

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 10/30/2013
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NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 4807 ILLINOIS RD FORT WAYNE, IN 46804
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G000000	<p>This was a home health initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: October 25, 28, 29, and 30, 2013 Partial Extended Survey Date: October 25, 2013</p> <p>Facility Number: IN012399</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 13 Home Health Aide Only: 45 Personal Care Only: 0 Total: 58</p> <p>Sample: RR w/HV: 5 RR w/oHV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 1, 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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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, policy review, and interview, the agency failed to ensure all staff followed infection control practices for 1 of 5 home visit observations with the potential to affect all the agency's patients. (#1)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation on 10/28/12 at 8:00 AM, employee F was observed providing a shower to patient #1. Employee F failed to change gloves and perform hand hygiene after they washed and rinsed the patient's buttocks area and then proceeded to hand a clean towel to the patient to dry off. 2. On 10/28/13 at 1:00 PM, employee A indicated the aide should have changed gloves and performed hand hygiene prior to touching the clean towels. 3. The agency's policy titled "Standard Precautions," #04.01.A, reviewed 8/2013 states, "Gloves- ... Gloves shall be changed between tasks and procedures on the same patient after contact with 	G000121	The Assistant director of Nursing and Alternate Administrator has counseled and educated employee F on proper glove techniques per BrightStar Standard Precautions policy. This was completed on 10/29/2013. All employee's were notified on 11/8/2013 by the Director of Nursing to complete the standard precautions inservice training within the next 30 days. The Director of Nursing has inserviced the ADON and 2 RN Case Managers on 11/8/2013 on continuing to educate and monitor correct glove usage while bathing during Supervisory visits to the home. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/08/2013			

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	material that may contain a high concentration of microorganisms."			

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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 clinical record review and interview, the agency failed to ensure the registered nurse (RN) completed the tasks ordered by the physician on the plan of care for 1 of 10 clinical records reviewed with the potential to affect all the agency's patients receiving skilled nursing (SN) services. (#6)</p> <p>Findings include</p> <p>1. Clinical record #6, start of care date 7/10/13 contained a Plan of Care dated 7/10-9/7/13 with orders for SN to visit once every 5 days for complete assessment and colostomy care to include changing the colostomy appliance and educating the client on colostomy care. An order dated 7/25 changed the visits to every 3-5 days and an order dated 9/1/13 changed the visits to every 10 days.</p> <p>A. The record failed to evidence the SN educated the patient on colostomy care on 7/10, 7/15, 7/18, 7/21, 7/24, 7/26, 8/1, 8/4, 8/7, 8/12, 8/17, 8/22, 8/27, and 9/1/13.</p>	G000158	The Director of Nursing has inserviced nursing staff on following the written plan of care and orders established by the physician for each patient. The nursing staff has also been inserviced on obtaining vital signs with every assessment on every visit. This was completed on 11/8/2013. 10% of all clinical records will be audited quarterly for evidence that the nurse visit notes are following the plan of care and physician orders and include vital signs on every visit. The Director of Nursing will be responsible for monitor these corrective actions to ensure that this deficiency is corrected and will not recur.	11/08/2013			

