the potential for discharge to an LTAC and failed to evidence the agency provided information or assistance to assist the patient and caregiver in finding an appropriate LTAC or SNF (Skilled Nursing Facility). A review of the clinical record failed to evidence documentation of discharge planning that included agency assistance in finding an appropriate LTAC or SNF when a higher level of care was required. A review of a document titled "Case Conference/Coordination of Care", dated 4/22/21, evidenced "Care Planning: Cont. [continue] w/ [with] POC [Plan of Care] @ this time. Discussed all options for when client requires a higher level of care." The document also evidenced a section labeled "Recertification Report" which indicated "Son [and] wife at risk for caregiver burnout." The sections for Personal Care Support, Coordination of Care, Discharge Planning, Interdisciplinary Referral, and Required Follow Up were blank. The document failed to evidence the agency discussed potential discharge of the patient to an LTAC or SNF, failed to evidence the physician was involved in any discharge planning, failed to evidence what options were discussed related to when the patient needed a higher level of care, and failed to evidence		· 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

documentation of discharge planning that included information to assist the patient and caregiver in choosing an appropriate LTAC or SNF.

Review of a second "Case Coordination/Care Planning" document, dated 6/20/21, indicated "Son is experiencing caregiver burnout D/T (due to) he works 5 days/week and is the main caregiver for his father when he's not working," The Personal Care Support, Coordination of Care, Discharge Planning, and Interdisciplinary Referral sections were blank. The document failed to evidence the agency provided information or discharge planning related to appropriate LTACs or SNFs, included the physician in discharge planning, and assisted the caregivers in finding an appropriate LTAC or SNF.

A review of a document titled "Discharge Summary" evidenced a reason for discharge of "Transfer/Admit to other agency/organization" and indicated patient #6 was discharged to Entity I (Long Term Acute Care Facility), with a discharge date of 7/29/21.

During an interview on 1/5/22 at 2:38 PM, person E (a primary caregiver for patient #6) indicated they began contacting skilled nursing facilities approximately 1 - 2 months prior to the patient's actual discharge from the agency. Person E stated entity L (a case management company) assisted in finding an LTAC for the patient. Person E also stated they didn't know that the agency could have helped find an appropriate LTAC. Person E denied knowledge of the agency's discharge/transfer policies and stated no one from the agency had discussed discharge planning. Person E indicated working with entity L to locate an appropriate facility because they thought entity L managed the patient's overall care and the agency only managed the patient's home health aide services.

On 1/5/22 at 12:38 PM, the administrator confirmed there were no additional documents available and

	the surveyor was the complete clinical record.			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to ensure a complete and accurate discharge summary was provided to the receiving facility or health care practitioner that included all necessary medical information and post-discharge goals of care for 3 of 4 closed records reviewed. (Patients 6, 7, and 8) Findings include: 1. Review of an undated Policy titled, Discharge Policy 02.23, &stated, &4. Patient s needs for continuing care to meet physical and psychological needs are identified...need to plan for discharge or transfer to another level of care/organization...6. The physician will be involved....and specific ongoing care needs will be identified and addressed as part of the plan. 8. A discharge plan shall be developed that is documented in writing and includes written/verbal instruction regarding the patient s ongoing care needs..." 2. A review of the closed clinical record of patient #8 on 1/5/2021, evidenced a start of care date of 6/14/2020, and contained a Physician Notification form dated 8/4/2020 stating the patient had been admitted to entity G (a hospital) on 7/31/2020, would be discharging from entity G, then be admitted to a rehabilitation facility, entity H, and the home health agency s services for patient #8 were on hold. The record failed to evidence a discharge summary being sent to entity G.	G0564	· The Administrator and Director ofNursing (Clinical Manager) will review the current Discharge Policy and presentchanges required to the Governing Body for approval of policy change by2.18.22. · Discharge process checklist toinclude discharge summary requirement and notification process will bedeveloped by Director of Nursing and approved by Governing Body by 2.18.22. · The Director of Nursing will in-serviceall RN Case Managers on the discharge process and checklist that will includethe notification process and discharge summary requirement by 2.21.22. · 100% of potential discharges will bereviewed by care management team during case conferences to ensure entiredischarge process is followed. Discharge process checklist will be utilized forevery discharge and kept with all discharge records in QAPI binder. · 100% of all discharges will beaudited within 5 days of discharge by DON to ensure all steps werefollowed. · 25% of all home health client	2022-02-21

