STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K107	A. BUILDING 00 B. WING	08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIGHTSTAR HEALTHCARE	9292 N MERIDIAN ST STE 211 INDIANAPOLIS, IN 46260

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G 0000 Bldg. 00	This visit was for a Federal recertification and State relicensure survey with two complaints. This was a fully extended survey. Survey Dates: August 5, 6,and 7, 2019 Fully Extended Survey: 8/6/2019 Complaints: IN00260591 - unsubstantiated, lack of sufficient evidence IN00288278 - unsubstantiated, lack of sufficient evidence Facility #: IN011449 Medicaid Vendor #: 201171470 Provider #: 15K107 Admission Census: 13 Total Active Census: 47 Active Skilled: 12 Active aide only: 35 BrightStar Healthcare is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 8/07/2019. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Conditions of Participation: 42 CFR 484.20 Reporting OASIS Information; §484.65 Quality assessment and performance improvement, and §484.70 Condition of participation: Infection prevention and control. These deficiencies reflects State Findings cited in	G 0000	/p>	

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

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	accordance with 410 IAC 17. Refer to State Form for additional State findings. Quality Review completed 9/4/19			
G 0370 Bldg. 00	Based on CMS Casper Report document review, agency policy review, and interview, the agency failed to ensure Outcome Assessment Information Set (OASIS) data was reported / transmitted to the state agency at least every 30 days after the assessment was completed for 2 of 2 active clinical records reviewed of adult patients that received skilled services and required comprehensive assessments (G 372), failed to evidence the encoded OASIS data that reflected the patient's status at the time of assessment (G374), and failed to ensure all OASIS data submissions were actually received by the state for 1 of 1 agency (G 378). The cumulative effect of these systemic problems resulted in the agency's inability to electronically report OASIS data as required. The agency was found to be out of compliance with this condition, 42 CFR 484.20 Reporting OASIS Information. The findings include: 1. The CMS CASPER Outcome and Case Mix Report dated 7/30/2019, with review of time periods dated 01/01/2017 through 12/31/2017, 01/01/2018 through 12/31/2018, and 01/01/2019 through 7/30/2019 failed to evidence the agency submitted information monthly and stated "No Date Returned for Selected Criteria."	G 0370	Administrator will contact CMS to fix account by 9/20/19. 100% of all current adult patients that receive skilled services client records will be audited by 9/27/19 to ensure compliance with comprehensive assessments. The agency will submit all OASIS data beginning 10/4/19 after next visit completed for adult skilled home health patients. The Administrator and DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	09/20/2019

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	2. On 8/05/2019 at 4:45 PM, the administrator relayed that the agency had not submitted OASIS for at least 3 years, or more, that their jHaven account was not accepting their submissions and that they had worked with CMS in the past to correct and that their new electronic medical record program, Kantime, which the agency was currently using, should have fixed the problem. Documentation of the communication with vendors and attempts to correct the problem and evidence of submission was requested at time of interview. No further information was presented for review by the agency by survey exit. 3. Clinical record 1, with start of care [SOC] 5/31/2016, included most recent plans of care for the certification periods 5/10/2019 to 7/08/2019 and 7/09/2019 to 9/06/2019 with orders for skilled nurse services 10 hours a day, 5 days a week 50 hours a week X 60 days. 4. Clinical record 2, with SOC 4/16/2016, included most recent plans of care for the certification periods 5/22/2019 to 7/20/2019 and 7/21/2019 to 9/19/2019 with orders for skilled nurse respite services, maximum of 24 hours per week, 105 hours per month per caregiver needs. Patient 2's 18th birthday was 4/15/2019.			
G 0418 Bldg. 00	Based on record review and interview, the agency failed to provide updated written notice of the patient's rights and responsibilities for 5 of 5 records reviewed wth start of care was before 01/13/2018. [1, 2, 3, 4, and 6] Findings Include:	G 0418	The DON will in-service the RN Case Managers on 9/19/19 on the need to furnish all home health patients with written patient rights documentation updated effective January 13, 2018. RN Case Managers will ensure all home health patients are educated and	11/23/2019

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	1. Clinical record 3, pediatric patient with start of care [SOC] of 5/22/17 and current certifiction period of 7/09/2019 to 9/06/2019 with skilled nurse services, failed to evidence the initialed/ signed written patient rights documentation updated effective January 13, 2018, indicating receipt of rights including participation in care, investigation of complaints, treatment or care, mistreatment, neglect or abuse, documenting complaint resolution, protecting patient during investigation, immediate reporting of abuse. 2. Clinical record 4, pediatric patient with SOC of 5/22/17 and current certifiction period of 7/16/2019 to 9/13/2019 with skilled nurse services, failed to evidence the initialed/ signed written patient rights documentation updated effective January 13, 2018, indicating receipt of rights including participation in care, investigation of complaints, treatment or care, mistreatment, neglect or abuse, documenting complaint resolution, protecting patient during investigation, immediate reporting of abuse. 3. Clinical record 6, with start of care of 02/03/2016 and current certifiction period of 7/24/2019 to 9/216/2019 with orders for home health aide services only, failed to evidence the initialed/ signed written patient rights documentation updated effective January 13, 2018, indicating receipt of rights including participation in care, investigation of complaints, treatment or care, mistreatment, neglect or abuse, documenting complaint resolution, protecting patient during investigation, immediate reporting of abuse. 4. Interview with Employee B on 08/06/2018 at 12:15 PM, she stated that patient rights documentation was provided electronically and		receive a copy of the patient rights documentation by or at their next re-certification visit beginning 9/23/19. RN Case Managers will obtain signatures from patients to ensure receipt and understanding of patient's rights documentation. All home health patients will have the updated patient rights documentation by 11/23/19. The DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	

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	understood that written evidence of receipt of patient rights was no longer required. No evidence of the receipt of electronic notification, and patient preference, was provided for review by survey exit. 5. Clinical record 1, with SOC 5/31/2016, included most recent plans of care for the certification periods 5/10/2019 to 7/08/2019 and 7/09/2019 to 9/06/2019 with orders for skilled nurse services 10 hours a day, 5 days a week 50 hours a week X 60 days, failed to evidence the initialed/ signed written patient rights documentation updated effective January 13, 2018, indicating receipt of rights including participation in care, investigation of complaints, treatment or care, mistreatment, neglect or abuse, documenting complaint resolution, protecting patient during investigation, immediate reporting of abuse. 6. Clinical record 2, with SOC 4/16/2016, included most recent plans of care for the certification periods 5/22/2019 to 7/20/2019 and 7/21/2019 to 9/19/2019 with orders for skilled nurse respite services, maximum of 24 hours per week, 105 hours per month per caregiver needs. Patient 2's 18th birthday was 4/15/2019, failed to evidence the initialed/ signed written patient rights documentation updated effective January 13, 2018, indicating receipt of rights including participation in care, investigation of complaints, treatment or care, mistreatment, neglect or abuse, documenting complaint resolution, protecting patient during investigation, immediate reporting of abuse. 410 -IAC - 17-12-3(a)(2)			
G 0460 Bldg. 00				

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	Based on record review and interview, the agency failed to provide education on the risks and potential adverse outcomes, and failed to provide physician notification for refusal of treatment for 1 of 2 active records reviewed of pediatric patient received skilled nursing care and services. Findings Include: Clinical record review for patient #4 included Skilled Nursing Visit Notes dated 7/13/2019, 7/12/2019, 6/18/2019, 5/24/2019, 5/17/2019, 5/24/2019, 5/09/202019, 5/8/2019, 5/6/2019, 5/3/2019, 5/1/2019, 4/28/2019, 4/27/2019 that the skilled nurse (SN) documented the patient refused vital signs. Page 2 of the Skilled Nursing Visit Notes, section titled "Physician Notification" was blank on each of the dates noted above. Additionally, there was no written documentation in the narrative indicating any education on the risks/potential adverse outcomes as well as no narrative documentation of communicating the refusals with the physician. Employee interview conducted on 08/06/2019 at 12:15 PM, with employee A, registered nurse, stated that the education and notification was not currently happening, but would document the information going forward.	G 0460	The DON will in-service all nursing staff on 9/23/19 on the need to educate the patient on the risks/potential adverse outcomes and need to notify the physician and DON of refusal of treatment, including but not limited to refusal of vital signs. 10% of all home health 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.	09/23/2019
G 0484 Bldg. 00	Based on document review, policy review, and interview, the agency failed to ensure they documented the investigation(s) and resolutions of all complaints for 1 of 1 agency.	G 0484	The Administrator reviewed the complaint policy and process with the DON on 9/17/19. The agency will investigate all complaints made by a patient, a patient's family or guardian, or a healthcare	09/17/2019

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	The findings include: The agency policy titled "Section 02.26.C - Investigation of Abuse, Neglect, and Exploitation" was received on 8/07/2019 at 5:10 PM. The policy states, "The agency will investigate complaints made by a patient, a patient's family or guardian, or a healthcare provider regarding treatment or care furnished by the agency or that the agency failed to furnish. ... Brightstar will document the receipt of the complaint and initiate a complaint investigation within 10 days ... All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after receipt ... unless the agency has and documents reasonable cause for the delay." During the entrance conference on 8/5/2019 at 1 PM, the complaint logs and investigations were requested. The agency complaint logs were presented on 8/06/2019 and 8/07/2019 contained complaints and allegations dated from 11/06/2016 to 6/22/2018 and 3/16/2017 to 6/27/2019 respectively. The complaint log failed to contain documentation that identified the patients, an investigation, and a resolution of the complaints. During a home visit on 8/06/2019 at 9 AM, the primary care giver [PCG] for patient 1 relayed that she filed a complaint with the agency regarding the care provided by employee I, a registered nurse, in October 2017. The PCG relayed that she / he was not informed of the resolution of the complaint. The PCG relayed that employee I called the PCG at work to report that patient 1 had fallen three times, "was fighting" the nurse, was on the floor in the basement and unclothes for one hour, and declined bathing.		provider regarding treatment or care furnished by the agency or that the agency failed to furnish. The agency will document the receipt of the complaint and initiate an investigation within 10 days. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has and documents reasonable cause for the delay. The Administrator will audit the complaint log monthly to ensure deficiency is corrected and will not recur. This plan of correction is in effect as of 9/17/19.	