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	<p>B. A SN visit note dated 7/21/13 failed to evidence the SN performed vital signs as part of the assessment.</p> <p>2. On 10/25/13 at 1:55 PM, employee A indicated a complete assessment includes a head to toe assessment and vital signs unless otherwise specifically ordered by the physician.</p> <p>3. On 10/28/13 at 10:00 AM, employee G indicated the nurses always start their assessments with a full set of vital signs.</p>			
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G000159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review and interview, the agency failed to ensure certification period dates followed Outcome and Assessment Information Set (OASIS) and federal date guidelines for 5 of 10 clinical records reviewed (#1, 2, 3, 6, and 8) and failed to ensure as needed (PRN) orders included reasons and limits for 7 of 7 (# 3, 4, 5, 7, 8, 9, and 10) clinical records records reviewed with PRN visit orders with the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 10/27/12, contained a Plan of Care (POC) dated 7/28-9/25/13 and the current one dated 9/25-11/23/13. The dates for the current certification period should be 9/26-11/24/13.</p>	G000159	The Director of Nursing has inserviced nursing staff on following the OASIS and federal date guidelines spreadsheet for certification period beginning and ending dates which will include making the certification start date the day after the precious certification end date. Nurses will discontinue the practice of making the certification start date the same date as the previous certification end date. The Director of Nursing has also inserviced the nursing staff that PRN orders need to include reasons and limits. This was completed on 11/8/2013.10% of all clinical records will be audited quarterly for evidence that the Plan of Care certification dates are correct per OASIS guidelines and all PRN orders include reason and limits.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is correct and will not recur.	11/08/2013			

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	<p>2. Clinical record #2, SOC 8/5/13, contained a POC dated 8/5-10/4/13 and should be dated 8/5-10/3/13.</p> <p>3. Clinical record #3, SOC date 8/23/13, contained a POC dated 8/23-10/21/13 with orders for Skilled Nurse (SN) visits once every 14 days within the 60 day certification period and PRN SN visit per client or physician request. The current POC is dated 10/21-12/20/13 and should be dated 10/22-12/20/13. The PRN visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p> <p>4. Clinical record #4, SOC 9/19/13, contained a POC dated 9/19-11/17/13 with orders for SN visit once every 2 weeks during the certification period and SN PRN visits at the request of the physician, family, and/or client. The PRN visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p> <p>5. Clinical record #5, SOC 9/19/13 contained a POC dated 9/19-11/17/13 with orders for SN visit once every 2 weeks during the certification period and SN PRN visits at the request of the physician, family, and/or client. The PRN</p>			

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	<p>visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p> <p>6. Clinical record #6, SOC date 7/10/13 contained a POC dated 7/10-9/7/13. The next POC is dated 9/7-11/5/13 and should be dated 9/8-11/6/13.</p> <p>7. Clinical record #7, SOC date 8/30/13 contained a POC dated 8 /30-10/28/13 with orders for SN every 2 weeks for the certification period and PRN SN visits at the request of the physician, family and/or client. The PRN visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p> <p>8. Clinical record #8, SOC 10/4/13, contained a POC dated 10/4-12/12/13 with orders for SN visit once every 2 weeks during the certification period and SN PRN visits at the request of the physician, family, and/or client. The POC should be dated 10/4-12/2/13. The PRN visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p>			

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	<p>9. Clinical record #9, SOC 8/22/13, contained a POC dated 8/22-10/20/13 with orders for SN visit every 2 weeks for the certification period and PRN SN visits at the request of client/family. The PRN visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p> <p>The current POC is dated 10/20-12/18/13 and should be dated 10/21-12/19/13.</p> <p>10. Clinical record #10, SOC 9/6/13, contained a POC with orders for SN visit every 2 weeks for the certification period and PRN SN visits at the request of client/family. The PRN visits order failed to include a reason for the visit or the number of visits allowed before additional physician orders would need to be obtained.</p> <p>11. On 10/28/13 at 1:55 PM, employee A indicated the agency's instructions told them to include the last day of first certification period as the first day of the next certification period. Employee A provided document agency used which was dated 2002.</p> <p>12. On 10/29/13 at 2:00 PM, employee A indicated they were not aware PRN orders</p>						

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	needed reasons and limits.			