	Review of a Physician Notification form dated 2/1/2021, evidenced the notification stated the patient was admitted to entity G on 01/27/2021, and the agency's services were on hold. The record failed to evidence a discharge summary had been sent to entity G. Review of a Discharge Summary document that was dated 7/29/21, stated the patient was being discharged, the patient had been at a rehabilitation facility since approximately 2/1/21, and the agency was notified on 7/26/2, the patient would not be returning home. The document revealed the patient had been on hold since 1/27/21. 3. A review of the clinical record for patient #6, discharge date 7/29/21, revealed a plan of care for the certification period of 6/24/21 - 8/22/21, which evidenced a primary diagnosis of multiple sclerosis (a degenerative and often terminal disease causing damage to the covering of the spinal cord and nerves), and secondary diagnoses of hypertension (high blood pressure), and type 2 diabetes (impairment in the way the body regulates and uses sugar). The patient used a Hoyer lift (a mechanical lift used for patients who are unable to bear weight) for transfer, a bedside commode, and both manual and electric wheelchairs. The patient was oriented with periods of forgetfulness. Functional limitations included endurance and ambulation with a prognosis of fair. The patient received home health aide services 11 hours per day, 5 days per week for bathing, dressing, catheter care, transfer/mobility assistance, safety, light housekeeping, and range of motion. A review of the 60-day clinical summary revealed the patient required maximum hands-on assistance w/ with all ADLs (activities of daily living). Patient #6 also needed assistance with feeding at times. The patient had generalized weakness in all extremities, was non-weight bearing, wheelchair-bound while up, incontinent at night, and required medication set up and reminders. The patient's goals included that the patient will perform self-care activities within ability; the patient will remain safe in own home; the patient will experience no new skin breakdown; the patient will be free of signs/symptoms of depression, and the patient will be free of falls. A review of a discharge summary evidenced a last date of service of 7/28/21, with a discharge date of 7/29/21. A section labeled "Summary of		recordswill be audited quarterly thereafter to ensure compliance with this standard · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

	and Functional Status" evidenced "HHA (home health aide) to assist w/ (with) ADLs. Client requires [sic] use of ceiling lift for all transfer. W/C (wheelchair) bound. A&O (alert and oriented) w/ periods of forgetfulness." A section labeled "Condition at Discharge" evidenced "stable", and indicated a copy of the discharge summary, plan of care, and medication list was faxed to the physician. A section labeled "Discharge Planning" evidenced "patient D/C (discharged) to [Name of entity I] (Long Term Acute Care Facility)." The discharge summary failed to include the patient's full and accurate current medical information including, but not limited to, current diagnoses, current physical condition, functional status/limitations, mental/psychosocial status, nutritional needs, diabetic needs, pain status, fall risk, knowledge/education related to illness, support systems, reason for transfer, progress toward goals, and post-treatment goals; and failed to evidence that a complete and accurate discharge summary was sent to the facility to which the patient was transferred. 4. A review of the clinical record for patient #7 revealed a plan of care for the certification period of 11/22/20 - 1/20/21, which indicated a primary diagnosis of cerebral palsy (impaired muscle coordination and other disabilities, often caused by brain injury or lack of oxygen to the brain), and secondary diagnoses of Shprintzen Goldberg Syndrome (a rare connective tissue disorder with head/facial, skeletal, and cardiac anomalies), esophageal reflux (a condition where stomach acid flows backward through the esophagus to the throat and/or mouth), scoliosis (curvature of the spine), and pneumonitis due to aspiration (inflammation of the alveoli, or air sacs, in the lungs caused by the passage of food or liquid into the airway and/or lungs). The patient utilized a wheelchair, shower bench, depends, low bed, and received g-tube (gastrostomy tube) feedings (liquid nutrition via a special tube inserted through the abdomen and into the stomach). Functional limitations included incontinence, contracture, hearing, endurance, ambulation, speech, and nutrition. Patient #7 was alert and nonverbal with a prognosis of good. The patient received home health aide services for bathing, dressing, personal care, elimination, g-tube care, assistance with mobility/transfer, range of motion, positioning, safety, meal preparation, and oral feedings. The 60-day summary evidenced the patient lived with a parent and required 24-hour care. A review of the discharge summary evidenced a last date of service of 1/18/21. The patient was			

	discharged 1/19/21; The discharge summary indicated the reason for admission to homecare as Shprintzed Goldberg Syndrome and scoliosis. The summary of care and patient's physical, psychosocial, and functional status evidenced "HHA (home health aide) to assist w/ ADLs.." A section labeled "Condition at Discharge" indicated "stable." A section labeled "Discharge Planning" evidenced "N/A" (not applicable). The discharge summary evidenced that a copy of the plan of care and current medication list was sent to the physician on 1/24/21. The discharge summary failed to include the patients full and accurate current medical information including, but not limited to, current diagnoses, current physical condition, functional status, mental/psychosocial status, nutritional needs, pain status, knowledge/education related to illness, progress toward goals, and post-treatment goals: and failed to evidence where the patient was transferred and/or who would be responsible for the patient's continued care needs. 5. On 1/5/22 at 2 PM, the agency's discharge summary process was reviewed with the administrator. The administrator stated the clinician sends a discharge summary to the patient's physician upon discharge. The administrator also stated not being aware a discharge summary was required to be provided to the facility or hospital receiving the patient and was not sure of the content required for a discharge summary.			
G0598	Discharge plans communication 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the agency failed to ensure discharge plans were communicated with the responsible physician	G0598	· The Administrator and Director ofNursing (Clinical Manager) will review the current Complaint Policy andCoordination of Care policy and present changes required to the Governing Bodyfor approval of policy change by 2.18.22. · Complaint process will be reviewedand updated by Administrator and Director of	2022-02-21

