

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 05/08/2013
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NAME OF PROVIDER OR SUPPLIER  BRIGHTSTAR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9292 N MERIDIAN ST STE 308 INDIANAPOLIS, IN 46240
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G000000	<p>This visit was a Home Health Initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: May 7 and 8, 2013 Partial Extended Dates: May 7 and 8, 2013</p> <p>Facility Number: 011449</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor - Team Leader Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 10 Home Health Aide Only: 0 Personal Care Only: 0 Total: 10</p> <p>Sample: RR w/HV: 0 RR w/o HV: 10 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 15, 2013</p>	G000000		

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

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

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	Survey revised May 21, 2013. je			

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G000102	<p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to provide patients with the OASIS Privacy Notice in advance of furnishing care to the patient in 6 of 10 records reviewed with the potential to affect all patients who receive care. (#2, #4, #5, #6, #8, and #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Policy titled "Bill of Rights, OASIS Privacy Notice, and Patient Complaint Grievance" policy number 02.06, undated, states, "1. Upon admission, the admitting clinician shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient during the initial evaluation visit before treatment is begun. The Oasis Privacy Notice will be furnished to all skilled care Medicaid clients as well."</li> <li>2. Clinical record #2, start of care 2/6/12, did not contain the OASIS Privacy</li> </ol>	G000102	G 102 The Administrator has inserviced the nursing staff on the need to provide a written Oasis Privacy Notice to all Medicaid clients in advance of, or during the initial evaluation visit, before treatment has begun. The Agency has provided all current MCD clients with the Oasis Privacy Notice as of 5/24/2013. 100% of the current MCD client records have been audited to ascertain that we are in compliance as of 5/24/13. 10% of MCD client records will be audited quarterly to ensure ongoing compliance with this standard. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	05/24/2013			

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	<p>Notice.</p> <p>3. Clinical record #4, start of care 3/29/13, did not contain the OASIS Privacy Notice.</p> <p>4. Clinical record #5, start of care 1/22/13, did not contain the OASIS Privacy Notice.</p> <p>5. Clinical record #6, start of care 12/5/12, did not contain the OASIS Privacy Notice.</p> <p>6. Clinical record #8, start of care 12/17/12, did not contain the OASIS Privacy Notice.</p> <p>7. Clinical record #9, start of care 12/17/12, did not contain the OASIS Privacy Notice.</p> <p>8. During an interview on 5/8/13 at 5:10 PM, employee G, Administrator, indicated the OASIS Privacy Notice needed to be presented to each patient and filed in their chart.</p>			

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G000114	<p><b>484.10(e)(1(i-iii))</b> <b>PATIENT LIABILITY FOR PAYMENT</b> Before the care is initiated, the HHA must inform the patient, orally and in writing, of:</p> <p>(i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;</p> <p>(ii) The charges for services that will not be covered by Medicare; and</p> <p>(iii) The charges that the individual may have to pay.</p> <p>Based on document review and interview, the home health agency failed to inform 10 of 10 patients (#1-10) the extent to which payment may be expected from Medicaid in writing with the potential to affect all patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Document titled "PSA Client Rights" dated 1/2012 states, "As a client or personal representative of the client of [home health agency] you have the right to: ... d. Be informed of the charges for the service we will provide."</li> <li>Clinical records #1-10 failed to evidence the patient was informed of the charges for the services to be provided.</li> <li>During an interview on 5/8/13 at 5:00 PM, employee G, Administrator,</li> </ol>	G000114	G 114The DON has inserviced the nursing staff on the need to furnish all MCD clients with a Notice of Financial Expectations in advance of, or during the initial evaluation visit, before treatment has begun.The Agency has provided all current MCD clients with the Notice of Financial Expectations as of 5/24/2013.100% of current MCD client records have been audited to ascertain that we are in compliance as of 5/24/13. 10% of MCD client records will be audited quarterly to ensure compliance with this standard.The DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	05/24/2013			

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	indicated the home health agency does not have a form for their Medicaid patients and needs to create one.			