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G000335	<p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure comprehensive assessment which included the Outcome and Assessment Information Set (OASIS) start of care paperwork had been completed and was complete and accurate for 7 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#1, 3, 5, 6, 8, 9, and 10)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record #1, SOC 10/27/2012 failed to evidence a Comprehensive Assessment with OASIS data elements had been completed. 2. Clinical record #3, start of care (SOC) date 8/23/13, contained a Comprehensive Adult Nursing Assessment with OASIS elements for SOC. The assessment failed to evidence sections Patient ID number, Date of Referral, Primary reason for home health, date last contacted and visited physician, Advance Directives, Mouth, Vital Signs, breath sounds, Genitourinary, 	G000335	The Director of Nursing has inserviced nursing staff on using and completing the OASIS comprehensive assessment start of care paperwork instead of the BrightStar initial assessment when admitting skilled nursing Medicaid patients over the age of 18 and/or not pregnant. This was completed on 11/8/2013. 10% of all clinical records will be audited quarterly for evidence that the OASIS comprehensive assessment start of care paperwork is completed for the appropriate patients on admission. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is correct and will not recur.	11/08/2013			

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	<p>Nutritional Status, Elimination, Abdomen, Genitalia, Musculoskeletal, Financial ability to pay for medications, Appliances/special equipment/organizations, Safety Measures, Instructions/Materials provided, Summary Checklist, Durable Medical Equipment (DME) Supplies, Professional Services, and Rehabilitation Potential/Goals were completed. The of document also failed to evidence the signature of the person completing the form.</p> <p>A. The Plan of Care dated 10/21-12/20/13 lists a walker, cane, and wheel chair listed under the DME section.</p> <p>B. During home visit observation on 10/28/13 at 10:30 AM, DME seen in home included a walker, cane and wheel chair.</p> <p>C. On 10/28/13 at 2:45 PM, employee A indicated they did not know why the form was not completed, signed and dated.</p> <p>3. Clinical record #5, SOC 9/19/13 contained a Comprehensive Adult Nursing Assessment with OASIS elements for SOC. The assessment failed to evidence sections Date last contacted/visited physician and DME</p>						

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	<p>Supplies were completed.</p> <p>A. The plan of care dated 9/19-11/17/13 lists a walker in the DME section.</p> <p>B. During home visit observation on 10/28/13 at 12:30 PM, the patient was using a walker.</p> <p>4. Clinical record #6, SOC 7/10/13, contained an unsigned, untimed, and undated Comprehensive Adult Nursing Assessment with OASIS elements. The assessment failed to evidence sections Reason for Assessment, Patient ID number, Social Security Number, Date of Referral, Date last contacted/visited physician, Immunizations, prior hospitalizations, Risk for Hospitalization, Overall status, Prognosis, Primary caregiver, Integumentary status, Mental Status, Psychosocial, Musculoskeletal, Functional Limitations, Fall Risk Assessment, Prior Functioning, Activities Permitted, Financial ability to pay for medications, Safety Measures, Summary Checklist, DME supplies, Professional Services, Rehabilitation Potential/Goals, and Discharge Plans were complete.</p> <p>A. The POC dated 7/10-9/7/13 lists a walker and colostomy supplies under the DME section.</p>						

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	<p>B. On 10/25/13 at 12:40 PM, employee A indicated the comprehensive assessment for start of care is not complete because the nurse was just practicing documenting on the forms.</p> <p>5. Clinical record #8, SOC 10/4/13 contained a Comprehensive Adult Nursing Assessment with OASIS elements for SOC. The assessment failed to evidence sections Certification period; Date of Referral; Immunizations; Pertinent History and/or Previous Outcomes; Advance Directives;, Prognosis; Nose, Mouth, Throat Summary Checklist; Professional Services skilled nurse frequency / duration; and Rehabilitation Potential/Goals were completed.</p> <p>6. Clinical record #9, SOC 8/22/13, primary diagnosis diabetes, contained an unsigned, untimed, and undated Comprehensive Adult Nursing Assessment with OASIS elements. The assessment failed to evidence sections Patient ID number, certification period, Social Security Number, Date of Referral, last contact/visit to physician, Immunizations, Prior hospitalizations, Primary Caregiver, Diabetic Foot Exam, Functional Limitations, Safety Measures, Summary Checklist, DME Supplies,</p>			
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	<p>Professional Services, Rehabilitations Potential/Goals, and Discharge Plans were completed.</p> <p>7. Clinical record #10, SOC 9/6/13, contained a Comprehensive Adult Nursing Assessment with OASIS elements for SOC. The assessment failed to evidence sections Certification Period, Date of Referral, last contact/visit date to physician, Immunizations, Prior Hospitalizations, Primary caregiver, Functional Limitations, Professional Services, and Rehabilitation Potential/Goals were complete.</p> <p>8. The agency' policy titled "Documentation for Claims Submission," #02.20.B, revised 8/2013 states, "10. Medicaid/Other Insurance Claims: ... c) Skilled clients will have the comprehensive assessment, including OASIS, documented in their files and the plan of care will reflect the needs identified. Assessments and re-assessments will follow Medicaid guidelines."</p>						