	closed records reviewed. (patients #3, 6, 7). Findings include: 1. Review of an undated Policy titled Section 02.23 Discharge page 1 of 2 stated, 6. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan. 10. To avoid charges of abandonment at the time of discharge, agency documentation should include the following (not meant to be all-inclusive): - Evidence that the decision was not made unilaterally. The patient, family and physician participated in the decision to discharge the patient from the agency. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary care physician. Page 2 of 2 states 13. The physician will be informed of the change in status and an order will be sent to the physician for confirmation of discharge. 2. On 1/04/2022 the clinical record of patient #3 was reviewed. The record failed to evidence any documentation of communication with ordering provider in relation to any concerns or barriers staff experienced related to providing care for patient. Clinical record also failed to evidence any documentation of communication with ordering provider regarding agency s intent to discharge patient for cause. 3. Complaint binder was submitted for review on 1/04/2022 at 10:00 AM. Entry for patient 3 consisted of printed out emails and copies of cell phone text messages between complainant and administrator. Headers of pages revealed print dates of 1/3/2022 and 1/4/2022 respectively. Contents of the binder failed to evidence any other forms or documents pertaining to patient. 4. During an interview on 1/05/2022 at 1:40 PM, employee D, alternate clinical manager, stated that the ordering provider had not been contacted in relation to concerns regarding patient 3 and caregiver, nor was physician contacted regarding impending discharge.		Nursing and approved by GoverningBody by 2.18.22. · The Administrator and Director ofNursing will in-service RN Case Managers, HR Manager, and other members of theleadership team on the complaint process by 2.21.22, including case conferencerequirements, employee education/disciplinary actions, and documentationprocess. · 100% of complaints will be reviewedby Administrator quarterly to ensure entire complaint process was followed. Allcomplaint records will be kept in QAPI binder. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard · The Administrator will be responsiblefor monitoring corrective actions to ensure that this deficiency is correctedand will not recur.	

5. On 1/06/2022 at 12:48 PM, nurse K for Dr. J (ordering provider for patient 3) returned call and left voicemail which stated, I don t see where anybody from Brightstar Home Care has contacted us {regarding patient 3} &I don t see anything in here &. (On 1/05/2022 at 11:29 AM, surveyor left message with provider s office inquiring if agency had contacted provider s office regarding discharging patient 3 from service).

6. A review of the comprehensive assessment for patient #6, completed on 6/20/21, for the certification period of 6/24/21 - 8/22/21, evidenced "Son thinking about LTAC (Long Term Acute Care) for pt. (patient). Will notify office of decision." A section titled "Summary Checklist" indicated the care plan was reviewed, but failed to evidence if it was reviewed with the physician or if the physician was notified that the patient's son was contemplating placement of the patient in a long-term care facility. A section titled "Communication and Coordination of Care" indicated "Home Health Aide", but failed to evidence the content or type of care coordination done with the home health aide and failed to specify the home health aide with whom care coordination occurred. The "physician" option in the section was blank, and failed to evidence potential discharge plans were communicated to the physician.

A review of the most recent plan of care, completed 6/20/21 by employee D (Registered Nurse),for the certification period of 6/24/21 - 8/22/21, evidenced a 60-day progress summary which indicated no changes at this time, and stated the physician was "notified of current findings." A section titled "Discharge Plans" included "1. When the client no longer has a need of services. 2. When the client moves to a location outside of the agency service area. 3. When the client needs a higher level of care." The 60-day progress summary and plan of care failed to evidence whether the physician was notified that the patient's son was contemplating transferring the patient to a long-term care facility.

A review of a document titled "Case Conference/Coordination of Care", dated 4/22/21, indicated coordination of care participants of "home health aide" only, and failed to evidence care coordination with the physician, skilled nurse, case manager, personal service agency, or other services. The document also indicated "Discussed all options for when

	client requires a higher level of care" but failed to evidence if discharge to an LTAC was discussed and whether plans were discussed with the patient's physician and caregivers. A section titled "Progress and Barriers Toward Goals" indicated "continue to monitor" but failed to evidence what was being monitored, the progress and barriers toward goals, and whether the plans to continue monitoring were communicated with the patient's physician and primary caregivers. A review of a second case conference note, dated 6/20/21 indicated the patient's primary caregiver was experiencing caregiver burnout due to working full time while being the primary caregiver to patient #6 when not at work, and indicated the son was trying to keep the patient at home, but "gets overwhelmed at times." A section titled "Progress and Barriers Toward Goals" was blank. The document failed to evidence discharge planning that included notification to the physician concerning changes or difficulties in the patient's level of care, or that a skilled facility was being considered by the patient's caregiver. A review of the discharge summary evidenced a last date of service of 7/28/21, with a discharge date of 7/29/21. The discharge summary indicated that a copy of the discharge summary, plan of care, and medication list was faxed to the physician on 7/29/21. 7. A review of the comprehensive assessment for patient #7, completed 11/20/21, for the certification period 11/22/20 - 1/20/21, indicated the care plan was reviewed/updated and was developed/reviewed with patient involvement. Communication and coordination of care included the skilled nurse and family. The assessment failed to evidence whether discharge planning was discussed with the patient, caregiver, and physician.			

A review of a plan of care completed 11/20/21, evidenced "no changes made at this time" and indicated the physician was notified of findings. The plan of care failed to evidence that discharge planning was discussed with the patient, caregiver, and physician.