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	The complaint log for 2017 included an entry dated 9/01/2017 that indicated the PCG called and filed a complaint against employee I. An entry dated 10/16/2017 documented the PCG for patient 1 met with the previous DON and requested employee I be removed from the patient's case. An entry dated 10/20/2017, entered by the previous DON states that the PCG took Patient 1 for an ophthalmology exam and was informed that Patient 1 with a bleed behind the eye. On 8/7/2019 at 5:35 PM, the administrator indicated the previous DON met with family of Patient 1 and completed the investigation. the administrator indicated the investigation should have included documentation regarding the investigation and resolution. 410 -IAC - 17-12-3(c)(2)			
G 0536 Bldg. 00	Based on record review and interview, the agency failed to ensure there were no discrepancies between patients medication profile and the medications listed on the plan of care for 3 of 4 active patient records reviewed. (#3, #4, and #6). Findings include: 1. Review of clinical record for patient #3 included review of the medication profile dated 7/9/2019 and the plan of care for certification period	G 0536	The DON will in-service all nursing staff by 9/27/19 on the need to review the medication profile and medications listed on the plan of care to ensure patient records do not have any discrepancies. All medication changes will be reported to the DON prior to administration. 100% of the client records will be audited in the next 60 days and 10% of all home health client records will be	09/27/2019

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	7/9/2019 through 9/6/2019 with the following discrepancies: (1) Medication profile for Polyethylene Glycol states 8.5 gm 1/2 cap via g-tube whereas the plan of care indicates Polyethylene Glycol 8.5 gm in 4 oz water; (2) Medication profile for Diazepam does not include a dose or purpose whereas the plan of care states 2 ml via g-tube daily; (3) Flonase on the medication profile does not indicate a purpose for administration; (4) Pediasure on medication profile does not indicate a purpose for administration; (5) Medication profile for Real Food Blend states 6 oz. (ounces) via g-tube with no purpose whereas the plan of care for the Real Food Blend states 8 oz. bolus via g-tube. 2. Review of clinical record for patient #4 included review of the medication profile dated 7/16/2019 and the plan of care, for certification period 7/16/2019 - 9/13/2019 with the following discrepancies: (1) Medication profile for Diastat indicates 10.5 mg via g-tube, PRN whereas the plan of care indicated Diastat dose of 12.5 mg; (2) Medication profile for vitamin B indicates per g-tube daily and plan of care indicates Vitamin B supplement via g-tube daily. There was no documentation indicating what type of vitamin B to administer or the dosage to administer; (3) Medication profile for Tylenol states 500 mg crushed per g-tube prn for pain and plan of care states Tylenol 500 mg crushed per g-tub for headache. There was no frequency indicated on the plan of care. 3. Clinical record 6 was reviewed on 8/7/2019. A review of the plan of care for the certification period of 7/24/2019 through 9/21/2019 and a review of the medication profile dated 07/22/2019 evidenced the following discrepancies: (1) Medication profile for Voltaren Gel indicates to		audited quarterly thereafter 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.	

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	apply topically to skin, 2 times a daily for pain whereas the plan of care states Voltaren 1% topical gel every 4 hours prn (as needed). Medication profile did evidence a strength and a discrepancy between twice daily versus every 4 hours. (2) Medication profile listed aspirin, carvedilol, cholecaliferol, gabapentin, lisinopril, Norco, and Norvasc whereas the plan of care did not include any of these medications. An interview was completed on 8/7/2019 at 1:41 p.m. with employee A and employee B. During the interview, employee B explained that the assessment information should push the information to the plan of care, but it was not working. Employee A concurred that the information was missing. 4. An interview was conducted on 08/06/2019 at 12:15 PM with employee A and B. Employee A concurred that the information was missing/ did not match on the plan of care versus the medication profile.			
G 0546 Bldg. 00	Based on record review and interview, the agency failed to complete the recertification within the 5-day window before the end of the 60-day recertification period for 2 of 4 active records reviewed with skilled services [# 2 and 4] and 1 of 2 closed records reviewed with home health only services [#8]. Findings Include: 1. Record review for patient #4 was completed on 8/5/2019, including plan of care for periods	G 0546	The Agency revised the policy that states all home health patients will complete their recertification within the 5-day window before the end of the 60-day recertification period or patient will be discharged/transferred on 9/9/19. The DON has in-serviced the RN Case Managers on the need to complete the patient's recertification within the 5-day window before the end of the 60-day recertification period on	11/23/2019

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	5/17/2019 through 7/15/2019 and the most current recertification dates of 7/16/2019 through 9/13/2019. Plan of care for the period commencing 7/16/2019 should have been completed between 7/11/2019 and 7/15/2019. The plan of care was signed and dated 7/16/2019. Comprehensive Pediatric Nursing Assessment was completed on 7/16/2019. Physician Notification form, dated 7/15/2019, documented "recertification visit for client due 7/15 - scheduled nurse called to jury duty on that date - rescheduled for 7/16/2019." Interview with employee A, she stated that she should have sent someone else, but usually makes sure to get them completed before being off (i.e. vacation). 2. Patient 2's clinical record was reviewed on 8/5/19 at 1:52 p.m. The diagnoses included, but were not limited to, autistic disorder and chronic respiratory distress. The "PHYSICIAN NOTIFICATION," dated and signed 5/20/19 by the nurse and physician, indicated a "Missed Visit Date" for the recertification visit due 5/21/19. The reason for the missed visit was indicated as the family requested the visit be delayed until after school gets out on 5/24/19. The completion week was indicated as to be the week of 5/28/19. The "HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT" with a certification period of 5/22/19 to 7/20/19 was signed and dated on 6/5/19. The "MEDICATION PROFILE" was signed and dated on 3/27/19 and secondly, on 6/5/19.		9/9/19. RN Case Managers will ensure all home health patients receive a copy of the new policy by or at their next re-certification visit beginning 9/23/19. All home health patients will have the updated policy by 11/23/19. The DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	

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	The "RECERTIFICATION OF CARE PHYSICIAN ORDER" was dated on 6/5/19. On 8/7/19 at 11:42 a.m., during an interview the Director of Nursing indicated the client's mother liked to be present during the assessment and wanted to wait until school was out to keep the client focused on school. The DON also indicated the client did not have any change in care or was not discharged with the assessment completed on 6/5/19 (the week after 5/28/19 with this missed visit date 15 days after the recertification's assessment was due). At this same time during an interview, the DON and Administrator indicated the assessment should had been completed in a more timely manner. 3. Copies of plans of care [POC] visit notes and assessments for Cliical record 8 was received from the administrator and reviewed on 8/07/2019. The start of care was 02/08/2018. The POC presented for review for the certification period dated 10/06/2018 to 12/04/2018 included orders for home health aide services 6 hours a day, 7 days a week, for assistance with activities of daily living, for a total of 42 hours per week. The POC was signed my the previous Direcor of Nursing and dated 10/09/2018. The POC included a resumption of care summary which indicated the nurse colaborated with the physican and patient / family member / caregiver on 10/01/2018 to determine scope of services, visit frequencies, and duration of the certification period. The resumption of care summary stated, "Patient was admitted to the hospital acute exacerbation of asthma and CHF [congestive heart failure] from 9/13/2018 to 10/01/2018 then rebab [rehabilitation] from 10/01/2018 to 10/08/2018. Patient was futher hospitalized from 10/08/2018 to 10/10/2018 when she was admitted to home hospice" and discharged to home. The record failed to			

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	evidence a recertification assessment or a resumption of care assessment in which the POC dated 10/06/2018 to 12/04/2018 was based. ON 8/7/2019 at 1: 05 PM, observation of the alternate administrator [AA] utilizing a lap top computer, searching for the requested assessments for clinical record 8 noted that multiple visit notes were included in a portable document format [PDF] in which the AA searched; the PDF did not contain a title that indicated which visit notes were within the PDF. When asked if multiple visits were scanned together for one patient, the AA confirmed that they were. The alternate administrator indicated he could not locate the requessed ROC or a recertification assessment completed for the POC dated 10/06/2018. 4. During the entrance conference on 8/05/2019, the administrator indicated the agency was using 2 electronic medical record [EMR] systems and the agency did not have a method to provide the Indiana State Department of health surveyor access to either EMR program. Per the ADM, documentation would need to be downloaded and then the agency would print the records requested. When asked if the agency would provide a computer with access to each EMR program, the response was that there were items in the EMR's that they did not wish to share with the state surveyors. 5. On 8/06/2019 at 3:30 PM, the administrator relayed the agency still did not have a method to provide full access of the clinical records to the state agency surveyors. 410 -IAC - 17-14-1(a)(1)(b)			

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	15K107	A. BUILDING 00 B. WING	08/07/2019

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G 0572 Bldg. 00	Based on observation, record review and interview, the skilled nurse failed to give a client's prescribed medication, Levothyroxine/ Synthroid, timely as ordered by the physician and to ensure the prescribed cranberry pills were given as ordered by the physician for 1 of 2 home skilled visits conducted with a gastrostomy tube (G-tube) (Patient 1) and the agency failed to include patient- specific measurable outcomes and goals on the plan of care for 2 of 4 [3 and 4] active records reviewed with orders for skilled nursing services and 1 of 2 [6] active records reviewed with orders for home health aide services only. Findings Include: 1. The "MEDICATION ORDERS AND ADMINISTRATION" policy was provided by the Administrator on 8/7/19 at 4:30 p.m. This current policy indicated the following: "...6. Prior to administration of any medication by any route, the nurse will verify the following: ...* Medication is the correct dose, route and time...." 2. Fall Risk Assessment for patient #4, dated 7/16/2019 indicated a score of 14 (high risk = 12 or above) and page 7 of 12 on the Comprehensive Pediatric Nursing Assessment, under the heading "Safety" indicated fall prevention as a safety measure. The plan of care faile to evidence of individualized, patient-specific, measurable outcomes and goals for fall precautions on the plans of care. 3. Fall Risk Assessment for patient #3, dated 7/9/2019 indicated a score of 19 (high risk = 12 or	G 0572	The DON will in-service all nursing staff by 9/27/19 on the need to follow medication administration records/plan of care as signed by the physician. The DON will in-service RN Case Managers on 9/23/19 to ensure that each patient receives an individualized written plan of care that will be reviewed with patient and left in the home. The POC will include patient specific goals with measurable outcomes and be based on the medical diagnosis, physician's orders, comprehensive assessment findings, and patients input. 100% of all charts will be audited for individualized measurable outcomes and goals by 11/23/19, then 10% of all home health client records will be audited quarterly thereafter 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.	11/23/2019