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G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Outcome and Assessment Information Set (OASIS) recertification paperwork was completed for 3 of 5 clinical records reviewed of patients receiving services longer than 60 days with the potential to affect all the agency's patients. (#6 and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, SOC 10/27/2012, contained a plan of care (POC) dated 7/28-9/25/13 with notes of a 60 day reassessment visit made. The next certification period dated 9/25-11/23/13 contained notes of a 60 day reassessment visit made. The record failed to evidence any Reassessment / Recertification forms with OASIS elements had been completed.</p> <p>A. On 10/25/13 at 10:40 AM,</p>	G000339	<p>The Director of Nursing has inserviced nursing staff on using and completing the OASIS recertification paperwork for the 60 day comprehensive reassessments instead of BrightStar reassessment documents when they are visiting the skilled nursing Medicaid patients over the age of 18 and/or not pregnant within the last 5 days of every 60 day certification period. This was completed on 11/8/2013. 10% of all clinical record will be audited quarterly for evidence that the OASIS recertification paperwork is completed for the appropriate patients within the 5 days at the end of their certification period. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is correct and will not recur.</p>	11/08/2013			

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 10/30/2013
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	<p>employee A indicated the agency was told by a consultant to focus on SN services only for this survey and to keep the patients separate as in Home Health patients versus Home Health Skilled patients for PA (Medicaid Certification). Employee A also indicated all charts were survey ready.</p> <p>B. On 10/29/13 at 2:20 PM, both employees A and B indicated patient #1 was not a PA client and was not selected to participate in this survey preparation but would become a PA client once the agency is certified. Employee A indicated the patients would still remain separate as far as Home Health Only versus Home Health Skilled so the OASIS paperwork will only be filled out on the Home Health Skilled or PA clients, not previous patients.</p> <p>2. Clinical record #6, start of care (SOC) 7/10/13, contained a plan of care (POC) dated 9/7-11/5/13 with notes of a 60 day reassessment visit made. The record failed to evidence a Reassessment / Recertification form with OASIS elements was completed.</p> <p>3. Clinical record #9, SOC 8/22/13, contained a POC dated 10/20-12/18/13. The record failed to evidence a Reassessment / Recertification form with</p>			

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	<p>OASIS elements was completed.</p> <p>4. On 10/25/13 at 2:35 PM, employee A indicated the agency is not officially certified as a PA agency and asked if they should have specific forms.</p> <p>5. On 10/29/13 at 1:15 PM, employee A indicated the recertification visit for patient #9 was completed by the nurse and documented on the Skilled Nurse Visit notes and the agency pulls the OASIS data from them.</p> <p>6. The agency' policy titled "Documentation for Claims Submission," #02.20.B, revised 8/2013 states, "10. Medicaid / Other Insurance Claims: ... c) Skilled clients will have the comprehensive assessment, including OASIS, documented in their files and the plan of care will reflect the needs identified. Assessments and re-assessments will follow Medicaid guidelines."</p>						