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure skilled nursing visits were made and blood pressure and pulse were performed in accordance with the plan of care in 3 of 10 records reviewed with the potential to affect all the agency's patients who received skilled nursing services. (#4, #7, and #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The policy titled "Skilled Nursing Services" policy number 02.10, dated 05/2011 states, "3. Registered Nurses do the following: ... Initiates the plan of care and necessary revisions and updates when needed ... Perform skilled nursing care as needed."</li> <li>2. Clinical record #4, start of care 3/29/13, contained a home health certification and plan of care dated 3/25/13 to 5/27/13 with orders for skilled nursing (SN) to visit once a week for eight weeks. The plan of care also</li> </ol>	G000158	G 158The DON has inserviced the nursing staff on the implementation and execution of the clients' POC. By 5/24/13, a process has been identified to give the nursing staff accessibility to each clients' POC as they make client visits. The DON will review all skilled notes for the MCD clients for the next 3 months, then audit 10% of all MCD client records quarterly to ensure compliance with the standard.The DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and does not recur.	05/24/2013

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	<p>had an order for SN to evaluate BP (blood pressure) and P (pulse) when patient cooperates. Review of the record evidenced the following:</p> <p>A. SN visited the patient on 4/12/13 and 4/26/13. SN missed a visit the week beginning on 4/15/13 and ending on 4/21/13.</p> <p>B. SN visited the patient on 4/12/13 and 4/26/13. BP and P were not taken on 4/12/13 due to "deferred pt [patient] sleeping." BP and P were left blank on Nursing Visit Record for 4/26/13. The Nursing Visit Note failed to evidence BP and P were taken on 4/26/13.</p> <p>C. During an interview on 5/8/13 at 5:15 PM, employee G, Administrator, indicated there was a missed visit the week beginning on 4/15/13 and ending on 4/21/13. Employee G further indicated that the BP and P should have been recorded on Nursing Visit Record for 4/26/13.</p> <p>3. Clinical record #7, start of care 10/2/12, contained a home health certification and plan of care dated 10/2/12 to 11/30/12 with orders for SN to visit every other week for 9 weeks. Review of the record evidenced the</p>			

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	<p>following:</p> <p>A. SN visited the patient on 10/2/12, 10/12/12, and 10/16/12. The record evidenced an extra visit the week beginning on 10/8/12 and ending on 10/14/12.</p> <p>B. During an interview on 5/8/13 at 5:22 PM, employee G, Administrator, indicated there was an extra visit.</p> <p>4. Clinical record #9, start of care 12/17/12, contained a home health certification and plan of care dated 12/17/12 to 2/14/13 with orders for SN to reform BP and P every visit. Review of the record evidenced the following:</p> <p>A. SN visited the patient on 1/7/13 and 2/4/13. The Nursing Visit Notes failed to evidence the BP and P were taken those visits.</p> <p>B. During an interview on 5/8/13 at 5:32 PM, employee G, Administrator, indicated that the BP and P should have been recorded on the Nursing Visit Record for 1/7/13 and 2/4/13.</p>			

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G000159	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the plan of care contained the duration of all Skilled Nursing visits in 1 of 10 records reviewed with the potential to affect all of the agency's patients. (#5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Medical Plan of Care, Physician Orders and Medical Supervision" policy number 02.14 dated 05/2011 states, "2. The medical plan of care shall meet the following: ... iii. Frequency and duration of visits."</li> <li>Clinical record #5, start of care 1/22/13, contained a home health certification and plan of care dated 3/24/13 to 5/22/13 and evidenced Skilled Nursing to visit patient every</li> </ol>	G000159	G 159The DON has educated the nursing staff on the need to fill out the client POC in total, including frequency and duration of skilled nursing visits.The DON corrected the POC for clinical record #5 on 5/23/2013 as new POC was due at this time. Clients' physician will not be returning this document with signature, due to client expiring during the night 5/23/13. 100% of the current MCD client records have been audited to ascertain compliance as of 5/24/2013. 10% of MCD client records will be audited quarterly to ensure compliance with the standard.The DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.	05/24/2013			