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	above) and page 7 of 12 on the Comprehensive Pediatric Nursing Assessment, under the heading "Safety" indicated fall prevention as a safety measure. Physician order dated 7/9/2019, states one of the goals to be "free from falls." The plan of care faile to evidence of individualized, patient-specific, measurable outcomes and goals for fall precautions on the plans of care. 4. Review of clinical record #6 failed to evidence of individualized, patient-specific, measurable outcomes and goals for chronic pain and for nutrition risk as evidenced by the following: Record review of Comprehensive Non-Skilled Assessment for certification period 5/25/2019 through 7/23/2019 indicated that the patient has chronic pain with breakthrough pain greater than 3 times daily with worsening pain upon movement. Nutrition assessment on the above named assessment showed a risk score of 7 (6 or more = high risk. Coordinate with physician, dietician, social services professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care). Review of plan of care for certification period does not include any HHA assistance with nutrition or pain as well as there are no goals addressed for pain or nutrition. Review of Aide Care Plan, dated 01/18/2019 includes meal preparation as well as assist with ambulation. No precautions for pain management with the ambulation or any ADL's Fall Risk Assessment for patient #6, dated 06/20/2019 indicated a score of 7 (high risk of 4 or more is considered at risk for falling) and page 15 of the Comprehensive Non-Skilled Assessment indicated fall prevention strategies as a safety measure. The plan of care faile to evidence of			

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	individualized, patient-specific, measurable outcomes and goals for fall precautions on the plans of care. An interview was completed with employee A on 8/7/2019. Employee A reviewed the clinical record and agreed that there was nothing addressed on chronic pain on the care plan. Employee A explained the process for a patient at risk for nutrition should include a follow-up communication with the physician or CICOA for other resources, but with it just being aide care, it was missed. She agreed that the skilled nurse (SN), during her monthly supervisory visit, should be following up on this as well as providing education 5. An interview with employee A and employee B was conducted on 8/6/2019 at 12:15 PM. The plans of care for the above patients were reviewed during the interview and employee A stated that there were no patient-specific, measurable outcomes and goals. 6. On 8/6/19 from 8:23 a.m. to 9:40 a.m., a home visit was conducted at the home of Patient 1. The following was observed: Employee G was observed to pour 10 cc (cubic centimeters) (2 teaspoons) of CoQ (supplement) into a medication cup. Next, the Levothyroxin/ Synthroid 88 mcg (microgram) tablet was crushed and added to the liquid medication. The medication was then drawn up into a syringe and given to the resident along with the "Real Food" tube feeding through the client's G-tube (gastrostomy tube-a flexibe tube that is inserted through the stomach wall where liquids and medications could be given). No cranberry pills were given. The medications present during this home visit included, but were not limited to, Synthroid/ Levothyroxine 88 mcg "1 tab (tablet) via (by) G-tube or by mouth daily.			

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	Give in the morning on an empty stomach." No Cranberry tablets were present. During this time, Employee G was interviewed and indicated Patient's 1 thyroid medication was always given after breakfast, and the dosage was changed 3 to 4 months ago. He indicated a medication change should be communicated to the Director of Nursing or the Administrator. If the change of medication was not on the new medication administration record [MAR], the office would need to be called. Employee 20 and the client's sister indicated no recent supply of Cranberry pills was purchased, and that this medication had not been given in July either. Patient1's clinical record was reviewed on 8/6/19 at 10:15 a.m. The diagnoses included, but were not limited to, Cerebal Palsy, dysphagia, hypothyroidism, unspecified visual loss. Review of the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 7/9/19 to 9/6/19 included, but were not limited to, the following medications: CoQ liquid [As Prescribed by Physician]: 10 ml (milliliters)/ daily in a.m. Oral or by G-tube, Levothyroxin 88 mcg oral tablet [as Prescribed by Physician] daily in a.m. oral or via G-tube, Cranberry oral tablet 2 tablets daily in a.m. Review of the "Medication Profile," signed 7/5/19, indicated 1 medication change. This medication change indicated the medication, Levothyroxine, had a dose increase of 75 mcg to 88 mcg. Also, this medication profile included the following information related to drug interactions: "Levothyroxine food. Applies to: Levothyroxine. The timing of meals relative to your Levothyroxine dose can affect absorption of the medication			

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	Therefore, Levothyroxine should be taken on a consistent schedule with regard to time of day and relation to meals to avoid large fluctuations in blood levels, which may alter its effects...It is important to tell your doctor about all other medications you use, including vitamins and herbs...." A review of the MAR for May, 2019 indicated the following: Levothyroxine 75 mcg was discontinued on 5/9/19 and 88 mcg was started. Directions were to give in the morning on an empty stomach; Cranberry pill - 2 tablets by mouth or G-tube daily in the morning with no signature indicated as given. A review of the MAR for June, 2019 indicated the following: Levothyroxine 75 mcg (only dosage indicated) 1 tab via G-tube or by mouth daily with instructions to given in the morning on an empty stomach was indicated and signed per nurse each day. Cranberry pill - 2 tablets by mouth or G-tube daily in the morning with no signature indicated as given. A review of the MAR for July, 2019 indicated the following: Levothyroxine was indicated with 75 mcg crossed out and changed to 88. Directions were to give in the morning on an empty stomach; Cranberry pill - 2 tablets by mouth or G-tube daily in the morning with no signature indicated as given. On 8/6/19 at 12:20 p.m., during an interview the Administrator indicated a medication change was generally reported through the family to the office. 410 -IAC 17-13-1(a)			

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G 0574 Bldg. 00	Based on interview and record review, the agency failed to ensure to individualize a client's plan of care related to the time and route of a medication, the amount of fluid for G-tube flushes, and included potential long term goals and/ or discharge plans for 2 of 2 skilled patient records reviewed receiving skilled nursing services (#1 and 2) and failed to ensure that the individualized plan of care included all medications and matched the medication profile including dosage, type of medication, or frequency for 3 of 4 [3, 4, and 6] active patient records reviewed. Findings include: 1. The "NURSING PLAN OF CARE" policy was provided by the Administrator on 97/19 at 5:10 p.m. This current policy indicated the following: "... The nursing plan of care must contain the following: *A Plan of care and appropriate patient identifying information ...*Medications, diet and activities ...*The discharge note...." 2. Client 1's clinical record was reviewed on 8/6/19 at 10:15 a.m. The client's diagnoses included, but were not limited to, Cerebal Palsy, dysphagia, hypothyroidism, unspecified visual loss. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 7/9/19 to 9/6/19 included, but were not limited to, the following: Medications, included but were not limited to, "Levothyroxine 88 mcg (micrograms) (0.88 mg) (milligrams) oral tablet [As Prescribed by Physician]... Miralax oral powder for reconstitution [As Prescribed by Physician]: -17 grams in 8 oz (ounces) water /every Monday,	G 0574	The DON will in-service the RN Case Managers on 9/23/19 regarding the importance of accuracy of medications listed and g-tube flushes in both the Plan of care and on medication profile in chart. Elements that are essential include dosage, type and frequency. 100% of the client records will be audited in the next 60 days and 10% of all home health client records will be audited quarterly thereafter 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.	09/23/2019

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	Wednesday, Friday / via G-tube ... Skilled Nursing: - GASTROINTESTINAL: - SN (Skilled nursing) TO ADMINISTER _ Real Food blend FEEDING VIA G-tub 4 times daily PER MD (Medical Doctor) ORDERS. Flush per protocol/ orders... 21 ...SN TO ADMINISTER MEDICATION AS ORDERED BY MD ... 22. Rehabilitation Potential/ Discharge Plans/ Goals: - (no information was indicated) ..." 3. Client 2's clinical record was reviewed on 8/5/19 at 1:52 p.m. The diagnoses included, but were not limited to, autistic disorder and chronic respiratory distress. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 7/21/19 to 9/18/19 included, but were not limited to, the following: "...Skilled Nursing : - GASTROINTESTINAL:- SN (Skilled nursing) FOR INSTRUCTION/ REINFORCEMENT OF ADMINISTRATION OF GASTROSTOMY FEEDINGS INCLUDING SAFETY MEASURES, TUBE PLACEMENT, CARE OF EQUIPMENT, AND PREPARATION OF FEEDINGS ... SN TO ADMINISTER ALL MEDICATIONS AS ORDERED AND TO FLUSH GT BEFORE AND AFTER MED ADMINISTRATION TO MAINTAIN PATENCY ... 22. Rehabilitation Potential/ Discharge Plans/ Goals: - (no information was indicated)..."4. Review of clinical record for patient #3 included review of the medication profile dated 7/9/2019 and the plan of care for certification period 7/9/2019 through 9/6/2019 with the following discrepancies: (1) Medication profile for Polyethylene Glycol states 8.5 gm 1/2 cap via g-tube whereas the plan of care indicates Polyethylene Glycol 8.5 gm in 4 oz water; (2) Medication profile for Diazepam does not include a dose or purpose whereas the plan of care states 2 ml via g-tube daily; (3) Flonase on the medication profile does not indicate a purpose			

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	for administration; (4) Pediasure on medication profile does not indicate a purpose for administration; (5) Medication profile for Real Food Blend states 6 oz. (ounces) via g-tube with no purpose whereas the plan of care for the Real Food Blend states 8 oz. bolus via g-tube. 5. Review of clinical record for patient #4 included review of the medication profile dated 7/16/2019 and the plan of care, for certification period 7/16/2019 - 9/13/2019 with the following discrepancies: (1) Medication profile for Diastat indicates 10.5 mg via g-tube, PRN whereas the plan of care indicated Diastat dose of 12.5 mg; (2) Medication profile for vitamin B indicates per g-tube daily and plan of care indicates Vitamin B supplement via g-tube daily. There was no documentation indicating what type of vitamin B to administer or the dosage to administer; (3) Medication profile for Tylenol states 500 mg crushed per g-tube prn for pain and plan of care states Tylenol 500 mg crushed per g-tub for headache. There was no frequency indicated on the plan of care. 6. Clinical record 6 was reviewed on 8/7/2019. The plan of care for the certification period of 7/24/2019 through 9/21/2019 was missing diagnosis codes, DME and Supplies, Safety Measures, Nutritional Requirements, Allergies, Activities Permitted, Mental Status, Prognosis, Orders for Discipline ad Treatments, Rehabilitation Potential/ Discharge Plans/ Goals, Physician's Signature and Date Signed, and a Clinician's Signature. This same plan of care for certification period 7/24/2019 through 9/21/2019 and a review of the medication profile dated 07/22/2019 evidenced the following discrepancies: (1) Medication profile for			