A review of a "Case Conference/Coordination of Care" document, dated 11/20/20, evidenced coordination of care participants included the skilled nurse, home health aide, and patient. The document failed to evidence coordination of care occurred with the patient, caregiver, or physician. Sections labeled "Discharge Planning", "Interdisciplinary Referral", "Care P"lanning, and "Coordination of Care" were blank. The document failed to evidence discharge planning occurred, including concerns, changes in care, and family involvement; and failed to evidence whether the physician was notified of any concerns, changes, or discharge plans.

A review of a second case conference note, dated 1/17/21, evidenced the registered nurse suggested using a Hoyer lift, however, the patient's mother/primary caregiver refused. The "Coordination of Care Participant" section was blank and failed to evidence if the patient's aide, nurse, case manager, or physician was included in coordination of care or discharge planning. The "Recertification Report" section indicated "Client doing well at this time. No changes at this time." Additional documentation at the bottom, separately dated 1/19/21, indicated "RN (Registered Nurse) notified our caregiver arrived to clients [sic] home for scheduled shift and notified by family that a new company was providing care." The document failed to evidence if the patient's caregiver or physician was contacted concerning refusal of services and immediate discharge.

A review of the discharge summary evidenced the last date of service was 1/18/21, with a discharge date of 1/19/21. A copy of the discharge summary, plan of care, and current

	medication list was faxed to the physician on 1/24/21. 8. On 1/5/22 at 2 PM, the administrator was interviewed concerning the agency's discharge/transfer process. The administrator stated a discharge summary is sent to the patient's physician upon discharge. The administrator was but was not aware that a discharge summary should be provided to the transfer facility or new home health organization. When queried as to how the agency communicated plans and changes, including discharge or the patient, the administrator stated the agency was told by previous surveyors to stop using communication or progress notes, so the agency uses the call logger in the ABS Scheduling system to log phone calls. The administrator also stated that employees text and email each other, the patients, and their caregivers. When queried as to where the documentation of the texts and emails were kept, the administrator stated she could print out the emails and provide screenshots of the texts for applicable patients. When queried as to whether the agency provided the complete clinical record for patients #6 and 7 the administrator stated the complete record was provided for both patients.			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to ensure coordination of care included the patient, the patient's representative (if any), and the patient's caregivers, as appropriate in 4 of 8 records reviewed. (Patient #1, 6, 7, & 8) Findings include: 1. Review of a Policy titled, Care Coordination Policy 02.19 dated 12/19, stated Policy: Upon admission to BrightStar Care of Indianapolis,	G0608	· The Administrator and Director ofNursing (Clinical Manager) will review the Care Coordination Policy and presentchanges required to the Governing Body for approval of policy change by2.18.22. · Care Coordination form will bereviewed and required changes will be made with approval of Governing Body by2.18.22. · The Director of Nursing will in-serviceall RN Case Managers on the care coordination policy and procedure by2.21.22. All personnel providingservices shall maintain effective	2022-02-21

	each patient will be assigned a designated care manager &to facilitate communication &The Director of Nursing (DON) or care manager will act as a liaison with other organizations...to ensure effective coordination of related services...Procedure ...H. Proper communication upon &.including the opportunity for questions between the giver and receiver of patient information &I. Integration of services, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness..J. Coordination of care deliver to meet the patient s needs....8. will communicate changes in a timely manner...10. The transmission of patient care information will be timely, accurate, and standardized...4. The Director of Nursing (DON) or designee will be responsible for the coordination, and ongoing communication between service providers...D. Sharing relevant information to facilitate coordination..." 2. A review of the closed clinical record of patient #8 on 1/5/2021, evidenced a start of care date of 6/14/2020 which contained a Physician Notification form dated 8/4/2020 stating the patient was admitted to entity G on 7/31/2021, would be discharging from entity G, be admitted to a rehab facility, entity H, and the agency s services for the patient was on hold. The record failed to evidence care coordination or any kind of communication in the clinical record between the agency and entit 3. A review of the clinical record for patient #1 revealed a plan of care for the certification period of 12/11/21 - 2/8/21. The patient lived alone in an independent senior living community and received home health aide services under Medicaid Prior Authorization (a type of insurance) for 35 hours/week for bathing, personal care mobility assistance, safety, positioning, light housekeeping. A review of the 60-day progress summary evidenced that on 12/7/21 "the registered nurse collaborated with the patient, family, case manager, and physician to determine the scope of services, visit frequencies, and duration for the recertification period of 12/11/21 - 2/8/22. The patient and family agree with the scope of service as outlined in this plan of treatment including ordered disciplines, visit frequency, and duration." The plan of care evidenced orders may be accepted by person M (a physician) and person N (a physician) but failed to evidence if findings were reviewed with all physicians for care coordination purposes, and failed to evidence the plan of care was provided to the additional physicians for review. The plan of care failed to evidence a frequency and duration		communications to ensure that their effortsappropriately complement one another and support the objectives of the patient's care. The means of communication andthe results shall be documented in the clinical record or minutes of case conferences. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

were discussed with the patient, family, and physician. The plan of care also failed to evidence care coordination was discussed with the patient, caregiver, and physician including, but not limited to, the patient's health, mental, and psychosocial status, discharge plans, care preferences, goals and progress toward goals, and satisfaction with services. The plan of care also failed to evidence care coordination occurred with the patient's waiver agency.

