

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 11/20/2012	
NAME OF PROVIDER OR SUPPLIER  BRIGHTSTAR OF MID-NORTH INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 25 EXECUTIVE DRIVE SUITE C LAFAYETTE, IN 47905			
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N0000	<p>This was a revisit for an initial home health state licensure survey conducted October 10, 2012.</p> <p>Survey dates: November 19 and 20, 2012</p> <p>Facility: #012722</p> <p>Medicaid Vendor: N/A</p> <p>Surveyors: Bridget Boston, RN, PHNS</p> <p>Five (5) deficiencies were found corrected during this survey. Two (2) deficiencies were recited.</p> <p>Census: 5 Skilled: 2 Aide only: 3</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 27, 2012</p>	N0000					

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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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review and interview, the agency failed to ensure home health aide services were provided as ordered on the physician directed plan of care in 1 of 2 active records reviewed with orders for home health aide services only (# 6-B) with the potential to affect all the patients who receive home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record # 6-B, start of care 10/1/12, included a physician ordered plan of care with orders for home health aide 5 days a week from 10:30 AM to 3 PM that stated, "Provide companionship, housekeeping, meal prep PRN, medication reminders, and transportation / errands PRN."</p> <p>A. The record included a document signed by the attending physician and dated 10/18/12 that stated, "[Patient] has a problem with seizures and blacking out. [patient] has a cardiac microvascular disease and cardiac endothelial dysfunction. [Patient] has a</p>	N0522	1.A.1)2)3) - The Administrator has developed protocols for various precautions including seizure, bleeding, falls, oxygen, diabetes and swallowing (see attachment a,b,c,d,e,f) and will begin using them on all current and future patients by 12-07-12. These precaution protocols are patient-specific, nurse-directed interventions and clearly explain what needs to be done by the patient and the visit staff. Measurable goals will be included in the patient-specific plan of care. Additional precaution protocols will be developed as needed. All visit staff will be oriented on how to use these precaution protocols prior to seeing any patient that has a specific precaution listed on the plan of care (see attachment G). The Administrator or designee will verify these precautions are listed on the client's plan of care using the "client admission checklist form". The Administrator or designee will also review all patient charts during the quarterly chart review for compliance and to confirm that this deficiency has been corrected and will not recur. The precautions will be reviewed and approved by the PAC (see	12/07/2012			

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	<p>history of complications of cardiac myocardial infarction, cerebral strokes and seizures. [Patient] requires a healthcare worker, home health aid [sic] would be sufficient, to observe [patient] condition and to summon emergency personnel when needed, when [patient] family is not available."</p> <p>1.) The clinical record failed to evidence specifically when the aide was to summon emergency response for this patient and the interventions to be implemented by the aide while in the home, in the event the patient demonstrated seizure activity.</p> <p>2.) The record evidenced a document titled "PC2 / SS2 Aide / homemaker / Companion Plan of Care" dated 10/1/12. The document failed to evidence instructions specific for this patient and the precautions to be taken in the event of seizure activity and specific fall precautions to implement in the home.</p> <p>3.) On 11/20/12 at 10 AM, during a telephone interview, the patient indicated the episodes lead to to blackouts and was not aware when they are occurring. The patient indicated a recent episode occurred approximately 2 weeks ago, while employee R was present in the</p>		<p>attachment H), BOD (see attachment I) and the Medical Director (sent to MD) by 12-06-12. 1.B.2. - As of 12-06-12, the Administrator or RN designee will be responsible for reviewing all home health aide paperwork as it is turned in and will use the patient-specific plan of care as a guide to review and verify that the home health aide has completed all tasks according to the plan of care. Once this is verified, the Administrator or RN designee will sign at the bottom of each page of documentation reviewed to verify compliance. The dcumentation will be reviewed each week during the weekly case conference meeting for verification and recorded in the meeting minutes. The weekly case conference meeting minutes are reviewed by the Administrator and verification of compliance and to confirm that this deficiency has been corrected and will not recur. The Administrator reports this to the PAC every Quarter.</p>				