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	Voltaren Gel indicates to apply topically to skin, 2 times a daily for pain whereas the plan of care states Voltaren 1% topical gel every 4 hours prn (as needed). Medication profile did evidence a strength and a discrepancy between twice daily versus every 4 hours. (2) Medication profile listed aspirin, carvedilol, cholecaliferol, gabapentin, lisinopril, Norco, and Norvasc whereas the plan of care did not include any of these medications. An interview was completed on 8/7/2019 at 1:41 p.m. with employee A and employee B. During the interview, employee B explained that the assessment information should push the information to the plan of care, but it was not working. Employee A concurred that the information was missing. 7. An interview was conducted on 08/06/2019 at 12:15 PM with employee A and B. Employee A concurred that the information was missing/ did not match on the plan of care versus the medication profile. 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(i - xiii)			
G 0580 Bldg. 00	Based on record review and interview, the agency failed to administer services as ordered by the physician for 1 of 4 active records reviewed with orders for skilled nurse services.[4] Findings Include: Review of clinical record #4, included a plan of care established by the physician for the	G 0580	The DON will in-service all nursing staff by 9/27/19 on the need to review the physicians orders to ensure patient records are accurate and up to date at all times. DON educated all nursing staff to follow physician's orders or report a change required to the DON so an order can be requested. 100% of the client	09/27/2019

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	certification period 5/17/2019 through 7/15/2019, which indicated under "Medications" Lamotrigine 225 mg daily am - 250 mg daily pm. Review of medication profile dated 5/14/2019 indicated Lamotrigine 250 mg crushed per g-tube, twice daily with a start date of 1/24/2019. Clinical record did not include an updated physician order for the medication change. An interview with Employee A was conducted on 8/6/2019 at 12:15 PM. She stated that the order came from the mom and going forward, they will confirm with the physician first going forward and get the order. 410 -IAC - 17-13-1(a)		records will be audited in the next 60 days and 10% of all home health client records will be audited quarterly thereafter 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.	
G 0602 Bldg. 00	Based on record review and interview, the agency failed to provide physician notification for refusal of treatment for 1 of 2 active pediatric records reviewed with orders for skilled nurse services.[4] Findings Include: Clinical record review for patient #4 included Skilled Nursing Visit Notes dated 7/13/2019, 7/12/2019, 6/18/2019, 5/24/2019, 5/17/2019, 5/24/2019, 5/09/202019, 5/8/2019, 5/6/2019, 5/3/2019, 5/1/2019, 4/28/2019, 4/27/2019 that the skilled nurse (SN) documented the patient refused vital signs. Page 2 of the Skilled Nursing Visit Notes, section titled "Physician Notification" was blank on each of the dates noted above. Additionally, there was	G 0602	The DON will in-service all nursing staff by 9/27/19 on the need to educate the patient on the risks/potential adverse outcomes and notify the physician and DON of refusal of treatment. 10% of all home health 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.	09/27/2019

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	no written documentation in the narrative indicating any education on the risks/potential adverse outcomes as well as no narrative documentation of communicating the refusals with the physician. Employee interview conducted on 08/06/2019 at 12:15 PM, with employee A, she stated that the education and notification is not currently happening, but will document the information going forward. 410 -IAC - 17-14-1(a)(1)(G)			
G 0606 Bldg. 00	Based on record review and interview, the agency failed to ensure patient identified needs that affect patient safety were coordinated for 1 of 2 active records reviewed with orders for home health aide services only.[6] Findings include: Record review for patient #6 of most current plan of care for certification period 7/24/2019 through 9/21/2019 indicate the patient has a BKA [below knee amputee] and used a wheelchair for mobility. Review of plan of care for certification period 5/25/2019 through 7/23/2019 indicate the patient has a BKA, used a wheelchair and slide board to assist with mobility. The plan of care for certification period 5/25/2019 through 7/23/2019 indicated under heading "HHA to Perform/ Assist with: ... # 12. "Report any noted malfunctions of DME as needed." The 60-day summary additionally states "Slide board	G 0606	The DON will in-service the RN Case Managers on 9/23/19 on the agency's policy 2.21 and federal guidelines to complete a supervisory visit at least every 30 days, and to observe and assess aide during provision of care at least every 60 days. 100% of the supervisory visit documentation will be audited in the next 60 days and 10% of all home health client records will be audited quarterly to ensure compliance with this standard. The Administrator and DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	09/23/2019

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	and wheelchair both require repair." Review of Comprehensive Non-Skilled Assessment, dated 05/21/2019 indicated on page 19 the patient needed transfer equipment board and wheelchair. Page 20 indicated "(1) DME equipment assessed for obvious signs of malfunction; and (2) No obvious signs of malfunction noted." HHA Supervisory Visit Form, dated 06/20/2019, section entitled "Home Safety Assessment: Assessment of Client Transfer Process" was blank as well as "Type of Transfer Observed" section was also blank. "Safe Transfer Instructions for the Client/ Caregiver/ or Aide include:" section stated the patient remained in the wheelchair throughout the visit. No documentation in the notes of instructions. The DME section stated "No presence of any obvious equipment malfunction." The plan of care for certification period 03/26/2019 through 5/24/2019 indicate under heading "HHA to Perform/ Assist with: ... #12. Report any noted malfunctions of DME as needed. The 60-day summary stated "Slide board and wheelchair both require repair." Review of Comprehensive Non-Skilled Assessment, dated 03/24/2019 indicated on page 20 that "(1) DME equipment assessed or obvious signs of malfunction and (2) No obvious signs of malfunction noted." Review of the HHA Supervisory Visit Form dated 05/21/2019, the section entitled "Home Safety Assessment: Assessment of Client Transfer Process" was blank as well as "Type of Transfer Observed" section was also blank. "Safe Transfer			

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	Instructions for the Client/ Caregiver/ or Aide include:" section stated that the patient remained in the wheelchair throughout the visit. The record failed to evidence documentation in the notes for instructions. The DME section stated "Yes, presence of any obvious equipment malfunction." If marked yes, explain malfunction section stated "Slide board still needs to be repaired/ replaced." HHA Supervisory Visit Form, dated 04/25/2019, section entitled "Home Safety Assessment: Assessment of Client Transfer Process" was blank as well as "Type of Transfer Observed" section was also blank. "Safe Transfer Instructions for the Client/Caregiver/or Aide include:" section states that the patient remained in the wheelchair throughout the visit. The record failed to evidence documentation in the notes for instructions. The DME section stated "Yes, presence of any obvious equipment malfunction", If marked yes, explain malfunction section states "Slide board still needs to be repaired/replaced." The plan of care for certification period 01/25/2019 through 3/25/2019 indicates under heading "HHA to Perform/ Assist with: ... #12. Report any noted malfunctions of DME as needed." The 60-day summary stated "slide board and wheelchair both require repair." Review of Comprehensive Non-Skilled Assessment, dated 03/24/2019 indicated on page 20 that "(1) DME equipment assessed or obvious signs of malfunction and (2) No obvious signs of malfunction noted." HHA Supervisory Visit Form, dated 03/24/2019, section entitled "Home Safety Assessment: Assessment of Client Transfer Process" was blank as well as "Type of Transfer Observed"			

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	section was also blank. "Safe Transfer Instructions for the Client/ Caregiver/ or Aide include:" section stated that the patient remained in the wheelchair throughout the visit. The record failed to evidence documentation in the notes for instructions. The DME section stated "Yes, presence of any obvious equipment malfunction." If marked yes, explain malfunction section states "Slide board still needs to be repaired/ replaced." HHA Supervisory Visit Form dated 02/22/2019, The DME section stated "Yes, presence of any obvious equipment malfunction", If marked yes, explain malfunction section states "Slide board still needs to be repaired/ replaced." Review of the HHA Supervisory Visit Form, dated 12/24/2018, The DME section stated "Yes, presence of any obvious equipment malfunction", If marked yes, explain malfunction section states "Slide board still needs to be repaired/replaced." An interview was conducted on 08/07/2019 at 1:41 PM with employee A and employee B. Employee B explained that CICOA needed to address the repair / replacement of equipment and that "we are at their mercy." Employee B additionally stated that the slide board and wheelchair were still being used, but could not confirm what the malfunction issues were. Employee A explained that the DME section on the HHA Supervisory Note form should have included an explanation of the issues with the equipment. When surveyor inquired on the issue of checking off that there were no obvious malfunctions, if there were, employee A stated "Sometimes people just check a box." Surveyor asked to review notes of communications with CICOA, but did not receive them by survey exit.			

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G 0612 Bldg. 00	410 -IAC 17-12-2(h) Based on observation, record review, and interview, the agency failed to provide the patient and caregiver with a copy of the current plan of care for 1 of 2 home observations.[3] Findings include: A home observation was completed on 8/6/2019 at 8:25 AM at the residence of Patient 3. At such time, Patient documentation was reviewed to show that the most recent plan of care was dated 11/1/2018 through 1/9/2019 and it was whited out. Handwritten in its place noted period 1/2019 through 2/2019. An interview was conducted on 8/6/2019 at 11:15 p.m., with employee A, employee B and employee F. Both employee A and B explained that the plan of care was a rolling document and they were told that copies no longer needed to be in the home.	G 0612	The DON will in-service the RN Case Managers on 9/23/19 on the need to furnish a current and accurate POC to the patient and caregiver by or at the patient's next visit. RN Case Managers will ensure all home health patients receive a copy of their POC by or at their next re-certification or supervisory visit beginning 9/23/19. All home health patients will have the updated POC by 11/23/19. 10% of all home health client records will be audited quarterly to ensure compliance with this standard. The DON will be responsible for monitoring the RN Case Managers paperwork to ensure this deficiency is corrected and does not recur.	11/23/2019
G 0616 Bldg. 00	Based on observation, record review, and interview, the agency failed to provide current written information for medication instructions for 1 of 2 home observations of skilled nurse care. [3] Findings include: A home observation was conducted on 8/6/2019 at 8:25 AM at the residence of Patient 3. During	G 0616	The DON will in-service all RN Case Managers on 9/23/19 on the need to furnish a current and accurate POC and medication administration record to the caregivers. The DON will in-service all nursing staff by 9/27/19 on the need to follow the patient's current and accurate medication administration record	10/04/2019