A review of a verbal order dated 12/7/21 at 3 PM, and signed by employee D, evidenced person O (primary care physician) was notified of the assessment findings and agreed and approved of the need for services. The order indicated "The physician, patient/caregiver, and nurse have collaborated in the development of the plan of care as listed below" and evidenced orders may be accepted from person M (a physician) and person N (a physician), but failed to evidence care coordination occurred with persons M and N, failed to identify the caregiver with whom care coordination occurred, failed to specify the care coordination was discussed, and failed to include previously identified "family" in the care coordination. The verbal order evidenced a frequency and duration of "HHA - 35 hour/week" and 15 hours/week of waiver but failed to evidence care coordination with a personal services agency.

A review of a document titled "Case Conference/Coordination of Care", dated 12/7/21, evidenced coordination of care participants included skilled nurse, patient, and family, but failed to evidence care coordination that included the patient's aide(s), primary caregiver, and all physicians involved, and failed to evidence which family members participated in the care coordination meeting. The document evidenced fall prevention, hospitalization risk, and the emergency room visit on 11/27/21, but failed to evidence care coordination with the patient, family, and physicians related to seizure safety and treatment, such as a seizure plan or an emergency call button. Options for personal care support, care planning, medication management, coordination of care, discharge planning, interdisciplinary referral, and dietary/nutritional needs were blank. The option for identification of patient concerns, health problems, functional challenges and barriers, and safety issues was also blank. Patient progress towards goals and/or barriers to progress evidenced "ongoing" and failed to include coordination of care with the patient, family, and physicians concerning the patient's goals and progress. The document also failed to

evidence care coordination with the personal service agency that provided the waiver services.

4. A review of the clinical record for patient #6, discharge dater of 7/29/21, evidenced a comprehensive assessment dated 6/20/21, for certification period 6/24/21 -8/22/21. The assessment evidenced "Son thinking about LTAC (Long Term Acute Care) for pt. (patient). Will notify office of decision." The assessment also indicated "Care Plan Developed" and "Care Plan Reviewed", and evidenced communication and coordination of care occurred with the home health aide. The assessment failed to evidence if the home health aide was the patient's agency-provided caregiver, and what care coordination was discussed with or provided by the aide. The assessment also failed to evidence care coordination with the physician, nurse, case manager, primary caregiver, or personal service agency, and failed to evidence care coordination related to discharge planning and assistance with identifying an available and appropriate LTAC.

A review of the plan of care, dated 6/24/21 - 8/22/21, evidenced the patient lived with a son, who was the primary caregiver. The patient required maximum assistance for all care, meal prep, and feeding, was chairbound, forgetful, and required a mechanical lift. The plan of care failed to evidence the physician was notified that the caregiver was experiencing "burnout" and considering placement of the patient in a long-term care facility, and failed to evidence care coordination occurred with all parties to prepare for possible discharge.

A review of a document titled "Case Conference/Coordination of Care", dated 6/20/21, evidenced "Son is experiencing caregiver burnout .... Son trying to keep pt (patient) in home w/ (with) him but gets overwhelmed at times." The document failed to evidence care coordination involved the physician, skilled nurse, the agency provided aide, personal service agency, or primary caregiver to discuss the potential transfer to a facility, the caregiver burnout, or the patient's increased level of care.

5. A review of the clinical record for patient #7 revealed a plan of care for the certification

home with the mother, was non-verbal, received g-tube feedings (gastrostomy tube - a catheter placed through the patient's abdomen into the stomach in order to receive liquid nutrition), and required 24-hour care. The plan of care indicated on 11/20/21 the registered nurse collaborated with the physician, case manager, and caregiver "to determine the scope of services, visit frequencies, and duration." The plan of care failed to evidence the patient's current medical, psychosocial, nutritional, functional, pain, communication, and safety statuses were discussed with all parties, and failed to evidence ongoing care needs were discussed.

A review of a discharge summary, for discharge date 1/19/21, evidenced the patient was "stable" and was transferred/admitted to other agency/organization. A copy of the discharge summary and medication list was sent to the physician on 1/24/21. The discharge summary failed to evidence case coordination that included notifying the physician of the reason for transfer and the patient's current medical information, environment, care needs, goals, and progress toward goals.

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6. An agency document titled, 'Patient Update' dated 11/09/202 written by office support staff F, stated, " [Home health aide H] ...considered discontinuing the case, but [he/she] feels bad Ms. Nancy. [Home health aide I] also has made accommodations [him/herself] by bringing his own toilet paper and hand soap and even brought [his/her] own wipes to clean [patient 3] up as needed. [Home health aide I] truly does not want to get [him/herself] into a situation all because [complainant] will not answer [his/her] phone." The record failed to evidence documentation of efforts made by the agency to coordinate care to resolve reported problems in 1 (patient 3) of 1 closed record reviewed.