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	<p>other week starting week of 4/1/13. The plan of care failed to evidence a duration for Skilled Nursing visits.</p> <p>3. During an interview on 5/8/13 at 5:31 PM, employee G, Administrator, indicated the plan of care was missing a duration for Skilled Nursing visits.</p>			

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G000170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure skilled nursing visits were made and blood pressure and pulse were performed in accordance with the plan of care in 3 of 10 records reviewed with the potential to affect all the agency's patients who received skilled nursing services. (#4, #7 and #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Skilled Nursing Services" policy number 02.10, dated 05/2011 states, "3. Registered Nurses do the following: ... Initiates the plan of care and necessary revisions and updates when needed ... Perform skilled nursing care as needed."</li> <li>Clinical record #4, start of care 3/29/13, contained a home health certification and plan of care dated 3/25/13 to 5/27/13 with orders for skilled nursing (SN) to visit once a week for eight weeks. The plan of care also had an order for SN to evaluate BP (blood pressure) and P (pulse) when patient cooperates. Review of the</li> </ol>	G000170	G 170 The DON has inserviced the nursing staff on the implementation and execution of the clients' POC. By 5/24/13, a process has been identified to give the nursing staff accessibility to each clients' POC as they make client visits. The DON will review 100% of skilled notes for the MCD clients for the next 3 months, then audit 10% of all MCD client records quarterly to ensure compliance with the standard. The DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and does not recur.	05/24/2013			

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	<p>record evidenced the following:</p> <p>A. SN visited the patient on 4/12/13 and 4/26/13. SN missed a visit the week beginning on 4/15/13 and ending on 4/21/13.</p> <p>B. SN visited the patient on 4/12/13 and 4/26/13. BP and P were not taken on 4/12/13 due to "deferred pt [patient] sleeping." BP and P were left blank on Nursing Visit Record for 4/26/13. The Nursing Visit Note failed to evidence BP and P were taken on 4/26/13.</p> <p>C. During an interview on 5/8/13 at 5:15 PM, employee G, Administrator, indicated there was a missed visit the week beginning on 4/15/13 and ending on 4/21/13. Employee G further indicated that the BP and P should have been recorded on Nursing Visit Record for 4/26/13.</p> <p>3. Clinical record #7, start of care 10/2/12, contained a home health certification and plan of care dated 10/2/12 to 11/30/12 with orders for SN to visit every other week for 9 weeks. Review of the record evidenced the following:</p> <p>A. SN visited the patient on 10/2/12,</p>			

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	<p>10/12/12, and 10/16/12. The record evidenced an extra visit the week beginning on 10/8/12 and ending on 10/14/12.</p> <p>B. During an interview on 5/8/13 at 5:22 PM, employee G, Administrator, indicated there was an extra visit.</p> <p>4. Clinical record #9, start of care 12/17/12, contained a home health certification and plan of care dated 12/17/12 to 2/14/13 with orders for SN to perform BP and P every visit. Review of the record evidenced the following:</p> <p>A. SN visited the patient on 1/7/13 and 2/4/13. The Nursing Visit Notes failed to evidence the BP and P were taken those visits.</p> <p>B. During an interview on 5/8/13 at 5:32 PM, employee G, Administrator, indicated that the BP and P should have been recorded on the Nursing Visit Record for 1/7/13 and 2/4/13.</p>			

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G000224	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the home health aide plan of care was updated at least every 60 days as required by agency policy in 1 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients receiving home health aide services. (#5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The policy titled "Medical Plan of Care, Physician Orders and Medical Supervision" policy number 02.14 dated 05/2011 states, "18. The care plan will be reviewed, evaluated and revised as needed at least every sixty (60) days and/or as needed."</li> <li>2. Clinical record #5, start of care 1/22/13, contained a home health certification and plan of care dated 3/24/13 to 5/22/13. The record failed to evidence a home health aide (HHA) plan</li> </ol>	G000224	G 224The DON has educated the nursing staff on the development of the aide POC at the time of the clients' start of care with the clients' participation, making sure a copy of this POC is in both the clients' home and clinical record.The DON has ensured that all current MCD clients have an aide POC in their home and clinical record if indicated as of 5/24/13.100% of current MCD client records have been audited to ascertain compliance as of 5/24/13. 10% of MCD client records will be audited quarterly to ensure compliance with this standard.The DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.	05/24/2013