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	the observation, the home folder was found filed away in the second drawer of a file tote cabinet and was reviewed to include the most current medication profile dated 5/22/2017. The patients clinical record was reviewed and evidenced the most current medication profile was dated 7/9/2019. During interview on 8/6/2019 at 8:25 AM, employee I stated that she has administered medications for this patient all the time and she knew the medications by heart. The employee stated that she would go to the office every Monday to turn in paperwork, get supplies, and any documentation for the patient. An interview was conducted on 8/6/2019 at 11:15 AM, with employee A, employee B and employee F. Employee A indicated that she agreed with the discrepancy. Additionally, employee A stated that employee I giving medications from memory was a problem that she had with another RN as well in the past, but she would re-educate this employee as well. She indicated that the process was supposed to include the use of the employee table since the most current profile was there and not in the home.		and report any changes to the DON. RN Case Managers will ensure all nursing staff receive a copy of their POC and medication schedule/instruction by 10/4/19. The DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	
G 0640 Bldg. 00	Based on agency document review and interview, the agency failed to ensure the quality assurance program was capable of showing measurable improvement and measured, analyzed and tracked quality assurance indicators, including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, HHA services, and operations (G 642); failed to ensure the quality assurance program	G 0640	The Administrator and DON will review and revise the quality assurance program and the agency's current policy by 10/11/19. Quarterly QAPI meetings will occur, beginning 4th quarter of 2019. All data will be reviewed, and an action plan established for all issues	10/11/2019

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	utilized quality indicator data, including measures derived from OASIS and other relevant data, to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement (G 644); failed to ensure the quality assurance program must include program activities (G 646); failed to ensure the quality assurance program focused on high risk, high volume, or problem prone areas (see G 648); failed to ensure the quality assurance program considered the incidence, prevalence and severity of problems (see G 650); failed to ensure the quality assurance program led to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patient (G 652); failed to ensure performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions (G 654); failed to ensure actions aimed at performance improvement occurred and were sustained (G 658); and failed to ensure the governing body was involved with the ongoing quality assurance program (G 660) for 1 of 1 agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484: 65 Condition: Quality Assessment / Performance Improvement. The findings include: The facility policy titled, Performance Improvement, was provided by the administrator on 8/07/2019 at 5:10 PM. The policy stated, the agency shall develop, implement, maintain, and evaluate a performance improvement quality assessment plan to measure, assess, and improve		identified. Education and corrections will be established from the findings. Home Health and PSA lines of business will be separated for quality purposes. The Administrator and DON will be responsible for monitoring these client records quarterly to ensure this deficiency is corrected and does not recur.	

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	the performance of clinical and other processes as needed. The QAPI information/ book was reviewed on 8/07/2019 at 2:30 PM with the administrator. The QAPI failed to be delineated from their PSA agency and failed to evidence a program, which collected objective data, that was measured, and analyzed in addition failed to evidence any PIP as evidenced by the following: The logged complaints that were in the QAPI book, was reviewed. The administrator indicated the resolutions to the complaints would be in the individual patient records. The fall incidents were reviewed and that there was no evidence of a follow up. The administrator responded that the registered nurse should have gone to the home to assess and did not. Within the information identified by the administrator as the agency QAPI, was multiple discharge summaries of patients that were discharged in 2019 and were not listed on the agencies discharge list. The administrator relayed that they their other agency's information, a Personal Service Agency located and operated out of the same office, was also included in the QAPI information, that they did not separate the two agencies information. During an interview, the administrator indicated the management team met weekly to review complaints and incidents and look for trends. The administrator relayed that if 5 episodes / incidents occured in an area, then the agency would determine a trend and initiate a performance improvement project [PIP]. When asked what data the agency was collecting, the administrator			

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	responded "same" and that they "log it." When asked about the log of complaints for 2019, a list of 25 complaints dated through 6/28/2019, the administrator confirmed the QAPI information was not up to date. When asked directly what was the agency program and what objective information was the agency gathering, the administrator responded that the agency was logging information that was passed to them, for example a fall, an antibiotic order, or an infection. 410 IAC 17-12-2			
G 0680 Bldg. 00	Based on observation, record review and interview, the home health agency failed to ensure standard infection control practices related to handwashing and glove use were followed during patient care (See G682) and failed to have an active infection control program to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infections and communicable diseases and incorporated the information into the agencies QAPI (quality assurance and performance improvement) program (See G684). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484.70 Condition of participation: Infection prevention and control.	G 0680	The Administrator and DON will review the infection control program regulation and the agency's current policy by 10/4/19. The Administrator and DON will ensure the agency has a program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases specific to care and services provided in the home setting by 10/11/19. The agency will observe and evaluate services from all disciplines to identify sources or causative factors of infection, track patterns and trends of infections; and establish a corrective plan for infection control if needed and monitor the effectiveness of the corrective plan. All data will be reviewed in Quarterly Quality meetings with plan of action and	10/11/2019

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			follow-up. The Administrator and DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	
G 0682 Bldg. 00	Based on observation, interview and record review, the agency failed to ensure standard infection control practices related to handwashing and glove use were followed during patient care for 1 of 2 home visits observed of skilled nurse care. (Patient 1) Findings include: The "Infection Control Plan" was provided by the Administrator on 8/6/19 at 1:45 p.m. This current policy included the following: "...Goals: a. To prevent infection and cross-contamination between clients and staff. ...c. Limiting the spread of infections associated with procedures and use of medical equipment, devices and supplies ... "Hand Hygiene Policy and Procedure. Policy Hand washing is the first line of defense in infection control ... Procedure... 2. When To Wash: Hands should be washed whenever: ...* after glove removal. *Wearing gloves does not replace the need for hand hygiene ... Hands should also be washed: ... * before preparing or eating food 3. How To Wash ... a. Proper hand washing with soap and water: ...*rub your hands vigorously together for at least 15 - 20 seconds. ...*rinse well under running water *dry your hands with a disposable paper towel. ...*use a towel or your elbow to turn off the faucet ...."	G 0682	The DON and RN Case Managers will in-service all staff on infection prevention and the standard precautions identified by the CDC and HICPAC by 9/27/19. Handwashing observation will be incorporated into supervisory visits at a minimum of every 60 days and documented on a supervisory visit form. 100% of the supervisory visit documentation will be audited in the next 60 days and 10% of all home health client records will be audited quarterly to ensure compliance with this standard. The DON and RN Case Managers will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	09/27/2019

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	HAND HYGIENE OBSERVATION WORKSHEET ...Caregiver understands key elements of hand hygiene practices. Criteria ...Washed hand before putting on gloves. Washed hands after glove removal ...Washed hands before and after assisting client with mobility ... Hand hygiene is performed and gloves are used appropriately as recommended by CDC's Standard Precautions and required by OSHA's Bloodborne Pathogens Standard. Criteria Washed hands after assisting client with toileting... Standard Precautions Policy stated, "4. Standard Precautions apply to the following: ...b. Gloves - Gloves are to be worn when touching blood, body fluids, secretions, excretions and other contaminated items... Gloves shall be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms...." On 8/6/19 from 8:23 a.m. to 9:40 a.m., a home visit was conducted at the resdience of Patient 1. The following was observed: In the kitchen with Client 1 sitting at the table, Employee G began preparation for Client 1's breakfast and medications. Employee G handwashed for 10 seconds, held the paper towel holder down with his right index and middle wet fingers to obtain paper towels, and then, dried his hands with the paper towel. Next, Employee G prepared Client 1's coffee with milk obtained from the refrigerator in a large cup inserting a straw and giving it to the Client, who began to drink from the straw. After donning a pair of gloves Employee G prepared the client's medications by obtaining a new syringe, crushing 1 pill and mixing it with the liquid medication, followed by opening the tube feeding solution, and then, obtained water for the G-tube			

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	flush. After completing the medication administration and tube feeding, Employee G removed his gloves, rinsed out the cup, tube, syringe and plunger used during the feeding. This equipment was then placed on the top of the basket used to store her medications and equipment. Then, Employee G handwashed. On the second trip to the bathroom after Client 1 had urinated, Employee G with gloved hands used toilet paper to wipe her rectal area. With the same gloves Employee G buttoned the client's pants and assisted the client to the sink where she was assisted to handwash. After removing these gloves, Employee G assisted Client 1 by holding her hands as she walked to the sitting room. No handwashing or handgel use was observed. During an interview Employee G indicated handwashing should be before meals and before giving medication. Handwashing should be 15 to 30 seconds with soap and water, and one should dry thoroughly. Gloves should be used before toileting or before contact with any secretions. 410 IAC 17-12-1(m)			
G 0684 Bldg. 00	Based on record review and interview, the agency failed to have an active infection control program to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infections and communicable diseases and incorporated the information into the agencies QAPI (quality assurance and performance improvement) program for 1 of 1 agency	G 0684	The Administrator and DON will review the infection control program regulation and the agency's current policy by 10/4/19. The Administrator and DON will incorporate all aspects of infection control program into the quarterly QAPI data review and provide action plans, follow-up, and education as indicated for	10/04/2019

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	The findings include: During an interview on 8/07/2019 at 2:30 PM, the administrator indicated the management team met weekly to review complaints and incidents and look for trends. The administrator relayed that if 5 episodes / incidents occur in an area, then the agency determines a trend and initiates a performance improvement project [PIP]. When asked what data the agency was collecting, the administrator responded same and that they "log it." The QAPI information failed to evidence an infection control or prevention program. When asked directly what was the agency's program and if any infection prevention or observation was completed in the field, the administrator responded that the agency was logging information that was passed to them, for example an antibiotic order or an infection.		identified issues. The Administrator and DON will be responsible for monitoring this program to ensure this deficiency is corrected and does not recur.	
G 0726 Bldg. 00	Based on record review and interview, the agency failed to ensure the LPN's performance was evaluated during a supervisory visit for 1 of 1 record reviewed receiving skilled nurse services from a LPN (Licensed Practical Nurse). (Patient 2) Findings include: The agency policy titled, "CLINICAL SUPERVISION OF HOME CARE AIDES AND LPN'S," dated May 2013, was provided by the Administrator on 8/7/19 at 5:10 p.m. This current policy indicated the following: "...2. ...Supervisory visits on LPN's will be done every sixty (60) days to observe quality of care, reassess goals and	G 0726	The Administrator in-serviced the DON and RN Case Manager on 9/17/19 on clinical supervision of LPNs. The DON or RN Case Manager will evaluate the LPNs performance in the provision of services, treatments, patient education, communication with supervisor, and data collection on patient at least every 60 days during a supervisory visit. 100% of the supervisory visit documentation will be audited for 60 days, starting 9/23/19, and 10% of all home health client records will be audited quarterly	09/17/2019

