

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804
--	---

(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
--------------------	--	---------------	---	----------------------

N000000	<p>This was a home health state licensure survey.</p> <p>Facility number: 012399</p> <p>Survey dates: April 16-18, 2013</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 19 Home Health Aide Only: 102 Personal Care Only: 143 Total: 264</p> <p>Sample: RR w/HV: 5 RR w/o HV: 2 Total: 5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">April 18, 2013</p>	N000000		
---------	---	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2013	
NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804			
(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			
N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, document and policy and procedure review, and interview the agency failed to ensure the Home Health Aides (HHA) followed infection control policies and procedures for 2 of 2 HHA home visits with the potential to affect all the agency's patients receiving HHA services. (#1 and 2)</p> <p>Findings include</p> <p>1. During home visit observation for patient #1 on 4/17/13 at 8:00 AM, the HHA, employee J, was observed washing hands prior to care. HHA failed to scrub hands together for longer than five seconds.</p> <p>During interview on 4/17/13 at 8:40 AM, employee A indicated staff should be washing hands long enough to sing the ABC song.</p> <p>2. During home visit observation on 4/17/13 at 10:30 AM, employee L, a HHA, was observed showering patient #2 and failed to wash from front to back.</p>	N000470	N0470 The Director of Nursing has counseled and educated employee J on proper Handwashing per policy and procedure and employee L on correct Bathing per policy and procedure. Both were completed on 4/19/13. All employee's were notified on 4/22/13 by the Director of Nursing to complete a Handwashing and Bathing inservice training in the next 30 days. The Director of Nursing will ensure that the correct Handwashing and Bathing procedures will be included in the monthly BrightStar Newsletter that goes out to all employee's for the month of May and June. A powerpoint slide with specific emphasis on 15-20 sec Handwashing will be included into the Infection Control portion of the Orientation slide show that is presented to all new employee's in addition to the Handwashing policy, procedure and quiz that is already included in their Orientation packet. The additional slide will be completed by 5/1/13 by the Director of Nursing. The Director of Nursing has inserviced Kim Kuhns ADON on 4/19/13 on	05/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2013	
NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The HHA washed patient's buttocks and rectal area, then washed the perineal area and foley catheter site. The HHA then rinsed the sponge, applied more soap, and washed the patient again in the same order.</p> <p>During interview on 4/17/13 at 11:10 AM, employee A indicated the staff should always wash from front to back.</p> <p>3. The agency's undated policy titled "Section 04.01.K-Hand Washing" states, "2. When to Wash: Hands should be washed whenever: ... after glove removal ... 3. How to Wash ... a. Proper hand washing with soap and water ... rub your hands vigorously together for at least 15-20 seconds."</p> <p>4. The agency's undated policy and procedure titled "BedBath and Shower" states, "Shower Procedure: ... 4. Assist the patient in washing the hair, face, ears and neck first. Continue assisting with washing from the head to the toes, washing the perineal area last bathing from front to back to avoid contamination."</p> <p>5. The agency's job description titled "Home Health Aide" states, "Essential Job Functions/Responsibilities: ... 3. Follow principles of infection control and</p>		<p>emphasizing correct bathing procedures during orientation. The Director of Nursing has inserviced Kim Kuhns ADON and Sandy Hewson RN Case Manager on 4/19/13 on continuing to educate and monitor correct Handwashing and Bathing during Supervisory visits of our Home Health Aides and Nurses. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804
--	---

(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
	Universal Precautions."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2013	
NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804			
(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			
N000496	<p>410 IAC 17-12-3(b) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (1) The patient's family or legal representative may exercise the patient's rights as permitted by law. Based on document review, clinical record review, policy review, and interview, the agency failed to inform patients of all their rights for 5 of 5 records reviewed (#1-5)with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> On 4/16/13 at 10:20 AM, review of admission packet Patients' Rights and Responsibilities form failed to evidence the patient had the right to exercise his or her rights and the patient's family or legal representative may exercise the patient's rights as permitted by law. Clinical records #1-5 evidenced the patient had received the Patients' Rights and Responsibilities document. On 4/16/13 at 10:35 AM, employee A indicated they did not see that right listed on the form. The agency's undated policy titled "Section 02.05-Bill of Rights" states, "2. 	N000496	N0496 The Director of Nursing has added the statement "the patient has the right to exercise his or her rights and the patient's family or legal representative may exercise the patient's rights as permitted by law" to the Patient's Rights and Responsibilities document in the admission packet and to the Bill of rights policy.	04/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804
--	---

(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
	In the event that the client is unable to make decisions, the Home Care Bill of Rights shall be given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Home Care Bill of Rights shall be documented."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804
--	---

(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
--------------------	--	---------------	---	----------------------

N000524	<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> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review, policy review, and interview the agency failed to ensure the plan of care included all required elements for 3 of 5 clinical records reviewed with the potential to affect all the agency's patients. (#1, 3, and 4)</p> <p>Findings include</p> <p>1. Clinical record #1 contained a Plan of Care (POC) dated 2/19-4/20/13 with</p>	N000524	N0524 The Director of Nursing has inserviced nursing staff that all POC's require an indication of amount, frequency and duration of visits as well as list all DME that is in the patient's home. 10% of all clinical records will be audited quarterly for evidence that each POC includes an indication of amount, frequency and duration of visits and lists all DME supplies. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected	04/19/2013
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2013	
NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>orders for respite Home Health Aide (HHA) services to 104 hour per month. The POC failed to indicate amount, frequency, and duration of HHA visits.</p> <p>During interview on 4/17/13 at 1:40 PM, employee B indicated the amount, frequency, and duration of HHA visits did not change since the previous certification period and they are not sure why the nurse changed it to read 104 hours per month.</p> <p>a. During home visit observation on 4/17/13 at 8:00 AM, the following Durable Medical Equipment (DME) were observed in the home: Hoyer lift, shower chair, hospital bed, air mattress, foley catheter, and wheel chair. The POC failed to include these DME.</p> <p>b. During interview on 4/17/13 at 8:40 AM, employee A indicated a consultant told the agency only to list any DME the agency provides.</p> <p>2. Clinical record #3 contained a POC dated 3/4-5/3/13 with orders for HHA services up to 24 hours a day up to 7 days per week. The POC failed to include a duration for the HHA visits and all DME.</p> <p>During home visit observation on 4/17/13 at 11:50 AM, employee K asked the patient if they had a shower chair and</p>		and will not recur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>the patient indicated they did have a shower chair. The shower chair was not on the POC.</p> <p>3. Clinical record #4 contained a POC dated 12/17/12-2/15/13 with orders for HHA up to 2 hours a day, up to 3 days per week. The order failed to include a duration.</p> <p>4. The agency's undated policy titled "Section 02.23- Medical Plan of Care, Physician Orders and Medical Supervision" states, "2. The medical plan of care shall meet the following: ... Include the following: ... ii. Type of services and equipment required, iii. Frequency and duration of visits."</p>			
--	---	--	--	--