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	<p>of care (POC).</p> <p>3. During an interview on 5/8/13 at 5:30 PM, employee G, Administrator, indicated the HHA POC should be developed at the start of care and updated every 60 days.</p>			

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G000337	<p><b>484.55(c)</b> <b>DRUG REGIMEN REVIEW</b> The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the medication profile was updated and accurate when there were medication changes in 3 of 10 clinical records reviewed with the potential to affect all patients at this agency. (#2, #3, and #7)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 2/6/12, included a Home Health Certification and Plan of Care for the certification period from 4/8/13 to 6/6/13. Review of the clinical record evidenced the following:</p> <p>A. A "Nursing Visit Record" dated 4/11/13 indicated the patient was anxious and took a Xanax. The "Medication Profile Sheet" last reviewed and signed off by employee H, former Nursing Supervisor, on 4/4/13. failed to evidence the Xanax order.</p>	G000337	G 337The DON has educated the nursing staff on investigating medications taken by the client that are not on the POC, verify them with the clients' physician, educate the client on these medications, document education, add new medication to the medication profile sheet, review medication for interactions with other medications being taken, and date medication profile sheet then and with every recertification. 100% of all MCD client records will be audited for the next 3 months, then 10% of MCD client records will be audited quarterly for accurate review of the medication profile sheet and to ensure compliance with this standard. The DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.	05/24/2013			

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	<p>B. On 5/7/13 at 5:00 PM, employee G, Administrator, indicated Xanax should have been on the Medication Profile.</p> <p>3. Clinical record #3, start of care 10/9/12, included a Home Health Certification and Plan of Care for the certification period from 4/9/13 to 6/7/13. Review of the clinical record evidenced the following:</p> <p>A. A "Medication Profile Sheet" last reviewed and signed off by employee H, former Nursing Supervisor on 2/5/13 failed to evidence a signature of review for the certification period 4/9/13 to 6/7/13.</p> <p>B. On 5/7/13 at 5:02 PM, employee G, Administrator, indicated the Medication Profile needed a signature for certification period 4/9/13 to 6/7/13.</p> <p>4. Clinical record #7, start of care 10/2/12, included a Home Health Certification and Plan of Care for the certification period from 10/2/12 to 11/30/12. Review of the clinical record evidenced the following:</p> <p>A. The "Medication Profile Sheet" last reviewed and signed off by employee H,</p>			

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	<p>former Nursing Supervisor on 10/2/12 failed to evidence an order date for oxygen, Flonase, and Astepro.</p> <p>B. On 5/8/13 at 5:25 PM, employee G, Administrator, indicated an order date should have been written next to each medication.</p>			

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse (RN) completed a discharge assessment within 48 hours of when the patient was discharged for 1 of 4 discharged records reviewed with the potential to affect all patients who are discharged. (#10)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The policy titled "Reassessments of Skilled Care, Resumption of Care, Transfers &amp; Discharge" policy number 02.22, undated, states, "4. Transfer and/or discharge information will be completed on patients who transfer or discharge from the agency preferably within 48 working hours (or knowledge of) transfer or discharge."</li> <li>Clinical record #10, start of care 2/6/13, identified the patient was discharged from the agency on 5/1/13. The record failed to evidence a discharge assessment had been completed.</li> </ol>	G000341	<p>G 341The DON has educated the nursing staff on the need to complete a discharge assessment within 48 hours (or knowledge of) of transfer or discharge.The DON has completed all needed discharge paperwork for MCD clients as of 5/24/13.100% of all current MCD client records have been audited for compliance as of 5/24/13. 10% of MCD client records will be audited quarterly to ensure compliance with the standard.The DON will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.</p>	05/24/2013

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	3. On 5/8/13 at 5:32 PM, employee G, Administrator, indicated the discharge assessment was not filled out.			