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	establish if needs are being met...." Patient 2's clinical record was reviewed on 8/5/19 at 1:52 p.m. The diagnoses included, but were not limited to, autistic disorder and chronic respiratory distress. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 7/21/19 to 9/18/19 included, but were not limited to, the following: "...Skilled Nursing :- GASTROINTESTINAL:- SN (Skilled nursing) FOR INSTRUCTION/REINFORCEMENT OF ADMINISTRATION OF GASTROSTOMY FEEDINGS INCLUDING SAFETY MEASURES, TUBE PLACEMENT, CARE OF EQUIPMENT, AND PREPARATION OF FEEDINGS ... SN TO ADMINISTER ALL MEDICATIONS AS ORDERED AND TO FLUSH GT (GASTROSTOMY TUBE) BEFORE AND AFTER MED ADMINISTRATION TO MAINTAIN PATENCY...." The DON (Director of Nursing) completed the "Supervisory Visit" on 7/19/19 (no time). This visit indicated the nurse was an (LVN) (Licensed Vocational Nurse). This supervisory visit included, but was not limited to, a "yes" answer to the questions which included the following: "... 9. Carrying out the established Plan of Treatment? ...12. Demonstrates competent skills and expertise. 13. Follows infection control measures, i.e. proper hand hygiene/handwashing, proper bag technique, proper cleaning of reusable equipment before and after use." On 8/7/19 at 6:35 p.m., during an interview, employee A, indicated during the 7/19/19 supervisory visit she had interviewed the patient's		thereafter 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.	

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BRIGHTSTAR HEALTHCARE	9292 N MERIDIAN ST STE 211 INDIANAPOLIS, IN 46260

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	mother during the visit only. She indicated she did not observe the nurse completing any of the procedures as the patient was busy playing a video game and indicated she was not aware that the supervisory visit of the LPN included the observation of the LPN completing an ordered nursing task. Employee A indicated the 7/19/2019 LPN supervisory visit was the only supervisory visit that she was aware. 410 - IAC 17-14-1(a)(1)(J)			
G 0802 Bldg. 00	Based on record review and interview, the agency failed to ensure the home health aides were not assigned to administer medications for 1 of 2 closed records reviewed that received only aide services. (#7). The findings include: The agency's undated policy titled Clinical Supervision of Home Care Aides and LPN's stated, "The agency shall provide Home Care Aide services under the direction and supervision of a registered nurse when personal care services are indicated, ordered by the physician, and in compliance with state and federal regulations. " The clinical record for patient #7 was received on 8/06/2019 for review. The start of care date was 11/10/2016. The plan of care dated 5/17/2018 to 7/15/2018 included diagnosis of Alzheimer disease and orders for home heath aide [HHA] services 8 hours per day, 7 days a week to provide care while primary caregiver slept, mobility by mechanical	G 0802	The DON will in-service all RN Case Managers and home health aide staff by 9/27/19 on their scope of practice. The RN Case Managers will provide direction and supervision for all personal care services indicated, ordered by the physician, and maintain compliance with state and federal guidelines. 10% of all home health client records will be audited quarterly to ensure compliance with this standard. The RN Case Managers and DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	09/27/2019

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	lift, a hoyer, and stated, "Client requires max [maximum] assist for all activities of daily living, ... cannot transfer, prepare meals, or be left alone at any time ... requires care 24 hours a day." An undated document titled "Additional Client Preferences" stated under daily routine, "Meds [Medication] - crush and put in applesauce or with shake." The comprehensive assessment dated 5/15/2018, completed by employee C, documented that Patient 7 with diagnosis of Alzheimer, oriented "X 1" - not specified, dysphagia, missing teeth - does not specify if there were any teeth, hard of hearing on the left, non - pitting dependent edema was present bilateral lower extremities and buttocks, weight was unknown, ate a regular diet mechanical soft texture, nutrition screen completed and was scored at a 7 which indicated high risk. Employee C documented on the assessment "N/A" following the nutrition assessment where asked for Risk intervention and plan, management, and education provided. Employee C documented that gross motor skills were not assessed due to Patient not able to follow directions and weakness in upper and lower extremities, "weak hand grips," and contractures were present at wrists and elbows of bilaterally. Primary reason for home health was to assist with activities of daily living. The home health aide documentation was reviewed on 8/06/2019 and evidenced 8 home health aides provided care from 5/18/2018 until discharge on 6/14/2018, employees J, K, L, M, N, O, and P, which all documented they provided assistance with "self administration of medications." Employee J documented assistance with self administration of medications on May 21 and 28, 2018 and June 3, 7, 9, and 14, 2018.			

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	Employee K documented assistance with self administration of medications on May 21 and 28, 2018. Employee L documented assistance with self administration of medications on May 19, 20, 23, 26, 27, 30, and June 01, 2018. Employee M documented assistance with self administration of medications on June 4, 5, 8, and 13, 2018. Employee N documented assistance with self administration of medications on June 6, 2018. Employee O documented assistance with self administration of medications on June 11, 2018. Employee P documented assistance with self administration of medications on May 18, 2018. Employee C, registered nurse case manager was interviewed on 8/07/2019 at 11:25 AM. Employee C that the document titled "Additional Client Preferences" was a communication tool between the family and the caregivers and relayed that the primary care giver left the medications for Patient 7 out and that the aides did administer to Patient 7 per the Client Preference. Employee C relayed that the patient was bed bound, pocketed foods, and required oral suctioning. During interview, the administrator [ADM] entered the room, and relayed that the document titled "Additional Client Preferences" was not part of the clinical record, that the document was information from the family, to be used by the office staff to communicate with the field staff. Per the ADM, the aides are not to administer medications and she will interview those aides that remain employed. 410 IAC 17-14-1(h)(1)(14)			
G 0814 Bldg. 00				

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	Based on record review and interview, the agency failed to ensure the registered nurse made a supervisory visit at least every 60 days, to observe and assess each aide during the provision of care for 1 of 2 closed records reviewed who received only home health aide services. (#7). The findings include The agency's undated policy titled Clinical Supervision of Home Care Aides and LPN's stated, "The agency shall provide Home Care Aide services under the direction and supervision of a registered nurse when personal care services are indicated, ordered by the physician, and in compliance with state and federal regulations ... The home health aide client will have a supervisory visit ... and the aide must be present at least every 60 days." The clinical record for patient #7 was received on 8/06/2019 for review from the administrator [ADM]. The admission referral, dated 11/10/2016, stated under description of services, "All ADL's [activities of daily living] ... choking precautions." The start of care was 11/10/2016. The plans of care [POC] dated 3/18/2019 to 5/16/2018 and 5/17/2018 to 7/15/2018 included diagnosis of Alzheimer disease, polyarthritis, hypertension, and renal insufficiency. Durable medical equipment listed on the POC's included, suction machine, hoyer lift, and hospital bed. Each POC included orders for home heath aide [HHA] services 8 hours per day, 7 days a week, to provide care while primary caregiver slept, mobility by mechanical lift, a hoyer, and stated, "Client requires max [maximum] assist for all activities of daily living, ... cannot transfer,	G 0814	The DON will in-service the RN Case Managers on 9/23/19 on the agency's policy 2.21 and federal guidelines to complete a supervisory visit at least every 30 days, and to observe and assess home health aide during provision of care at least every 60 days. 100% of the supervisory visit documentation will be audited for 60 days and 10% of all home health client records will be audited quarterly thereafter to ensure compliance with this standard. The Administrator, DON, and RN Case Managers will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	09/23/2019

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	prepare meals, or be left alone at any time ... requires care 24 hours a day." Discharge date was 6/14/2018. Documentation of aide spervisory visit notes were dated 4/12/2018 and 6/12/2018, by employee C. The supervisory visit dated 6/12/2018 included documentation that an aide was present during the supervisory visit. The visit note failed to evidence the observation of the aide performing any home health aide services. The documentation of the aide visits for the previous certification period [5/17/2019 to 7/15/2018] were requested. Eight pages of aide visits with time in and out were received on 8/06/2019, from the administrator, and reviewed. The aide visits were logged in the agency's program called Santrax. The log failed to evidence any aide was present in the home on 6/12/2018 as documented on the nurse note dated 6/12/2018. In an interview on 8/06/2018 at 2:10 PM, the ADM indicated there were no documentation of aide supervisory visits found between April 12 and June 12 of 2018. On 8/07/2019 at 11:25 AM, register nurse case manager for Patient 7, Employee C was interviewed. Reviewed the supervision visit notes dated 4/12/2018, 5/15/2018, and 6/12/2018 with employee C. She relayed that she tried to get to the patient's home every 30 days. When asked if and where it was documented that the home health aide services ordered and rendered, were observed during the supervisory visit, employee C indicated there was no documentation and indicated she did not observe the aides render care to Patient 7. Employee C relayed that Patient 7 required little care and that the aides did not do			

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	much with the patient, she described patient 7 as bed bound, non -verbal, pocketed foods, and required oral suctioning.			
G 0948 Bldg. 00	Based on interview, the Administrator failed to ensure Surveys were provided unrestrictive access to electronic patient records persuant to the State Operations Manual Appendix B for 1 of 1 agency. Findings include: During the entrance conference on 8/05/2019, the administrator indicated the agency was using 2 electronic medical record [EMR] systems and the agency did not have a method to provide the Indiana State Department of health surveyor access to either EMR program. Per the ADM, documentation would need to be downloaded and then the agency would print the records requested. When asked if the agency would provide a computer with access to each EMR program, the response was that there were items in the EMR's that they did not wish to share with the state surveyors. On 8/06/2019 at 3:30 PM, the administrator relayed the agency still did not have a method to provide full access of the clinical records to the state agency surveyors.	G 0948	At the time of survey, we were moving from paper and scheduling software to EMR system. Only 30% of our patients were on the new system, and only 50 % of the documentation for the 30% could be viewed in the new EMR system when surveyors arrived. During survey, we used several cases of paper printing years of documents from our cloud storage server, scheduling software, and new EMR system in order to meet the surveyors requests. We have cancelled the EMR system upgrade for this year in order to ensure all regulations are met in 60 days by using our paper and scheduling software. After the survey conducted on 8/7/19, BrightStar felt it was best to return to paper charting until we are able to find an EMR system that meets the needs of agency, the COP guidelines, and the surveyor's requirements. The surveyors will have unrestricted access to all paper charts as always.	11/03/2019
G 0966 Bldg. 00		G 0966	The DON will in-service all RN	09/23/2019