An agency document titled, 'Customer Complaint' dated 11/11/2021 written by office support staff F, stated, "[Person F, caregiver for patient 3] called to say that [he/she] always has tissue paper next door at [his/her] house, and [he/she] only buys the small packs because they always come up missing from [patient 3's] place. [Person F] states [he/she] knows that [home

	health aide J] was the one who reported to the office that [patient 3] did not have tissue, but [home health aide J] should have called [person F] first and not the office because [person F] would have brought some right over... I know [person F] blames [home health aide J] for reporting the toilet paper, but [home health aide J] only reported that [patient 3] did not have any briefs in the home last night to change [patient 3]. The record failed to evidence documentation of efforts made by agency to coordinate care to resolve reported problems in 1 (patient 3) of 1 closed record. A review of the clinical record for patient #3, evidenced home health aide orders for care, 7 days a week, 14 hours per day. Patient #3's diagnoses included Multiple Sclerosis (MS - disease in which the immune system eats away the protective covering of the nerves), Cerebrovascular Accident (CVA - damage to the brain from interruption of its blood supply), early onset dementia, dysphagia (difficulty swallowing), gastrostomy-tube with enteral feedings (tube inserted through the belly to bring nutrition directly to the stomach), indwelling urinary catheter (tube inserted into urethra to drain urine from the bladder), and wound to coccyx (tailbone area). The date of the last care visit was 11/17/2021. The date of discharge was 11/17/2021. Review of the clinical record failed to evidence documentation of care coordination efforts made to resolve the concerns reported by staff members, home health aides I and J, related to lack of supplies in the home of patient 3. Review of complaint log on 1/05/2022, failed to evidence documentation that employee complaints were addressed, failed to evidence documentation that the agency made efforts to coordinate care in order to resolve reported problems reported by employees I and J regarding patient 3 and person F in 1 (patient 3) of 1 closed record reviewed.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the agency failed to ensure clinical notes documented pertinent communication with patients, their families/caregivers, physicians,	G0716	· The Administrator and Director ofNursing (Clinical Manager) will review the current Plan of Care Policy, CareCoordination Policy, Case Conference Policy, and Clinical Record Policy andpresent	2022-02-21

	personal service agencies, and other applicable persons/entities as part of the clinical record for 1 of 1 active records reviewed (patient #1) and 2 of 4 closed records reviewed (patients #6, 7). Findings include: 1. A review of the clinical record for patient #1, start of care date 3/7/17, evidenced a plan of care for the certification period 12/11/21 2/8/22, which indicated the patient lived alone in an independent senior community, had a history of seizures, required assistance with all aspects of activities of daily living, received 35 hours per week of home health aide services from the agency, and received attendant care services for 15 hours per week. The plan of care also evidenced the patient was seen in the emergency department on 11/27/21, due to a seizure, and returned home the same day, with no changes in medication. The plan of care indicated that on 12/7/21, the registered nurse collaborated with the patient, family, case manager, and physician to determine the scope of services visit frequencies, and duration for the recertification period of 12/11/21 2/8/22. The plan of care failed to evidence who the patient s primary caregivers were, what agency provided attendant care, and what services were received and failed to evidence care coordination or review of the plan of care by all physicians. Continued review of the clinical record failed to evidence communication notes, progress notes, or another appropriate form that included documentation including, but not limited to, when and how the patient s		changes required to the Governing Body for approval of policy change by2.18.22. · The Director of Nursing will in-serviceall RN Case Managers and team leaders on the updated policies by 2.21.22. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard. · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

seizure was reported, who reported the seizure, follow-up as to the quality and duration of the seizure, the cause of the seizure, if the agency notified an emergency caregiver, if care coordination occurred with the personal service agency, if the emergency alert necklace was used, if the patient was transported by ambulance, and if the agency notified all physicians involved.

A review of a document titled Case Conference/Coordination of Care evidenced the document was an every 60-day case conference. Participants included skilled nurse, patient, and family. Options for telephone Contact , Care Coordination , Follow-up , and Other were blank. The document evidenced fall prevention measures were discussed, the patient s risk of hospitalization was a score of 8, and the patient went to the emergency room on 11/27/21 for a seizure. The patient s weight was steady. The document failed to evidence care coordination occurred with all physicians on the plan of care, the personal service agency, agency-provided staff, including the patient s home health aide(s), or the case management company. Further review of the clinical record for certification period 12/11/21 2/8/21 failed to reveal communication notes, progress notes, or other similar forms the evidenced documentation of receipt of information, communication, care coordination, or follow-up related to the patient s seizure, or related to day-to-day management of the patient s care needs and scheduling with the patient, staff, caregivers, physicians, and other entities as applicable.

2. A review of the clinical record for patient #6, discharge date 7/29/21, revealed a discharge summary and evidenced the patient discharged to entity I (a long-term care facility), but failed to evidence documentation of communication with the patient, caregiver, physician, case management company, or long-term care facility concerning the patient s progression toward discharge. Continued review of the clinical record failed to evidence documentation of communication notes, progress notes, or other appropriate forms which documented the day-to-day management of the patient leading to discharge including, but not limited to, care coordination with physician, family, personal

service agency, the agency provided aide services, increased level of care, follow-up, and notification of and preparation for pending discharge.