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	<p>home. The patient indicated the staff are present in the home to summon assistance when needed. The patient indicated the aide was not required for hands on care with personal hygiene and medications were self administered from the prescription bottles in which they were dispensed.</p> <p>B. The clinical record evidenced documents titled "Weekly Personal Care Note" dated October 18, 19, 22, 23, 24, and 25 and November 1, 2, 5, 6, 7, 8, and 9, 2012, completed by employee R. The documents failed to evidence the employee provided meal prep and medication reminders.</p> <p>On 11/19/12 at 3:25 PM, employee E indicated the patient did not require the tasks listed on the plan of care and the documentation completed by employee R on the documents titled "Weekly Personal Care Note" were the only tasks completed by the staff and required by the patient.</p> <p>2. The undated policy titled "Section 02.14 - Medical Plan of Care, Physician Orders, and Medical Supervision" states, "Medical care shall follow a written medical plan of care established and periodically reviewed by the physician ... . Be developed in consultation with the agency staff. Include all services to be</p>						

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	provided if a skilled service is being provided. Cover all pertinent diagnosis. Include the following: ... Type of services and equipment required, frequency and duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, ... any safety measures to protect against injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment, any other appropriate items. ... The medical plan of care will be used as the care plan and will include reasonable, measurable, and realistic goals as determined by the patient assessment. The care plan will also addresses rehabilitation potential and discharge plans."				

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N0524	<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"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure an individualized plan of care was developed and included all the required elements in 4 of 4 active clinical records (# 1-B, 4-B, 6-B, and 7) reviewed with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record # 1-B included a plan</p>	N0524	<p>1.2.3.A.B.4.A.B.C.5. - The Administrator has developed protocols for various precautions including seizures, bleeding, falls, oxygen, diabetes and swallowing (see attachments a,b,c,d,e,f) and will begin using them on all current and future patients by 12-07-12 and clearly explains what needs to be done by the patient and the visit staff. Measurable goals will be clearly included in the patient-specific plan of care. Additional precautions will be developed as</p>	12/07/2012

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	<p>of care dated 10/9/12 through 12/7/12 with the admission diagnoses Acute Lymphoid Leukemia that states, "Safety Measures ... Neutropenic precautions, Fall Precautions." The plan of care failed to evidence interventions and patient specific measurable goals for the identified patient needs.</p> <p>2. Clinical record #4-B included a plan of care dated 9/27/12 through 11/27/12 with the diagnoses congestive heart failure, atrial fibrillation, and diabetes mellitus that stated, "Safety Measures: Oxygen, Bleeding, diabetic, and fall precautions." The plan of care failed to evidence interventions and patient specific measurable goals for the identified patient needs.</p> <p>On 11/19/12 at 2:30 PM, employee E indicated, since the last survey, the plan of care was not reviewed, amended or updated and did not contain all required elements.</p> <p>3. Clinical record # 6-B, start of care 10/1/12, included a physician ordered plan of care with the admission diagnoses 1) Aftercare Myocardial infarction and 2) Seizure Disorder and orders for home health aide only 5 days a week from 10:30 AM to 3 PM that stated, "Provide companionship, housekeeping, meal prep</p>		<p>needed. These precautions will be patient-specific and specific nurse-directed interventions will be included on the plan of care and the specific precautions form will be used and included in the patient record. All patients at risk for falls that require a gait belt, will have gait belts to be used when appropriate and will be included in the "other" section of the falls precaution as part of the patient-specific, nurse-directed interventions and will also be recorded in the patient's plan of care. All current patient charts will be reviewed by BrightStar staff in the weekly case conference meetings. All patient specific precautions will be discussed and verified and recorded in the meeting minutes. The Administrator or designee will review all patient charts quarterly to verify compliance and ensure this deficiency has been correct and will not recur. A quarterly report will be forwarded to the PAC for review.</p>				