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	Based on observation, interview and record review, the facility failed to assess patient's behavior, which were identified during 2 case conferences, with modifications and/or interventions to address a patient's response of noise verbalization instead of the use of words for 1 of 2 skilled home visits conducted. (Patient 1) Findings include: On 8/6/19 from 8:23 a.m. to 9:40 a.m., a home visit was conducted at patient 1's home. The following was observed: As Patient 1 was sitting at the kitchen table, she was continually vocal with short spurts of noises. Her sister, who was sitting at the table working on her computer, told the client "no barking" with instructions to use words only. The patient continued to be verbal with "barking." When Employee G gave the patient her coffee, he also instructed the patient to use words and to not "bark." As Employee G continued to prepare and administer the patient's medications and tube feeding, she continued to "bark" with periodic corrections to use words by her sister throughout this home visit. During an interview patient 1's sister indicated they were trying to get this behavior corrected to remind patient 1 to use words and not to "bark." Patient 1's clinical record was reviewed on 8/6/19 at 10:15 a.m. The patient's diagnoses included, but were not limited to, Cerebal Palsy, dysphagia, hypothyroidism, unspecified visual loss. The clinical record failed to evidence an assessment of the patient's behavior with modifications and/ or interventions as evidenced by the following: The "CASE CONFERENCE/ COORDINATION OF CARE," dated 5/8/19, signed by the Director of Nursing and the patient's sister indicated the		Case Managers on the need to properly document change in condition and coordinate care with other providers to ensure patient needs are met by 9/23/19. Care Coordination form will be completed for documentation and a case conference will held at a minimum of every 60 days to ensure information is exchanged, pertinent facts are communicated, and goals are evaluated. The agency will ensure all patients are assessed according to state guidelines and when a change in condition or incident occurs. Weekly case conferences will be held to review coordination of care for patients seen and for patients with urgent needs. Care plans will be updates as changes occur. 10% of all home health client records will be audited quarterly to ensure compliance with this standard per agency policy. The Administrator and DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. /p>	

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	following areas were discussed: Recertification Report - no change to the Plan of Care and "moving forward;" and Other - "Behavior mod (modification) - consistency." The goals set for identified concerns included, but were not limited to, to add in daughter input for behavior mod. The skilled/non-skilled interventions established to reach goals were tube feedings and meds as ordered, daily assessments and follow up with the physician if changes, and care conference. No specific behavior interventions were identified. The "CASE CONFERENCE/COORDINATION OF CARE," dated 7/5/19, signed by the Director of Nursing and the patient's sister indicated the following areas were discussed: Coordination of Care - "wants to add behavior mod to future care conf. (conference) discuss (discussions);" the Recertification Report - "no change to the Plan of Care;" and Other - "frequent urinary tract infections, recent gastrointestinal illness." No other behavior information/interventions were indicated. The goals set for identified concerns included, but were not limited to, to add in daughter input for behavior mod. The skilled/ non-skilled interventions established to reach goals were tube feedings and meds as ordered, daily assessments and follow up with the physician if changes, and care conference. No specific behavior interventions were identified. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 7/9/19 to 9/6/19, indicated no information related to the behavior mod model initiated. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 5/10/19 to 7/8/19, indicated the following: "60 DAY SUMMARY: On 5/8/19, the RN Case			

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	Manager collaborated with patient, skilled nurse and caregiver to determine the scope of services, visit frequencies, and duration for the recertification period of 05/10/2019 through 07/08/2019...Family would like caregivers to be consistent with behavior mod model they have initiated. Plan to discuss at upcoming care conference and educate staff...." No further information was indicated related to patient 1's behavior. On 8/7/19 at 1:00 p.m., during an interview the Administrator indicated the patient was to be referred to Speech Therapy. This information was requested. On 8/7/19 at 6:50 p.m., when inquired, no further information was received in regards to the Speech Therapy referral.			
G 0984 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure a gastrostomy tube (G-tube) feeding was administered in a manner to prevent complications with a G-tube for 1 of 2 skilled home visits with observation of a G-tube feeding (patient 1) and failed to ensure that skilled nurse medication administration was provided in accordance with accepted professional standards of practice for 1 of 2 home observations of a skiled nurse (patient 3). Findings include: 1. The "Administration of Enteral Feedings, Gastrostomy or Jejunostomy Tube" policy was	G 0984	DON will provide individual in-service with the RN noted to review orders and standards of care by 9/27/19. Follow-up observation of these skills by RN noted will be performed by DON and documented within 30 days. The DON will also in-service all nursing staff on g-tube feedings/medication administration per agency policy by 11/23/19. The DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/23/2019

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	provided by the Administrator on 8/7/19 at 5:10 p.m. This current policy indicated the following: "Gastric feeding by gastrostomy tube is relatively safe to administer provided gastric emptying is normal... Procedure ...7. Bolus or Intermittant (sic) Feeding Syringe: ...B. Attach syringe to end of tube and fill with formula. c. Elevate syringe above patients head, open tube and allow emptying gradually. d. Continue to refill syringe and administer the prescribed amount of formula...." 2. On 8/6/19 from 8:23 a.m. to 9:40 a.m., a home visit was conducted at patient 1's home. The following was observed: In preparation of patient 1's medications, the crushed Levothyroxine medication was added to the liquid CoQ medication. Next, an unmeasured amount of water was added to the "Real Food" tube feeding. After Employee G, , registered nurse, vented patient 1's G-tube (gastrostomy tube), the tip of a 60 cc (cubic centimeters) syringe was attached to the G-tube. With the syringe plunger patient 1's medications were pushed through the G-tube followed with the diluted "Real Food" tube feeding, and then, the water flush. No gravity was utilized to administer the medications or tube feeding. During an interview Employee G indicated during his orientation, the medications and feedings were pushed in utilizing the syringe and not gravity. Employee G indicated he had not tried gravity. The patient's sister indicated when she had seen gravity used in the past, the medications and feedings had taken 20 minutes to 1 hour to do it by gravity. On 8/7/19 at 2:58 p.m., during an interview the			

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	Director of Nursing indicated gravity should be used to administer a resident's tube feeding unless the feeding was too thick. She indicated she had not observed patient 1's tube feeding being administered. 3. A home observation was conducted on 8/6/2019 at 8:25 AM. During the observation, employee I, a registered nurse, administered medications to patient #3 without any medication profile or Medication Administration Record (MAR) present. During interview with employee I, on 8/6/2019 at 8:25 AM, she stated that she administers medications all the time for this patient and knows the medications by heart. The employee stated that she goes to the office every Monday to turn in paperwork, get supplies and any documentation for the patient. An interview was conducted on 8/6/2019 at 11:15 AM, with employee A, employee B and employee F. Employee A indicated that she agreed with the discrepancy. Additionally, employee A stated that employee I giving medications from memory was a problem that she had with another RN as well in the past, but she will re-educate this employee as well. She indicated that the process was supposed to include the use of the employee table since the most current profile is there and not in the home.			
G 1012 Bldg. 00	Based on record review and interview, the agency failed to ensure that the clinical record included physician orders for 1 of 2 active pediatric records reviewed with orders for skilled nurse services. (3)	G 1012	The DON and RN Case Managers reviewed the policy for Physician Orders on 9/19/19. All orders include findings of their assessments, including the level	09/19/2019

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	Findings Include: Review of clinical record #3, included a plan of care established by the physician for the certification periods 7/9/2019 through 9/6/2019. Page 2 of 3, section entitled "Skin Integrity" stated "keep area around G-tube clean and dry, change per MD order." Clinical record failed to evidence a specific and detailed physician order for changing the G-tube or the area around the G-tube. Interview with Employee A was conducted on 8/6/2019 at 11:15 AM, she stated that there was not a physician order on the chart as mom changed, provided site care, responded that it should be documented on the plan of care, and would be going forward. 410 -IAC - 17-15-1(a)(1)-(7)		of assistance required, equipment needed, and person responsible for services required will be designated. 100% of the client records will be audited for completeness and continuity of physician orders in the next 60 days and 10% of all home health client records will be audited quarterly thereafter 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.	
G 1022 Bldg. 00	Based on record review and interview, the agency failed to ensure a discharge summary was submitted to the primary care physician at discharge for 1 of 2 closed records reviewed, who received only aide services. (#7). The findings include: The clinical record for patient #7 was received on 8/06/2019 for review. The start of care date was 11/10/2016. The plan of care dated 5/17/2018 to 7/15/2018 included diagnosis of Alzheimer disease and orders for home heath aide [HHA] services 8 hours per day, 7 days a week to provide care while	G 1022	The DON will in-service all RN Case Managers on 9/23/19 on the need to properly document the discharge of a patient. A discharge summary will be sent to the primary care physician within 5 business days of the patient's discharge. 10% of all home health 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.	09/23/2019

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	primary caregiver slept, mobility by mechanical lift, a hoyer, and stated, "Client requires max [maximum] assist for all activities of daily living, ... cannot transfer, prepare meals, or be left alone at any time ... requires care 24 hours a day." An undated document titled "Additional Client Preferences" stated under daily routine, "Meds [Medication] - crush and put in applesauce or with shake." The record failed to evidence a physican order to discharge from home health services nor documentation of a transfer of care to the hospice. Patient 7 died on 6/28/2018. On August 7, 2019 at 4 PM, the administrator indicated the patient was admitted to the hospice and did not return to the agency. 410 IAC 17-15-1(a)(6)			
G 1024 Bldg. 00	Based on interview and record review, the agency failed to ensure the documentation in the clinical records were complete and accurate for 1 of 6 active clinical records reviewed (patient #1) and failed to ensure that clinical records were authenticated for 1 of 2 active records reviewed with orders for only home health aide services (patient 6). Findings include: 1. Patient 1's clinical record was reviewed on 8/6/19 at 10:15 a.m. The patient's diagnoses included, but were not limited to, Cerebal Palsy, dysphagia, hypothyroidism, unspecified visual loss.	G 1024	Administrator and DON reviewed the policy 9/17/19 and will in-service the RN Case Managers and all nursing staff on clinical record standards by 9/27/19. All entries will be legible, clear, complete, and appropriately authenticated with title that is dated and timed. Agency will audit 100% within 60 days and continue this process until all nursing staff are in compliance. 10% of all home health client records will be audited quarterly thereafter to ensure compliance with this standard. The DON will be responsible for monitoring these corrective actions to ensure that	09/27/2019

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	The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 5/10/19 to 7/8/19, indicated patient 1 was allergic to "Flexeril and Sulfa (antibiotic)." The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" with the certification period of 7/9/19 to 9/6/19, indicated patient 1 was allergic to "Flexeril (muscle relaxant), Keflex (antibiotic)." The "Care Summary" indicated the patient had received Keflex last month for a urinary tract infection "with no further issue." The dated 7/1, 7/6, 7/7, 7/10, 7/11, 7/12, 7/15, 7/20, 7/21, 7/24, 7/27, and 7/28/2019 "Skilled Nursing Visit Note" photocopies did not include the "Time In" or "Time Out" for the skilled nursing visits. In these photocopies nursing visits the "SKILLED PROCEDURES/ PROGRESS NOTES" indicated an 8:30 (no a.m. or p.m.) arrival date with no other times given. 2. Patient 6 record review evidenced the HHA Supervisory Visit Forms for dates of 05/21/2019, 04/25/2019, and 03/24/2019 does indicate that the aide was present for these visits, but there was no signature from the HH aide for any of the above dates. Record review of the plan of care of Patient 6, for certification period 07/24/2019 through 9/21/2019, did not include the clinician's signature nor the attending physician's signature. An interview was conducted on 08/07/2019 with employee A and employee B. Employee A concurred that the documents should have been signed, that the signatures were missing. 410 IAC 17-15-1(a)(7)		this deficiency is corrected and will not recur.	

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N 0000 Bldg. 00	This was a state re-licensure home health survey with two complaints. Survey Dates: August 5, 6,and 7, 2019 Complaints: IN00260591 - unsubstantiated, lack of sufficient evidence IN00288278 - unsubstantiated, unsubstantiated, lack of sufficient evidence, patient not found on active or closed census Facility #: IN011449 Medicaid Vendor #: 201171470 Provider #: 15K107 Admission Census: 13 Total Active Census: 47 Active Skilled: 02 Active aide only: 35	N 0000		
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.			

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	Based on record review and interview, the agency failed to ensure each employee who will have direct patient contact had a physical examination by a physician or nurse practitioner, not more than 180 days before the employee had direct patient contact for 1 of 1 record review of the director of nursing. (Employee A). The findings include: The personnel record of Employee A with date of hire 3/20/2019 and first patient contact date 04/01/19, failed to evidence a physical exam of sufficient scope to ensure the employee will not spread infections or communicable disease. The file evidenced a letter from a physician, dated March 27, 2019, which stated, "In my medical opinion ... can work with no restrictions ... last physical exam was 5/03/2018." Reviewed findigs with the administrator on 8/07/2019 at 4:25 PM. On 8-07-2019 at 7:15 PM, the administrator indicated the human recourses used the letter from the physician as the physical exam.	N 0462	The Administrator will in-service all HR staff on 9/23/19 on the need to ensure all new employees must have a physical exam of sufficient scope to ensure the employees will not spread infections or communicable disease no more than 180 days prior to first patient contact. As of 9/23/19, HR Manager will review all new hire documentation after completion of orientation to ensure each employee record contains a physical exam of sufficient scope no more than 180 days prior to first patient contact. All charts were audited by 10/4/19. All employees found without adequate physicals or proper documentation will be removed until the deficiency is corrected. In addition, 10% of all employee records per agency policy will be audited quarterly to ensure this deficiency is corrected and will not recur. Administrator will be responsible for monitoring these corrective actions.	09/23/2019
N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test			

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	using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis			

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	examination within the previous twelve (12) months. Based on record review and interview, the agency failed to ensure that the clinical manager, who had direct patient contact, had documentation of a tuberculosis evaluation which includes a baseline two-step test (TST) or documentation of a negative TST during the past 12 months, or a chest x-ray with documentation of no active disease in 1 of 1 clinical manager record reviewed (Employee A). The findings include: The personnel record of the director of nursing, Employee A with first patient contact date 04/01/19, failed to evidence a negative record of TST testing, or chest x-ray since date of hire 3/20/2019. Reviewed findigs with the administrator on 8/07/2019 at 4:25 PM who relayed that employee A previous employer used only the risk assessment and that was what the human resource director used as the baseline screening. On 8-07-2019 at 7:15 PM, the administrator stated that she had forgot to ask the director of nursing if she had documentation of a negative TST screen history or a chest x-ray. The Director of Nursing indicated she had only completed annual risk assessments with her previous employer and did not have a TST nor a recent chest x-ray.	N 0464	The Administrator will in-service all HR staff on 9/23/19 the need to ensure all new employees must have a tuberculosis evaluation which includes a baseline two-step test (TST) or documentation of a negative TST during the past 12 months, or a chest x-ray with documentation of no active disease prior to patient contact. As of 9/23/19, HR Manager will review all new hire documentation after completion of orientation to ensure each employee record contains a tuberculosis evaluation which includes a baseline two-step test (TST) or documentation of a negative TST during the past 12 months, or a chest x-ray with documentation of no active disease, prior to first patient contact. All charts were audited by 10/4/19. All employees found without adequate or proper documentation will be removed until the deficiency is corrected. In addition, 10% of all employee records per agency policy will be audited quarterly to ensure this deficiency is corrected and will not recur. Administrator will be responsible for monitoring these corrective actions.	09/23/2019
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e)			

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	(e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on document review and interview, the home health agency failed to ensure a description of the most current description of the applicable Indiana state law regarding Advanced Directives, updated 11/01/2018, was provided to all patients of the agency for 1 of 1 agency. The findings include: The administrator provided the agency admission documents in a red folder following the entrance conference on 8/05/2019. The packet included the previous version of the Indiana Advance Directives, dated July 1, 2013. Interview with Employee B on 08/06/2019 at 12:15 PM, she stated that documentation was provided electronically and understood that written evidence of receipt was no longer required. No evidence of the receipt of electronic notification and patient preference for receipt of information was provided for review by survey exit. The Administrator produced a copy of the letter which she relayed was mailed by regular United States Postal Service to each patients home in November 2018, with instructions to review the revised Indiana State regarding Advance Directives and direction on how to log onto the Client Portal to review their plan of care, schedules, Service Plans, Emergency Plan, Transportation Waiver, Home	N 0518	The DON will in-service the RN Case Managers on 9/19/19 on the need to furnish and educate all home health patients with the most current description of the applicable Indiana state law regarding Advanced Directives, updated 11/01/2018, and obtain patient/POA signature of receipt and understanding. RN Case Managers will ensure all home health patients understand and receive a copy of the Advanced Directives by or at their next re-certification visit beginning 9/23/19. All home health patients will have the updated Advanced Directives by 11/23/19. The DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	11/23/2019

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	Health Aide Task List, Physican Orders, Medication Lists, and Admission Packet which included information and education on Infection Control, medication management, patient rights, and management of care within the agency.			
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on document review and interview, the agency failed to ensure the registered nurse made a supervisory visit at least every 30 days, to observe and assess each aide during the provision of care for 1 of 2 closed records reviewed who received only home health aide services. (#7). The findings include The agency's undated policy titled Clinical Supervision of Home Care Aides and LPN's stated, "The agency shall provide Home Care Aide services under the direction and supervision of a registered nurse when personal care services are indicated, ordered by the physician, and in compliance with state and federal regulations ... The home health aide client will have a supervisory visit every 30 days." The clinical record for patient #7 was received on 8/06/2019 for review from the administrator [ADM]. The admission referral, dated 11/10/2016,	N 0606	The DON will in-service the RN Case Managers on 9/23/19 on the agency's policy 2.21 and federal guidelines to complete a supervisory visit at least every 30 days, and to observe and assess aide during provision of care at least every 60 days. 100% of the supervisory visit documentation will be audited in the next 60 days and 10% of all home health client records will be audited quarterly to ensure compliance with this standard. The Administrator and DON will be responsible for monitoring these client records to ensure this deficiency is corrected and does not recur.	09/23/2019

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	stated under description of services, "All ADL's [activities of daily living] ... choking precautions." The start of care was 11/10/2016. The plans of care [POC] dated 3/18/2019 to 5/16/2018 and 5/17/2018 to 7/15/2018 included diagnosis of Alzheimer disease, polyarthritis, hypertension, and renal insufficiency. Each POC included orders for home heath aide [HHA] services 8 hours per day, 7 days a week, to provide care while primary caregiver slept, mobility by mechanical lift, a hoyer, and stated, "Client requires max [maximum] assist for all activities of daily living, ... cannot transfer, prepare meals, or be left alone at any time ... requires care 24 hours a day." Discharge date was 6/14/2018. Supervisory aide visits notes were dated 4/12/2018, 5/15/2018, and 6/12/2018 by employee C. In an interview on 8/06/2018 at 2:10 PM, the Administrator indicated there was no documentation of aide supervisory visits found between April 12 and May 15, 2018. On 8/07/2019 at 11:25 AM, registered nurse case manager for Patient 7, Employee C was interviewed. Reviewed the supervision visit notes dated 4/12/2018 and 5/15/2018 with employee C. She relayed that she tried to get to the patient's home every 30 days.			
N 9999 Bldg. 00	Based on interview, the agency failed to evidence they developed a policy and proceedure to comply with the Indiana State requirement, pursuant to Indiana Code 16-27-2.5, effective 7/01/2017 for 1 of 1 agency.	N 9999	BrightStar Healthcare was following our policy on drug screening at the time of the survey. After further review, our policy met Indiana Code 16-27-2.5. BrightStar has a	08/07/2019

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	The findings included: On 8/06/2019 at 3:35 PM, the administrator relayed that the agency was not aware of the requirement related to drug screens pursuant to Indian Code 16-27-2.5.		written drug testing policy that is distributed and acknowledged by all employees during orientation. All BrightStar employees are drug screened upon hire and also if there is suspicion that an employee is engaged in the illegal use of a controlled substance.	