3. A review of the clinical record for patient #7 evidenced a discharge summary with a discharge date of 1/19/21. The discharge summary indicated the patient s primary caregiver only wanted one caregiver. The summary also indicated the registered nurse suggested a mechanical lift to transfer the patient, and the patient s primary caregiver stated he/she lifted the patient just fine. Continued review of the same document evidenced an entry added on 1/19/21, which indicated the registered nurse was notified the agency caregiver arrived at the patient s home for a scheduled shift and was notified by the family that a new company was providing care. Continued review of the clinical record failed to evidence communication notes, progress notes, or other appropriate forms which documented the day-to-day management of the patient including, but not limited to, follow-up concerning the caregiver s request for only 1 agency caregiver, and follow-up concerning the need for a mechanical lift and the caregiver s response. The record also failed to evidence follow-up concerning the reason a new company was initiated, and if the caregiver had a possible complaint about care.

4. On 1/3/21 at 2:49 PM, the administrator was interviewed concerning the agency policy and process for maintaining a clinical record. The administrator stated the agency did not use an EMR (electronic medical record) and maintained all patient records on paper, in a binder. When the binder was thinned or a patient was discharged, the paper note was scanned to a cloud storage, and the paper record was stored offsite in a secure storage facility. When queried as to how the agency documented day-to-day communication about patients, the administrator stated the scheduling software contained a call logger, where calls were documented. When queried as to whether the call logger was part of the clinical record and could be accessed by all authorized individuals or provided to the patient upon request, the administrator stated all office employees and case managers had access to the call logger, but not all could print. When queried as to where calls not related to scheduling were documented, the administrator stated they could be logged in the call logger. When queried as to the clinical notes that showed documentation of day-to-day

	the administrator stated that during the previous recertification survey, the surveyors told them they should no longer document using communication notes, so they stopped. The administrator also stated that office staff and clinicians text and email patients, physicians, caregivers, employees, and entity L (a case management company). When asked if the texts and emails were part of the clinical record, the administrator stated whoever they were sent to could print them out or send screenshots of texts if requested. When queried as to how the surveyor would know if a text or email existed, and to whom it was sent, if there was no record of it in the paper chart, the administrator had no further information. On 1/6/22 at 3:15 PM, the administrator was interviewed concerning the clinical record and preparing clinical notes and stated during a previous survey, the surveyors told them they should not document on communication notes, but they were not told why. The administrator verified that all closed records given to the surveyors during this survey were complete, there was no additional paperwork available, and all active records were complete for the time period and items requested. The administrator was queried as to the content of the texts and emails provided for patient #3, and stated, That s not even everything. The administrator stated there were texts and emails from the patient s daughter, who called the administrator a C and other foul language and made threats. The administrator stated, I didn t even give you everything. I m not giving you things where she calls me foul names. When queried as to whether there was further documentation for patient #3 s record, the administrator stated, I m not giving you that stuff. It s horrible. The surveyor queried as to whether there was more documentation for the clinical records reviewed for this survey, and the administrator stated all records were complete as requested. When queried as to the emails and texts not given for patient #3, the administrator stated she would not give those emails or texts.			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the agency failed to ensure continuing	G0718	· The Administrator and Director ofNursing (Clinical Manager) will review Clinical Record Policy and present changesrequired to the Governing Body for approval of policy change by 2.18.22.	2022-02-21

	communication with all physicians and/or other health care practitioners involved with the patient s plan of care for 2 of 4 active records reviewed (patients #1, 5) and 2 of 4 closed records reviewed. (patient #6, 7) Findings include: 1. A review of an undated Policy titled, Clinical Record & Documentation 02.13 , stated, &7. Phone calls or other communication with patients, families &will be documented in the chart &9. When services are not provided, the reason for the missed visit will be documented &and reported to the physician & 2. A review of the clinical record of patient #5 on 1/3/2021, evidenced a start of care date of 2/8/2021 which contained a plan of care with a certification period of 11/14/2021 through 1/12/2022, with orders for Skilled Nursing 8 hours a day, 5 days a week, to administer tube feedings and medications during school hours and assessment of the patient per shift. A review of skilled nursing visits revealed missed visits occurred on 11/15/2021, 11/16/2021, 11/24/2021, 11/25/2021, 11/26/2021, 12/09/2021, 12/10/2021, 12/13/2021 through 12/17/2021, and 12/24/2021. The clinical record failed to evidence the physician was notified of missed visits. 3. A review of the clinical record for patient #1 evidenced a plan of care for the certification period of 12/11/21 - 2/8/22 indicated "May accept orders from person M (a physician) and person N (a physician)." The record failed to evidence the plan of care was reviewed with person M and person N for collaboration of care and review of findings and failed to evidence the plan of care was sent to all physicians for		· The Administrator and Director ofNursing will review Physician Notification form, including missed visitdocumentation and patient condition reporting, and required changes will bemade with approval of Governing Body by 2.18.22. · The Director of Nursing will in-serviceall RN Case Managers and team leaders on the updated policies and processes forclinical record documentation and missed visit reporting by 2.21.22. · 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard · The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.	

to the emergency department on 11/27/21 due to a seizure. The patient returned home the same day with no medication changes. The record failed to evidence that all physicians on the plan of care were notified of the patient's seizure and subsequent trip to the emergency department.