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	<p>PRN, medication reminders, and transportation / errands PRN, and Safety Measures: Seizure ... fall precautions."</p> <p>The record included a document signed by the attending physician and dated 10/18/12 and stated, "[Patient] has a problem with seizures and blacking out. [patient] has a cardiac microvascular disease and cardiac endothelial dysfunction. He/ She has a history of complications of cardiac myocardial infarction, cerebral strokes and seizures. [Patient] requires a healthcare worker, home health aid [sic] would be sufficient, to observe [patient] condition and to summon emergency personnel when needed, when [patient] family is not available."</p> <p>A. The record evidenced a document titled "PC2 / SS2 Aide / homemaker / Companion Plan of Care" dated 10/1/12. The document failed to evidence instructions specific for this patient and the precautions to be taken in the event of seizure activity and specific fall precautions to implement in the home.</p> <p>B. The clinical record failed to evidence specifically when the aide was to summon emergency response for this patient and the interventions to be implemented by the aide while in the</p>						

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	<p>home, in the event the patient demonstrated seizure activity.</p> <p>4. Clinical record # 7 included a plan of care dated 11/18/12 through 1/16/13 with the diagnoses Huntington's Disease and medications included Haloperidol, 0.5 mg [milligrams], two twice a day, Lorazepam 0.5 mg at bedtime as needed, and mirtazime 30 mg by mouth every bedtime. The plan of care included orders for home health aide only services 1 to 2 times a week throughout the care period and stated, "Safety Measures: Universal precautions, fall precautions ... Goals: Skilled Nursing ... "Client will have no falls during episode of care ... Home Health Aide: ... HHA to provide reminders of fall precautions for client every visit," and orders for the aide to provide aide services 1 -2 times a week to assist with showering, shampoo, oral care, shaving, skin care, dressing, and fall precautions for client every visit. The plan of care and aide assignment failed to evidence the specific fall precautions identified and implemented by the nurse and to be followed by the aide while rendering care.</p> <p>The record evidenced document titled "Communication Form" dated 11/16/12 that stated, "Client states on 11/12/12 [patient] was walking back from her</p>						

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	<p>mailbox when she tripped on her concrete steps and fell - landing on her right forearm and hand, small scabbed areas on digits 1, 2, &amp; 3 right hand multiple scabbed areas on RFA [right forearm] on 12 cm [centimeter] X 6 cm area, denied hitting head, also states 11/15/12 at noc [night] [patient] fell getting out of bed and landed on her back, denied hitting head or other injury, MAEW [moves all extremities well], VS [vital signs] today."</p> <p>A. The plan of care failed to evidence specific nurse directed interventions the aide was to implement and remind the patient during the rendering of aide services weekly, to prevent falls. The aide assignment sheet is void of interventions to prevent falls and states, "Reinforce fall precautions and steps to prevent falls with client every visit."</p> <p>B. On 11/20/12 at 2:05 PM, employee E indicated she had never been to the patient's home or completed a supervisory visit. The patient declined appliances for mobility assistance. Employee E stated, "The patient falls" when describing the patient's gait. The patient required direct hands on assistance from the aide to dress, undress, and shower. The aides were given a gait belt to use in the home, but she is not aware if one was used or to be used on this patient.</p>						

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	<p>C. On 11/20/12 at 2:32 PM, employee E indicated the agency did not implement a fall prevention program / policy / procedure and prevention was addressed individually during case conference held weekly on Thursdays. There was no evidence this patient was reviewed after the agency was aware the patient had fallen on 11/12/12 and 11/15/12.</p> <p>5. The undated policy titled "Section 02.14 - Medical Plan of Care, Physician Orders, and Medical Supervision" states, "Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, chiropractor, optometrist or podiatrist. Be developed in consultation with the agency staff. Include all services to be provided if a skilled service is being provided. Cover all pertinent diagnosis. Include the following: Mental status, Type of services and equipment required, frequency and duration 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, therapy modalities specifying length of treatment, any other appropriate items. ... All medications,</p>						

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	<p>treatments and services provided to patients must be ordered by a physician. ... The medical plan of care will be used as the care plan and will include reasonable, measurable, and realistic goals as determined by the patient assessment. The care plan will also addresses rehabilitation potential and discharge plans."</p>			