STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR HEALTHCARE	9102 N MERIDIAN STREET STE 100 , INDIANAPOLIS, Indiana, 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 Survey Dates: 05/20/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/27/2025, and 06/03/2025. Active Census: 46 At this Emergency Preparedness survey, Brightstar Healthcare was found in compliance with the Emergency Preparedness Requirements for Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR by Area 3 on 6/6/2025.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal and State licensure complaint of a home health provider. Complaint # IN00115639 Survey Dates: 05/20/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/27/2025, and 06/03/2025. Unduplicated 12-month Skilled Admissions: 64 An Immediate Jeopardy, identified at §484.50 Patient Rights began on 01/28/2025, when it was identified the agency failed to ensure a patient received ordered 24-hour care and passed away on 01/28/2025, while unattended in a house fire. On 01/28/2025 HHA #1 had completed their shift with Patient #1 and left the patient's home between 8:10 - 8:15 AM. Between 8:45-8:50 AM, LPN #1 arrived at Patient #1's place of residence, saw smoke coming from the home and called 911. The patient was left unattended, without a home health staff member, for 35 minutes. Fire Incident and Coroner reports confirmed, Entity 2, a local fire department was dispatched at 8:54 AM, arrived on the scene at 8:59 AM, and the patient was pronounced dead	G0000		

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G0000	Continued from page 1 at 9:09 AM. Interview with Person 3, the responding Fire Captain, confirmed patient was found dead and alone in the home. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 05/23/2025 at 11:06 AM. The provider submitted a removal plan on 05/26/2025, which was found to be unacceptable, and again on 05/30/2025 at 6:59 PM which was acceptable. The Immediate Jeopardy was removed on 06/03/2025 at 11:55 AM. BrightStar HealthCare is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 06/03/2025 through 06/02/2027 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights, 484.60 Care Planning, coordination, quality of care, and 484.65 Quality assessment and performance improvement (QAPI). These deficiencies reflect State Findings cited in accordance with 410 IAC 17. See the State Form for State only deficiencies. Abbreviations used: RN - Registered Nurse POC - Plan of Care SOC - Start of Care HHA - Home Health Aide LPN - Licensed Practical Nurses DON - Director of Nursing QR by Area 3 on 6/06/2025.	G0000		
G0406	Condition of Participation: Patient rights. CFR(s): 484.50	G0406		

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G0406	Continued from page 2 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure patient rights were maintained; failed to ensure a patient's were free from neglect (see G0430), and failed to ensure services were provided as ordered in the POC (see G0436) for 1 of 1 patient death's reported. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services, which could result in the agency not providing quality care. These practices had the potential to impact all 46 active home health patients serviced by the agency. Findings include: 1. Review of the clinical record for Patient #1 with a start of care date 06/13/2019, and a recertification period of 12/16/2025 to 02/13/2025, with a primary diagnosis of quadriplegia (paralysis that affects all a person's limbs and body from the neck down), indicated the patient was bedbound, required complete assist w/transfers, extensive assist w/dressing/grooming, bathing/hygiene, incontinence care, lived alone, and had minimal family/outside supports. The record indicated the patient was to receive home health aide services 24 hours per day, 7 days per week. 2. A review of a Fire Incident report, provided by Person 3, dated 01/28/2025 indicated Entity 2, a local fire department, was dispatched on 01/28/2025 to "residence fire with entrapment" at 8:54 AM, and arrived at Patient #1's home at 8:59 AM. A section titled 'IGNITION' stated, "… Area of Origin … Bedroom … Heat Source … Candle … Item First Ignited … Bedding; blanket, sheet, comforter … Cause of Ignition … Unintentional … Factors Contributing to Ignition 1 … Heat source too close to combustibles … Human Factors Contributing to Ignition … Unattended or unsupervised person …"	G0406		

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G0406	Continued from page 3 A review of Entity 5's, a local county coroner office, 'Field Deputy Report', provided by Person 3, dated 01/29/2025 confirmed Patient #1's time of death was pronounced at 9:09 AM. A review of Entity 5's 'Report of Examination', provided by Person 3, dated 01/29/2025, indicated Patient #1 had cocaine and cannabis in their system. "CAUSE OF DEATH Arteriosclerotic and hypertensive cardiovascular disease … MANNER OF DEATH Natural … COMMENT Based upon the scene and circumstances of the death as currently known, combined with the autopsy and toxicology findings, the cause and manner of death are determined as above …" 3. On 05/21/2025 at 10:33 AM, in an interview with HHA 1, indicated on their last shift with Patient #1, they left the home between 8:10-8:15 AM, and it was not uncommon for HHA 1 to leave the patient, and the next aide was not yet there. On 01/28/2025, HHA 1 did not know who was coming next or when, but knew the next shift was filled. HHA 1 set up the patient's bedside table with needed items, including the patient's cigarettes, and ensured their candle was "on", noted the patient would have the aides start a new candle if the current one "was almost finished" and had a candle going all the time to be able to light their cigarettes independently. HHA 1 indicated when she left the patient, they were awake, sitting up in bed, smoking. On 05/21/2025 at 8:36 AM, during an interview, Person 3, the responding Fire Captain with Entity 2, a local fire department, confirmed 01/28/2025 Patient #1 was found dead and alone in their home. On 05/21/2025 at 10:50 AM, during an interview, LPN 1 indicated was scheduled to see Patient 1 on 01/28/2025, arrived between 8:45-8:50 AM to see smoke coming from the home and called 911. On 05/21/25 at 11:08 AM, during an interview, RN 1, case manager for Patient #1, indicated the patient was to have home health aides 24/7, and should not be left alone. When queried as to how the agency ensured 24/7 coverage, indicated 'that's scheduling'. On 05/21/2025 at 11:30 AM, during an interview, the ADMIN and DON indicated they were aware the patient had	G0406		

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G0406	Continued from page 4 been left alone at times. On 05/21/2025 at 3:30 PM, during an interview with Administrative Staff 6 and the Administrator, Administrative Staff 6 indicated the patient's schedule was created based on the authorization from Entity 11, the patient's payor source, shifts were 10 hour days with 14 hour nights, and would try to ensure someone could come early or leave later to cover when there might be lapses, however schedules were not overlapped or staggered. The Administrator indicated the AM shift for 1/28/2025 was to start at 8:00 AM, the assigned staff was not available until 10:00 AM. On 05/21/2025 at 3:46 PM, during an interview, the Administrator indicated the agency was aware of the upcoming lapse of coverage the evening of 1/27/2025 and had also informed the patient, who was agreeable. The Administrator indicated the nurse already scheduled to see the patient on 1/28/2025 was contacted to move visit up to 9:00 AM. The Administrator indicated was aware there had been a 35 minute lapse in the patient's care that morning. On 05/22/2025 at 2:45 PM, during an interview, the ADMIN and DON were queried as to how Patient #1 could have gotten drugs in their system while receiving 24-hour care, the DON indicated it was possible an aide was doing laundry in the back of the home or had not been at bedside with patient. Indicated employees have not reported drug use, just hints and smells of marijuana.	G0406		
G0430	Be free from abuse CFR(s): 484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure a patient's right to remain free from neglect, harm, and death, in 1 of 2 bedbound patients reviewed. (Patient #1) Findings include:	G0430		

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G0430	Continued from page 5 1. A review of an agency policy titled 'Rights and Responsibilities Policy' stated, "… The establishment and revision of the plan of care, including the disciplines that will furnish the care and the frequency of visits … 11. The right to be free from … neglect …" 2. Review of clinical record for Patient #1 with a start of care date 06/13/2019, a recertification period of 12/16/2024 to 02/13/2025, with a primary diagnosis of quadriplegia (paralysis that affects all a person's limbs and body from the neck down) was bedbound, required complete assist w/transfers, extensive assistance w/dressing/grooming, bathing/hygiene, incontinence care. Lived alone, minimal family/outside supports. Resumption of Care Physician Orders dated 02/21/2024 indicated orders for Home Health Aide services were 24 hours per day 7 days per week. The record evidenced serial home health aide visit notes and skilled nurse visit notes, which indicated home health services had been provided: On 1/23/2025, from 8:00 AM-6:00 PM, and 7:58 PM-6:00 AM. The patient was without an aide present for 1 hour and 58 minutes. On 1/24/2025, from 7:40 AM-6:00 PM, and 6:00 PM-8:00 AM. The patient was without an aide present for 1 hour and 40 minutes. On 1/26/2025, from 8:10 AM-6:09 PM, and 8:04 PM to 6:03 AM. The patient was without an aide present for 8 minutes, and later, for 1 hour and 55 minutes. On 1/27/2025, the patient did not receive care until 5:39 PM-8:15 AM, with an LPN visit occurring 10:37 AM - 11:49 AM. The patient was without care during the day for 10 hours and 24 minutes. On 05/21/2025 at 10:33 AM, during an interview with HHA #1, indicated their last shift with Patient #1, was from 6:00 PM the previous evening, ended at 8:00 AM the morning of 01/28/2025, and had left the home between 8:10-8:15 AM. HHA #1 indicated it was not uncommon to leave the patient alone prior to the next aide arriving. They did not know who was coming for the next shift or when, but knew the next shift was filled. HHA	G0430		

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G0430	Continued from page 6 #1 reported they had set up the patient's bedside table with needed items, including the patient's cigarettes, and ensured patient's candle was "on", noted that Patient #1 would have the aides start a new candle if the current one "was almost finished", and the patient had a candle going all the time to be able to light the cigarettes independently. On 05/21/2025 at 11:08 AM, during an interview, the RN Case Manager/Assistant Director of Nursing indicated Patient #1, was to have home health aide services 24 hours per day 7 days per week, and should not be left alone. During an interview on 05/21/2025 at 11:30 AM, the Administrator reported Patient #1 was left alone at times at the Patient's request and confirmed Patient #1 did have an order for 24 hour care. The Administrator indicated missed visits were communicated to the insurance company case managers handling Patient #1's workman's compensation. During an interview on 05/21/2025 at 3:32 PM, Administrative staff #6 reported Patient #1 was to receive 24 hour care for 7 days a week and the shifts where scheduled for 14 hours overnight and 10 hours for days to ensure there were no lapses in service. The shifts were 8:00 AM to 6:00 PM and 6:00 PM until 8: 00 AM. The Administrator also reported on January 28th, 2025 the agency was aware there would be a gap in Patient #1's schedule from 8:00 AM until 10:00 AM. The patient was aware of this the night before and contacted a nurse to come at 9:00 AM and reported the Aide stayed until 8:15 AM with the nurse arriving at about 8:50 AM, leaving a 35 minute gap. On 05/22/2025 at 11:45 AM, during an interview, when queried as to whether they were aware the patient kept a candle lit, the Administrator indicated they were aware. When queried as to whether staff had been educated against keeping the candle lit, indicated no education had been provided to staff. On 05/22/2025 at 1:57 PM, during an interview, HHA 8 indicated they had cared for Patient #1 and would sometimes go and get the patient something to eat, would light cigarettes for the patient as they could not do this for themselves, and stated the patient "would have us pick up candles" at the store and the	G0430		

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G0430	Continued from page 7 patient would have to stay by themselves and be alone for that time. When queried as to whether they knew the patient was a 24 hour per day 7 day per week patient, indicated, "I don't know, it was never told to me, if so I would have wanted to know … was under the impression [Patient #1] could be left alone for a bit". On 05/22/2025 at 2:06 PM, during an interview, RN 4 indicated had cared for Patient #1 on occasion and when queried as to whether the patient should have been left alone, stated "probably not, [Patient #1] was completely bedbound". Indicated patient was chain smoker, would light cigarettes with the candle, and had a candle going constantly while awake. When queried as to whether there had been occasions when the aide was not present when RN 4 arrived for a nursing visit, RN 4 confirmed there were times an aide was not present, as their arrival time may have fallen during 4:30 - 5:30 PM, "between day and evening shift". On 05/22/2025 at 2:44 PM, during an interview, HHA 2 confirmed had cared for Patient #1, and would run errands, go out to get food, or get cigarettes for the patient and the patient would be left alone at those times. Indicated the patient was a heavy smoker, could hold a cigarette in his left hand, and could extinguish it in the ashtray. The patient could light the cigarettes themselves with a candle, and kept a candle lit. HHA 2 indicated when they would arrive to the home a candle was going all the time, "before I came, after I left". Indicated was aware this was a 24/7 case, when they arrived sometimes there was another HHA, sometimes not. Same when leaving. Indicated that some evenings there would be an aide to relieve them, but the arrangement did not involve having the next shift come early or stay late to ensure coverage. 410 IAC 17-12-3(b)(4)(A)	G0430		
G0436	Receive all services in plan of care CFR(s): 484.50(c)(5) Receive all services outlined in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide services as ordered in the Plan of Care for Patient #1 a bedbound patient with quadriplegia (paralysis that affects all a person's limbs and body	G0436		

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G0436	Continued from page 8 from the neck down), for 1 of 2 bedbound patients' clinical records reviewed. (Patient #1) Findings include: 1. A review of an agency policy titled 'Rights and Responsibilities Policy' stated, "… The establishment and revision of the plan of care, including the disciplines that will furnish the care and the frequency of visits …" A review of an agency policy titled, 'Missed Visits Policy' stated, "… Missed visits will be communicated to the client's Licensed Prescriber or designee … Missed visits will be documented as an incident report and uploaded into the client's chart … If a visit is missed for any reason, the clinician should attempt to reschedule it for the same day or week so that the Licensed Prescriber ordered frequency is maintained and would not be considered a missed visit …" 2. A review of the clinical record for Patient #1 with a start of care date of 06/13/2019, a recertification period of 12/16/2025 to 02/13/2025, and a primary diagnosis of quadriplegia (paralysis that affects all a person's limbs and body from the neck down) the comprehensive assessment dated 12/16/2024 indicated the patient was bedbound, required complete assistance with transfers, extensive assistance with dressing/grooming, bathing/hygiene, incontinence care. The patient lived alone, and had minimal family/outside supports. Review of the record failed to evidence documentation of missed visit or lapses in care being reported to the patient's physician. The record contained 'Resumption of Care Physician Orders' dated 02/21/2024 which evidenced orders for Home Health Aide services 24 hours per day 7 days per week. The record evidenced an authorization from Entity 11 (payor source), dated 12/18/2020 which indicated the patient was to receive home health aide services "24/7".	G0436		

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G0436	Continued from page 9 The record contained a plan of care dated 12/16/2024 for the recertification period of 12/16/2024 to 02/13/2025 which failed to evidence the frequency and duration for the home health aide services ordered. The record evidenced serial home health aide visit notes and skilled nurse visit notes, which indicated home health services had been provided: On 1/23/2025, from 8:00 AM-6:00 PM, and 7:58 PM-6:00 AM. The patient was without an aide present for 1 hour and 58 minutes. On 1/24/2025, from 7:40 AM-6:00 PM, and 6:00 PM-8:00 AM. The patient was without an aide present for 1 hour and 40 minutes. On 1/26/2025, from 8:10 AM-6:09 PM, and 8:04 PM to 6:03 AM. The patient was without an aide present for 8 minutes, and later, for 1 hour and 55 minutes. On 1/27/2025, the patient did not receive care until 5:39 PM-8:15 AM, with an LPN visit occurring 10:37 AM - 11:49 AM. The patient was without care during the day for 10 hours and 24 minutes. 3. On 05/21/2025 at 10:33 AM, in an interview with HHA #1, indicated their last shift with Patient #1, was from 6 PM the previous evening, ended at 8 AM the morning of 01/28/2025, and had left the home between 8:10-8:15 AM. HHA #1 indicated it was not uncommon to leave the patient and the next aide would not be there yet, and indicated did not know who was coming for the next shift or when, but knew the next shift was filled. HHA #1 indicated had set up the patient's bedside table with needed items, including the patient's cigarettes, and ensured patient's candle was "on", noted that Patient #1 would have the aides start a new candle if the current one "was almost finished", and the patient had a candle going all the time to be able to light the cigarettes independently. On 05/21/2025 at 11:08 AM, during an interview, RN 1 indicated had been the case manager for Patient #1 who was to have home health aide services 24 hours per day 7 days per week, and should not be left alone. When queried as to how the agency ensured 24-hour coverage, RN 1 indicated 'that's scheduling'.	G0436		

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G0436	Continued from page 10 On 05/21/2025 at 11:30 AM, during an interview, the Administrator and DON indicated they were aware the patient had been left alone at times. On 05/21/2025 at 3:30 PM, during an interview, Administrative Staff 6 indicated Patient #1's schedule was created based on the patient's insurance, Entity 11's, authorization, shifts were 10 hour days with 14 hour nights, and would try to ensure someone could come early or leave later to cover when there might be lapses. Schedules were not overlapped or staggered. On 05/21/2025 at 3:36 PM, during an interview, when queried as to whether the MD for Patient #1 had been made aware when the patient's hours could not be fulfilled or visits had been missed, the Administrator indicated that no missed visits had been reported to the MD. On 05/22/2025 at 2:06 PM, during an interview, RN 4 indicated had cared for Patient #1 on occasion and when queried as to whether the patient should have been left alone, indicated "probably not, [Patient #1] was completely bedbound". When queried as to whether there had been occasions when the aide was not present when RN 4 arrived for a nursing visit, RN 4 confirmed there were times an aide was not present, as their arrival may have fallen during 4:30 - 5:30 PM, "between day and evening shift". On 05/23/2025 at 12:51 PM, during an interview with Person 10, a nurse practitioner for Person 12, the physician for Patient #1, indicated there were no records on file of communication from the home health agency notifying the doctor when hours had not been fulfilled or when visits had been missed for Patient #1.	G0436		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any	G0570		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0570	Continued from page 11 revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to include all elements required in the Plans of Care (see G0574), and failed to ensure MD was notified with changes in patient's condition (see G0590). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services, which could result in the agency not providing quality care. These practices had the potential to impact a total 46 active home health patients serviced by the agency. *	G0570		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted;	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025

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G0574	Continued from page 12 (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the POC had correct certification periods, duration of services, all services the agency provided, prognosis, hospitalization risk, and rehabilitation potential for 4 of 5 active records reviewed (Patients #3, #4, #5, and #6), and 1 of 2 closed records reviewed (Patient #1). Findings Include: 1. A review of an agency policy titled 'Care Planning Process Policy' stated, "… 3. Based on the assessment and conclusions, the plan of care will include, but not be limited to: … D. Specific services and treatments to be provided … F. Type, frequency, and duration … N. Prognosis …" 2. A review of the clinical record for Patient #1 with a start of care date of 06/13/2019, contained a recertification period of 12/16/2025 to 02/13/2025, contained comprehensive assessment dated 12/16/2024, with a primary diagnosis of quadriplegia (paralysis that affects all a person's limbs and body from the neck down) indicated the patient was bedbound, required complete assistance with transfers, extensive	G0574		

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G0574	Continued from page 13 assistance with dressing/grooming, bathing/hygiene, and incontinence care. The patient lived alone, with minimal family/outside supports. The record contained a 'Home Health Certification and Plan of Care' dated 12/16/2024 which failed to evidence the frequency and duration for home health aide services. The record contained 'Resumption of Care Physician Orders' dated 02/21/2024 which evidenced orders for Home Health Aide services 24 hours per day 7 days per week. The record contained a 'Home Health Certification and Plan of Care' signed and dated by RN 1 on 12/17/2024 for the recertification period of 12/16/2024 to 02/13/2025 (59 days), the document failed to evidence an accurate certification period, and failed to evidence the frequency and duration for the home health aide services ordered. On 05/27/2025 at 10:12 AM, RN 1, when queried regarding recertification periods on the Plan of Care, indicated, the way their system works, the day a recertification assessment is completed, becomes the first day of the new certification period, the agency's electronic medical records system was doing that and, "we can't change that". On 05/27/2025 at 10:51 AM, the DON indicated was aware that certification periods were 60 days long, recert visits needed to be completed in the 5-day window previous to the end of the certification period, and was also aware the agency's electronic medical records system would automatically change the dates of the next certification period. The system would make the first day of new certification period, the day the recertification visit was completed, failing to ensure the certification dates were accurate. The DON indicated the agency had tried to fix this, but there was no way to do so. On 05/27/2025 at 1:10 PM, the DON was queried as to patient plans of care with missing frequency and durations for disciplines, the DON indicated the frequencies and durations were not there, and they should be.	G0574		

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G0574	Continued from page 14 3. Review of the clinical record for Patient #3 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 10/25/2023 for the certification period of 02/05/2025 through 04/05/2025 and signed by RN 3. Review of the clinical record for Patient #3 revealed a recertification assessment dated 02/05/2025 and signed by RN 3. Review of the clinical record for Patient #3 revealed a recertification assessment dated 04/02/2025 and signed by RN 2. The assessment indicated Patient #3 has a tracheostomy (a surgical procedure where an opening is made in the trachea (windpipe) to create a new airway for breathing), uses a cough vest, and has a feeding tube. Review of the clinical record for Patient #3 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 10/25/2023 for the certification period of 04/02/2025 through 05/31/2025 and signed by RN 2. The POC evidenced Patient #3 has the following diagnosis but is not limited to, mandibulofacial dysostosis (also known as Treacher Collins Syndrome, which is a rare genetic disorder characterized by malformations of the skull, facial bones, and parts of the ear; it specifically affects the growth of bones in the face leading to underdeveloped cheekbones and jaw), Cleft palate (a birth defect where there's an opening in the roof of the mouth (palate)), and seizure disorder (a neurological (brain) condition characterized by recurrent seizures, which are sudden, brief episodes abnormal electrical activity in the brain that can cause changes in behavior, sensations, awareness, and muscle movements). The POC evidenced a blank surgical procedure subsection. The POC subsection titled "DME and Supplies" evidenced diapers, brace, cane, other - Mickey button (also known as a Mic-Key button, is a low profile, button-like gastrostomy tube, a type of feeding that allows nutrition, fluids, and medication to be delivered directly into the stomach through an opening in the abdominal wall), Infinity pump (a pump used to deliver tube feedings to an individual through a gastrostomy tube), nebulizer (device used to produce a fine spray of liquid used for inhalation of a medication), gloves, and suction. The POC subsection titled "Safety Measures" indicated but is not limited	G0574		

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G0574	Continued from page 15 to " … Seizure Precautions …" The POC subsection titled "Orders for Treatment and Discipline" evidenced but is not limited to treatments for the SN to perform, and " … Other, SN Skilled Nursing as needed, attend MD appointments with family as indicated to help with understanding of instructions/changes to care …" The POC failed to evidence an accurate certification period, all pertinent diagnosis, DME: cough vest, tracheostomy supplies, and feeding tube supplies, the seizure plan, aspiration precautions, and the frequency and duration of SN services. During an interview on 05/27/2025 at 2:03 PM, RN 2 indicated they were familiar with Patient #3. When queried about the certification periods, RN 2 indicated they do not enter any dates into the POC. When queried about how they determine which diagnosis to include on the POC, RN 2 indicated they are required to have the principal diagnosis, and then one or two secondary diagnosis. When queried if the presence of a tracheostomy or Mickey button should be included on the POC, RN 2 indicated "100%" When queried if tracheostomy supplies or the cough vest were considered DME, RN 2 indicated yes. When queried about what safety measures should be included for a patient with a Mickey button and tracheostomy, they indicated aspiration precautions. When queried about the frequency and duration of SN services received, RN 2 indicated "I am aware of the requirement for hospice, and it makes sense it carries over into home health" 4. A review of Patient #4's clinical record evidenced POCs with a SOC date of 01/28/2013 and certification periods from 03/15/2025 to 05/13/2025, 05/12/2025 to 07/10/2025, and signed by RN 5. The POC evidenced the following diagnoses: Paralysis (the inability to move a part or more of the body), Depression (constant low mood and lack of interest in activities), Bradycardia (low heart rate), and Bladder disease (a condition causing urinary incontinence). The POC indicated but was not limited to, " … daily HHA and SN for personal care, bowel program catheter management …". The POC included an order with a start date of 09/18/2024 and an end date of 09/21/2024. The order indicated but was not limited to, " … SN … As Needed, SN may cover blister on left lower back and any others that may occur with dry gauze for protection; if blister ruptures, may clean with soap/water, pat dry and cover with hydrocolloid for protection …". The section titled "22. Goals/Rehabilitation Potential/Discharge Plans"	G0574		

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G0574	Continued from page 16 had not included an area for rehabilitation potential. The POC failed to evidence the certification periods with the last date of the previous POC, duration of HHA and SN services, frequency of SN services for the bowel program and catheter management, prognosis, the patient's risk of hospitalization, and rehabilitation potential. During an interview with RN 5 on 05/27/2025 at 10:18 AM, they explained they saw the patient 11 to 14 times a week for Patient #4's bowel program and bladder assessment and in the afternoon for catheter care and medication set-up was one time a week. They indicated the HHA performed transfers, brushed teeth, changed bedding, assisted with dressing, meal preparation, ran errands, picked up the patient's medications from the pharmacy, and drive the patient to the doctor's office. They explained certification periods were every 60 days and the POC covered the period. When queried regarding the orders for the blister on the POC, they indicated the patient had not had a blister for a while and had it included on an as needed basis in case it returned. They explained they would call the physician to confirm the order if the blister returned. RN 5 indicated the prognosis, rehabilitation potential, and hospital risk should be included. 5. A review of Patient #5's clinical record evidenced POCs with an SOC date of 08/11/2021 with a certification period from 03/05/2025 through 05/03/2025 and 04/30/2025 through 06/28/2025. The POC evidenced the following diagnoses: Stroke (a medical emergency caused by blood not flowing to the brain appropriately), Chronic Obstructive Pulmonary Disease (a disease causing breathing problems and constricted airflow), Hypertension (high blood pressure), and Aphasia (a neurological condition where the person has difficulty communicating). The POC indicated the patient received HHA services seven hours a day for seven days a week. The section titled "22. Goals/Rehabilitation Potential/Discharge Plans" had not included an area for rehabilitation potential. The POC failed to evidence the certification periods with the last date of the previous POC, duration of HHA services, and rehabilitation potential. During an interview with RN 3 on 05/27/2025 at 11:13	G0574		

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G0574	Continued from page 17 AM, when queried regarding Patient #5's rehabilitation potential, they explained the patient had a "good/fair" rehabilitation potential. They indicated the certifications were 60 days and the next certification period started from the time of the recertification period assessment. They indicated the POC covered the services provided during the certification period on the POC. 6. Review of the clinical record for Patient #6 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 06/24/2024 for the certification period of 03/24/2025 through 05/22/2025 and signed by RN 4. Review of the clinical record for Patient #6 revealed a recertification assessment dated 03/24/2025 and signed by RN 4. Review of the clinical record for Patient #6 revealed a recertification assessment dated 05/19/2025 and signed by RN 2. The assessment subsection titled "Education/Training" indicated but was not limited to, " … added SN for wound care 3x/week - educated wife and HHA on s/s [signs and symptoms] of wound infection/complication to report …" Review of the clinical record for Patient #6 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 06/24/2024 for the certification period of 05/19/2025 through 07/17/2025 and signed by RN 2. The POC evidenced Patient #6 has the following diagnosis but is not limited to, peripheral neuropathy (damage to the nerves outside ethe brain and spinal cord resulting in symptoms such as numbness, tingling, or weakness), Parkinsons disease (a progressive neurological disorder characterized by tremors, rigidity, slowness of movement, and balance problems), Ischemic Heart Disease (condition where the heart muscle doesn't receive enough blood and oxygen due to narrowed or blocked arteries), and Hypertension (high blood pressure (the force exerted by blood against the walls of the arteries as it is pumped by the heart throughout the body). The POC subsection titled "Orders for Treatment and Discipline" indicated the SN provides wound care three times a week. The POC failed to evidence an accurate certification period, duration for SN services, and the	G0574		

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G0574	Continued from page 18 interventions, frequency, and duration of HHA services. During an interview on 05/27/2025 at 1:32 PM, Person 8, a family member of Patient #6, indicated Patient #6 receives 44 hours per week for the HHA services. During an interview on 05/27/2025 at 1:53 PM, RN 2 indicated they were familiar with Patient #6. When queried about the services Patient #6 received, RN 2 indicated skilled nursing, and HHA was also showing on the patient schedule. When queried if you would want to include what services, frequency, and duration are received, RN 2 indicated the information pulls over from the previous assessment, so if the information was not included previously this could be why the information is missing. When queried how to determine certification periods, RN 2 indicated the dashboard has a date assigned, and they were taught to complete the visit the day before the due date within five days. 410 IAC 17-13-1(a)(1)(D)(iii, iv, v, xiii)	G0574		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure providers were promptly notified with patients' changes in condition, in 1 of 2 bedbound patients reviewed. (Patient #1) Findings include: 1. A review of agency policy titled 'Contents of the Clinical Record Policy' stated, "… Q. Statement of any changes in the patient's condition related to care and service … V. Relevant communication to the patient's Licensed Prescriber …" 2. A review of the clinical record for Patient #1 with a start of care date of 06/13/2019, a recertification	G0590		

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G0590	Continued from page 19 period of 12/16/2025 to 02/13/2025, and a primary diagnosis of quadriplegia (paralysis that affects all a person's limbs and body from the neck down) was bedbound, required complete assistance with transfers, extensive assistance with dressing/grooming, bathing/hygiene, and incontinence care. The patient lived alone, with minimal family/outside supports. Medications included but were not limited to: Baclofen (medication used to relax certain muscles) 20 milligrams (mg) tablet, one tablet twice daily by mouth and Lyrica (medication used to treat nerve pain that may associated with injury to the spinal cord, among other causes) 300 milligrams (mg) capsule, one capsule twice daily, by mouth. Skilled nursing visits were ordered daily for wound/skin assessment, vital signs, change dressing around suprapubic catheter site, assess for urinary tract infection, assess, assist with home health aide care as indicated, and report congestive heart failure symptoms. The record contained a plan of care dated 12/16/2024 for the recertification period of 12/16/2024 to 02/13/2025 which failed to evidence vital sign parameters reportable to the physician, had been included. The record contained a nursing visit note dated 12/09/2024 conducted by RN 4, and evidenced the patient's vital signs were: blood pressure 160/90, Temperature: 97.8 Fahrenheit, Pulse: 57, Breaths per minute: 10, and the following: "… Comments/Intervention: Client is very drowsy. HHA stated that the client took only [their] baclofen and lyrica this morning, and stated, "I have never seen [Patient #1] take two of the one medication at the same time" … Arousable by sternal rub. Oriented to person and place. VS (vital signs) Stable … Nurse spoke to patient on the importance of taken medication as prescribed … Notes: … Client was very drowsy during this nursing visit. This RN did not witness the client take any medication, but per HHA, the client took [their] baclofen and lyrica this morning at a higher dose than [the aide] has seen [Patient #1] take before. VS (vital signs) stable …" The record contained a separate document titled 'Narrative Note' dated 12/10/2024 and completed by RN 4 at 3:40 PM on 12/10/2024, which stated, "This RN called and spoke with [Person 13, patient care coordinator for Person 12, Patient #1's physician] regarding the client's prescribed medication usage. At the client	G0590		

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G0590	Continued from page 20 visit on 12/9/24, the client required sternal rubbing to be aroused to assess for orientation. The HHA stated the client had only taken his baclofen and lyrica that morning, and more of those medications than [the aide] had seen [patient] take previously. Person 13 made a note and said that [they] would pass the information along to Person 12, the physician, for future appointments." The record contained a nursing visit note dated 12/21/2024 conducted by RN 6, evidenced an elevated blood pressure reading of 162/102, the note also contained instructions, "… check BP … notify MD if issues …" and failed to evidence the nurse had contacted the patient's physician to notify of the elevated reading. 3.On 05/22/2025 at 9:32 AM, during an interview, the DON indicated if there are changes in patients' condition they notify the MD, then if the patient is a workman's compensation case, the workman's compensation case manager is notified. On 05/22/2025 at 1:31 PM, in an interview, RN 6 indicated had cared for Patient #1 on occasion. When queried as to whom would be notified with changes in patients' condition or any concerns, RN 6 indicated would, "call my case manager, the office manager, or the case manager" with Entity 11. When queried as to the whether the physician had been contacted regarding the elevated blood pressure reading for Patient #1 discovered on 12/21/2024, RN 6 indicated had not done so, but it was their current understanding the nurses themselves were to contact the MD directly, and stated the agency had provided this education to staff shortly after the death of Patient #1, which included notifying patients' MDs, for example, when patients were non-compliant with meds or had elevated blood pressure readings. On 05/22/2025 at 2:06 PM, in an interview, RN 4 indicated had cared for Patient #1, and when queried about the 12/09/2024 visit which indicated the patient was very drowsy and required sternal rub for arousal, and whether the patient's provider had been contacted, RN 4 indicated they recalled the visit and indeed the patient responded to the sternal rub and they had stayed with the patient until the patient was stable and vital signs were stable, and had contacted the physician and documented same.	G0590		

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G0590	Continued from page 21 On 05/27/2025 at 10:21 AM, in an interview, Person 14, a nurse practitioner for Person 12, Patient #1's physician, indicated they were in receipt of phone message from RN 4, dated 12/10/2024, which indicated during the previous day's nursing visit of 12/09/2024, the patient had required sternal rubbing to be aroused, and Person 14 indicated understood the agency had called emergency medical system (EMS) to respond to incident. 410 IAC 17-13-1(a)(2)	G0590		
G0640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the Governing Body approved the frequency and detail of the data collection(see G644) the agency failed to ensure clear expectations for patient safety were established and implemented (see G0660). These practices had the potential to impact all 46 active patients. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care, resulting in non-compliance with Condition of Participation CFR	G0640		

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G0640	Continued from page 22 484.65 Quality Assessment/Performance Improvement. *	G0640		
G0644	Program data CFR(s): 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the Governing Body approved the frequency and detail of the data collection for 1 of 1 Agency. Findings include: 1. A review of a policy titled, 'Governing Body No. 4-001' stated, "The Governing Body of BrightStar Healthcare will serve as the governing authority for the home services program, which will function according to BrightStar Healthcare's bylaws/processes and will assume full legal authority and responsibility for the operation of BrightStar Healthcare … The Governing Body will review BrightStar Healthcare's … and other information relevant to the quality of patient care (i.e., unusual occurrences in care delivered is also consistently provided through a defined process) at least annually … 2. Meeting minutes will be maintained for each meeting …" 2. A review of the meeting minutes from 05/19/2025 indicated their 2024 year to date discussion included Quality Assessment Performance Improvement (QAPI)	G0644		

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G0644	Continued from page 23 review which consisted of policy changes, office staff changes - new RN Case Manager. The record failed to evidence what policy changes occurred and failed to identify the discussion regarding details of QAPI. 3. On 05/22/2025 at 9:15 AM, the Director of Nursing indicated they had created Performance Improvement Projects and new policies Mid-February 2025, but hadn't presented them to the Governing Body for review and approval. 410 IAC 17-12-2(a)	G0644		
G0660	Executive responsibilities for QAPI CFR(s): 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness; (3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the Governing Body failed to ensure a program for quality monitors and patient safety were established and implemented with 1 of 1 agency.	G0660		

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G0660	Continued from page 24 Findings include: 1. A review of a policy titled, 'Governing Body No. 4-001' stated, "The Governing Body of BrightStar Healthcare will serve as the governing authority for the home services program, which will function according to BrightStar Healthcare's bylaws/processes and will assume full legal authority and responsibility for the operation of BrightStar Healthcare. Procedure 1. The Governing Body will review BrightStar Healthcare's bylaws/processes and other information relevant to the quality of patient care …" A review of a policy titled 'Compliance Plan Policy No. 4-009' stated, "BrightStar Healthcare has established this plan to ensure that quality patient care is provided in a manner that complies with all applicable laws and regulations. It is the policy of BrightStar Healthcare that: … (2) there is periodic monitoring and oversight of compliance with those laws … (5) mechanisms exist to investigate … correct non-compliance. Procedure … 2. The CO oversees the education of personnel regarding proper compliance, the auditing and monitoring of the statutes of compliance, and the reporting, investigation … correction of non-compliance … 3. The CO reports on the compliance plan to the Quality Assurance Performance Improvement (QAPI) and The Governing Body (at least annually) … 5. Periodic audit and monitoring plans will be developed …" A review of a policy 'Sentinel Event Policy No. 4-007' stated, "A sentinel event and associated reporting requirements are part of the organization's overall performance improvement and risk management plan … Definition: Sentinel event: An unexpected occurrence involving death or serious physical …" 2. A review of the Governing Body meeting minutes from 05/19/2025 indicated their 2024 year to date discussion included Quality Assessment Performance Improvement (QAPI) review, policy changes, office staff changes - new RN Case Manager. The record failed to evidence what policy changes occurred and failed to identify the discussion of QAPI. 3. A review of the meeting minutes from the Quarterly Quality Committee meeting Minutes dated 05/19/2025	G0660		

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G0660	Continued from page 25 indicated data collection/tracking of customer satisfaction, clinical quality, infection control, risk management which included falls, hospitalizations, infections, HIPPA Events, Incident Reports - Unusual Event Findings, Medication errors by staff and Near Misses by Staff. Performance Improvement Projects developed were: Infections in clients, LPN's and HHA's must have supervisory visit every 30 days per regulations with state, Call logger not being using correctly, Incident reports, and Missed visits. The record failed to identify what the Incident - unusual event findings were. 4. On 05/22/2025 at 9:15 AM, the Director of Nursing indicated they had created Performance Improvement Projects and new policies Mid-February 2025, but hadn't presented them to the Governing Body for review and approval.	G0660		
G0772	Documentation of competency evaluation CFR(s): 484.80(c)(5) The HHA must maintain documentation which demonstrates that the requirements of this standard have been met. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure home health aides completed competency testing upon hire with 3 of 3 home health aides. (HHA 1, 2, and 3) Findings include: 1. The record reviews of HHA 1, 2, and 3 failed to evidence written competency testing was conducted upon hire. 2. On 05/23/2025 at 1:38 PM, Administrative Staff 5, human resources, indicated they were unaware a written test for HHA's were a requirement. 3. On 05/27/2025 at 10:10 AM, when queried the DON and Administrator indicated they were unaware a written competency test was required for HHA's upon hire.	G0772		

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G0772	Continued from page 26 410 IAC 17-14-1(l)(2)	G0772		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the HHAs practiced within their scope by transporting and running errands for patients for 2 of 5 active clinical records reviewed. (Patients #2 and #4) and 1 of 2 closed records reviewed. (Patient #1) Findings Include: 1. An agency HHA job description indicated but was not limited to, " … Essential Job Functional/Responsibilities … 5. Provide transport to doctor appointment, outside activities and shopping …" 2. A review of the clinical record for Patient #1 evidenced a home health aide care plan which indicated tasks for the aide included, "Action: Complete Errands … Frequency: As Per Client Request … For: Home Health Aide" The record contained serial home health aide notes, dated from 12/11/2024 through 01/27/2025. Each visit evidenced the task titled "complete errands" had been marked "completed". On 05/21/2025 at 10:33 AM, when queried if home health aides should be providing transport or running errands for patients, the Administrator indicated they communicate to patients that the agency does not provide this. When queried if he was aware these items were listed as tasks on Aide Care Plans of current patients, the Administrator indicated was not aware of this, but was aware that it may be occurring, and staff had not been directed to do so.	G0800		

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G0800	Continued from page 27 On 05/22/2025 at 1:31 PM, RN 6 indicated Home Health aides provided errands and shopping for agency patients. Indicated was aware patient was to receive 24/7 care. Indicated sometimes Patient #1 would not have an aide present when they arrived for nursing visits, as the aides would sometimes go to the store for Patient #1. On 05/22/2025 at 1:57 PM, HHA 8 indicated had cared for Patient #1, would sometimes go and get the patient something to eat, would light cigarettes for the patient as they could not do this for themselves, stated, the patient "would have us pick up candles" at the store. On 05/22/2025 at 2:06 PM, RN 4 indicated had cared for Patient #1, when queried as to whether the patient should have been left alone, indicated "probably not, [Patient #1] was completely bedbound". Indicated the Case Manager had informed the patient that home health aides could not pick up medications, but RN 4 indicated had been aware aides would pick up food and prescriptions for the patient. 3. A review of the plan of care for Patient #2 indicated a start of care of 04/30/2024 and recertification period of 04/30/2025 and resumption of care on 05/13/2025 with a diagnosis of quadriplegia (the inability to move a part or more of the body) and orders for a home health aide 5-7 days a week for up to 8 hours. A document received from the agency on 05/23/2025 at 2:50 PM titled Plan of Care Active electronically signed by the Assistant Director of Nursing indicated the home health aide duties included but were not limited to the home health aide tasks included "errands." In a section titled "Independent Level of Assistance Who Helps" the plan of care evidenced, "errands complete assist . . . Brightstar . . . transportation complete assist . . . Brightstar." During an interview on 05/23/2025 at 2:34 PM HHA #7 aide for Patient #2, they reported transporting Patient #2 to appointments and shopping. When queried if this was as a home health aide or as part of a separate personal service agency, they reported they were not sure what the difference was. HHA #7 reported they were instructed to do this by Administrative Staff #6. Patient #4's clinical record included a document with a "Plan of Care Effective Date: 05/12/2025" and "Case Type: Personal Care Service". The POC evidenced the HHA provided assistance with errands and transported the	G0800		

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G0800	Continued from page 28 patient "As Per Client Request". 4. A review of Patient #4's clinical record evidenced the documents titled "Consolidated Care Notes" for HHA 5's visits. HHA 5 indicated in the visit notes, they completed errands for the patient on 03/24/2025, 03/26/2025, 03/29/2025, 03/31/2025, 04/04/2025, 04/08/2025, 04/09/2025, 04/13/2025, 04/15/2025, 04/17/2025, 04/18/2025, 04/23/2025, 04/24/2025, 04/27/2025, 04/29/2025, 04/30/2025, 05/02/2025, 05/10/2025, 05/11/2025, 05/14/2025, and 05/16/2025 and transported and ran errands for the patient on the visit note dated 04/28/2025. The task was evidenced as completed by "C" (sic Completed). Patient #4's clinical record included "Consolidated Care Notes" for HHA 4. The visit notes evidenced they completed errands and transported the patient for the visits dated 03/24/2025, 04/05/2025, 04/06/2025, 04/07/2025, 04/19/2025, 04/20/2025, 04/21/2025, 05/03/2025, 05/04/2025, 05/05/2025, 05/17/2025, 05/18/2025, and 05/19/2025. The task was evidenced as completed by "C" (sic Completed). Patient #4's clinical record included "Consolidated Care Notes" for Former Employee 6, per Other Roster. The visit notes evidenced they completed errands and transported the patient for the visits dated 03/25/2025, 03/26/2025, 03/27/2025, 03/28/2025, 04/01/2025, 04/02/2025, and 04/03/2025. The task was evidenced as completed by "C" (sic Completed). Patient #4's clinical record included "Consolidated Care Notes" for HHA 9. The visit notes evidenced they completed errands only for the visits dated 04/08/2025, 04/10/2025, 04/30/2025, and 05/06/2025 and errands and transported the patient for the visit dated 04/09/2025. The task was evidenced as completed by "C" (sic Completed). During an interview with HHA 5 on 05/27/2025 at 9:26 AM, they indicated they rarely transported the patient, but occasionally will take Patient #4 to their doctor's appointments. They explained the patient mostly had Person 6, a former HHA, assist them with driving where they needed. HHA 5 explained they knew what tasks they could complete based on the task list on their line.	G0800		

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G0800	Continued from page 29 During an interview with RN 5 on 05/27/2025 at 10:18 AM, they indicated the HHA performed transfers, brushed teeth, changed bedding, assisted with dressing, meal preparation, ran errands, picked up the patient's medications from the pharmacy, and drove the patient to the doctor's office. During an interview with RN 3 on 05/27/2025 at 11:13 AM, when queried regarding the tasks HHA's were not able to complete, they indicated the HHAs had to abide by the HHA guidelines by not transporting the patient, and had to stay with the patient.	G0800		
G0808	Onsite supervisory visit every 14 days CFR(s): 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services— (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure Home Health Aides were supervised no less often than every 14 days, for 2 of 3 active clinical records reviewed with SN and HHA services (Patients #4 and #6) , and for 1 of 2 closed clinical records reviewed. (Patient #1) Findings include:	G0808		

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G0808	Continued from page 30 1. A review of an agency policy titled "Client Supervisory Visit Policy" indicated but was not limited to, " … Unless state regulations are more stringent, client supervisory visits will be performed at the following intervals: For skilled care, visits are to be performed every sixty (60) days (certification period) at a minimum) …" 2. A review of the clinical record for Patient #1 failed to evidence documentation of completed supervisory visits from 12/1/2024 through 01/28/2025. On 05/27/2025 at 10:39 AM, in an interview, the DON indicated supervisory visits of HHA's were conducted every 30 days, and when queried if it made a difference whether the case was skilled or un-skilled, indicated "always 30 days, the RN must supervise". On 05/27/2025 at 1:09 PM, in an interview, the DON submitted a home health aide supervisory visit note for Patient #1 dated 12/16/2024, which failed to evidence the name of the aide being supervised. When queried, the DON indicated there was no name due to the fact the document was a 'draft', and had not been fully completed by the nurse, and confirmed there were no other home health aide supervisory visits 12/16/2024 through 1/27/2025. 3. A review of Patient #4's clinical record evidenced POCs with a SOC date of 01/28/2013 and certification periods from 03/15/2025 to 05/13/2025 and 05/12/2025 to 07/10/2025 signed by RN 5. The POC indicated but was not limited to, " … daily HHA and SN for personal care, bowel program catheter management …". Patient #4's clinical record evidenced HHA supervisory visit notes dated 03/25/2025 by RN 5 and 04/25/2025 by RN 7. The clinical record failed to evidence supervisory visit notes for an HHA were completed every 14 days for a patient receiving SN and HHA services. During an interview with RN 5 on 05/27/2025 at 10:18 AM, they indicated they only performed supervisory visits when asked on the HHA. They explained supervisory visits were done monthly. 4. Review of the clinical record for Patient #6	G0808		

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G0808	Continued from page 31 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 06/24/2024 for the certification period of 05/19/2025 through 07/17/2025 and signed by RN 2. The POC evidenced Patient #6 has the following diagnosis but is not limited to, peripheral neuropathy (damage to the nerves outside ethe brain and spinal cord resulting in symptoms such as numbness, tingling, or weakness), Parkinsons disease (a progressive neurological disorder characterized by tremors, rigidity, slowness of movement, and balance problems), Ischemic Heart Disease (condition where the heart muscle doesn't receive enough blood and oxygen due to narrowed or blocked arteries), and Hypertension (high blood pressure (the force exerted by blood against the walls of the arteries as it is pumped by the heart throughout the body). The POC subsection titled "Orders for Treatment and Discipline" indicated the SN provides wound care three times a week. Review of the clinical record for Patient #6 revealed a HHA care plan signed by RN 2 and dated 05/19/2025. Review of the clinical record for Patient #6 revealed a document titled "Customer Supervisory Visit Status: Complete" dated 03/24/2025 and signed by RN 4, and visits dated 04/25/2025 and 05/22/2025 and signed by RN 2. The clinical record failed to evidence a supervisory visit was performed every 14 days by an RN. During an interview on 05/27/2025 at 1:53 PM, RN 2 indicated "I don't know the answer to that," when queried about how often supervisory visits should be completed for HHA caring for a patient who also receives SN. RN 2 indicated the dashboard instructs when supervisory visits are due by assigning the visits.	G0808		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed to execute all of their responsibilities for the day-to-day operations of the home health agency, for 1 of 1 Agency.	G0948		

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G0948	Continued from page 32 Findings include: 1. A review of an agency policy titled 'Rights and Responsibilities Policy' stated, "… The establishment and revision of the plan of care, including the disciplines that will furnish the care and the frequency of visits … 11. The right to be free from … neglect …" The Administrator failed to ensure a patient's right to remain free from neglect, when the frequency and duration of services for 24-hour care, 7 days a week was not provided as ordered, periodically subjecting patient to being without the ordered care/services. 2. A review of an agency policy titled, 'Missed Visits Policy' stated, "… Missed visits will be communicated to the client's Licensed Prescriber or designee … Missed visits will be documented as an incident report and uploaded into the client's chart … If a visit is missed for any reason, the clinician should attempt to reschedule it for the same day or week so that the Licensed Prescriber ordered frequency is maintained and would not be considered a missed visit …" The Administrator failed to provide services as ordered in the Plan of Care for Patient #1 a bedbound patient with quadriplegia (paralysis that affects all a person's limbs and body from the neck down), failed to provide 24-hour care, 7 days per week as ordered. 3. A review of agency policy titled 'Contents of the Clinical Record Policy' stated, "… Q. Statement of any changes in the patient's condition related to care and service … V. Relevant communication to the patient's Licensed Prescriber …" The Administrator failed to ensure providers were promptly notified with patients' changes in condition. 4. A review of a policy titled, 'Governing Body No. 4-001' stated, "The Governing Body of BrightStar Healthcare will serve as the governing authority for the home services program, which will function according to BrightStar Healthcare's bylaws/processes and will assume full legal authority and responsibility for the operation of BrightStar Healthcare … The	G0948		

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G0948	Continued from page 33 Governing Body will review BrightStar Healthcare's … and other information relevant to the quality of patient care (i.e., unusual occurrences in care delivered is also consistently provided through a defined process) at least annually 2. Meeting minutes will be maintained for each meeting …" The Administrator failed to ensure the Governing Body approved the frequency and detail of the data collection. 5. A review of a policy titled 'Compliance Plan Policy No. 4-009' stated, "BrightStar Healthcare has established this plan to ensure that quality patient care is provided in a manner that complies with all applicable laws and regulations. It is the policy of BrightStar Healthcare that: … (2) there is periodic monitoring and oversight of compliance with those laws … (5) mechanisms exist to investigate … correct non-compliance. Procedure … 2. The CO oversees the education of personnel regarding proper compliance, the auditing and monitoring of the statutes of compliance, and the reporting, investigation … correction of non-compliance … 3. The CO reports on the compliance plan to the Quality Assurance Performance Improvement (QAPI) and The Governing Body (at least annually) … 5. Periodic audit and monitoring plans will be developed …" The Administrator failed to ensure clear expectations for patient safety were established and implemented. 6. A review of a policy titled 'Tuberculosis Screening of Health Care Workers Policy (2-Step) Policy No. 9-005' stated, "… The requirements contained in this document are minimum requirements and are applicable to all direct employees or contracted staff of BrightStar Healthcare who perform hands-on care … Baseline TB Screening and Testing at Hire: … If employee presents negative TB skin test or TB blood test from >1 year ago, then must have a new 2 step TB skin test or TB blood test with the second TB skin test administered 1 to 3 weeks after the first TB skin test was read … In addition to above, all new employees must also complete a TB Screening Questionnaire …" The Administer failed to ensure TB testing and screenings were completed per their policy.	G0948		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR HEALTHCARE	9102 N MERIDIAN STREET STE 100 , INDIANAPOLIS, Indiana, 46260

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G0948	Continued from page 34 7. The Administrator failed to ensure home health aides completed competency testing upon hire with 3 of 3 home health aides. 8. On 05/23/2025 at 9:20 AM, the Administrator indicated this as a valuable learning curve and an important opportunity for the agency's growth. 410 IAC 17-12-1 (c)(1)	G0948		
G0960	Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the DON failed to ensure services was continuously available for a 24 hour, 7 days a week case 1 of 1 - 24 hour care patient. (Patient #1) Findings include: 1. A review of a policy titled 'Responsibilities/Supervision of Clinical Services Policy No. 4-003' stated, "… services will be available 24 hours a day, seven (7) days a week. The Director of Nursing (DON) or registered nurse designee will be responsible for the clinical direction of the organization and will take reasonable steps to ensure that: 1. Services are continuously available 2. Care and services provided by organization personnel ,,, are coordinated and integrated …" 2. On 05/21/2025 at 11:30 AM, during an interview, the ADMIN and DON indicated they were aware Patient #1 had been left alone at times. 3. During an interview on 05/21/2025 at 3:32 PM Administrative staff #6 reported Patient #1 was to receive 24 hour care for 7 days a week and the shifts where scheduled for 14 hours overnight and 10 hours for days to ensure there were no lapses in service. The shifts were 8:00 AM to 6:00 PM and 6:00 PM until 8: 00 AM.	G0960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025

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G0960	Continued from page 35 4. On 05/21/2025 at 3:32 PM, the Administrator indicated on 01/28/2025, the agency was aware there was a gap in Patient #1's schedule from 8:00 AM until 10:00 AM and had made the patient aware the night before and contacted a nurse to come at 9:00 AM and reported the Aide stayed until 8:15 AM, the nurse arrived at about 8:50 AM, leaving a 35 minute gap. 5. On 05/22/2025 at 11:24 AM, the DON indicated they had not been involved with scheduling and assigning patients to staff members, they leave it up to the schedulers. 410 IAC 17-14-1(a)(1)(K)	G0960		