A review of a document titled Case Conference/Coordination of Care evidenced care coordination participants included the skilled nurse, patient, and family, but failed to evidence the physician responsible for the plan of care and the physician's also contributing to the plan of care were consulted for care coordination and informed of the patient's seizure and subsequent visit to the emergency department on11/27/21.

4. A review of the clinical record for patient #6 evidenced a comprehensive assessment dated 6/20/21, for the certification period of 6/24/21 - 8/22/21, which indicated the patient's son was thinking about placing the patient in a long term care facility. The record failed to evidence the agency notified the physician responsible for the plan of care of the patient's change in level of care and the potential for discharge to a long-term care facility.

A review of a document titled "Case Conference/Coordination of Care, indicated "Son is experiencing caregiver burnout ...Son trying to keep pt (patient) in home w/ (with) him but gets overwhelmed at times." The record failed to evidence the physician responsible for the plan of care was notified of the patient's increased level of care, the caregiver's burnout necessitating the possible transfer of the patient to a long-term care facility.

5. A review of the clinical record for patient #7 evidenced a document titled "Case Conference/Coordination of Care", dated 1/17/21, which indicated the registered nurse suggested a mechanical lift to transfer the patient.. A separate entry at the bottom, dated 1/19/21, evidenced the registered nurse was notified that the agency caregiver arrived at the patient's home for a scheduled shift and was informed a new agency was providing services. The document failed to evidence the physician responsible for the plan of care participated in care coordination, was notified of the need for a mechanical lift, or was notified that the patient

	had terminated services without notice and was receiving services from another agency. 410 IAC 17-14-1(a)(1)(G)			
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure a completed discharge or transfer summary was written and sent to the primary care physician or other health care professional who was responsible for the patient's care after discharge within 5 business days of the patient's discharge or within 2 business days of a planned transfer to another facility, for 2 of 4 closed records reviewed. (patients #5 and 8) Findings include: Review of a undated Policy titled, Discharge Policy 02.23, &stated, &4. Patient s needs for continuing care to meet physical and psychological needs are identified...8. A discharge plan shall be developed that is documented in writing and includes written/verbal instruction regarding the patient s ongoing care needs &"	G1022	· The Administrator and Director ofNursing (Clinical Manager) will review the current Discharge Policy and presentchanges required to the Governing Body for approval of policy change by2.18.22. · Discharge process checklist, includingdischarge summary, will be developed by Director of Nursing and approved byGoverning Body by 2.18.22. Clinical records containing pertinent past andcurrent findings in accordance with accepted professional standards shall bemaintained for every patient in the discharge summary. · The Director of Nursing will in-serviceall RN Case Managers on the discharge process, including the discharge summaryrequirements by 2.21.22. · 100% of potential discharges will bereviewed by care management team during case conferences to ensure entiredischarge process is followed. Discharge process	2022-02-21

1. Review of an undated Policy titled, Transfer 02.24 , stated & 1. Patient transfer may be needed, hospitalization occurs &transferred to another service provider &2. A written summary, including the patient s discharge &will indicate &has transferred and will be documented and kept in the patient s clinical record. 3. The patient s physician will be notified and an order obtained &

2. A review of the closed clinical record of patient #8 on 1/5/2021, evidenced a start of care date of 6/14/2020, which contained a Physician Notification form dated 8/4/2020, which stated the patient was admitted to entity G (an acute care hospital) on 7/31/2020, would be discharged from entity G, and then be admitted to a rehabilitation facility, entity H, and the agency s services for the patient were on hold. This record failed to evidence a discharge summary was sent to entity G.

Review of a Physician Notification form dated 2/1/2021, revealed patient #8 was admitted to entity G on 1/27/2021, and the agency's services were on hold. This record failed to evidence a discharge summary was sent to entity G.

Review of a Discharge Summary document dated 7/29/2021, evidenced patient #8's most recent certification period had been 12/20/2021 to 2/17/2021, with last date of service 1/27/2021, and stated patient was "d/c'd [discharged] from services while at rehab[ilitation] facility due to patient requires 24 hour care" The document indicated patient #8 had been on hold since 1/27/2021.

During an interview on 1/6/2022 at 12:09 PM, employee D, alternate clinical manager, stated not having realized when a patient had been admitted to a hospital, that a discharge summary is required be submitted to that entity.

3. A review of the clinical record for patient #5 revealed a discharge summary, with a discharge date of 7/29/21, which indicated the patient was

discharge and kept with all discharge records in QAPI binder.

· 100% of all discharges will be auditedwithin 5 days of discharge by DON to ensure all steps were followed.

· 25% of all home health client recordswill be audited quarterly thereafter to ensure compliance with this standard

· The Director of Nursing will beresponsible for monitoring corrective actions to ensure that this deficiency iscorrected and will not recur.

	transferred to entity I (a long-term care facility), and indicated a copy of the discharge summary was sent to the physician. The document failed to evidence a completed copy of the discharge summary was sent to entity I, who was responsible for providing ongoing care to the patient after discharge from the home health agency. 410 IAC 17-15-1(a)(6)			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE