PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLE B. WING 07/27/2		ETED		
	PROVIDER OR SUPPLIER			9521 IN	ADDRESS, CITY, STATE, ZIP CODE IDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N 0000							
Bldg. 00	This visit was for a state home health complaint survey. Complaint #: IN00222596 - Substantiated Deficiencies are cited.		N 0	000			
	Survey Date: 7/24/ Facility #: 012189						
N 0444 Bldg. 00	a home health age present full time at in order to qualify administrator, who supervising physic required by subse following:	nagement An individual need not be ency employee or be the home health agency as its administrator. The o may also be the cian or registered nurse ction (d), shall do the					
	agency's ongoing Based on record rev administrator failed home health agency agency. The findings includ 1. Record review o on 7/25/17 failed to came to a resolutior reviewed. The adm agency complaint/ir a. Review of a	riew and interview the to organize and direct the to organize and direct the tris ongoing functions in 1 of 1 e: e: f the complaint/incident log evidence the administrator in 4 of 4 complaint/incidents inistrator failed to follow the	N 0-	144	By 9/30/17 Administrator, Office Managers, Director of Nursing and Case Management person will have met and reviewed the following policies and assure to our policies will be followed as stated: Policy titled "Section 02.07B - Client Complaint Policy" stated: "Policy BrightStar Care addresses all complaints involving clients of BrightStar Care. Client complaints can be received in a variety of forms, such as a phone call to the office a letter or note from the client of the state o	nnel e hat d	09/30/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	<u>00</u>	COMPLETED 07/27/2017			
	PROVIDER OR SUPPLIER STAR OF LAKE CO		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	for patient #1 failed according to agency listed on the docume stated " I [admini [person #26] in regal He/She said he/she [employee G] called [patient #1] asked he what he/she thought him/her [family men lawyer's today and wood. He/She said [employee of moleoking and to just pleas with any changes or interview on 7/27/1' indicated there was complaint. Person # never even received and the only employ administrator. Person was informed by adcannot do anything. During an interview administrator indicate patient #1 was the total b. Review of "Incident Report" with 11/17/16 for patient resolution according document stated " Outcomes 11/9 @ 2 said he/she spoke with said he/she is good a place. [Employee Even envelope of moleoking and they for 100's of dollars in it member][person #2: bank." The agency	to evidence a resolution policy. The last outcome ent was dated 8/30/16 and strator] followed up with rds to the police report, was aware. He/She asked why l and I told him/her that im/her to. He/She said that's . He/She said him/her and imber] were going to the vill decide what they need to imployee G] is doing a good the keep him/her in the loop cancellations." During an to at 9:21 a.m. person #26		family, or a message delivered the caregiver. BrightStar Care management will respond to a and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire an intent of BrightStar Care to provide the best possible care each of our clients, and to treat them as if they were a member our own family. Policy titled "Section 02.44 – Home And Community Based Services Unusual Occurrence Reporting" stated "1. Anyone with knowledge of an incident which affects or potentially affect the individual's health, safety a welfare shall submit an initial Incident Report known as Reportable Unusual Occurren (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) ho of the time the incident occurren or from the point of knowledge the incident. 3. All initial Incident Report involving an allegation suspicion of abuse, neglect, exploitation, or the death of an individual must be submitted within twenty-four (24) hours of the incident or knowledge of. Any staff suspected, alleged, of involved in an incident of abus neglect, or exploitation must be suspended immediately after the incident occurs and during the provider's investigation of the incident. Reportable Unusual Occurrences (RUO): a) Alleged occurrences	d by elegany ing on and eto at ects and ce urs ed, elegan elegan elegan file file file file file file file file		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	COMPL	ETED
			B. WIN	G		07/27/	2017
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t.					
DDICLIT		JUNETY INIDIANIA			DIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNITINDIANA		HIGHLA	ND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	patient #2 (complai	nant) and/or the family			suspected or actual abuse,		
		wed up with concerning the			neglect or exploitation of an		
		an interview on 7/25/17 at			individual shall be reported to		
	_	histrator indicated the			Adult Protective Services (APS	S)	
	_	nt #2 is in the treatments,			for a consumer over the age of	•	
		es of the incident report.			or Child Protective Services		
	resolution, outcome	s of the meldent report.			(CPS) for a consumer under the	ne	
	e Pavian of	agency document titled			age of 18 g) Suspected of		
		vith a date reported of 7/27/16			observed criminal activity by a		
	_	to evidence a resolution			staff member, employee or ag		
					of a provider, a family membe		
	according to agency policy. The last outcome				an individual receiving service		
	reported on the incident report document was				the individual receiving service		
	dated 7/25/16 and stated " [employee B]				p) Inadequate staff suppor		
	_	mily." During an interview on			with the potential for endanger		
		the administrator stated the			the health, safety or welfare of		
		employee H was terminated			individual. This includes, but i		
	and employee B cal	led the family.			not limited to, inadequate		
					supervision of an individual an	ıd	
		agency document titled			inadequate training of staff		
	_	vith a date of incident as			7. If an incident involves		
		4 failed to evidence a			suspected or actual abuse,		
		g to agency policy. The			neglect, exploitation, and/or de	eath	
		Plan to Resolve (Immediate			of a person the reporting entity	/	
		once Police report is received,			shall also report the incident to	o:	
	1 -	duct an investigation"			APS for clients over the age o	f 18	
		on 7/25/17 at 2:58 p.m. the			and CPS for clients under the	age	
		ated the resolution for patient			of 18. The initial incident repo	rt	
	1 -	raiting for a police report.			must include the following in		
	During the interview	w the administrator and			regard to the report made to A	.PS	
	employee B also in	dicated that there should			or CPS: a. The name of the		
	probably be more d	ocumented and that they			person contacted b. The		
	needed to do a bette	er job with details.			telephone number c. The dat	e of	
					contact d. The county of conf		
	2. The undated age	ncy policy titled "Section			8. The reporting entity shall m		
	02.07B - Client Cor	mplaint Policy" stated "Policy			available a copy of the initial II		
	BrightStar Care addresses all complaints				[incident report], at a minimum		
	involving clients of BrightStar Care. Client				the individual or individual's le	gal	
complaints can be received in a variety of forms,				representative, the case			
	such as a phone call to the office, a letter or note				manager, APS or CPS, the		
		imily, or a message delivered			individual's other service		
		rightStar Care management			providers, if relevant, a local la	aw	
	ı		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
			B. WING		07/27/2017	
			CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	CR.		NDIANAPOLIS BLVD, SUITE (`	
DDICHT				•)	
BRIGHT	STAR OF LAKE C	JUNIT INDIANA	HIGHL	_AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		y and all such complaints,		enforcement agency."		
		rt to reach a resolution that		Policy titled "Section 02.45 -		
		atisfaction. It is the desire and		Abuse Neglect" Policy:		
		r Care to provide the best		BrightStar recognizes that up	l l	
		ch of our clients, and to treat		occasion recipients of our ca	l l	
	-	re a member of our own family.		may become subject to phys	l l	
		en a client complaint is reported		or mental abuse, neglect, or exploitation. BrightStar requ		
	_	Care office, the information,		all staff to be alert for obviou		
		il as possible, will be captured		suspected situations jeopard		
		e Customer Complaint Report.		a client's right to considerate		
		mation will be placed into the		humane treatment and to be	l l	
		regiver of record) if appropriate.		of abuse, neglect, or exploita		
		n will be communicated to the		whether it be physical, ment		
		f Nursing or designee. 4. The		financial. The staff of Bright	Star	
		f Nursing and/or designee will nplaint within 10 calendar days		is mandated to report in India	ana	
	_	ings to the Owner and		any outright or suspected ca	l l	
	_	ollectively, they will reach a		of abuse, neglect, abandonn	l l	
		omplaint and will advise the		or exploitation to the APS ho	l l	
		lly or in writing of the planned		at: 1-800-992-6978 (Toll fre		
		ion within 30 calendar days		Indiana) Outside of Indiana:	1-	
		ceives the complaint. 5. The		-800-545-7763, Ext. 20135	-44	
		ector of Nursing will then		Procedure: 1. BrightStar star will be oriented to signs and	³¹¹	
		/Caregiver situation over the		symptoms indicating possible		
		ty days to assure that the issue		abuse or neglect. 2. Definit		
		orily resolved and that the client		are defined as follows:		
	and/or family is sa	-		Vulnerable Adult: Anyone 1	8	
				years of age or older, who		
	3. The undated ag	ency policy titled "Section		regardless of where the pers	son is	
	02.44 - Home And	Community Based Services		living, is unable or unlikely to)	
	Unusual Occurren	ce Reporting" stated "1.		report abuse or neglect with		
	Anyone with know	vledge of an incident which		assistance because of ment	l l	
	-	ly affects the individual's		physical function impairment		
		welfare shall submit an initial		his/her emotional status. (N	l l	
		own as Reportable Unusual		Indiana law defines endange		
). 2. All providers are required		adults as those individuals 1		
	_	of RUO within forty-eight (48)		years or older who are incap	l l	
		he incident occurred, or from		of managing their property o		
	_	edge of the incident. 3. All		caring for themselves becau illness, disability, or other	9C 01	
		port involving an allegation or		incapacity and are harmed of	r	
	suspicion of abuse	, neglect, exploitation, or the		incapacity and are narried of		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 07/27/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	twenty-four (24) ho knowledge of. 4. A involved in an incide exploitation must be the incident occurs investigation of the Occurrences (RUO) actual abuse, neglectindividual shall be a Services (APS) for or Child Protective consumer under the or observed criminal employee or agent of an individual receindividual of an intraining of staff suspected or actual and/or death of a pealso report the incidente age of 18 and Company of the incidente age of 18 and Company of the incidente agent of the county of contastall make available [incident report], at or individual's legal manager, APS or Coservice providers, it enforcement agency	ncy policy titled "Section			threatened with harm as a rest of abuse, neglect or exploitation of the person's personal service property or both.) Exploitation: The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary of personal benefit, profit, or gain without the informed consent of the elderly or disabled person. 3. The definition of Reportable Conduct as listed includes: Financial exploitation of an individual receiving agency services in an amount of \$25 cmore; 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient resources and living situation. Reports of demands for goods exchange for services 13. The BrightStar Agency will complete a written report using the Provider Investigation form and include the following information: Incident date The alleged victim The alleged perpetrator Any witness(es) Tallegation Any injury or adversaffect Any treatment required The investigation summary Ar action taken 14. The Agency	on ses, or	
	_	ect" Policy: BrightStar n occasion recipients of our			investigate complaints made b		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> 00 </u>	COMPLETED
			B. WING		07/27/2017
			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	_
NAME OF I	PROVIDER OR SUPPLIEF	R		1 INDIANAPOLIS BLVD, SUITE (<u> </u>
DDICUT		NI INITA INIDIANIA			J
BRIGHT	STAR OF LAKE CO	JUNIT INDIANA	пібі	HLAND, IN 46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		E COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	care may become si	ubject to physical or mental		client, a client's family or	
	abuse, neglect, or ex	xploitation. BrightStar		guardian, or a client's health	care
		be alert for obvious or		provider, regarding treatmen	nt of
	suspected situations	s jeopardizing a client's right to		care furnished by the agency	y or
	_	e treatment and to be free of		that the agency failed to furn	nish,
	abuse, neglect, or ex	xploitation whether it be		or a lack of respect for the cl	lient's
	_	financial. The staff of		property by anyone furnishin	
		ated to report in Indiana any		services on behalf of the age	-
	outright or suspected cases of abuse, neglect, abandonment, or exploitation to the APS hotline at: 1-800-992-6978 (Toll free in Indiana) Outside of Indiana: 1800-545-7763, Ext. 20135 Procedure: 1. BrightStar staff will be oriented to signs and symptoms indicating possible abuse or			15. BrightStar will documen	t the
				receipt of the complaint and	
				initiate a complaint investiga	
				within 10 days after the ager	ncy's
				receipt of the complaint. All	
				components of the investiga	
	neglect. 2. Definitions are defined as follows:			will be documented and the	
	Vulnerable Adult: Anyone 18 years of age or			investigation and documenta will be completed within 30 of	
	older, who regardle	ss of where the person is		after the agency receives the	
	living, is unable or	unlikely to report abuse or		complaint, unless the agenc	
	neglect without assi	istance because of mental or		a documents reasonable car	-
	physical function in	npairment or his/her emotional		for delay"	
	status. (Note: India	ana law defines endangered		All employees will have a	
	adults as those indi-	viduals 18 years or older who		verification from the state the	ev
	_	naging their property or caring		have been registered as a H	-
		nuse of illness, disability, or		before they have any first pa	
		d are harmed or threatened		contact.	
		lt of abuse, neglect or		Performance Improvement F	Plan
		person's personal services,		will include any customer	
		Exploitation: The illegal or		complaints, incidents, and	
		cess of a caretaker, family		employee complaints to	
		ndividual who has an ongoing		collaborate all of our service	
	_	e elderly or disabled person		disciplines to meet the need	s of
	_	of an elderly or disabled		the clients, staff and the	
		y or personal benefit, profit, or		community. Risk Manageme	
		formed consent of the elderly		infection control, and clinical	
	_	3. The definition of		quality will also be part of thi	
	Reportable Conduct as listed includes:			quarterly team meeting to m	
	Financial exploitation of an individual receiving			sure the needs of our clients	
	agency services in an amount of \$25 or more;			being met as well as their we	CII
		fy victims of exploitation		being and safety.	
		l/or misuse of patient's money			
	An inability of care	giver/family to account for			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED		
			B. WING		07/27/2017	
NAME OF F	PROVIDER OR SUPPLIEF		STREET A	ADDRESS, CITY, STATE, ZIP C	CODE	
NAME OF F	ROVIDER OR SUPPLIER	X.	9521 IN	IDIANAPOLIS BLVD, SU	JITE O	
BRIGHTS	STAR OF LAKE CC	OUNTY INDIANA	HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION (X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	HOULD BE COMP	LETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		TE
	1	property. Discrepancies				
	•	esources and living situation.				
	_	s for goods in exchange for				
		he BrightStar Agency will				
		report using the Provider				
	_	and include the following				
		ent date The alleged victim				
		rator Any witness(es) The ary or adverse affect Any				
	treatment required The investigation summary Any action taken 14. The Agency will investigate complaints made by a client, a client's family or guardian, or a client's healthcare provider, regarding treatment of care furnished by					
		he agency failed to furnish, or				
		r the client's property by				
	_	services on behalf of the				
		tStar will document the receipt				
		d initiate a complaint				
		10 days after the agency's				
	_	laint. All components of the				
	investigation will b	e documented and the entire				
	investigation and do	ocumentation will be				
	completed within 3	0 days after the agency				
		aint, unless the agency has a				
	documents reasonal	ble cause for delay"				
	5 Review of perso	onnel records on 7/26/17				
		nealth aide that provided care				
		rith the state of Indiana. The				
	1 ~	to ensure licensure on the				
		employee J). A review of the				
		aployee J, date of hire 2/23/16,				
	_	ed an Indiana home health				
		ue date of 3/11/16. Review of				
	the Indiana State D	epartment of Health document				
	titled "Employee R	ecords", that was partially				
		ministrator, evidenced a first				
	patient contact date	of 2/29/16. This is 11 days				
	before employee J	was issued a home health aide				
	license. Employee	J provided patient care for				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
			B. WING		07/27/2017			
			CTREET	ADDRESS CITY STATE ZID CODE				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
55161176	TAB 05 41/5 00	LINET CINEDIANIA	9521 INDIANAPOLIS BLVD, SUITE O					
BRIGHTS	STAR OF LAKE CO	UNIYINDIANA	HIGHL	AND, IN 46322				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROWNERS BY AN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
_		ome health aide license on						
	-	document dated 3/2/16 titled						
		npanion Care Note and						
		Comments/Remarks:						
		his morning and wanted to get						
		yee J] gave her a sponge bath						
	and change [sic] line	en on bed wet from water".						
		1 B C						
		agency's Performance						
	Improvement program on 7/25/17 failed to							
address the misappropriation of funds in 2016								
	performance improvement meetings. The agency							
	performance improvement program has a table of							
	quality indicators with one domain listed as Risk							
	•	ne indicator listed as unusual						
	occurrence reporting	g. Misappropriation of funds						
	was never addressed	d. However review of the						
	complaint/incident l	log evidence 4 cases of						
	misappropriation 3	of which were in a 3 week						
	time frame. The mi	sappropriations evidenced in						
	the agency complain	nt/incident log are dated						
	7/28/16, 8/6/16, 8/1	-						
N 0446	410 IAC 17-12-1(d	2)(3)						
	Home health agen							
Bldg. 00	administration/mai							
Blug. 00	Rule 12 410 IAC 1	-						
	12 710 1/10 1							
	Sec. 1(c)(3). The a	administrator, who may						
	also be the superv							
		equired by subsection (d),						
	shall do the follow							
		ed personnel and ensure						
		ucation and evaluations.						
		riew and interview the	N 0446	It is the Administrator's	10/31/2017			
		to ensure employment of	11 0440	responsibility to make sure pro				
	administrator ranca	to ensure employment of		l separation, to make oure pre	, p = .			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l í	UILDING	ONSTRUCTION 00	(X3) DATE COMPI 07/27	LETED
	PROVIDER OR SUPPLIER			9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWING WAY OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IIE	DATE
	qualified personnel	, adequate staff education and			policies and procedures are b	eina	
	evaluations in 1 of	-			followed. During survey it was found that not all of the		
	The findings includ	le:			employees had all of their required 12 in-services. At the	Э	
	Review of perso	onnel record and agency			time of hire and annually		
	_	7/26/17 evidenced 10 of 12			thereafter all employees will		
	home health aide personnel records reviewed failed to have the minimum of 8 hours of in-service training required by the state of Indiana (Employees D, E, F, G, H, I, J, O, R, S). During				complete 8 mandatory in serv	ices	
					and then more than 100		
					in-services are available to the		
					to make sure required in-servi	ces	
	an interview on 7/2	7/17 at 1:00 p.m. the			are achieved through out the year. Up to and including		
	administrator indica	ated I had the complete records			required in-services are as		
	of the in-services for all home health aide employees.				follows: Infection		
					Control/Universal Precautions	:	
					Communication Documentation		
		onnel records on 7/26/17			Elements of Body Functions,	,,,	
		nealth aide that provided care			Maintaining a clean and safe		
		ith the state of Indiana. The			environment, Fire Safety, Elde	er	
		I to ensure licensure on the			Abuse and Neglect,		
		employee J). A review of the			Confidentiality and HIPPA,		
	_	nployee J, date of hire 2/23/16,			Personal Hygiene and groomi	ng,	
		ed an Indiana home health			Safety transfer techniques,		
		the date of 3/11/16. Review of			Range of Motion, Nutrition, an	ıd	
		epartment of Health document			Medication Assistance.		
		ecords", that was partially			Employees who do not obtain		
		ministrator, evidenced a first			their 12 required in-services w	/111	
		of 2/29/16. This is 11 days was issued a home health aide			be removed from providing patient care. The above is to		
		J provided patient care for			assure the following policy is		
		nome health aide license on			followed, "STAFF INSERVICE	:0	
	_	document dated 3/2/16 titled			HOME HEALTH AIDE	-0,	
		npanion Care Note and			CONTINUING EDUCATION A	AND	
		" Comments/Remarks:			COMPETENCY EVALUATION		
		this morning and wanted to get			PROGRAM". To assure		
		yee J] gave her a sponge bath			employees delivering client ca	ıre	
		nen on bed wet from water".			or service receive appropriate		
	8. [0.0] 111				training to meet state and fede		
	3. Review of person	onnel records on 7/26/17			regulations. In-service educa		
	_	health aides that needed further			programs will cover those are	as	
	skill competency assessment which failed to be				required by state and federal		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETE			ETED	
			B. WING 07/27/2017			2017	
NAME OF I	ROVIDER OR SUPPLIEI	2			ADDRESS, CITY, STATE, ZIP CODE		
					IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TA		DEFICIENCY)		DATE
	documented as acco	omplished. Review of			guidelines and will be based o	n	
	employee D person	nel record evidenced an			identified staff and client need	S.	
	agency document dated 4/15/15 titled				The agency should maintain		
		ssment Skill Check List for			documentation of all in-service	:	
		' that stated under areas			education. The 12 hour per		
	subtitled "Compete	ncy for the Home Health			calendar year requirement for		
	Aide" and "Comment""17. Optional Skills:				home health aide in-services r	nay	
	Hoyer Lift needs tng [training] depending on				be prorated according to the		
	type 25. Meal preparation Diabetic Diet				employee's date of hire and		
	Low sodium Low cholesterol/fat needs addl [additional] tng" Review of employee I personnel record evidenced an agency documents titled "Competency Assessment Skill Check List for Home Health Aide" dated 4/15/15 that stated				records maintained per calend		
					year. 10% of employee files w		
					be audited quarterly and finding	igs	
					reported to the Performance		
					Improvement Committee.		
	under areas subtitle	d "Competency for the Home			By October 31, 2017 current employees will meet our Nursi	na	
	Health Aide" and "	Comment""4. Blood Pressure			Supervisor or Nurse Designee	-	
	needs tng 16. N	Making occupied beds needs			have their annual clinical	10	
	tng 17. Optiona	l Skills: Hoyer lift needs tng			competency performed. All sta	ıff	
	25. Meal prepar	ration Diabetic Diet Low			members who provide direct		
		sterol/fat needs tng" The			client care will have a clinical		
	administrator failed	to ensure all the home health			competency assessment as		
	aides had a comple	ted skills competency.			stated in our policy Section 03	.06	
					- Clinical Competency Prograr		
	_	ency policy titled "Section			Established competency		
		e Evaluations" stated "			assessment will be documente	ed	
	-	lizes a performance evaluation			and will be established as bas	ed	
		promote the development of			on their staff member's		
		e performance evaluation			classification. This will be done	9	
	*	ot only performance against			annually and on going in		
		so a time for each employee			accordance with laws and		
		n how improvement and better			regulations, any time there is a		
		eved. It is primarily a chance			concern with a staff member's		
		s and weaknesses and help the			clinical competency and when		
		to their full potential in order			introducing new client care procedures, techniques or		
	_	success. This process is a very			equipment as well as initially a	.+	
	important developmental time for BrightStar and its employees. Branch Managers and employees are strongly encouraged to discus job performance and goals on a regular basis.				their orientation.	ıı	
					uicii orientation.		
					By October 31, 2017 current		
					employees who are eligible wi	II .	
		tion between the employee and			have an annual performance		
	manager should pro	ovide the employee a good			arraman perfermance		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING		COMPLETED 07/27/2017			
	PROVIDER OR SUPPLIER STAR OF LAKE CO	UNTY INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	sense of how their proma performance provide employees provide evaluations are an intemployees should for participating in the provide the lines of communattempts to conduct annually, however a conducted in the evaluation and responsibilities. Performance conducted at any time when job requirement problems occur, or in PEER REVIEW: Provide engine each professional direspective practice are porting and peer propose evaluation annually performed at lease employees evaluation annually performed at lease employees address areas of consideration of the peemployee A, date of agency document the dated 11/13/15. The evaluation evidence administrator and agency and peer providence administrator and agency document in dated 11/13/15. The evaluation evidence administrator and agency document and ag	erformance is perceived. evaluations are conducted to with the opportunity to discuss identify and correct age new ideas, recognize ss positive, effective ing goals. Performance inportant management tool. eel comfortable actively review process and keeping dication open. BrightStar Care performance evaluations in evaluation may also be ent of a promotion, change in dilities or to address any open e evaluations may be ine for any reason including ints are not being met, improvement is needed. Colicy: BrightStar Care agency of each professional cir respective practice acts or er reporting and peer review. Incy ensures compliance of		evaluation complete in accordance to our policy Secti 03.05 - Performance Evaluation Each employee and manager discuss strengths and weaknesses and help the employee develop to their full potential in order to achieve optimal success. Job responsibilities, new ideas, positive and effective approact will be discussed to meet goal Any change in an employee's duties or responsibilities will be addressed as an open issue. Or going performance evaluations may be conducted at any time any reason when job requirements are not being may problems occur or improvement is needed. Addendum: Persons responsible for this correction is the Administrator and Nursing Supervisor or Nursing Designee. Governing Body reviewed in-services, employee audit list, and in-service logs on 9/25/17. PLAN: With the requirements of the regulations mandatory in-services the following will be included at our 8 hour orientation and annually thereafter: Infection Control/Universal Precautions, RACI for Fire Safety, Confidentiality & HIPAA, Red Flag Program, Alzheimer's Disease, Effective Communication Skills in Healthcare, Reporting and Documenting Client Care, Basic Nutrition and Hydration, Passive and Active Range of Motion,	on ons. will hes s. e On s for et, nt		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	evaluation. 6. Review of the period of the	ersonnel record on 7/26/17 for f hire 8/4/14, evidenced no e evaluation in record. The gency management failed to had an annual performance ersonnel record on 7/26/17 for f hire 3/26/13, evidenced an atted "Annual Performance annual Performance inistrator failed to ensure annual performance ersonnel record on 7/26/17 for f hire 9/28/11, evidenced an atted "Performance Evaluation" was the most current atton evidenced in employee inistrator failed to ensure annual performance.			Recognizing and Reporting Abnormal Observations, Performing Safe Transfers, Bathing Tips, and Medication Reminders. These in-services will be overseen by the Nursing Supervisor or the Nursing Designee. An additional 100 in-services are available through each employee's portal to complete the additional four required to mee their 12 in-services, there are disease specific and caregiver tips including a wide variety of demonstration through an In The Know BrightStar Developed Program. Monthly in-services will also be offered to all employees the third Wednesday of the month held in our office featuring different caregiver tips not included in the basic mandatory in-services. Employees are being sent new mandatory in-services by 10/5/17 for completion by the end of the year or they are to be removed from their shifts. A log is created showing who has done them, how many they have done, and how many need to be completed by the end of the yea to have met their 12 required in-services. If they are not compliant, they will be placed inactive until credentialing is completed. Files are being audited to make sure that the caregiver has had an initial skills competency and are active with the state registry. Our files		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R		NDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CO	ANAIGNI YTNIIC		AND, IN 46322		
	1			, 114D, 114 TOOLL		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				checks. Staff was notified that they		
				need to come in and schedule		
				competency check off in our office.		
				Our office has a new training room		
				which has a mechanical lift, washin	g	
				station, transfer equipment,		
				walkers, canes, etc. for nurse (nurse	e	
				designee) to perform skills		
				competency on a living person		
				during this session. Due to the		
				equipment being set up in our new		
				training area check offs are		
				scheduled on 10/3, 10/5, 10/6, 10/12, 10/13, 10/20 and 10/21. For		
				anyone that cannot make those		
				sessions they will have individual		
				training at their convenience to		
				make sure it is done. On going		
				thereafter competencies are being		
				checked monthly to assure all		
				annual competencies are being dor	ne	
				prior to the annual due date makin		
				us out of compliance. If an employe	- I	
				has a competency are that is not		
				satisfactory, an employee will not b	ne e	
				sent to a client with that specific		
				need unless additional training has		
				been done with the nursing		
				supervisor or designee. For exampl	e,	
				additional training needed on a		
				mechanical lift. Employee file will		
				have a tag that specifies do not sen	d	
				to a mechanical lift client. Nursing		
				Supervisor or Nursing Designee will		
				then schedule additional training		
				and once training is satisfactory		
				competency will then show the dat		
				this was observed and the tag from		
				employee file will be lifted. This wil	1	
				be monitored by running monthly		

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		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/27/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				reports for compliance. Competenc	У
				skills and due dates are being	
				entered into our computer system	
				to track nearing expiration dates.	
				All new hires will have skills competency, mandatory 8	
				in-services at our 8 hour orientation	,
				take the HHA test, and will be	''
				registered with the state. New hires	
				will not be scheduled any patient	
				contact until we can print out their	
				activeness with the state and place	it
				in their file. Administrator will	
				oversee this.	
				Employee files are being audited an	d
				any employee that does not have a	n
				annual evaluation is being brought	
				into this office for it to be	
				completed. If employee cannot	
				come in, it will be marked on	
				evaluation if it was a phone	
				evaluation and that it was complete	
				If an employee cannot do either, an	
				employee will be sent a letter statir	-
				that in order to continue to see our	
				clients a review will need to be	
				performed. If employee still is not	
				helping us to remain compliant they	′
				will be removed from any patient contact until it is complete. This will	
				be overseen by the Administrator.	
				Monitoring of the above is being	
				maintained in our software system	
				showing when employee have had	
				competency checks and when they	
				are due and when employee has ha	d
				an annual review and when the nex	
				one is due. Reports will be ran 30	
				days prior to the next month and	
				administration will call the employe	e

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		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/27/2017
	ROVIDER OR SUPPLIER		9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				to schedule reviews and competencies that are due. Those that do not get them complete prio to their annual due date will be removed from any patient contact until it is complete. Administrator will oversee this. In-Service log has been created for every employee and date of year showing all in-services completed in that time frame. As employee completes in-services will be logged Quarterly administration will check the logs and call employees advising how many have been completed so far and how many need to be completed by the end of the year. Employees who fail to complete in-services by the end of the year will be removed from all patient contact until it is complete. This will be overseen by the Administrator.	l. 3
N 0456	410 IAC 17-12-1(e Home health agen	су			
Bldg. 00	be responsible for assurance program following: (1) Objectively and and evaluate the quappropriateness of (2) Resolve identification (3) Improve patients Based on record rev	The administrator shall an ongoing quality in designed to do the dispersion of systematically monitor quality and figure problems.	N 0456	By 9/30/17 Administrator, Offic Managers, Director of Nursing	

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		07/27/	/2017
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		tematically monitored and			and Case Management perso		
		y and appropriateness of			will have met and reviewed th		
	_	olved identified problems in 1			following policies and assure t		
	of 1 agency.				our policies will be followed as stated:	•	
	The Cardinan in the d				Policy titled "Section 02.07B -		
	The findings includ	c.			Client Complaint Policy" state		
	1 Record review o	of the complaint/incident log			"Policy BrightStar Care		
		evidence the administrator			addresses all complaints		
		n in 4 of 4 complaint/incidents			involving clients of BrightStar		
		ninistrator failed to follow the			Care. Client complaints can b	е	
	agency complaint/ii	ncident policy.			received in a variety of forms,		
					such as a phone call to the off a letter or note from the client		
		agency document titled			family, or a message delivered		
		with a date reported of 8/30/16			the caregiver. BrightStar Care	-	
	_	to evidence a resolution			management will respond to a		
		y policy. The last outcome			and all such complaints, maki		
		ent was dated 8/30/16 and istrator] followed up with			every effort to reach a resoluti	on	
		ards to the police report,			that meets the client's		
		was aware. He/She asked why			satisfaction. It is the desire ar	nd	
		d and I told him/her that			intent of BrightStar Care to provide the best possible care	to	
		nim/her to. He/She said that's			each of our clients, and to trea		
		t. He/She said him/her and			them as if they were a member		
	him/her [family me	mber] were going to the			our own family.		
		will decide what they need to			Policy titled "Section 02.44 -		
	_	mployee G] is doing a good			Home And Community Based		
		se keep him/her in the loop			Services Unusual Occurrence		
		r cancellations." During an			Reporting" stated "1. Anyone		
		7 at 9:21 a.m. person #26 no resolution to the			with knowledge of an incident which affects or potentially aff		
		\$26 indicated that he/she never			the individual's health, safety		
		pology from BrightStar and the			welfare shall submit an initial		
		he spoke with was the			Incident Report known as		
	1	on #26 indicated that he/she			Reportable Unusual Occurren	ce	
	was informed by ad	lministrator that BrightStar			(RUO). 2. All providers are		
	cannot do anything	without a police report.			required to report incidents of		
	1	y on 7/25/17 at 2:52 p.m. the			RUO within forty-eight (48) ho		
		ated that the resolution for			of the time the incident occurr or from the point of knowledge	-	
	patient #1 was the t	ermination of employee F.			the incident. 3. All initial Incident		
					and moracine. 5. 7 in milital more		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
			B. WI	NG		07/27/	2017 l
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	b. Review of	agency document titled			Report involving an allegation	or	
	"Incident Report" v	vith a date reported of			suspicion of abuse, neglect,		
	11/17/16 for patien	t #2 failed to evidence a			exploitation, or the death of ar	1	
	resolution accordin	g to agency policy. The			individual must be submitted		
	document stated "	. Treatments, Interventions,			within twenty-four (24) hours of		
	Outcomes 11/9 @	2:35p [employee E] called and			the incident or knowledge of.		
	said he/she spoke v	vith the [family member] and			Any staff suspected, alleged,		
		at hiding money all over the			involved in an incident of abus		
	place. [Employee l	E] said they looked and found			neglect, or exploitation must b		
	one envelope of mo	oney and then they continued			suspended immediately after t		
	looking and they for	ound another envelope with			incident occurs and during the	;	
	100's of dollars in i	t. He/She said the [family			provider's investigation of the		
	member][person #2	28] was going to take it to the			incident. Reportable Unusual	ad	
	bank." The agency	only received testimony from			Occurrences (RUO): a) Alleg suspected or actual abuse,	eu,	
	the home health aid	le. The agency failed to ensure			neglect or exploitation of an		
	patient #2 (complai	inant) and/or the family			individual shall be reported to		
	member were follo	wed up with concerning the			Adult Protective Services (APS	3)	
	resolution. During	an interview on 7/25/17 at			for a consumer over the age of	-	
	2:52 p.m. the admir	nistrator indicated the			or Child Protective Services	1 10	
	resolution for patie	nt #2 is in the treatments,			(CPS) for a consumer under the	ne	
	resolution, outcome	es of the incident report.			age of 18 g) Suspected of		
					observed criminal activity by a		
	c. Review of	agency document titled			staff member, employee or ag		
		with a date reported of 7/27/16			of a provider, a family membe		
		d to evidence a resolution			an individual receiving service		
		y policy. The last outcome			the individual receiving service	es.	
	_	ident report document was			p) Inadequate staff suppor	t	
		stated " [employee B]			with the potential for endange	9	
		amily." During an interview on			the health, safety or welfare o		
		n. the administrator stated the			individual. This includes, but i	S	
		employee H was terminated			not limited to, inadequate		
	and employee B ca	lled the family.			supervision of an individual ar		
					inadequate training of staff		
		agency document titled			7. If an incident involves		
	_	with a date of incident as			suspected or actual abuse,	acth	
	_	4 failed to evidence a			neglect, exploitation, and/or de		
		g to agency policy. The			of a person the reporting entity		
		. Plan to Resolve (Immediate			shall also report the incident to		
		Once Police report is received,			APS for clients over the age o and CPS for clients under the		
	_	duct an investigation"			of 18. The initial incident repo		
	During an interview	v on 7/25/17 at 2:58 p.m. the			or ro. The initial incluent repu	11.	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì	ILDING	ONSTRUCTION 00	(X3) DATE COMPI 07/27 /	ETED
NAME OF I	PROVIDER OR SUPPLIEF	- {			ADDRESS, CITY, STATE, ZIP CODE		
BRIGHT	STAR OF LAKE CC	DUNTY INDIANA			IDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID	,	TATEMENT OF DEFICIENCIES		ID	,		(V5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)	1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG		ated the resolution for patient		IAU	must include the following in		DATE
		vaiting for a police report.			regard to the report made to A	PS	
		w the administrator and			or CPS: a. The name of the		
	_	dicated that there should			person contacted b. The		
		ocumented and that they			telephone number c. The dat	e of	
	needed to do a bette	_			contact d. The county of con-		
		2 Joe Will dealis.			8. The reporting entity shall m	ake	
	2. The undated age	ency policy titled "Section			available a copy of the initial II	₹	
	_	licy BrightStar Care addresses			[incident report], at a minimum		
		lving clients of BrightStar			the individual or individual's le	gal	
	Care. Client compl	aints can be received in a			representative, the case		
	variety of forms, su	ch as a phone call to the			manager, APS or CPS, the		
	office, a letter or no	te from the client or family, or			individual's other service providers, if relevant, a local la		
	_	d by the caregiver. BrightStar			enforcement agency."	ivv	
		will respond to any and all such			Policy titled "Section 02.45 -		
		gevery effort to reach a			Abuse Neglect" Policy:		
		ts the client's satisfaction. It is			BrightStar recognizes that upo	n	
		t of BrightStar Care to provide			occasion recipients of our care		
	_	re to each of our clients, and			may become subject to physic	al	
		ney were a member of our own			or mental abuse, neglect, or		
	I	1. When a client complaint is			exploitation. BrightStar requir		
		htStar Care office, the smuch detail as possible, will			all staff to be alert for obvious		
		ged onto the Customer			suspected situations jeopardiz	ing	
		2. The same information will			a client's right to considerate, humane treatment and to be f		
		mployee file (Caregiver of			of abuse, neglect, or exploitati		
		te. 3. The information will be			whether it be physical, mental		
		ne Owner, Director of Nursing			financial. The staff of BrightSt		
		e Owner, Director of Nursing			is mandated to report in Indiar		
		l investigate the complaint			any outright or suspected case	es	
	within 10 calendar	days and report the findings to			of abuse, neglect, abandonme	ent,	
	the Owner and Adn	ninistrator. Collectively, they			or exploitation to the APS hotl		
		ion of the complaint and will			at: 1-800-992-6978 (Toll free		
		her verbally or in writing of			Indiana) Outside of Indiana: 1	-	
	_	n or resolution within 30			-800-545-7763, Ext. 20135		
		the agency receives the			Procedure: 1. BrightStar staf	ſ	
	_	Owner and/or Director of			will be oriented to signs and symptoms indicating possible		
	_	nonitor the Client/Caregiver			abuse or neglect. 2. Definition	ns	
		ollowing (30) thirty days to			are defined as follows:	5	
		e has been satisfactorily			Vulnerable Adult: Anyone 18		
	resolved and that th	e client and/or family is	1		1		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	A. BUILDING 00 B. WING		COMPLETED 07/27/2017	
NAME OF I	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA	9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	satisfied"	•			years of age or older, who		
	3. The undated age 02.44 - Home And Unusual Occurrence Anyone with knowl affects or potentiall health, safety and w Incident Report knowledge of the point of knowledge of the initial Incident Repsuspicion of abuse, death of an individual twenty-four (24) however, death of an individual twenty-four (24) however, death of an incident occurs investigation of the Occurrences (RUO) actual abuse, neglecting individual shall be a Services (APS) for or Child Protective consumer under the or observed criminal employee or agent of an individual receiving staff support with the health, safety or This includes, but is supervision of an intraining of staff suspected or actual and/or death of a per support with the point of an intraining of staff suspected or actual and/or death of a per support with the point of an intraining of staff	ncy policy titled "Section Community Based Services e Reporting" stated "1. ledge of an incident which y affects the individual's relfare shall submit an initial own as Reportable Unusual 2. All providers are required of RUO within forty-eight (48) e incident occurred, or from dge of the incident. 3. All out involving an allegation or neglect, exploitation, or the tall must be submitted within turns of the incident or the incident. Reportable Unusual of the incident. Reportable Unusual of the incident. Reportable Unusual of the incident of the incident or the incident of a suspected or the incident of an incident. Reportable Unusual of the incident of an incident of a geoff 18 g) Suspected all activity by a staff member, of a provider, a family member eliving services or the individual. In the incident i			years of age or older, who regardless of where the person living, is unable or unlikely to report abuse or neglect withou assistance because of mental physical function impairment on his/her emotional status. (Note Indiana law defines endangered adults as those individuals 18 years or older who are incapated of managing their property or caring for themselves becaused illness, disability, or other incapacity and are harmed or threatened with harm as a rest of abuse, neglect or exploitation of the person's personal service property or both.) Exploitation: The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person using the elderly or disabled person using the elderly or disabled person. 3. The definition of Reportable Conduct as listed includes: Financial exploitation of an individual receiving agency services in an amount of \$25 comore; 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient of the patient of t	t or received ble sof with the sees, and go or	
	_	lent to: APS for clients over PS for clients under the age of			resources and living situation.	. 3	

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING 'ING	00		
			D. W			07/27	/2017
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			9521 IN	IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	STIMMARYS	TATEMENT OF DEFICIENCIES	- 1	ID	T		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		dent report must include the		1710	Reports of demands for good	e in	DATE
		to the report made to APS or			exchange for services 13		
		of the person contacted b.			The BrightStar Agency will	•	
		ber c. The date of contact d.			complete a written report using	a	
	_	act 8. The reporting entity			the Provider Investigation for		
	1	e a copy of the initial IR			and include the following		
		a minimum, to the individual			information: Incident date Th	ne	
		representative, the case			alleged victim The alleged		
	_	PS, the individual's other			perpetrator Any witness(es)	The	
		f relevant, a local law			allegation Any injury or adve	se	
	enforcement agency				affect Any treatment required		
	emoreomene agency	, -			The investigation summary A	•	
	4 The undated age	ency policy titled "Section			action taken 14. The Agency		
		ect" Policy: BrightStar			investigate complaints made	by a	
	_	n occasion recipients of our			client, a client's family or		
		ubject to physical or mental			guardian, or a client's healtho		
		xploitation. BrightStar			provider, regarding treatment		
	_	be alert for obvious or			care furnished by the agency		
		s jeopardizing a client's right to			that the agency failed to furnis		
		e treatment and to be free of			or a lack of respect for the clic property by anyone furnishing		
		xploitation whether it be			services on behalf of the age		
	_	financial. The staff of			15. BrightStar will document		
	BrightStar is manda	ated to report in Indiana any			receipt of the complaint and		
	outright or suspecte	ed cases of abuse, neglect,			initiate a complaint investigati	on	
	abandonment, or ex	eploitation to the APS hotline			within 10 days after the agend		
	at: 1-800-992-6978	3 (Toll free in Indiana) Outside			receipt of the complaint. All	•	
	of Indiana: 1800-	545-7763, Ext. 20135			components of the investigati	on	
	Procedure: 1. Brig	htStar staff will be oriented to			will be documented and the e	ntire	
	signs and symptom	s indicating possible abuse or			investigation and documentat		
	neglect. 2. Definit	ions are defined as follows:			will be completed within 30 da	ays	
		Anyone 18 years of age or			after the agency receives the		
	_	ss of where the person is			complaint, unless the agency		
		unlikely to report abuse or			a documents reasonable caus	se	
	_	istance because of mental or			for delay"		
		npairment or his/her emotional			All employees will have a		
	,	ana law defines endangered			verification from the state the		
		viduals 18 years or older who			have been registered as a Hbbefore they have any first pat		
		naging their property or caring			contact.	CIIL	
		use of illness, disability, or			Performance Improvement Pl	an	
		d are harmed or threatened			will include any customer	uii	
	with harm as a resu	lt of abuse, neglect or			win include any customer		

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 B. WING		COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR exploitation of the p	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Derson's personal services,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) complaints, incidents, and	Έ	(X5) COMPLETION DATE
	property or both.) improper act or proceed member, or other in relationship with the using the resources person for monetary gain without the information or disabled person. Reportable Conduct Financial exploitation agency services in a 7. Criteria to identify include: Abuse and An inability of care patient's money or pubetween patient's reach Reports of demands services 13. The complete a written in Investigation form a information: Incide The alleged perpetra allegation. Any injustreatment required Any action taken 1 investigate complain family or guardian, provider, regarding the agency or that the alack of respect for anyone furnishing segency. 15. Bright of the complaint and investigation within receipt of the complaint and investigation will be investigation and do completed within 30 receives the complaint receipts of the complaint and investigation will be investigation will be investigation and do completed within 30 receives the complaint and investigation will be investigation and do completed within 30 receives the complaint and investigation will be investigation and do completed within 30 receives the complaint and investigation will be investigation and do completed within 30 receives the complaint and investigation will be investigation will be investigation will be investigation and do completed within 30 receives the complaint and investigation will be investigation.	cess of a caretaker, family dividual who has an ongoing e elderly or disabled person of an elderly or disabled or or personal benefit, profit, or formed consent of the elderly 3. The definition of as listed includes: on of an individual receiving namount of \$25 or more; fy victims of exploitation for misuse of patient's money giver/family to account for property. Discrepancies sources and living situation. For goods in exchange for the BrightStar Agency will report using the Provider and include the following and the The alleged victiment of Any witness(es) The rey or adverse affect Any			employee complaints to collaborate all of our services a disciplines to meet the needs of the clients, staff and the community. Risk Management infection control, and clinical quality will also be part of this quarterly team meeting to mak sure the needs of our clients a being met as well as their well being and safety. ADDENDUM: All office employ and field case managers were given a Compliant Concerns/Complaint Form on 9/25/17. If any complaint is received it will be written on the form and given to the Administrator. The Administrativill contact all involved parties (client and/or employee) and complete an investigation. Once complaint is complete it will be entered into our software systems stating what the resolution was mark it to be followed up on (if marked for follow up a reminder is sent to the person Administrator or Nursing Supervisor) who needs to follow up and on what date. Any other agencies will be documented such as APS, CPS, Case Managers, etc. These will be monitored by the Administrator and then discussed as part of risk management during quarter performance Improvement meetings to see how we can grand improve from these	of , e re ree is or ce em s, er wer	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	OO	COMPLETED			
			B. WING		07/27/2017		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Improvement progra address the misappr performance improvement performance improvement and or quality indicators we management and or occurrence reporting was never addressed complaint/incident lemisappropriation 3 of time frame. The mis	agency's Performance am on 7/25/17 failed to ropriation of funds in 2016 wement meetings. The agency wement program has a table of with one domain listed as Risk me indicator listed as unusual g. Misappropriation of funds d. However review of the log evidence 4 cases of of which were in a 3 week isappropriations evidenced in int/incident log are dated 2/16, and 11/7/16.		experiences and make sure of clients are protected. They also will be discussed during week meetings with the Leadership team and appointed person from the Leadership team will be appointed for follow up if necessary. Governing Body reviewed Client Complaint/Concern on 9/25/11 approval.	oon ent		
N 0458 Bldg. 00	employees shall be policies. All employees certification, or regiperform the respective records of employee health services shall include docuthe job, including to the job, including the job, i	nagement Personnel practices for re supported by written byees caring for patients in ubject to Indiana licensure, gistration required to ctive service. Personnel rees who deliver home all be kept current and mentation of orientation to the following: red criminal history 27-2. rent license, certification, mance evaluations. riew the administrator failed to li records were current and	N 0458	By October 31, 2017 active employee files will be audited	10/31/2017		
	ensure all personnel complete in 1 of 1 a			employee files will be audited assure Policy Section 03/07 Personnel File are compliant a			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMP			ETED		
			B. WING			07/27/	07/27/2017	
							-	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE			
				9521 IN	IDIANAPOLIS BLVD, SUITE O			
BRIGHT	STAR OF LAKE CC	OUNTY INDIANA		HIGHLA	AND, IN 46322			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE	
	The findings includ	le:			include the following: Reference	ces,		
					National Background Check,	·		
	Personnel record	review conducted on 7/27/17			Discipline specific license,			
		he following in the employee			certification or registration and			
	records:	ine tone wing in the employee			verification of active status, an			
	1000145.				annual negative TB skin test o			
	a Review of t	the personnel record of			chest x-ray, pre employment			
		ced no signed copy of a job			physical stating they are free a	and		
		nnual performance evaluation.			clear of communicable disease			
	accompanion of all all	performance evaluation.			current cpr certification,			
	h Review of	the personnel record of			documentation of their job			
		ced no annual performance			orientation, documentation of			
	evaluation.	eed no annual performance			their job description (and signe	ed		
	Cvaruation.				by employee), qualifications a	nd		
	a Paviany of t	the personnel record of			receipt of their job description,			
		ced no annual performance			and annual performance			
	evaluation.	ced no annual performance			evaluations.			
	evaluation.				On going 10% of active emplo			
	4 Danian af	dh a mana ann al mana aid aif			files will be audited quarterly b	y		
		the personnel record of			the Administrator and			
	evaluation.	ced no annual performance			Compliance Coordinator.			
	evaluation.							
	. Daniem of	uh			Addendum: We were misguide	9		
		the personnel record of need no national background			with the background checks			
					needing to be through the stat			
	check of 2nd step o	f TB [tuberculosis] test.			repository. During our survey			
	f Daniana Ca	ha nargannal ragar 1 - f			found we were not compliant v	vitn		
		he personnel record of			all Background checks to be			
		ced no national background			completed as a National			
	check, or 2nd step of	of 1B test.			Background Checks. Every employee file is being audited	to		
	- Davison - C	dh a mana ann al mana al a f			make sure they have all of the			
		the personnel record of			credentials. Due to it being a	11		
		o evidence a current TB test			national background check we			
	during his/her empl	oyment with BrightStar.			need to run sometimes it can t			
	1. 10. 1. 10.	sha manannal accept of			up to 10 days for results to con			
		the personnel record of			in. Therefore, this time frame			
		to evidence any TB test prior			allowing us to get this complet			
	to employment with	n BrightStar.			by the end of the month. Going			
					forward every new hire will have	•		
		he personnel record of			completed National Backgrour			
		o evidence a current TB test,			Check at the time of their hire.			
	chest x-ray or annu-	al risk assessment.			oncon at the time of their fille.			

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	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING B. WING	<u>00</u>	COMPLETED 07/27/2017
	PROVIDER OR SUPPLIER STAR OF LAKE COUNTY INDIANA	9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(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 APPROPRIA' DEFICIENCY)	
	2. The undated agency policy titled "Section 03.07 - Personnel File" stated "1. Personnel files will be maintained for Agency employees 5. Personnel files who provide direct patient care will contain the following at a minimum: References, Limited criminal history, Discipline specific license, certification or registration as required by regulation and verification of active status. An annual negative TB skin test or chest x-ray per guidelines Pre-employment physical Current CPR certification Documentation of orientation to their job Qualifications and receipt of a job description Annual performance evaluations (performed every nine (9) to fifteen (15) months of active employment [sic]" The agency policy failed to reflect the current regulation of national criminal history background check.		Once recruiter hires employee will go through administration an audit to double check to ma sure all employees are complishefore patient contact. As an going compliance 10% of active employee volume will be audit for continued compliance. The Administrator will oversee this.	for ake ant on re ed
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 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.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
			B. WING 07/			07/27/	2017
		<u> </u>	<u> —</u>	STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹	9521 INDIANAPOLIS BLVD, SUITE O				
DDICUTO	STAR OF LAKE CO		HIGHLAND, IN 46322				
BRIGHTS	STAR OF LAKE CO	JUNIT INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	(2) The second s	tep of a two-step tuberculin					
	skin test using the Mantoux method must be						
	administered one (1) to three (3) weeks after						
	the first tuberculin	ı skin test was					
	administered.						
	(3) Any person w	ith:					
	(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						
	_	sis of tuberculosis.					
		e testing, tuberculosis					
	screening must:						
	(A) be completed						
		minimum, a tuberculin skin					
	test using the Mar						
	was subject to sub	ssay unless the individual					
	•	aving a positive finding on					
	a tuberculosis eva						
		ome health agency; or					
	(B) provide direct	• •					
		by a physician to work.					
		alth agency must maintain					
		tuberculosis evaluations					
	showing that any						
		ne home health agency; or					
	(B) having direct						
		ve finding on a tuberculosis					
		n the previous twelve (12)					
	months.	. a.e p.eeaeee ()					
		view the agency failed to	N ₀	464	Section 03.04 - "Health		09/30/2017
		oyees had a current tuberculin	1,0	707	Screening", Agency employees		07/30/2017
	test or a 2 step tuberculin test for new employees				and contract personnel must		
	_	ears tuberculin test. (employees			have documentation of baseline		
	E, F, M, R, S)	, and the crowning test. (company test			health screening prior to provide		
	_, -, - ,, - ,				care to patients. When the TB		
	i						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			i i	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		07/27/2017		
			CTDEE	T ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	2					
			9521 INDIANAPOLIS BLVD, SUITE O				
BRIGHT	STAR OF LAKE CC	OUNTY INDIANA	HIGH	ILAND, IN 46322			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DE OVIDERIO N. AN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
	The findings includ	<u> </u>		skin test is administered, it w			
	The imanigs metad	C.		read within 48-72 hours and			
	1 The undeted age	may policy titled "Section		documented as "non-signification	ant"		
	The undated agency policy titled "Section 03.04 - Health Screening" stated "1. All Agency			(negative) or "significant"			
				(positive) in millimeters of			
		tract personnel must have		induration. Recruiter and Nur	reina		
		aseline health screening prior		Supervisor will be re-educate	_		
		patients 4. Tuberculosis		immediately to make sure the			
	testing: All health care workers including direct			established policy is followed			
	employees and contract staff who will provide			no employee is hired without			
		nust have a baseline two-step		negative TB skin test or ches			
		t (TST) unless the individual		x-ray supporting a positive TI			
		that a Tuberculin skin test has		Skin test or chest x-ray	1		
		time during the previous		supporting a positive TB Skir	test		
	twelve (12) months and the result is negative. If			and are okay to work. New h			
	the individual does not have documented			will be reviewed by the			
		ive Tuberculin skin test within		Compliance Coordinator prio	r to		
	_	nths, a Tuberculin skin test		working their first assignmen			
	may be given at the	time of hire and repeated		make sure that compliance w			
	within one to three	weeks after the first tuberculin		credentials are met. 10% of			
	test was administer	ed. Administering, reading		employee files will be audited	1		
	and interpreting the	results of the Tuberculin skin		quarterly and findings reporte			
	test will be perform	ed by a licensed nursing		the Performance Improveme			
	professional who is	knowledgeable of Tuberculin		Committee.			
	skin tests. The heal	th care worker will be					
	educated concernin	g the administration and		Addendum - Policy addendu	n		
	reading of the Tube	erculin skin test 6. Any		was created and reviewed by			
	person with a docur	mented history of tuberculosis;		Governing Body on 9/25/17.			
	previously positive	test result for tuberculosis or		audits are being conducted to			
	newly positive resu	lt to the tuberculin skin testing		remove any employee from			
	must have a docum	ented negative chest x-ray to		patient contact until a two-ste	ep		
		of tuberculosis. 8. After		was complete if they did not	nave		
		perculosis screening must be		a current TB within the last 1			
	_	using the one-step method		months. Administrator is over	-		
		o are known to have converted		seeing this policy.			
		purified protein derivative]					
		e time of hire or after, will be					
	required to complet						
	questionnaire to verify that no known symptoms						
	•	are present. The form is kept					
	in the employee's health file. By signing the form,						
		ated that they are aware of the					
	I are employee male	acco mai mey are aware or me		1	ĺ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
			B. W	ING		07/27/	2017
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	R					
DDICUT	STAR OF LAKE CO				DIANAPOLIS BLVD, SUITE O		
БКІВПІ	STAR OF LAKE CC	JON I F INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	need to report any s	symptoms that might arise"					
		onnel records on 7/26/17					
	evidenced a document titled "Tuberculosis Test						
		e M dated 9/17/16. Employee					
	M date of hire was 9/22/16, no other TB test was						
	evidenced in personnel file. The agency failed to ensure employee M had a two-step tuberculin skin						
	test as per agency policy.						
	3. Review of personnel records on 7/26/17 evidenced a document titled "Tuberculosis Screening Test" for employee E dated 10/25/16.						
	Employee E date of hire was 11/2/16, no other						
		ced in personnel file. The					
		sure employee E had a					
	two-step tuberculin	skin test as per agency policy.					
	*	onnel records on 7/26/17					
		ent titled "Tuberculin Skin					
		F dated 4/19/15, no other TB					
		in personnel file. The agency					
	·	ployee F had an annual TB					
	test.						
	5 D	7/26/17					
		onnel records on 7/26/17 ent titled "PPD/Tuberculosis					
		nployee R dated 6/12/16.					
		f hire was 6/21/16, no other					
		ced in personnel file. The					
		sure employee R had a					
		as per agency policy, and					
		ployee R had a current annual					
	TB test.						
	6. Review of perso	onnel records on 7/26/17					
		ented chest x-ray dated					
	6/13/16 for employ	ee S. No other TB skin test or					
	chest x-ray was evi	denced in personnel record for					
		gency failed to ensure					
	employee S had a c	current annual TB test or chest					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING		COMPLETED 07/27/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) X-ray.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
N 0472 Bldg. 00	Rule 12 Sec. 2(a) must develop, implevaluate a quality performance improprogram must reflet home health organ (including those sounder arrangement agency must take improvements in the performance across. The home health assessment and program must use Based on record reversal failed to ensure the program addressed the inclusion of mistigation patient rights in 1 of the findings included. A review of the alternative improvement program address the misapproperformance improvement program address the misapproperformance improvement and or occurrence reporting was never addressed complaint/incident in misappropriation 3 time frame. The mistigation in the mistigation of the mistigation of the mistigation and the mistigation of the	The home health agency plement, maintain, and assessment and overment program. The ect the complexity of the nization and services provided directly or nt). The home health actions that result in the home health agency's ses the spectrum of care. agency's quality performance improvement objective measures. The agency with appropriation of funds and fill agency.	N 0472	By 9/30/17 Administrator, Of Managers, Director of Nursicand Case Management perswill have met and reviewed following policies and assurd our policies will be followed stated: Policy titled "Section 02.07B Client Complaint Policy" state "Policy BrightStar Care addresses all complaints involving clients of BrightStar Care. Client complaints can received in a variety of form such as a phone call to the call letter or note from the client family, or a message deliver the caregiver. BrightStar Camanagement will respond to and all such complaints, male every effort to reach a resolution to the client's	ng sonnel the e that as 3 - ted ar n be s, office, nt or red by are o any king		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
			B. W	ING		07/27/	2017
						01.7_1.1.	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THE OF I	NO TELL ON SOTTELL			9521 IN	IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		HIGHLA	AND, IN 46322		
OVA ID	GID O () DV G	TA TENTENT OF DEFICIENCIES			T		975
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	7/28/16, 8/6/16, 8/1	2/16, and 11/7/16.			satisfaction. It is the desire an	d	
				intent of BrightStar Care to			
	2. During an interv	iew on 7/25/17 at 2:40 p.m.			provide the best possible care	to	
	the administrator an	d employee B indicated that			each of our clients, and to trea	t	
	they talk about othe	r incident occurrences but			them as if they were a membe	r of	
		nt these conversations.			our own family.		
					Policy titled "Section 02.44 -		
	3 The undated poli	icy titled "Section 01.10 -			Home And Community Based		
		vement Plan" stated "1. The			Services Unusual Occurrence		
		op, implement, maintain and			Reporting" stated "1. Anyone		
		• •			with knowledge of an incident		
	evaluate a performance improvement quality assessment plan to measure, assess, and improve the performance of clinical and other processes's				which affects or potentially affe	ects	
					the individual's health, safety a	and	
		-			welfare shall submit an initial		
	as needed. 2. This	•			Incident Report known as		
		rganization and its services,			Reportable Unusual Occurrence	ce	
	_	vices provided directly or			(RUO). 2. All providers are		
	1	3. The plan will be designed			required to report incidents of		
		asures to improve client			RUO within forty-eight (48) hou	urs	
		erceptions of clients/families			of the time the incident occurre	ed,	
		d value of services. 4. The			or from the point of knowledge	of	
		cesses, which through			the incident. 3. All initial Incid	ent	
		services and disciplines, will			Report involving an allegation	or	
	meet the needs of cl				suspicion of abuse, neglect,		
		e purpose of the plan will be to			exploitation, or the death of an		
	*	agency outcomes through a			individual must be submitted		
	coordinated collabo	rative approach to assessing			within twenty-four (24) hours o	f	
	and improving orga	nizational performance. 6.			the incident or knowledge of.	4.	
	Objectives of the Pr	ogram are as follows: To			Any staff suspected, alleged, of	or	
	assess and evaluate	the quality of client care			involved in an incident of abus	e,	
	services provided, a	ppropriateness of services,			neglect, or exploitation must be	e	
	and satisfaction of c	elients and families. To			suspended immediately after t	he	
	identify deviations f	from agency and professional			incident occurs and during the		
	1	e improvement opportunities			provider's investigation of the		
	_	ning and evaluation. To			incident. Reportable Unusual		
		ack and resolve problems in			Occurrences (RUO): a) Alleg	ed,	
	client care services and satisfaction to insure [sic]				suspected or actual abuse,		
	resolution and/or improvement. To increase the				neglect or exploitation of an		
	awareness of each staff member of their role				individual shall be reported to		
	within the organization and foster involvement				Adult Protective Services (APS	S)	
		agency's performance			for a consumer over the age o		
					or Child Protective Services		
	i improvement progra	am. To meet state and federal	1		I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATIONS	1	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	regulatory requirement contribute to unantiful outcomes. 7. The operformance improses the mission, vision organization. Additure performance improses the agency's manage collected to allow the performance. Data based on the organiture provided, including directly or under an served. Processes the external. Data that collection includes satisfaction (clients Agency staff, etc. [4]. Utilization of service in responding to spermanagement and mediagnosis and demonstrates and the control of the contro	wement plan will be guided by and strategic goals of the tional activities for wement will be prioritized by ement team. 8. Data will be ne agency to monitor its collection will be prioritized zation's mission, services those services provided rangement, and populations racked may [sic] internal or may be used for data the following: Customer physicians, referral sources, etcetera]) Clinical outcomes. Sees. Effectiveness of programs ecific concerns such as pain edication management. Client egraphics. Adverse processes or services. rveillance and reporting, iene. Chart audit results. Track regulatory items that		TAG	(CPS) for a consumer under the age of 18 g) Suspected of observed criminal activity by a staff member, employee or ag of a provider, a family member an individual receiving service the individual receiving service p) Inadequate staff support with the potential for endanger the health, safety or welfare of individual. This includes, but in not limited to, inadequate supervision of an individual an inadequate training of staff 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or do of a person the reporting entity shall also report the incident to APS for clients over the age of and CPS for clients under the of 18. The initial incident report must include the following in regard to the report made to A or CPS: a. The name of the person contacted b. The telephone number c. The data contact d. The county of contact d.	ent or ent or of s or es. t ring f the s d . eath / or f 18 age or ext act act act act act act act act act ac	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R.		ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O		
PDICHT	STAR OF LAKE CO					
	TAN OF LAKE CO	JOINT I INDIANA		AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	`	results are available),		or mental abuse, neglect, or		
		t practices, using statistical		exploitation. BrightStar requi	I	
	_	ver possible 12. The plan		all staff to be alert for obvious		
		formance of existing processes		suspected situations jeopardi		
		identify/design new processes		a client's right to considerate, humane treatment and to be		
	based on priorities	, standards and resources"		of abuse, neglect, or exploita		
				whether it be physical, menta		
				financial. The staff of BrightS		
				is mandated to report in India		
				any outright or suspected cas		
				of abuse, neglect, abandonm		
				or exploitation to the APS hot		
				at: 1-800-992-6978 (Toll free		
				Indiana) Outside of Indiana:	1-	
				-800-545-7763, Ext. 20135	_{ff}	
				Procedure: 1. BrightStar sta will be oriented to signs and	II	
				symptoms indicating possible	,	
				abuse or neglect. 2. Definition		
				are defined as follows:		
				Vulnerable Adult: Anyone 18		
				years of age or older, who		
				regardless of where the person	on is	
				living, is unable or unlikely to		
				report abuse or neglect witho		
				assistance because of menta		
				physical function impairment his/her emotional status. (No		
				Indiana law defines endanger		
				adults as those individuals 18	I	
				years or older who are incapa		
				of managing their property or		
				caring for themselves because		
				illness, disability, or other		
				incapacity and are harmed or		
				threatened with harm as a res		
				of abuse, neglect or exploitati	I	
				of the person's personal serv	ices,	
				property or both.)		
				Exploitation: The illegal or		
				improper act or process of a		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R		NDIANAPOLIS BLVD, SUITE O	1	
BRIGHTS	STAR OF LAKE CO	OUNTY INDIANA		AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				other individual who has an ongoing relationship with the elderly or disabled person us the resources of an elderly or disabled person for monetary personal benefit, profit, or ga without the informed consent the elderly or disabled persor 3. The definition of Reportab	or of n	
				Conduct as listed includes: . Financial exploitation of an individual receiving agency services in an amount of \$25 more; 7. Criteria to identivictims of exploitation include Abuse and/or misuse of patie	or ify ::	
				money An inability of caregiver/family to account for patient's money or property. Discrepancies between patier resources and living situation	nt's	
				Reports of demands for good exchange for services 13 The BrightStar Agency will complete a written report usin the Provider Investigation for and include the following	ag	
				information: Incident date Ti alleged victim The alleged perpetrator Any witness(es) allegation Any injury or adve affect Any treatment required	The rse	
				The investigation summary A action taken 14. The Agenc investigate complaints made client, a client's family or guardian, or a client's healthd provider, regarding treatment care furnished by the agency that the agency failed to furnior a lack of respect for the cli	y will by a care t of or sh,	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 07/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				property by anyone furnishing services on behalf of the ager 15. BrightStar will document in receipt of the complaint and initiate a complaint investigation within 10 days after the agency receipt of the complaint. All components of the investigation will be documented and the endine the investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency a documents reasonable cause for delay" Performance Improvement Playwill include any customer complaints, incidents, and employee complaints to collaborate all of our services disciplines to meet the needs the clients, staff and the community. Risk Management infection control, and clinical quality will also be part of this quarterly team meeting to mal sure the needs of our clients abeing met as well as their well being and safety. Risk Management will include any complaints and what the finding were as well as ways we can protect our clients. ADDENDUM: Bright Star Care has an established Performance Improvement Program that support the mission of the organization. By integrating decollection, quality management and performance improvement emprovement	acy. the on cy's on ontire on cys has se an and of t, se are fund ogs

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING		COMPLETED 07/27/2017				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE IDIANAPOLIS BLVD, SUITE O				
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA	HIGHLAND, IN 46322					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
				the organization will define processes for improvement to areas vital to the success of the company. When quality indicators show that a problem exists, an action plan will be implemented to resolve the problem or improve care. Performance improvement activities will be data-driven are evidence-based. Typically, the action plan will be designed to either improve an existing process or create a new one the will enhance care. Persons closest to the activity will be utilized to develop a suggester action plan. Once the action plas implemented, data will be collected to determine whethe the intervention was successful to the intervention was successful to the intervention was successful to the successful to the intervention of clients and the families, and was sustained on time. This is overseen by the Nursin Supervisor and Administrator	ne nd e hat d blan r ul,			
N 0484 Bldg. 00	services shall main communications to appropriately comp support the objecti	nce improvement All personnel providing						
	results shall be do record or minutes Based on record rev	cumented in the clinical of case conferences. iew the agency failed to have amongst their team members	N 0484	By 9/30/17 the Administrator a Nursing Supervisor will meet v		09/30/2017		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED'S BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	and with other agen	cy's that provided care to their			all Nursing Case Managers ar	nd	
	patients. (#1, #4, #6)				review our Policy Section: 02. Coordination of Care, Clinical		
	The findings include:				Summary and Case Conferen Policy includes Care coordina		
	1. The undated age	ncy policy titled "Section			is effectively coordinated by		
	02.37 - Coordination Of Care, Clinical Summary And Case Conference" stated "1. Care coordination is effectively coordinated by members/disciplines of the health care team by case conferences that are held at a minimum of				members/disciplines of the he		
					care team by case conference	es	
					that are held at a minimum of		
					every 60 (sixty) days to ensure	9	
					information is exchanged,	and	
	every 60 (sixty) day	s to ensure information is			pertinent facts communicated changes in the client's needs,	and	
		nt facts communicated and			services, care and goals are		
	_	it's needs, services, care and/or			evaluated and appropriate		
	goals are evaluated and appropriate responses				responses made. Case		
		ferences may be held in			conferences may be held in		
	-	as a group meeting, by phone,			various ways, such as group		
		nust be documented as such.			meeting, by phone, fax or ema	ail,	
		that are reviewed during case			and must be documented as		
		nclude the following:			such. Suggested areas that a	re	
	_	givers or support system in the			reviewed during case		
	_	nt status and progress towards			conferences could include the		
		and effectiveness of the			following: Availability of		
	*	ordination with other agencies			caregivers or support system		
	-	he need arises. Discharge			the home setting, client status		
		riate. 4. Ongoing care			and progress towards goals,		
		rogress and action plans will			medications and effectiveness		
	-	eded when problems are			the treatment plan, coordination with our agencies and institution		
		mplex cases, the client,			if the need arises, and dischar		
		mily members might be			planning. Ongoing case	gc	
	_	c case conference with the			conferences shall be conducted	ed.	
		d representative's approval. 6.			to evaluate the client's status		
		ill be documented on the			progress and action plans will		
		in the progress notes.			formulated as needed when		
		s to the Plan of Care or Service			problems are identified. In		
		inicated by the Registered			complex cases, the family ma	y be	
		e staff members, the client			invited to participate. Case		
		ivers and/or physician as			conferences should be		
		se conference. 7. A Clinical			documented in the appropriate	9	
		ent's care, services rendered			form or in the progress note.		

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER STAR OF LAKE CO		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	and response to card documented on the the physician for sigminimum of every conferences and conshall be kept in the 2. Record review of complaint/incident record evidenced labetween the agency home health aide, a member. This was a. Record reviagency document to area of the document Steps" the following I was made aware of what was reported by 8/12/16. I called [pmember], and was a stopped. I told him from [patient #1] the continue services of him/her why and he to discuss it right no office through an ergoing on. [Employ told me that the [fait to get [patient #1] the/she believes that else offered any inf [family member] he F] had still been go and he/she had no ke BrightStar services him/her that I would her he/she is not go He/She said if any services and if any services and if any services are considered as a service of the said if any services and the said if any services are said if any services and the said if any services are said if any services and the said if any services a	e for each client will be appropriate form and sent to gnature if applicable at a 60 (sixty) days. 8. Case pies of clinical summaries			Changes in the Plan of Care was be communicated by the Registered Nurse to approprial staff members. Case conferent will be documented every 60 cand sent to the physician of the client's care, services rendered and their responses. Case conferences will be kept in the patient's chart. On going compliance will be monitored as 10% of active patient charts are audited every quarter. ADDENDUM: Steps taken to fout the cause of this was finding out that our 60 day summary was uncertainly not sufficient enough to cover case conference requirement. In the form was developed and approved by the governing both on 9/25/17 and is being put in place immediately. Nursing Supervisor and nursing design will be responsible for monitoring this by reviewing all reassessments and post hospitals done by nurse case management which will include these forms every 60 days.	te ces lays e d, ry ind ng vas the A dy	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ILDING	<u>00</u>	COMPL 07/27/	ETED	
	PROVIDER OR SUPPLIER		9521 INI	DDRESS, CITY, STATE, ZIP CODE DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	evidence any agency Summary for July 2 documentation that services with Bright c. During a red document dated 7/3 [registered nurse] was narrative Notes" was called [patient #1] for he/she said he/she was evidenced for the difficult wait to come by." It was evidenced for the evidenced an agency Report" with a date as 8/12/16 3:02 p.m. "[Employee P], nursuall from a property lives telling him/her to resume service with the exidenced care be employee (employee 8/15/16, 8/17/16, 8/18/16. f. Review of the evidenced an initial employee P on 8/31 conducted by employee of the evidenced and the evidenced and the employee P on 8/31 conducted by employee of the evidenced and the employee P on 8/31 conducted by employee of the evidenced and the evidence and th	cord review an agency 0/16 and signed by the RN ith initials titled "Nursing as evidenced that stated "I or a supervisory visit, but vas not feeling up for it right te/she has some things going and he/she would like me to No other nursing narrative note the month of July. the complaint/incident log y document titled "Incident and time of incident recorded . The incident stated se case manager, received a manager where [patient #1] that [patient #1] would like				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/27/2017	
	ROVIDER OR SUPPLIER		9521 IN	ADDRESS, CITY, STATE, ZIP CODE IDIANAPOLIS BLVD, SUITE O AND, IN 46322	0772011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	document titled "Cli 8/3/16. This docum medications two of central line. The medications are also document to the medications two of central line. The medication of the cli 7/25/17, start of care document titled "Cli and signed by employed an area subtitled "Ocare:" which listed a signed by the medication of the medi	al line continuously, and Cath es per central line weekly. ination of care documented in r any entity/agency/provider g patient #4's central line or eations per central line. Inical record for patient #6 on e 3/2/16, evidenced a ient Assessment" dated 3/2/16 byee N. This document had thers involved in client's a skilled nursing facility [#31]. Cailed to evidence any			
N 0486 Bldg. 00	shall coordinate its or social service p patient. Based on record to coordinate its health care provi	The home health agency is services with other health roviders serving the review the agency failed services with other ders serving the patient eviewed. (#4, #6)	N 0486	By 9/30/17 the Administrator a Nursing Supervisor will meet v all Nursing Case Managers an review our Policy Section: 02.3 Coordination of Care, Clinical Summary and Case Conferent Policy includes Care coordinated is effectively coordinated by	vith d 37 ce.
	1. The undated a	ngency policy titled		members/disciplines of the heat care team by case conference	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE COMPI 07/27	LETED	
	PROVIDER OR SUPPLIER		9521	ET ADDRESS, CITY, STATE, ZIP COD I INDIANAPOLIS BLVD, SUIT HLAND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE AP	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	Clinical Summar stated "1. Care of effectively coord members/discipl team by case con a minimum of even ensure informati pertinent facts conferences in the clicare and/or goals appropriate respecton ferences may such as a group re-mail, and must 3. Suggested are during case confollowing: Avais support system in Client status and Medications and treatment plan of agencies and insarises. Discharg appropriate. 4. conferences shall evaluate the clies and action plans needed when profin complex cases and/or family meto attend the case client's or author	linated by ines of the health care aferences that are held at very 60 (sixty) days to on is exchanged, ommunicated and ient's needs, services, are evaluated and onses made. 2. Case be held in various ways, meeting, by phone, fax or be documented as such. eas that are reviewed ferences could include the lability of caregivers or in the home setting. progress towards goals effectiveness of the Coordination with other titutions, if the need e planning as		that are held at a minimure every 60 (sixty) days to en information is exchanged, pertinent facts communicated changes in the client's neservices, care and goals are evaluated and appropriate responses made. Case conferences may be held various ways, such as growneeting, by phone, fax or and must be documented such. Suggested areast the reviewed during case conferences could include following: Availability of caregivers or support systhe home setting, client stand progress towards goal medications and effective the treatment plan, coordiwith our agencies and insifithe need arises, and displanning. Ongoing case conferences shall be conditioned to evaluate the client's staprogress and action plans formulated as needed which problems are identified. In complex cases, the family invited to participate. Case conferences should be documented in the appropriate of the progress of the communicated by the Registered Nurse to approximate the physician client's care, services remand their responses. Case	in oup remail, las hat are ethe tem in tatus als, eness of ination ditutions scharge ducted atus and s will be een remail may be ee priate ote. are will opriate ferences 60 days of the dered,	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		(X3) DATE SURVEY COMPLETED
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER.	B. WING	00	07/27/2017
				ADDRESS STORY OF THE STORY SORD	0112112011
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O	
BRIGHT	STAR OF LAKE CO	OUNTY INDIANA		AND, IN 46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	documented on t	the appropriate form or in		conferences will be kept in the	9
	the progress note	es. Subsequent changes		patient's chart. On going compliance will be	
	to the Plan of Ca	are or Service Plan will		monitored as 10% of active	
	be communicate	d by the Registered		patient charts are audited eve	ery
		riate staff members, the		quarter.	l
		nily/caregivers and/or		ADDENDUM: Steps taken to out the cause of this was findi	
	1 2	ded after the case		out that our 60 day summary	• 1
		A Clinical Summary of		not sufficient enough to cover	the
	the client's care, services rendered and			case conference requirement new form was developed and	. A
response to care for each client will be			approved by the governing bo	odv	
	documented on the appropriate form and			on 9/25/17 and is being put in	
	sent to the physician for signature if			place immediately. Nursing	
		ninimum of every 60		Supervisor and nursing design will be responsible for monitor	
		Case conferences and		this by reviewing all	"ig
	_	l summaries shall be kept		reassessments and post	
	in the client's ch	art."		hospitals done by nurse case management which will include	le
	2. Review of the	e clinical record for		these forms every 60 days.	
		25/17, start of care			
	-	ed an agency document			
	·	edication Profile" dated			
	8/3/16. This doc	cument contained			
	patient's medicat	tions two of which were			
	administered by	central line. The			
	medications liste	ed were Morphine			
	2000mg [milligr	am]/1000 ml [milliliter]			
	*	continuously, and Cath			
		ottles per central line			
	_	vas no coordination of			
		d in clinical record #4 for			
		y/provider who was			
		ent #4's central line or			
		edications per central			
	line.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	•	
				NDIANAPOLIS BLVD, SUITE	0	
	STAR OF LAKE CO			AND, IN 46322	T	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE	
N 0488 Bldg. 00	patient #6 on 7/3/3/2/16, evidence "Client Assessin signed by employ had an area substituted in the patient's care: " we nursing facility failed to evidence care with this factor with this fact	ii) and (j) ance improvement A home health agency d implement a policy of discharge of service to atient's legal representative, I responsible for the east fifteen (15) calendar ervices are stopped. b) day period described in his rule does not apply in umstances: afety, and/or welfare of the ncy's employees would be a significant risk if the home ntinued to provide services efuses the home health s. services are no longer ed on applicable equirements and the home orms the patient of rces to assist the patient				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
			B. W.	ING		07/27/	2017
	PROVIDER OR SUPPLIER			9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
	regulatory criteria, physician's order, agency informs the resources to assist discharge. Based on record revenue a 15 day discharge a 15 day discharge in the findings included age of the findings in the following discharge in good faith, to attend the findings of the findings in good faith, to attend the findings of the findings in good faith, to attend the findings of the findings in good faith, to attend the findings of the fi	and the home health e patient of community st the patient following view the agency failed to charge policy was in place for e: ncy policy titled "Section stated " Clients and/or their	N 0	488	By 9/30/17 the Administrator of update Policy titled "Section 0 - Discharge" and it will state "Clients and/or their legal representative or other individ responsible for the Client's cashall be given a notice of discharge of service at least fifteen (15) calendar days before services are stopped The fifteen (15) calendar day perior requirement does not apply in following circumstances: The health, safety and/or welfare of the Agency's employees woul at immediate and significant in the Agency continued to proviservices to the client, such as client and/or family have threatened agency staff, have weapons in the home or the home is in some other way are unsafe environment for agency staff. The client refuses the Agency's services or decides go to another agency. The client's services are no longer reimbursable based on applic reimbursement requirements the Agency informs the patient community resources to assist the client following discharge. The Agency must continue, in good faith, to attempt to provise services through the fifteen (1 day period. If the Agency can	2.41 ual re ore od the disk if de the end of the end	09/30/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2017	
	ROVIDER OR SUPPLIER		9521 II	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				provide such services during t period, its continuing attempts provide the services must be documented" Current clients will receive a le of this new policy by Septemb	etter
				30, 2017. Service Agreements will have an addendum with the change until new copies can be made as part of this agreements.	nis pe
N 0409	440 140 47 42 20	D/(2)/A)		ADDENDUM: Policy was re-written. Governing Body approved this policy on 9/25/1 as well as the letter that was mailed to all clients. Letter wa mailed to all clients on 9/25/17 and a copy was placed in their chart. Administrator was responsible for this. Consent of Care in all new Admissions was updated to include discharge notice of 15 days with a signar of receipt of this information of forward. On going monitoring be done by the Administrator of 10% of chart volume quarterly assure we have a copy of their consent of this information.	s 7 r for as ture oing will with r to
N 0498 Bldg. 00	exercise his or he home health agen (2) The patient health following: (A) Have his or herespect.	patient has the right to r rights as a patient of the acy as follows: nas the right to the her property treated with			
	Based on record rev	view and interview the agency	N 0498	By 9/30/17 Administrator, Office	ce 09/30/2017

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2017	
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTS	STAR OF LAKE CC	DUNTY INDIANA		NDIANAPOLIS BLVD, SUITE C AND, IN 46322	,
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		patient's property was treated		Managers, Director of Nursin	-
	_	at of 6 records reviewed. (#1,		and Case Management personal will have met and reviewed to	l l
	#2, #3, #4)			following policies and assure	
	The findings includ	le:		our policies will be followed a	
	The imanigs merad			stated:	
	1. The undated age	ency policy titled "Section		Policy titled "Section 02.07B	
	02.05 - Bill of Righ	its" stated " 11. A summary		Client Complaint Policy" state	ed
		s will be kept and presented to		"Policy BrightStar Care	
		y with recommendations and		addresses all complaints involving clients of BrightStar	
	resolution documen	nted, at least annually".		Care. Client complaints can	
	a Paviow of	the agency's performance		received in a variety of forms	l l
		nd meeting minutes on 7/25/17		such as a phone call to the o	ffice,
		ny meeting minutes or		a letter or note from the clien	
		vement indicators that		family, or a message delivered	-
	addressed misappro	ppriations or patient rights in		the caregiver. BrightStar Cal management will respond to	
	2016.			and all such complaints, mak	-
				every effort to reach a resolu	•
		nterview on 7/25/17 at 2:40		that meets the client's	
	-	tor and employee B indicated r where you enter complaint		satisfaction. It is the desire a	ind
	_	ooses things and places them		intent of BrightStar Care to	- 1-
		n the agency addresses these		provide the best possible car each of our clients, and to tre	
		ree B also indicated that the		them as if they were a memb	
	complaints/complia	ance they were addressing were		our own family.	
		e brought up by Joint		Policy titled "Section 02.44 -	
		s; hand washing, UTI [urinary		Home And Community Base	l l
	_	infections. The administrator		Services Unusual Occurrenc	
		dicated that the agency talks ts but they do not document		Reporting" stated "1. Anyone with knowledge of an inciden	l l
	such conversations.	_		which affects or potentially at	
	zam von viounono.			the individual's health, safety	l l
	2. Review of the ag	gency complaint/incident log		welfare shall submit an initial	
		ed 4 complaints in 2016 for		Incident Report known as	
	loss or theft of prop	-		Reportable Unusual Occurre	nce
	-	ts dates reported are: 7/27/16		(RUO). 2. All providers are required to report incidents o	f
	-	(patient #4), 8/30/16 (patient		RUO within forty-eight (48) h	l l
	#1) and 11/1//16 (p are as follows:	patient #2). The allegations		of the time the incident occur	
	are as follows.			or from the point of knowledg	e of
J					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPL	ETED
			B. W	B. WING		07/27/2017	
				CED FEET A	ADDRESS COMMUNICATE STREET, ST		-
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DDIGUE	OTAB OF LAWE OF	NI INITA INITA NA			IDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a. Record revi	iew of complaint/incident log			the incident. 3. All initial Incid	ent	
	evidenced a complaint for loss or theft of property				Report involving an allegation	or	
	for patient #3 that is	s recorded as 7/23/16 at 9:00			suspicion of abuse, neglect,		
	a.m. This complair	nt/incident failed to be			exploitation, or the death of an	1	
	evidenced in the cli	nical record for patient #3.			individual must be submitted		
	Who reported incid	ent is listed as "other". The			within twenty-four (24) hours o		
	agency document ti	tled "Incident Report" stated			the incident or knowledge of.		
	" Incident Descri	ption Received a call from			Any staff suspected, alleged, o		
	caregiver and then	family member advising that			involved in an incident of abus		
	there were 4 month	s of charges of the satellite			neglect, or exploitation must b		
	television bill on th	eir mother's/father's account			suspended immediately after t		
	for our caregiver, an iPhone bought for our				incident occurs and during the		
	caregiver and Amaz	zon orders purchased by or			provider's investigation of the		
	[sic] caregiver for p	personal items. As well, as			incident. Reportable Unusual	ad	
		ng brought to the home"			Occurrences (RUO): a) Alleg suspected or actual abuse,	eu,	
	The last "action pla	n steps" evidenced on report			neglect or exploitation of an		
		and stated "[Employee B]			individual shall be reported to		
	followed up with fa	mily." During an interview			Adult Protective Services (APS	3)	
	with the administra	tor on 7/25/17 at 2:52 p.m., the			for a consumer over the age o	,	
	administrator indica	ated that the resolution for this			or Child Protective Services		
	incident was emplo	yee B followed up with the			(CPS) for a consumer under the	ne	
	family and that emp	ployee H was terminated.			age of 18 g) Suspected o		
		v of the personnel file of			observed criminal activity by a		
		6/17 evidenced an agency			staff member, employee or ag		
		ISCIPLINARY ACTION			of a provider, a family member	r of	
		" Description of Incident:			an individual receiving service		
		terminated this date due to			the individual receiving service	es.	
	1	Star policies and procedures.			p) Inadequate staff suppor		
		e informed that [employee H]			with the potential for endanger	-	
	1 -	pay for his/her personal			the health, safety or welfare of		
		ig him/her an iphone, and			individual. This includes, but i	S	
		mazon orders for the client to			not limited to, inadequate		
		e also advised he/she was			supervision of an individual an		
		ldren to the client's home.			inadequate training of staff		
		advised his/her employment			7. If an incident involves		
		nediately and he/she is not to			suspected or actual abuse,	aath	
	· ·	clients on the phone or go to			neglect, exploitation, and/or de		
	their homes"				of a person the reporting entity shall also report the incident to		
					APS for clients over the age of		
		iew of complaint/incident log			and CPS for clients under the		
	evidenced an agenc	y document titled "Incident			and or o for chemic under the	uge	

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIED		9521 II	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) If idential" with a date of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) of 18. The initial incident repo	DATE
	incident listed as 00 incident report listed demographics. An subtitled "Narrative" "Client called to dis on the phone, he/sh where's my money approximately \$65 from his/her change there were two peotwo BrightStar empstated he/she had getalk to the schedule on 8/5. [person #2! home from a differ [Employee R] was missing on 8/9. Cl R]. Client said [embank and went shop from Walmart he/si [employee R] wontsaid a 2 dollar bill work of the completed, we coult that he/she is not get his/her [family mer comes into town. It Long Term). Once BrightStar will con resolution fails to fan interview on 7/2 administrator indic #4 was they were a administrator and et there should probalt that it sounds like were a subtitute of the sounds like were a subtitue of the sounds like were a subtitue of the su	8/06/2016 at 5:00 p.m. The department of patient #4 and area in the agency document of Details - Standard" stated scuss his/her schedule. While he said OMG [oh my God] of He/She said that - \$70 dollars [sic] missing he purse. He/She stated that ple in the home in addition to ployee's-total of four. Client one into his/her bedroom to the from BrightStar on the phone of and two others were in the ent agency on the 5th. There on 8/6. Noticed money itent thinks it was [employee apployee R] had worked at a poping for him/her and had a list the was trying to get back and a list he was trying to get back and a list in the change purse. The she should do, we advised alice report. Once that was ald investigate. Client stated being to make a report until mber], who is an attorney of the plant of Resolve (Immediate and Police report is received, duct an investigation." This collow agency policy. During 5/17 at 2:58 p.m. the lated the resolution for patient waiting a police report. The mployee B also indicated that only be more documented and we need to do a better job with ment failed to be evidenced in		must include the following in regard to the report made to a or CPS: a. The name of the person contacted b. The telephone number c. The da contact d. The county of cons. The reporting entity shall ravailable a copy of the initial lincident report], at a minimur the individual or individual's le representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local lenforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that up occasion recipients of our carmay become subject to physior mental abuse, neglect, or exploitation. BrightStar requirall staff to be alert for obvious suspected situations jeopardia a client's right to considerate, humane treatment and to be of abuse, neglect, or exploitat whether it be physical, menta financial. The staff of BrightS is mandated to report in India any outright or suspected casof abuse, neglect, abandonmor exploitation to the APS hot at: 1-800-992-6978 (Toll free Indiana) Outside of Indiana: -800-545-7763, Ext. 20135 Procedure: 1. BrightStar star will be oriented to signs and symptoms indicating possible abuse or neglect. 2. Definitionare defined as follows:	te of tact nake R n, to egal aw on e cal res or zing free cion I or tar na es ent, line in 1-

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING		COMPLETED 07/27/2017	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIGHT	STAR OF LAKE CO	UNTY INDIANA		NDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
IAG	c. Record revievidenced a complatitled "Incident Repcomplaint. The recofincident as 8/12/report listed patient "customer" as who agency document st Reported by [employed agency a	ew of complaint/incident log int listed on agency document ort" as "Incident Type" ord evidenced a date and time 16 3:02 p.m. The incident #1 as the client and reported the complaint. The ated " Incident Description over B]: [Employee P], nurse oved a call from a property ient #1] lives telling him/her uld like to resume service with alled him/her back to see if im/her. He/She said he/she he/she does not want [Employee B] asked him/her lained that [employee F] told is not going to be working for the ([employee F]) is starting is and because of this is show up whenever he/she is always had shifts Mon endnesday], and Friday from imployee B] looked back in the [employee F] would go Mon, and Friday one week and then the went Mon, Tues [Tuesday], and he/she never knew when oning to come or not. [Patient over F] was going shopping for two other people on all take him/her way longer his/her shopping. [Patient #1] that [employee F] was there he/she wants us to call him/her he doesn't go back. There has led with [patient #1] in any document titled "Incident subtitled "Action Plan Steps" Follow-up with Patient Family and a call from [person #26],	IAG	Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the perso living, is unable or unlikely to report abuse or neglect without assistance because of mental physical function impairment of his/her emotional status. (Not Indiana law defines endangere adults as those individuals 18 years or older who are incapat of managing their property or caring for themselves because illness, disability, or other incapacity and are harmed or threatened with harm as a rest of abuse, neglect or exploitation of the person's personal service property or both.) Exploitation: The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person of an elderly or disabled person. The definition of Reportable Conduct as listed includes: Financial exploitation of an individual receiving agency services in an amount of \$25 comore; 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patier money. An inability of caregiver/family to account for patient's money or property. Discrepancies between patients.	n is It or or e: ed ble e of ult on ces, of e	

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING		COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER STAR OF LAKE CO		9521 II	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	were being paid dire paying the caregiver #1] paid us. He/She his/her checking acc checks that were wr [employee D] (prev. him/her how much a of \$350, \$400, \$600 gather what he/she back to 10/15) and I else he/she found. Supervisor Comple off [sic] what happe fraud. 8/22/16 Foll Completed I called he/she had found ou He/She said he/she going to do. I told he/she had found ou he/She said he/she going to do. I told he/she he/she held to for the poher [family member and will decide what he/she needed anyth He/She thanked me up with Employee G] about the checks and to call the police so [Employee G] made the check fraud. Ca number]. He/She sa and they thanked him 8/30/16 Follow-up Completed I follow regards to the police	[patient #1], asking if we bettly or was [patient #1] I told him/her that [patient asaid he/she went through atten out to [employee F] and atten to please and find (as he/she only went et me know on Monday what atten to make the stand of the stand for		resources and living situation. Reports of demands for goods exchange for services 13. The BrightStar Agency will complete a written report using the Provider Investigation form and include the following information: Incident date The alleged victim The alleged perpetrator Any witness(es) allegation Any injury or advers affect Any treatment required The investigation summary Araction taken 14. The Agency investigate complaints made be client, a client's family or guardian, or a client's healthca provider, regarding treatment care furnished by the agency of that the agency failed to furnis or a lack of respect for the clie property by anyone furnishing services on behalf of the agen 15. BrightStar will document to receipt of the complaint and initiate a complaint investigation within 10 days after the agency receipt of the complaint. All components of the investigation will be documented and the er investigation and documentation will be completed within 30 day after the agency receives the complaint, unless the agency of a documents reasonable caus for delay" Performance Improvement Play will include any customer complaints, incidents, and employee complaints to collaborate all of our services and disciplines to meet the needs of t	En le

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATI			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. WING 07/27/2017			2017	
				_	<u> </u>	01.1_1.	
NAME OF I	PROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				9521 IN	IDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· L	DATE
	called and I told hir	m/her that [patient #1] asked	1		the clients, staff and the		
		said that's what he/she			community. Risk Management		
		id him/her and his/her [family			infection control, and clinical	•	
	-	g to the lawyer's today and			quality will also be part of this		
		ey need to do. He/She said			quarterly team meeting to mak	æ	
		ing a good job and to just			sure the needs of our clients a	re	
		r in the loop with any changes			being met as well as their well		
	_	This is the last entry for the			being and safety. Risk		
		ring an interview on 7/25/17			Management will include any f		
		ninistrator indicated the			complaints and what the findin	gs	
	resolution for this complaint was that the caregivers were terminated. d. Record review of complaint/incident log evidenced a complaint listed as loss of theft of				were as well as ways we can		
					protect our clients.		
					ADDENDUM: Letter was sent		
					all employee, office and field s		
	_	#2 with date and time of			reminding them of our client's		
		1/9/16 1:11 p.m. The agency			right and their responsibility in		
		cident Report" stated "			reporting any incidents,		
		n [Employee E] caregiver			complaints or concerns to the		
		nen the [family member] came			office. Governing body reviews	ea	
		as still at store) he/she said			this letter on 9/25/17. This		
		nber] told him/her "he/she is a			information is also include in the handbook for all new hires. The		
		employee E]. He/She said			will be over seen by the	15	
		dollars stolen and that's why			Administrator. Employees have	2	
	he/she was not back	_			acknowledgement they receive		
		omes 11/9 @ 2:35p			access to the handbook as we		
		d and said he/she spoke with			as an Erisa Disclosure that the		
		and said he/she is good at			have to have an email address		
		ver the place. [Employee E]			work for BrightStar and be awa		
		found one envelope of money			of policies and procedures.	0	
		nued looking and they found			or possession and procession		
		ith 100's of dollars in it.					
		mily member][person #28] was					
		ne bank." No other resolution					
		gency document. There was					
		nily or patient #2 being called					
	back for testimony or satisfaction of resolution. The only testimony the agency received was from employee E. During an interview on 7/25/17 at						
		nistrator indicated the					
		nt #2 complaint was in the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		07/27/2017		
			<u> </u>	_			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
			9521 INDIANAPOLIS BLVD, SUITE O				
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA	HIGHL	AND, IN 46322			
(V4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES	ID	T	(V5)		
(X4) ID				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	treatments, resolution	on, and outcomes of the					
	agency document ti	tled "Incident Report".					
	3. Review of the ag	gency admission packet on					
	-	an area titled "7. Code of					
		d "The following ethics and					
		atory for each employee to					
	meet on a continuous and ongoing basis both						
	within the privacy of a client's home or while acting as an employee of the Agency will 12.						
		- ·					
		t money goods or private					
	-	gain from the client 15.					
Not assume control of or assist with financial and/or personal affairs of the Client or of his/her							
	estate, including but	t not limited to Power of					
	Attorney, Conservat	torship or Guardianship. 17.					
	Not take or borrow	anything from the Client or					
		ven with permission. 18. Not					
		buse, neglect or exploitation.					
	-	are not to engage in any					
		such as dishonesty, forgery,					
		cuments or accounts without					
	-	r; misappropriation of funds,					
		pplies, profiteering as a result					
	_	e; disclosing to outside					
		es in or contemplated by the					
		or disappearance of records					
	or furniture, or any	similar irregularities"					
					<u> </u>		
					<u> </u>		
N 0502	410 IAC 17-12-3(b	o)(2)(C)					
	Patient Rights						
Bldg. 00	Rule 12 (b) The p	atient has the right to					
ŭ	exercise his or her	rights as a patient of the					
	home health agen	cy as follows:					
	(2) The patient h	nas the right to the					
	following:	-					
	•	plaint with the department					
	• •	nt or care furnished by a					
	home health agen						
	-	-	N 0502	Effective 9/30/17 the	09/30/2017		
	Based on interview the agency failed to				09/30/2017		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 07/27 /	ETED
BRIGHT	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	to file a complaint Department of File The findings incomplaint with personal the state hotline number of the state hotline number of the state hotline number of the agency do "Admission Pack Statement" that the Welcome, Scope Statement & Serfor Admission	erview on 7/26/17 at atient #3 he/she indicated know how to file a he state and did not have d by the agency with the aber included. erview on 7/27/17 at dministrator was queried ocument titled ket Acknowledgement isted "Emergency Plan e of Service, Mission vice Description Criteria Advance Directives - ecide (ISDH [Indiana at of Health]) Advance y for Agency HIPAA y Practices Code of			Administrator will make sure a new admission packets that include "Admission Packet Acknowledgement Statement" listing "Emergency Plan, Welcome, Scope of Service, Mission Statement & Service Description Criteria for Admission Advance Directive Your Right to Decide (ISDH [Indiana State Department of Health]) Advance Directives Policy for Agency HIPAA Noti of Privacy Practices Code of Ethics Bill of Rights and Responsibilities Universal Precautions and Patient's Right Infection Control & Handling Infectious Waste Basic Home Safety Guidelines Emergency Disaster Preparedness in the Home", and will have a section where the client can initial that they have received each individual information as well as signature line for their full name. Their signature will also indicate that they have been explained of the above and their question were answered (if any) at the softheir agreement to start services. A letter will be sent by 9/30/17 informing current clients how they can reach the state if they even have any concerns or complain address, phone number and hours. ADDENDUM: Letter was sent 9/25/17 to all current client on how they can reach the state. Ongoing this is in all admission	or s - ice ints it as a a le. it all as time they er ints; on	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER		9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	C] goes out to m the folder and ag Then when the n he/she goes over and they sign the administrator ind the client unders	licated when [employee eet client he/she leaves reement with the client. urse admits the client the form with the client agency document. The licated it is ensured that tands this document e lets them ask questions		packets and will be monitored the Administrator. During survives was felt that the pre-checked admission checklist was alread answering for the patient that the received this information. The checks were removed from this list and now client will have to initial that they receive this information by initialing our the rights and receiving our welcompacket.	ey it dy they pre s
N 0505 Bldg. 00	exercise his or her home health agen (2) The patient hollowing: (D) Be informed a furnished, and of a be furnished as fo (ii) The patient has the planning of the agency shall advisof the right to partifollowing: (AA) The care or (BB) Changes in	atient has the right to rights as a patient of the cy as follows: has the right to the about the care to be any changes in the care to llows: s the right to participate in a care. The home health he the patient in advance cipate in planning the treatment.			
	patient's failed to schedules or care provide care and	review and interview the be informed of their egivers that were to involved in the plan of ords reviewed. (#3, #4,	N 0505	The Administrator and Nursing Supervisor reviewed the Client Rights and Responsibilities document that is given to all client's at the time of starting service. A meeting will be held 9/30/17 advising all office personnel including the client service coordinators and nursi	t's by

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER.	B. WING	00	07/27/2017		
			_		0772772017		
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE			
RDICHT	STAR OF LAKE CC		9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
	1			AND, IN 40322			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	managers of the client's rights	DATE		
	The findings inc	iude:		and responsibilities including			
				the clients have the right "to b			
		e agency admission		informed that you may particip			
		7 evidenced an area		in the development of your pla	an of		
	subtitled "8. Cli	•		care treatment, the periodic			
	_	' this document stated		review and update, discharge plans, appropriate instruction	and		
	"As a client you have the right to: 6.			education in the plan of care,			
	Be informed that you may participate in the development of your plan of care treatment, the periodic review and update, discharge plans, appropriate instruction and education in the plan of			be informed of all treatments			
				agency is to provide, the			
				disciplines to provide care, an			
				the frequency of the visit/shifts be furnished. Also, to be	s to		
				informed with reasonable noti	ce		
	care, and be informed of all treatments			discharge of services.			
	· ·	provide, the disciplines					
		and the frequency of the		Addendum:			
		e furnished. Also, to be		ADDENDUM: All office emplo	VAA		
		reasonable notice of any		and field case managers were			
	discharge of serv			given a Compliant			
	discharge of ser	· 1005		Concerns/Complaint Form on			
	2 Review of cli	inical record #3 on		9/25/17. If any complaint is	.:_		
		ed an agency document		received it will be written on the form and given to the	nis		
		ory Visit" dated 11/1/16		Administrator. The Administra	tor		
	*	3		will contact all involved parties			
		ubjective Data (what		(client and/or employee) and			
		eports): upset not		complete an investigation. On			
	_	aregivers are coming		complaint is complete it will be entered into our software syst			
		chedule" Another		stating what the resolution wa			
		"Supervisory Visit" dated		mark it to be followed up on (i			
		" Subjective Data		marked for follow up a remind			
	` -	mily reports): Wants a		is sent to the person			
	schedule Wants a pill box" There is not agency documentation that evidence patient received a schedule or was informed of who his/her caregivers			Administrator or Nursing	NW .		
				Supervisor) who needs to folk up and on what date. Any other			
				agencies will be documented			
				such as APS, CPS, Case			
	would be.	-		Managers, etc. These will be			
	I		I	I	1		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING		COMPLETED 07/27/2017			
	PROVIDER OR SUPPLIER STAR OF LAKE CO		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
	9:16 a.m. patient does not know w at his/her house. house and I don't they just come in name, and I was of care. 3. Review of clir 7/27/17 evidence titled "Superviso that stated " Supatient/family recaregivers alway permanent sched record failed to e documentation o	interview on 7/26/17 at #3 indicated he/she ho is going to show up. They just come into my know who they are, a. I don't know anyone's not involved in my plan incal record #4 on ad an agency document ry Visit" dated 8/31/16 abjective Data (what ports): Not happy that is change, wants a ule" The clinical evidence any resolution if patient #4 thedule from the agency.		monitored by the Administrato and then discussed as part of risk management during quart Performance Improvement meetings to see how we can gand improve from these experiences and make sure or clients are protected. They als will be discussed during weekl meetings with the Leadership team and appointed person from the Leadership team will be appointed for follow up if necessary. All employees were sent a lett on the patient's right and how report any complaints. Governing Body reviewed Clied Complaint/Concern on 9/25/17 approval.	our erly Irow Ur o y om er to		
N 0508 Bldg. 00	or her rights as a pagency as follows: (2) The patient hollowing: (E) Confidentiality maintained by the The home health apatient of the agent	as the right to exercise his patient of the home health as the right to the ty of the clinical records home health agency. Agency shall advise the acy's policies and agency of clinical	N 0508	By 9/30/17 Administrator, Offic	ce	07/31/2017	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			- CARD FEET	ADDRESS OF A STATE OF SORE		
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
DDIOUT	OTAD OF LAKE O	OLINITY INIDIANIA		NDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE C	JUNIY INDIANA	HIGHL	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	observation the ag	ency failed to ensure clinical		Managers, Director of Nursing	9	
	records were safeg	guarded in a secure, locked		and Case Management perso		
	room in 1 of 1 age	ncy.		will have met and reviewed th		
				following policies and assure		
	The findings inclu	de:		our policies will be followed as	S	
				stated:		
	_	ency policy titled "Section		Policy Section 02.21 Client	L .	
		dical Record Security and		Medical Record Security which		
		'Policy: Medical records will		states that Medical Records v be retained for each client	VIII	
		h client receiving home care		receiving home care services		
	services. Medical record information is considered confidential. All records will be protected against loss, damage, or unauthorized access Retention of Records: 4. Clinical			Medical record information is	•	
				considered confidential. All		
				records will be protected agai	nst	
				loss, damage, or unauthorize		
	record information shall be safeguarded in a locked area when not in use by staff"			access. Procedure: All copies	of	
	locked area when	not in use by starr		paper record necessary for		
	2 During tour of	the agency on 7/24/16 at 10:52		continuity of care will be kept		
	_	cords were observed on open		the client's home. 2. At the tin		
		cked, lighted room of the		client discharge all records wi		
		ersonnel present in the room.		collected from the client's hon	ne	
		20 p.m. the clinical records were		for proper scanning and	in m4	
		ocked room with no personnel		subsequent destruction. 3. Cl records will be scanned into the		
	present.	P		BrightStar Corporate record		
	1			retention system for security a	and	
	3. During an inter	view on 7/25/17 at 2:30 p.m.		storage. 4. BrightStar Corpor		
	employee B stated	they were currently under		maintains a redundant backup		
	construction and h	e/she is having a new room		system of all scanned		
	built for the clinica	al records.		documents. 5. Paper docume	nts	
				are either shredded after		
				scanning or placed into a lock		
				file within the BrightStar office	e. 6.	
				As a security precaution,		
				BrightStar system log in		
				passwords have been pre-set		
				with a lockout feature that hel to prevent access to the	μο	
				BrightStar system by		
				unauthorized users. If a user	tries	
				more than three times to log i		
				the system with an incorrect		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				password that account will be locked. 7. For office that keep charts on their patients, a designated chart room must remain locked when unattended.	
				On 7/31/17 a new door was installed with a passcode lock access. This door will automatically lock when not occupied.	
N 0514	410 IAC 17-12-3(d	e)			
Bldg. 00	following: (1) Investigate of patient or the patient or the patient representative reg following: (A) Treatment or furnished. (B) The lack of reproperty by anyon behalf of the home (2) Document by complaint and the complaint.	oth the existence of the resolution of the			
	failed to ensure a re	riew and interview the agency solution according to agency applaints reviewed. (#1, #2,	N 0514	By 9/30/17 Administrator, Office Managers, Director of Nursing and Case Management persouill have met and reviewed the following policies and assure to our policies will be followed as a stated:	nnel e that
	on 7/25/17 failed to came to a resolution	f the complaint/incident log evidence the administrator in 4 of 4 complaint/incidents inistrator failed to follow the acident policy.		stated: Policy titled "Section 02.07B - Client Complaint Policy" stated "Policy BrightStar Care addresses all complaints involving clients of BrightStar Care. Client complaints can be	d

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
			B. W	NG		07/27/	2017
				CTDEET A	ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
DDIOLIT	OTAD OF LAVE OO	LINITY INITIANIA	9521 INDIANAPOLIS BLVD, SUITE O				
RKIGHTS	STAR OF LAKE CO	UNIY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	,,_	DATE
	a. Review of a	igency document titled			received in a variety of forms,		
	"Incident Report" w	with a date reported of 8/30/16			such as a phone call to the off	ice,	
	_	to evidence a resolution			a letter or note from the client		
	-	policy. The last outcome			family, or a message delivered	d by	
		ent was dated 8/30/16 and			the caregiver. BrightStar Care	,	
		strator] followed up with			management will respond to a	ny	
		ards to the police report,			and all such complaints, makir		
		was aware. He/She asked why			every effort to reach a resolution	on	
		and I told him/her that			that meets the client's		
		im/her to. He/She said that's			satisfaction. It is the desire an	ıd	
		t. He/She said him/her and			intent of BrightStar Care to		
	him/her [family member] were going to the				provide the best possible care		
	lawyer's today and will decide what they need to do. He/She said [employee G] is doing a good				each of our clients, and to trea		
					them as if they were a membe	r of	
	_	se keep him/her in the loop			our own family.		
		cancellations." During an			Policy titled "Section 02.44 -		
		7 at 9:21 a.m. person #26			Home And Community Based		
	indicated there was	-			Services Unusual Occurrence		
		26 indicated that he/she never			Reporting" stated "1. Anyone		
	-	ology from BrightStar and the			with knowledge of an incident		
	_	he spoke with was the			which affects or potentially affects		
		on #26 indicated that he/she			the individual's health, safety a welfare shall submit an initial	anu	
		ministrator that BrightStar					
		without a police report.			Incident Report known as Reportable Unusual Occurrent	<u></u>	
		on 7/25/17 at 2:52 p.m. the			(RUO). 2. All providers are	oc	
	_	ated that the resolution for			required to report incidents of		
		ermination of employee F.			RUO within forty-eight (48) ho	urs	
	r				of the time the incident occurre		
	b. Review of	agency document titled			or from the point of knowledge		
		with a date reported of			the incident. 3. All initial Incid		
	•	#2 failed to evidence a			Report involving an allegation		
	-	g to agency policy. The			suspicion of abuse, neglect,		
		Treatments, Interventions,			exploitation, or the death of an	1	
		2:35p [employee E] called and			individual must be submitted		
	~	rith the [family member] and			within twenty-four (24) hours o	of	
	_	at hiding money all over the			the incident or knowledge of.		
	place. [Employee E] said they looked and found				Any staff suspected, alleged, of		
one envelope of money and then they continued looking and they found another envelope with				involved in an incident of abus			
				neglect, or exploitation must b	е		
		. He/She said the [family			suspended immediately after t		
		8] was going to take it to the			incident occurs and during the		
	Linemic or Jupor Son #2	-1 20 20 20 mile it to the	1				ī

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			07/27/	/2017
					-		-
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
			9521 INDIANAPOLIS BLVD, SUITE O				
	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bank." The agency	only received testimony from			provider's investigation of the		
	the home health aid	e. The agency failed to ensure			incident. Reportable Unusual		
	patient #2 (complai	nant) and/or the family			Occurrences (RUO): a) Alleg	ed,	
	member were follow	wed up with concerning the			suspected or actual abuse,		
	resolution. During	an interview on 7/25/17 at			neglect or exploitation of an		
	2:52 p.m. the admir	nistrator indicated the			individual shall be reported to		
	resolution for patien	nt #2 is in the treatments,			Adult Protective Services (APS		
	resolution, outcome	es of the incident report.			for a consumer over the age of	f 18	
	c. Review of agency document titled				or Child Protective Services		
					(CPS) for a consumer under the		
	"Incident Report" with a date reported of 7/27/16 for patient #3 failed to evidence a resolution according to agency policy. The last outcome				age of 18 g) Suspected o		
					observed criminal activity by a		
					staff member, employee or ago		
	reported on the incident report document was dated 7/25/16 and stated " [employee B]				of a provider, a family member		
					an individual receiving services the individual receiving service		
	followed up with fa	mily." During an interview on			p) Inadequate staff suppor		
	7/25/17 at 2:52 p.m	the administrator stated the			with the potential for endanger		
	resolution was that	employee H was terminated			the health, safety or welfare of	-	
	and employee B cal	lled the family.			individual. This includes, but is		
					not limited to, inadequate	3	
	d. Review of a	agency document titled			supervision of an individual an	d	
	"Incident Report" w	vith a date of incident as			inadequate training of staff		
	8/6/16 for patient #4	4 failed to evidence a			7. If an incident involves		
	resolution according	g to agency policy. The			suspected or actual abuse,		
	document stated "	. Plan to Resolve (Immediate			neglect, exploitation, and/or de	eath	
		Once Police report is received,			of a person the reporting entity		
	BrightStar will cond	duct an investigation"			shall also report the incident to		
	During an interview	y on 7/25/17 at 2:58 p.m. the			APS for clients over the age of		
	administrator indica	ated the resolution for patient			and CPS for clients under the	age	
	#4 was they were w	vaiting for a police report.			of 18. The initial incident repo		
		w the administrator and			must include the following in		
		dicated that there should			regard to the report made to A	PS	
		ocumented and that they			or CPS: a. The name of the		
	needed to do a bette	er job with details.			person contacted b. The		
					telephone number c. The date		
	2. The undated agency policy titled "Section 02.07B" stated "Policy BrightStar Care addresses all complaints involving clients of BrightStar Care. Client complaints can be received in a				contact d. The county of cont		
					8. The reporting entity shall m		
					available a copy of the initial IF		
					[incident report], at a minimum		
	_	ch as a phone call to the			the individual or individual's leg	gal	
		te from the client or family, or			representative, the case		
	I		1				l .

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 07/27 /	ETED
	PROVIDER OR SUPPLIER STAR OF LAKE CO		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Care management of complaints, making resolution that mee the desire and intenthe best possible cat to treat them as if the family. Procedure reported to the Brig information, with a be captured and log Complaint Report. be placed into the erecord) if appropria communicated to the or designee. 4. The and/or designee will within 10 calendar the Owner and Admill reach a resolute advise the client eiththe planned solution calendar days after complaint. 5. The Nursing will then not situation over the fassure that the issue resolved and that the satisfied" 3. The undated age 02.44 - Home And Unusual Occurrence Anyone with known affects or potentially health, safety and we lincident Report known of the time the occurrence (RUO) to report incidents of the time the occurrence occurre	I by the caregiver. BrightStar will respond to any and all such gevery effort to reach a is the client's satisfaction. It is to f BrightStar Care to provide re to each of our clients, and ney were a member of our own 1. When a client complaint is htStar Care office, the smuch detail as possible, will ged onto the Customer 2. The same information will mployee file (Caregiver of te. 3. The information will be see Owner, Director of Nursing 1 investigate the complaint days and report the findings to ministrator. Collectively, they son of the complaint and will her verbally or in writing of the agency receives the Owner and/or Director of nonitor the Client/Caregiver of to have been satisfactorily			manager, APS or CPS, the individual's other service providers, if relevant, a local later enforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physic or mental abuse, neglect, or exploitation. BrightStar require all staff to be alert for obvious suspected situations jeopardize a client's right to considerate, humane treatment and to be fround abuse, neglect, or exploitation whether it be physical, mental financial. The staff of BrightSt is mandated to report in Indian any outright or suspected case of abuse, neglect, abandonme or exploitation to the APS hoth at: 1-800-992-6978 (Toll free Indiana) Outside of Indiana: 1-800-545-7763, Ext. 20135 Procedure: 1. BrightStar staff will be oriented to signs and symptoms indicating possible abuse or neglect. 2. Definitionare defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person living, is unable or unlikely to report abuse or neglect without assistance because of mental physical function impairment of his/her emotional status. (Not Indiana law defines endanger adults as those individuals 18 years or older who are incapal of managing their property or	esal es or car as ent, in en es ent or es ent es en	

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	INTERPRETATION NUMBER:		JILDING	NSTRUCTION 00	(X3) DATE COMPL 07/27 /	ETED
	PROVIDER OR SUPPLIER		•	9521 IN	ADDRESS, CITY, STATE, ZIP CODE DIANAPOLIS BLVD, SUITE O AND, IN 46322	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	suspicion of abuse, death of an individual twenty-four (24) he knowledge of. 4. A involved in an incice exploitation must be the incident occurs investigation of the Occurrences (RUO actual abuse, neglectindividual shall be services (APS) for or Child Protective consumer under the or observed criminal employee or agent of an individual receiving staff support with the health, safety on This includes, but is supervision of an intraining of staff suspected or actual and/or death of a pealso report the incice the age of 18 and C18. The initial inciffollowing in regard CPS: a. The name The telephone num The county of contashall make availabl [incident report], at or individual's legal manager, APS or C service providers, it enforcement agency	ort involving an allegation or neglect, exploitation, or the hall must be submitted within ours of the incident or any staff suspected, alleged, or lent of abuse, neglect, or esuspended immediately after and during the provider's incident. Reportable Unusual of a): a) Alleged, suspected or ext or exploitation of an exported to Adult Protective a consumer over the age of 18 Services (CPS) for a sage of 18 g) Suspected all activity by a staff member, of a provider, a family member eiving services or the green services p) Inadequate the potential for endangering twelfare of the individual. In a nicident involves abuse, neglect, exploitation, erson the reporting entity shall lent to: APS for clients over PS for clients under the age of dent report must include the to the report must include the to the report made to APS or of the person contacted be been contacted by the case PS, the individual's other for relevant, a local law of the policy titled "Section".			caring for themselves becaus illness, disability, or other incapacity and are harmed or threatened with harm as a resof abuse, neglect or exploitation of the person's personal serving property or both.) Exploitation: The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person usi the resources of an elderly or disabled person for monetary personal benefit, profit, or gain without the informed consent the elderly or disabled person 3. The definition of Reportable Conduct as listed includes: Financial exploitation of an individual receiving agency services in an amount of \$25 more; 7. Criteria to identify victims of exploitation include Abuse and/or misuse of patien money An inability of caregiver/family to account fo patient's money or property. Discrepancies between patien resources and living situation. Reports of demands for good exchange for services 13 The BrightStar Agency will complete a written report using the Provider Investigation formand include the following information: Incident date. The alleged victim The alleged perpetrator Any witness(es) allegation. Any injury or advergifiect. Any treatment required	ault on ces, or	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				IULTIPLE CC UILDING	00	(X3) DATE COMPL		
11112 12111	or condition.			/ING		07/27		
						011211	2017	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE			
			9521 INDIANAPOLIS BLVD, SUITE O					
BRIGHT	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	02.45 - Abuse Negl	ect" Policy: BrightStar			The investigation summary A	ny		
	recognizes that upo	n occasion recipients of our			action taken 14. The Agency	will		
	care may become si	ubject to physical or mental			investigate complaints made l	oy a		
	abuse, neglect, or e	xploitation. BrightStar			client, a client's family or			
	requires all staff to	be alert for obvious or			guardian, or a client's healthc			
		s jeopardizing a client's right to			provider, regarding treatment			
	· ·	e treatment and to be free of			care furnished by the agency			
	abuse, neglect, or exploitation whether it be				that the agency failed to furnis			
	physical, mental or financial. The staff of BrightStar is mandated to report in Indiana any outright or suspected cases of abuse, neglect, abandonment, or exploitation to the APS hotline				or a lack of respect for the clie			
					property by anyone furnishing services on behalf of the ager			
					15. BrightStar will document	-		
					receipt of the complaint and	ii iC		
	at: 1-800-992-6978 (Toll free in Indiana) Outside				initiate a complaint investigation	on		
	of Indiana: 1800-545-7763, Ext. 20135				within 10 days after the agend			
	_	thtStar staff will be oriented to			receipt of the complaint. All	, -		
		s indicating possible abuse or			components of the investigation	on		
	1 -	ions are defined as follows:			will be documented and the e	ntire		
		Anyone 18 years of age or			investigation and documentat	on		
	_	ess of where the person is			will be completed within 30 da	ıys		
	_	unlikely to report abuse or istance because of mental or			after the agency receives the			
	1 -	mpairment or his/her emotional			complaint, unless the agency			
		ana law defines endangered			a documents reasonable caus	se		
	•	viduals 18 years or older who			for delay"			
		naging their property or caring			Performance Improvement Plant will include any customer	all		
	_	nuse of illness, disability, or			complaints, incidents, and			
		d are harmed or threatened			employee complaints to			
		It of abuse, neglect or			collaborate all of our services	and		
		person's personal services,			disciplines to meet the needs			
		Exploitation: The illegal or			the clients, staff and the			
		cess of a caretaker, family			community. Risk Managemen	t,		
		ndividual who has an ongoing			infection control, and clinical			
		e elderly or disabled person			quality will also be part of this			
	-	of an elderly or disabled			quarterly team meeting to ma			
	_	y or personal benefit, profit, or			sure the needs of our clients a			
	gain without the inf	formed consent of the elderly			being met as well as their wel			
	or disabled person.	3. The definition of			being and safety.			
	Reportable Conduc	t as listed includes:			ADDENDUM: All office emplo			
	Financial exploitati	on of an individual receiving			and field case managers were	;		
	1	an amount of \$25 or more;			given a Compliant			
	7. Criteria to identi	ify victims of exploitation			Concerns/Complaint Form on			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
			B. W	ING		07/27/2017
				CERTIFIE	ADDRESS STATE STREET, SODE	
NAME OF P	ROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE	
5510117	TAD 05 LAKE 00	NI INITA INITA INI			IDIANAPOLIS BLVD, SUITE O	
BRIGHTS	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	include: Abuse and	d/or misuse of patient's money			9/25/17. If any complaint is	
	An inability of care	giver/family to account for			received it will be written on th	is
		property. Discrepancies		form and given to the		
		esources and living situation.			Administrator. The Administra	tor
	-	s for goods in exchange for			will contact all involved parties	;
	_	he BrightStar Agency will			(client and/or employee) and	
		complete a written report using the Provider			complete an investigation. On	
	Investigation form and include the following information: Incident date The alleged victim The alleged perpetrator Any witness(es) The				complaint is complete it will be	
					entered into our software system	
					stating what the resolution wa	
	allegation Any inju	ry or adverse affect Any			mark it to be followed up on (if	
	treatment required	The investigation summary			marked for follow up a remind	er
	Any action taken 1	4. The Agency will			is sent to the person	
	investigate complai	nts made by a client, a client's			Administrator or Nursing Supervisor) who needs to follo	
	family or guardian,	or a client's healthcare			up and on what date. Any other	
	provider, regarding	treatment of care furnished by			agencies will be documented	71
	the agency or that t	he agency failed to furnish, or			such as APS, CPS, Case	
	a lack of respect for	r the client's property by			Managers, etc. These will be	
	anyone furnishing s	services on behalf of the			monitored by the Administrato	r
	agency. 15. Bright	tStar will document the receipt			and then discussed as part of	
	of the complaint an	d initiate a complaint			risk management during quart	
	investigation within	n 10 days after the agency's			Performance Improvement	
	receipt of the comp	laint. All components of the			meetings to see how we can g	irow
	investigation will b	e documented and the entire			and improve from these	
	investigation and de	ocumentation will be			experiences and make sure or	ur
	completed within 3	0 days after the agency			clients are protected. They als	
	receives the compla	aint, unless the agency has a			will be discussed during week	
	documents reasonal	ble cause for delay"			meetings with the Leadership	
					team and appointed person from	om
					the Leadership team will be	
					appointed for follow up if	
					necessary.	
					Governing Body reviewed Clie	
					Complaint/Concern on 9/25/17	for
					approval.	
N 0532	410 IAC 17-13-1(4)				
IN UUUZ	Patient Care	u)				
Blda 00		Home health agency				
Bldg. 00	Tale 10 0ec. 1(u)	Home health agency				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. W	ING		07/27	/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			NDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CO	NUNTY INDIANA			AND, IN 46322		
					1		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION OF A CHARLES OF THE ACTION SHOULD BE SHOULD			(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCI)		DATE
		romptly notify a patient's					
		and legal representative if					
	professional staff and legal representative, if any, of any significant physical or mental						
		d or reported by the					
		se of a medical emergency,					
	the home health a	agency must know in					
		nergency system to					
	contact.				1		
		review the skilled nurse	N 0	532	Administrator and Nursing Supervisor reviewed Policy		09/30/2017
	1	he physician for			Section 02.01 - Standards of		
	significant physical changes in the				Practice. 1. The agency provide	les	
	patient's vital sig	gns and/or blood sugar in			services based on acceptable		
	4 of 6 records re	eviewed. (#1, #3, #4, #6)			professional standards for hor	ne	
					care and according to state ar		
	The findings inc	dude:			federal regulations as indicate		
	The imamgs me	ridde.			2. All agency staff will perform		
	1 The detect				within the guidelines of their stated discipline. 2. All clients	vazill	
		agency policy titled			be provided care based on a F		
		Medical Plan Of Care,			of Care or Service Plan that is		
	Physician Order				prepared by the Registered		
	Supervision" sta	ited " 5. The health			Nurse. A home health agency		
	care professiona	l staff of the home health			Skilled Plan of Care will be		
	agency shall pro	omptly alert the person			prepared by a Registered Nur	se	
	responsible for t	the medical component of			and reviewed, approved and		
		e to any changes that			signed by a physician. 4. Skille nursing visits are performed as		
	•	o alter the medical plan			ordered by the physician on th		
		ne Health Agency			Home Health Plan of Care and		
		• •			additional orders as needed. 5		
	-	promptly notify a patient's			Skilled observation and		
	1 ^ -	er appropriate licensed			assessment of the client's		
	professional stat	•			condition is performed upon e		
	representatives ((if any), of any significant			nursing visit and reported to the		
	physical or men	tal changes observed or			physician if indicated. 6. All pla of care are based on the	3115	
	reported by the	patient"			individualized needs of the clie	ents	
		-			who are being served by the		
	2. The undated	agency policy titled			agency.		
		Skilled Nursing			Administrator and Nursing		
	30011011 02.13 -	Drined Marshig	ı				I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WI	NG		07/27/	2017
				CTD DET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2					
DDIOLIT	OTAD OF LAKE OF	NUMBER OF THE PROPERTY OF THE			IDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CC	JUNIY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Services" stated	"1. Skilled nursing			Supervisor reviewed Policy		
	services are perf	Formed by Registered			Section 02.15 Skilled Nursing		
	Nurses or Licensed Practical Nurses				Services. 1. Skilled nursing		
					services are performed by		
	_	vision of a Registered			Registered Nurses or License	d	
		ance with the Nurse			Practical Nurse under the	ıraa	
	Practice Act	3. Registered Nurses			supervision of a Registered No in accordance with the Nurse	ui S C	
	do the following	: Perform initial			Practice Act. 2. Skilled nursing	1	
	admission assess	sments and periodically			care is performed in accordan		
	reassess the client's needs and coordinate				with the doctor's orders in a		
	services as needed. Initiates the plan of				medically approved plan of ca	re	
					for a home agency client. 3.		
	care or service plan and necessary				Registered nurses do the		
	revisions and updates when needed.				following: perform initial		
	Ensure that the p	physician is contacted			assessments and periodically		
	when there are c	hanges in the client's			reassess the client's needs an		
	condition. Perfo	orm skilled nursing care			coordinate services as needed	d.	
		me health agency clients.			Initiates the plan of care or service plan and necessary		
		each other nursing			revisions and updates when		
	_	_			needed, ensure that the physic	cian	
	-	needed. 4. Skilled			is contacted when there are	olal i	
		linical notes following			changes in the client's condition	on,	
	each visit the sai	me day care is rendered."			perform skilled nursing care as		
					needed for home health agend		
	3. The undated	agency policy titled			clients, supervise and teach o		
		Standards Of Practice"			nursing personnel when need		
		illed observation and			4. Skilled nurses prepare clinic	cal	
					notes following each visit the		
		e client's condition is			same day care is rendered. Administrator and Nursing		
	1 ^	each nursing visit and			Supervisor reviewed Policy		
	reported to the p	hysician if indicated"			Section 02.23 Medical Plan of		
					Care, Physician Orders and		
	4. Review of the	e clinical record for			Medical Supervision. 1. Medic	al	
	patient #1 on 7/2	27/17 evidenced an			care shall follow a written med	ical	
	1 *				plan of care established and		
	agency document titled "Supervisory Visit" dated 9/30/16 that had an area				periodically reviewed by the		
					physician, dentist, chiropracto		
		Signs". The agency nurse			optometrist or podiatrist. 2. Th		
	(employee P) red	corded the blood pressure			medical plan of care shall mee	ŧ	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
			B. W	ING		07/27/	2017
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUFFLIER			9521 IN	IDIANAPOLIS BLVD, SUITE O		
	STAR OF LAKE CC		_		AND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		e was no documentation			the following: be developed in consultation with the agency s	taff	
	in clinical record	l #1 that the physician			include all services to be provi		
	was ever contacted regarding a diastolic				if a skilled service is being	ucu	
	5. Review of the clinical record for patient #3 on 7/27/17 evidenced an agency document titled "Client Assessment" dated 9/29/16 and signed by a RN [registered nurse]. The document had an area subtitled "Vital Signs" and recorded patient #3's pulse as 54. There was no documentation in				provided, cover all pertinent		
					diagnoses, and include the		
					following: mental status, type of		
					services and equipment requir	ed,	
					frequency and during of visits,		
					prognoses, rehabilitation potential, functional limitations		
					activities permitted, nutritional		
					requirements, medications and		
					treatments, any safety measur		
					to protect against, injury,		
					instructions for timely discharg	е	
	clinical record #	3 that the physician was			or referral, therapy modalities		
		egarding a pulse of 54.			specifying length of treatment		
	over contacted in	egaranig a paise of 5 i.			any other appropriate items. 3	5.	
	a Daviana	of the clinical record for			The total medical plan of care shall be reviewed by the attended	dina	
					physician, dentist, chiropractor	-	
	-	nced an agency document			optometrist or podiatrist and	,	
		Care/Companion Care			home health agency personal	as	
		heet", dated 5/2/16, that			often as the severity of the		
	stated " Comn	nents/Remarks: make			patient's condition requires, bu		
	[sic] him/her a sa	andwhich [sic] and			least once every sixty (60) day		
	he/she took suga	ar and it was 360 so			4. A written summary for each		
	_	self/herself a [sic] insulin			patient shall be sent to the physician, dentist, chiropractor	•	
	1	(Rapid Release)" There			optometrist of podiatrist at leas		
	_	ntation in the clinical			every sixty (60) days. 5. The		
					health care professional staff of	of	
		plood sugar was reported			the home health agency shall		
		physician. An agency			promptly alert the person		
	document titled				responsible for the medical	- 4-	
	Care/Companion				component of the patient's car		
	Timesheet", date	ed 5/4/16, stated "			any changes that suggest a ne to alter the medical plan of car		
	Comments/Remarks: Client is a [sic] diabetic situation. Called ambulance".				6. Home health agency persor		
					shall promptly notify a patient's		
		cumentation evidenced			physician or other appropriate		
	1 11010 Was 110 do						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER		9521 I	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O LAND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	in the client recoreported to the p b. Review of patient #3 evidentitled "Supervisor The document has "Vital Signs" wire There was no do in clinical record ever contacted the pulse of 54. 6. Review of the patient #4 on 7/2 agency document #4 on patient #4 in The patient #4 in The patient #4 in The patient #5 in The	rd that these events were atient's physician. of the clinical record for need an agency document by Visit" dated 9/29/16. ad an area subtitled the apulse of 54 recorded. Cumentation evidenced at #3 that the skilled nurse he physician regarding a eclinical record for 17/17 evidenced an at titled "Client ed 6/1/16 with "Initial" high title. The skilled becument any vital signs a hitial assessment.	TAG	licensed professional staff and legal representatives (if any), any significant physical or medical emergency, the home health agency must know in advance which emergency system to contact. 8. The age may accept written orders from physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana in any other state. 9. If the age receives an order from a physician, dentist, a chiropractor podiatrist or an optometrist whicensed in another state, the home health agency shall take reasonable steps to determine that the order complies with the laws of the state where the orderiginated and the individual wissued the order examined the patient is licensed to practice that state. 10. All orders issue a physician, a dentist, a chiropractor, podiatrist or an optometrist for home health services must meet the same requirements whether the orderiginated in Indiana or another state. 11. Orders issued from another state may not exceed authority allowed under orders from the same profession in Indiana under IC 25. 12. All medications, treatments and skilled nursing services provide to patients must be ordered by physician including patient's name, physician's name, date	ency na na na or ency tor, no is elected er who elected er

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
NAME OF	DDOWNED OF CLIDE IS	<u>l</u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	IX.		NDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CO	DUNTY INDIANA	HIGHL	_AND, IN 46322		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	1	,	TAG	·	DATE	
TAG	pulse of 110 bea 8. Review of the patient #6 on 7/ agency docume Assessment" data a RN. The documentation with a recorded the paragraphs of the staff of the	ne clinical record for 27/17 evidenced an nt titled "Client ted 3/2/16 and signed by ament evidenced an area Signs". The skilled nurse tient's respirations as 25, ored. There was no in the clinical record that ceted the physician or ff at facility #31 of the tory status at the time of	TAG	the order and signature of RN/LPN taking the order. 13. orders may be initially obtained telephone and confirmed in writing by the physician in a timely/manner. 14. Orders may be received by fax, however agency will attempt to obtain original signatures for each signed order whenever possible. 15. Verbal orders may be taken by licensed agency personnel in accordance with applicable state and federal lay and organization policy. 16. Note stamped signatures are permitted. 17. The medical plof care will be used as the cast plan and will include reasonal measurable and realistic goal determined by the patient assessment. 18. The care play will also address rehabilitation potential and discharge plans. The care plan will also be reviewed, evaluated and revisas needed at least every sixty (60) days and/or as needed. Agency staff caring for the passible made aware of the care plan and any changes will be communicated to appropriate staff members. 21. The agency will perform an annual audit of staff compliance of verbal ord verification.	The ed by ay the ay aws lo an re ble, s as an n 1. 19. sed / 20. tient re	
				Administrator and Nursing Supervisor reviewed Policy 0 - Reporting Patient's Condition Physician. Policy: Clinicians with monitor, document, and report the patient's response to care	n to vill rt	

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2017
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O)
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				treatments provided on each home visit. Progress toward will be measured at regular intervals. Clinicians will establiand maintain ongong communication with the physician regular intervals. Clinicians will establiand maintain ongong communication with the clien physician may occur monthly more frequently when client's condition is unstable of changunexpectedly. Administrator and Nursing Supervisor will meet with Registered Nurse Case Managers to review all of the above policies by September 2017. Home health aides will sent a letter explaining their responsibilities for reporting change in condition to the Registered Nurse and an in-service of what signs and symptoms to look for includin pain, mental status, nutrition, elimination, skin, and abnorm findings. ADDENDUM: All employees to have access to their emails a requirement to work for our company to be kept apprised situations of policies and procedures. ERISA form is of stating they will do this and the compliance of being in receipt these notices. A letter and in-service was sent on condition to look for an abnormal repor conditions. This in-service is now a mandatory basic in-service in now a mandatory basic in-service in the service was sent on conditions. This in-service is now a mandatory basic in-service in the service was sent on conditions.	goals plish plician te t's or s ges 30, be ges in n file neir of of cions table also

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER		9521 I	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				at the time of hire and annually thereafter. Care Notes are being reviewed by nursing supervisor nursing designee to see if any change of condition was noted and not reported to the office.	ng or or
N 0534	410 IAC 17-13-3(b Service Plan))			
Bldg. 00	agency's manager designee shall pre client before provide the client. A perm service plan requires service plan. The (1) be in writing, condividual who pre (2) list the types as be provided; and (3) state that the state client are subject (A) temporarily substate the client are subject (B) permanently to the provision of arms.	epare a service plan for a ding personal services for lanent change to the res a written change to the service plan must: dated, and signed by the land schedule of services to services to be provided to lect to the client's right to: lispend; erminate; dd; or ladd; lay service.	N. 0524	The Administrator and Nursing	00/20/2017
	Based on record review the home health aides did not follow the service plan developed by the RN [registered nurse] in 4 of 6 clinical records reviewed. (#3, #4, #5, #6) The findings include:		N 0534	The Administrator and Nursing Supervisor reviewed Policy Section 02.16 - Nursing Plan of Care/Service Plan. 1. A nursing plan of care must be developed by a Registered Nurse for the purpose of delegating nursing directed client care provided through the home health agentical supervisors.	of g d
	"Section 02.16 - Care/Service Pla	agency policy titled Nursing Plan Of n" stated "1. A nursing t be developed by a		for clients receiving only home health aide services in the absence of a skilled service. 2 The nursing plan of care must contain the following: a plan of care and appropriate client	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			r í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		00	COMPL	
			B. WING			07/27/	2017
NAME OF F	PROVIDER OR SUPPLIER		S	TREET A	DDRESS, CITY, STATE, ZIP CODE		
					DIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		HIGHLA	ND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)		DATE
		e for the purpose of			identifying information, the nar		
	"	ng directed client care			of the client's physician, service to be provided, the frequency		
	provided through	n the Home Health			duration of visits, medications,		
	Agency for clien	ts receiving only home			diet, and activities, signed and		
	health aide servi	ces in the absence of a			dated clinical notes from all		
	skilled service.	2. The nursing plan of			personnel providing services,		
		n the following: A plan			supervisory visits, sixty (60) da summaries, the discharge note		
	of care and appr	opriate client identifying			and the signature of the	5	
	information The name of the client's physician Services to be provided The frequency and duration of visits Medications, diet and activities Signed				Registered Nurse who develop	ped	
					the plan. 3. A service plan mus	st	
					be developed by a Registered		
					Nurse or each client to define		
	and dated clinica	· ·			services provided by the agen 4. The service plan must contain		
					the following: a service plan ar		
	personnel provid	_			appropriate client identifying		
		ts Sixty (60) day			information, types and schedu		
		discharge note The			of the service to be provided, t	he	
	_	Registered Nurse who			signature and date of the Registered Nurse who develop	ood	
		an 3. A service plan			the plan, state that the service		
	_	ed by a Registered Nurse			be provided to the client are		
	for each client to	define the services			subject to the client's right to		
	provided by the	Personal Services			temporarily suspend, permane	ently	
	Agency. 4. The	service plan must			terminate, temporarily add, or	of	
	contain the follo	wing: A service plan			permanently add the provision any service, a client/family	UI	
	and appropriate	client identifying			signature and date no later that	ın	
	information Typ	es and schedule of the			fourteen (14) days after service		
	services to be pr	ovided The signature			begin or after a permanent		
	and ate of the Re	egistered Nurse who			change to the service plan.		
		an State that the services			The Administrator and Nursing Supervisor added an addition		
		the client are subject to			the policy as follows: 5. Home		
	-	to temporarily suspend,			health aides will indicate on th	eir	
	permanently terminate temporarily add, or permanently add the provision of any service. A client/family signature and				daily care notes the services (.e.	
					tasks) that were followed		
					according to the service plan a follows: a check indicating the	เร	
		, ,			service was complete, refused	(r)	
	uate no later that	n fourteen (14) days after			35. VICE Was complete, relused	(1)	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	LDING	NSTRUCTION 00	(X3) DATE : COMPL 07/27 /	ETED	
	PROVIDER OR SUPPLIEF STAR OF LAKE CC			9521 IN	DDRESS, CITY, STATE, ZIP CODE DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	change to the serior change to the serior change to the serior 2. Review of the patient #3 on 7/2 agency document Care/Companion 7/14/16 and sign document indica attendant/home [medication] associeaning, exercise motion] - passive Transportation, [Activities, preparand fall precauting attendant/home follow the "Personal Care as the serior care as the se	e clinical record of 27/17 evidenced an at titled "Personal and Plan of Care" dated and by the RN. The sted the personal care and the personal care and the personal care and clean for meals, sons. The			if the client refused the task the day or previously done (pd) written if the task was not complete because it was done a previous shift according to the client. A home health aide will perform any tasks not listed or the service plan unless a Registered Nurse approves it makes adjustments on the service plan according to the client's request. The updated policy will be send current home health aides and will be included in orientation to September 30, 2017. ADDENDUM: This will be the responsibility of the Administrate and Nursing Supervisor. An addendum was created and review by the Governing Body on 9/25/1 A letter was sent to all employees their responsibility and guideline. All employees have an ERISA or that they must keep their email addresses active and read their emails to keep updated on all policies and procedures. Nursing Supervisor or nursing designee wereview all timesheet/caregiver not to make sure the plan of care/servagreement is being followed. Any that are not complete will be brown into the office to correct notes accurately and be counseled/re-advised.	e on ne not	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING					COMPLETED 07/27/2017		
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BRIGHT	STAR OF LAKE CO	UNTY INDIANA			DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
1710		nis was not an ordered		1110			DATE
		ment titled "Personal					
	Care/Companion						
	3. Review of the	e clinical record of					
	patient #4 on 7/27/17 evidenced agency						
	documents titled	"Homemaker Service					
	Plan" and "Personal Care/Companion						
	Plan of Care" both dated 6/1/16 and both						
	signed by the RN. The document titled						
	"Homemaker Service Plan" indicated the						
	homemaker was to perform						
	housekeeping, cleaning kitchen/wash						
		loval, dusting, laundry,					
	1	nge, clean refrigerator,					
	•	vacuuming, sweeping,					
		e meal snack, errands,					
	_	versal precautions and					
	_	The document titled					
		Companion Plan of Care"					
		nealth aide was to					
		wer, sponge bath,					
		ral care, skin care, nail					
		dressing, toileting, med ders, linen change,					
		eaning, ambulation assist,					
		rands, recreational					
	·	e and clean meals, and					
		al and fall precautions.					
	_	and personal care					
		nealth aide failed to					
		emaker Service Plan"					
		al Care/Companion Plan					
	of Care" as follo	*					

State Form Event ID: VQEX11 Facility ID: 012189 If continuation sheet Page 72 of 123

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			UILDING	00	COMPL 07/27	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322					
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE	
	agency documer Service Note and 6/2/16 evidenced to follow the "H The homemaker have provided in vacuuming. b. Review of agency documer Service Note and "Personal Care/of and Timesheet" the homemaker afailed to follow homemaker was provided dusting cleaning range, of vacuuming, and health aide was provided shower shampoo hair, of care, toileting, lift assistance. The evidenced to have care and exercise	of clinical record #3 at titled "Homemaker d Timesheet" dated d the homemaker failed omemaker Service Plan". was not evidenced to oning, cleaning range, or of clinical record #3 at titled "Homemaker d Timesheet" and Companion Care Note dated 6/3/16 evidenced and home health aide the plans of care. The not evidenced to have g, laundry, ironing, cleaning refrigerator, sweeping. The home not evidenced to have totub, sponge bath, ral care, skin care, nail nen change and transfer home health aide was to provided incontinence the ROM which are not rsonal Care/Companion						
	agency documer	of clinical record #3 at titled "Homemaker d Timesheet" dated						

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ILDING	00	COMP	LETED 7/2017	
	PROVIDER OR SUPPLIEI			9521 IN	ADDRESS, CITY, STATE, ZIP CODE DIANAPOLIS BLVD, SUITE AND, IN 46322		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	6/5/17 evidenced the homemaker failed						
	to follow the plan of care. The homemaker was not evidenced to have						
		g, ironing, vacuuming,					
	and preparing meal/snack.						
	4. Review of th	e clinical record of					
	patient #5 on 7/2	27/17 evidenced an					
	agency documer	nt titled "Personal					
	Care/Companion	n Plan of Care" dated					
	4/12/17 and sign	ned by the RN. This					
	document indica	ated the home health aide					
	was to perform	sponge bath, shampoo					
	hair, oral care, s	kin care, nail care (file					
	only), dressing,	toileting, linen change,					
	laundry, light cl	eaning, transfer assist,					
	exercise ROM -	passive/interactive,					
	transportation, e	rrands, recreational					
	activities, prepar	re and clean meals, and					
	practice universa	al and fall precautions.					
	The home health	n aide failed to follow the					
	"Personal Care/0	Companion Plan of Care"					
	as follows:						
	a Review	of clinical record #5					
		nt titled "Personal					
	Care/Companion						
	_	ed 4/12/17, 4/14/17,					
		7, 4/28/17, 5/1/17, 5/3/17,					
		717 evidenced the home					
		ormed shampoo hair, this					
	-	lered on the plan of care.					
		-					
	b. Review of	of clinical record #5					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				JILDING	<u>00</u>	COMPLETED 07/27/2017	
NAME OF I	PROVIDER OR SUPPLIER	-	STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA			DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
		t titled "Personal					
	Care/Companion						
	Timesheet" dated	d 5/8/17, 5/12/17,					
	5/15/15, 5/17/17	, 5/22/17, 5/24/17,					
	5/26/17, 5/29/17	, 5/31/17 and 6/2/17					
	evidenced the ho	ome health aide					
	performed sham	poo hair that was not on					
	the plan of care a	and did not perform nail					
	care which was o	on the plan of care.					
	c Review o	f clinical record #5					
		t titled "Personal					
	Care/Companion						
	_	d 5/10/17 evidenced the					
		e performed shampoo					
		a task on the plan of					
		perform nail care,					
		eting that was a task on					
	the plan of care.						
	5. Review of the	e clinical record of					
		27/17 evidenced an					
	-	t titled "Personal					
	1 "	Plan of Care" dated					
	_	d by the RN. This					
	_	ted the home health aide					
	was to perform n	nail care (file only),					
	•	bowel movement,					
	_	ecreational activities,					
		and practice universal					
	and fall precaution	-					
	aide failed to fol	low the "Personal					
	Care/Companion	n Plan of Care" as					
	follows:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
			B. W	ING		07/27/	/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			DIANAPOLIS BLVD, SUITE O		
	STAR OF LAKE CO	DUNTY INDIANA			AND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	.	0.1: 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.					
		of clinical record #6					
		nt titled "Personal					
	Care/Companion Care Note and Timesheet" dated 3/2/16 evidenced the						
		e perform sponge bath,					
	linen change and	d ambulation assist which					
	was not ordered	as tasks on the plan of					
	care and the hon	ne health aide failed to					
	perform record b	powel movement,					
	recreation activi	ties and encourage fluids					
	which were task	s ordered on the plan of					
	care.						
	b. Review o	of clinical record #6					
		nt titled "Personal					
	Care/Companion						
	•	d 3/3/16 evidenced the					
		e perform ambulation					
		s not ordered on the plan					
		d to perform recreational					
		-					
		are, toileting, record					
		at and encourage fluids					
		s ordered on the plan of					
	care.						
	c Review o	of clinical record #6					
		nt titled "Personal					
	Care/Companion						
		d 3/4/16 evidenced the					
		e perform turn/reposition					
		rdered as a task on the					
	_	failed to perform nail					
	care, record bow	el movement and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				UILDING	<u>00</u>	COMPLETED 07/27/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA			DIANAPOLIS BLVD, SUITE O ND, IN 46322			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
		vities which were tasks						
	on the plan of ca	re.						
	d. Review o	of clinical record #6						
	agency documen	t titled "Personal						
	Care/Companion	Care Note and						
	Timesheet" dated	d 3/5/16 and 3/6/16						
	evidenced the ho	me health aide failed to						
	perform recreation	onal activities and nail						
	care as ordered of	on the plan of care.						
		f clinical record #6						
		t titled "Personal						
	Care/Companion							
	Timesheet" dated	d 3/7/16 evidenced the						
		had performed oral care						
	-	which was not tasks						
	•	lan of care and failed to						
	•	e, transfer assist and						
		vities which were tasks						
	on the plan of ca	re.						
		f clinical record #6						
		t titled "Personal						
	Care/Companion							
		d 3/8/16 evidenced the						
		e had performed sponge						
	bath, skin care, l	_						
	-	which was not ordered on						
	_	and failed to perform nail						
		onal activities which						
	were tasks on the	e plan of care.						
	g. Review o	of clinical record #6						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 B. WING			COMPLETED 07/27/2017			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA			DIANAPOLIS BLVD, SUITE O ND, IN 46322			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE	
		t titled "Personal		0			D.III	
	Care/Companion							
	•	d 3/9/16 evidenced the						
	home health aide	e had performed						
		which was not tasks						
		lan of care and failed to						
	perform nail care	e, toileting, record bowel						
	movement and re	ecreational activities						
	which were tasks	s on the plan of care.						
	h. Review o	of clinical record #6						
	agency documen	t titled "Personal						
	Care/Companion	Care Note and						
	Timesheet" dated	d 3/10/16 evidenced the						
	home health aide	e had performed sponge						
		assist, turn/reposition,						
	_	nich was not tasks						
	_	lan of care and failed to						
	perform toileting							
		ecreational activities						
	which were tasks	s on the plan of care.						
	i Paviawa	f clinical record #6						
		t titled "Personal						
	Care/Companior							
	•	d 3/11/16 evidenced the						
	home health aide							
		which was not tasks						
	-	lan of care and failed to						
	_	e or record bowel						
	-	were tasks on the plan						
	of care.	· · · r · ·						
	j. Review o	f clinical record #6						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		07/27	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	₹			DIANAPOLIS BLVD, SUITE O		
	STAR OF LAKE CO	DUNTY INDIANA			AND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		nt titled "Personal					
	Care/Companion						
	Timesheet" dated 3/13/16 evidenced the						
	home health aide had performed						
	-	which was not tasks					
	_	lan of care and failed to					
	perform nail car	e and record bowel					
	movement which	h were tasks on the plan					
	of care.						
	k. Review o	of clinical record #6					
	agency documer	nt titled "Personal					
	Care/Companion						
	•	d 3/14/16 evidenced the					
	home health aid	e had performed sponge					
		position which was not					
	-	the plan of care and					
		n nail care, toileting,					
	-	ovement, transfer assist					
		activities which were					
	tasks on the plar						
	tasks on the plai	i oi care.					
	1 Pavian a	f clinical record #6					
		nt titled "Personal					
	Care/Companion						
		d 3/15/16 evidenced the					
		e had performed sponge					
		skin care, linen change					
	and turn/reposition which was not tasks						
	ordered on the plan of care and failed to						
	perform nail car						
	movement and r	ecreational activities					
	which were task	s on the plan of care.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		07/27/	′2017
				GED FEET	ADDRESS OVEN STATE JID CODE		
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
DDICUT		LINITY INIDIANIA			IDIANAPOLIS BLVD, SUITE O		
вківпі	STAR OF LAKE CO	UNITINDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N 0545	410 IAC 17-14-1(a	, , , , ,					
Bldg. 00	Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the						
	following: (F) Coordinate se		N 0	545	By 9/30/17 the Administrator a	ınd	09/30/2017
	and other agency's p	rvices with a skilled nursing facility ncy's providing care to their patients cal records reviewed. (#4, #6) Nursing Supervisor will meet with all Nursing Case Managers and review our Policy Section: 02.37 Coordination of Care, Clinical					
	The findings include	e:			Summary and Case Conferent Policy includes Care coordinate		
	1. The undated agency policy titled "Section 02.37 - Coordination Of Care, Clinical Summary And Case Conference" stated "1. Care coordination is effectively coordinated by members/disciplines of the health care team by case conferences that are held at a minimum of every 60 (sixty) days to ensure information is exchanged, pertinent facts communicated and changes in the client's needs, services, care and/or goals are evaluated and appropriate responses made. 2. Case conferences may be held in various ways, such as a group meeting, by phone, fax or e-mail, and must be documented as such. 3. Suggested areas that are reviewed during case conferences could include the following: Availability of caregivers or support system in the home setting. Client status and progress towards goals Medications and effectiveness of the treatment plan Coordination with other agencies and institutions, if the need arises. Discharge planning as appropriate. 4. Ongoing care conferences shall be conducted to evaluate the				is effectively coordinated by members/disciplines of the her care team by case conference that are held at a minimum of every 60 (sixty) days to ensure information is exchanged, pertinent facts communicated changes in the client's needs, services, care and goals are evaluated and appropriate responses made. Case conferences may be held in various ways, such as group meeting, by phone, fax or ema and must be documented as such. Suggested areas that a reviewed during case conferences could include the following: Availability of caregivers or support system if the home setting, client status and progress towards goals, medications and effectiveness the treatment plan, coordinations.	alth s e and iil, re	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			07/27/	2017 I
						0.72.7	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
				9521 IN	IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	be formulated as ne	eded when problems are			with our agencies and institution	ons	
	identified. 5. In co	omplex cases, the client,			if the need arises, and dischar	ge	
	caregivers and/or fa	amily members might be			planning. Ongoing case		
	invited to attend the	e case conference with the			conferences shall be conducte		
	client's or authorize	ed representative's approval. 6.			to evaluate the client's status a		
	Care conferences w	rill be documented on the			progress and action plans will	be	
	appropriate form or	in the progress notes.			formulated as needed when		
	Subsequent change	s to the Plan of Care or Service			problems are identified. In		
	Plan will be commu	unicated by the Registered			complex cases, the family may	/ be	
	Nurse to appropriat	e staff members, the client			invited to participate. Case		
	and/or family/careg	givers and/or physician as			conferences should be		
	needed after the cas	se conference. 7. A Clinical			documented in the appropriate	;	
	Summary of the cli-	ent's care, services rendered			form or in the progress note.		
	and response to car	e for each client will be			Changes in the Plan of Care w	/111	
	documented on the	appropriate form and sent to			be communicated by the	4-	
	the physician for sig	gnature if applicable at a			Registered Nurse to appropria		
		60 (sixty) days. 8. Case			staff members. Case conferen		
	-	pies of clinical summaries			will be documented every 60 d	-	
	shall be kept in the	-			and sent to the physician of the client's care, services rendered		
	•				and their responses. Case	J,	
	2. Review of the cl	linical record for patient #4 on			conferences will be kept in the		
		re 6/1/16, evidenced an agency			patient's chart.		
	· ·	lient Medication Profile" dated			On going compliance will be		
		nent contained patient's			monitored as 10% of active		
		f which were administered by			patient charts are audited ever	·v	
		edications listed were			quarter.	,	
		[milligram]/1000 ml			ADDENDUM: Steps taken to fi	ind	
		ral line continuously, and Cath			out the cause of this was findir		
		les per central line weekly.			out that our 60 day summary v	0	
		mentation/coordination of care			not sufficient enough to cover		
		or any entity/agency/provider			case conference requirement.		
		g patient #4's central line or			new form was developed and		
		cations per central line.			approved by the governing boo	dy	
		1			on 9/25/17 and is being put in	-	
	3. Review of the cl	linical record for patient #6 on			place immediately. Nursing		
		re 3/2/16, evidenced a			Supervisor and nursing design	iee	
		lient Assessment" dated 3/2/16			will be responsible for monitori	ng	
		oyee N. This document had			this by reviewing all		
		Others involved in client's			reassessments and post		
		a skilled nursing facility (#31).			hospitals done by nurse case		
		failed to evidence any			management which will include	Э	
		· · · · · · · · · · · · · · · · · · ·	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/27/2017				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	coordination of care	with this facility.		these forms every 60 days.			
N 0546	410 IAC 17-14-1(a Scope of Services						
Bldg. 00			N 0546	Administrator and Nursing Supervisor reviewed Policy Section 02.01 - Standards of Practice. 1. The agency provic services based on acceptable professional standards for hor care and according to state ar federal regulations as indicate 2. All agency staff will perform	ne nd d.		
1. The undated agency policy titled "Section 02.23 - Medical Plan Of Care, Physician Orders And Medical Supervision" stated " 5. The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. 6. Home Health Agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representatives (if any), of any significant physical or mental changes observed or reported by the patient"			within the guidelines of their stated discipline. 2. All clients be provided care based on a Fof Care or Service Plan that is prepared by the Registered Nurse. A home health agency Skilled Plan of Care will be prepared by a Registered Nursand reviewed, approved and signed by a physician. 4. Skilled nursing visits are performed a ordered by the physician on the Home Health Plan of Care and additional orders as needed. 5 Skilled observation and assessment of the client's	will Plan se ed s ne d			

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER STAR OF LAKE CO			9521 IN	DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
	02.15 - Skilled Nur Skilled nursing serv Registered Nurses of under the supervision accordance with the Registered Nurses of initial admission as reassess the client's as needed. Initiates plan and necessary needed. Ensure that when there are char Perform skilled nur health agency clien nursing personnel with the same day care in the same day	sing Services" stated "1. vices are performed by of Licensed Practical Nurses on of a Registered Nurse in a Nurse Practice Act 3. do the following: Perform sessments and periodically needs and coordinate services of the plan of care or service revisions and updates when to the physician is contacted ages in the client's condition. Sing care as needed for home ts. Supervise and teach other when needed. 4. Skilled cal notes following each visit as rendered." Incy policy titled "Section of Practice" stated " 5. and assessment of the client's need upon each nursing visit physician if indicated" Initical record for patient #1 on an agency document titled dated 9/30/16 that had an al Signs". The agency nurse ded the blood pressure of no documentation in clinical hysician was ever contacted to blood pressure of 52. inical record for patient #3 on an agency document titled "dated 9/29/16 and signed by rse]. The document had an al Signs" and recorded patient mere was no documentation in that the physician was ever			condition is performed upon eanursing visit and reported to the physician if indicated. 6. All plat of care are based on the individualized needs of the clie who are being served by the agency. Administrator and Nursing Supervisor reviewed Policy Section 02.15 Skilled Nursing Services. 1. Skilled nursing services are performed by Registered Nurse under the supervision of a Registered Nurse Practical Nurse under the supervision of a Registered Nurse Practice Act. 2. Skilled nursing care is performed in accordance with the Nurse Practice Act. 2. Skilled nursing care is performed in accordance with the doctor's orders in a medically approved plan of care for a home agency client. 3. Registered nurses do the following: perform initial assessments and periodically reassess the client's needs an coordinate services as needed Initiates the plan of care or service plan and necessary revisions and updates when needed, ensure that the physic is contacted when there are changes in the client's condition perform skilled nursing care as needed for home health agency clients, supervise and teach of nursing personnel when needed. Skilled nurses prepare clinic notes following each visit the same day care is rendered. Administrator and Nursing Supervisor reviewed Policy Section 02.23 Medical Plan of	e e ans ents ents ents ents ents ents ents en	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W		00	— 07/27/2017	
			D. W.			07/27/	/2017
NAME OF F	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODE				
TOTAL OF T	KOVIDEK OK SOTTEIEI		9521 INDIANAPOLIS BLVD, SUITE O				
BRIGHTS	STAR OF LAKE CO	DUNTY INDIANA		HIGHL	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
		,			Care, Physician Orders and		
	a. Review of	the clinical record for patient			Medical Supervision. 1. Medi	cal	
		ency document titled			care shall follow a written me		
	_	npanion Care Note and			plan of care established and		
		5/2/16, that stated "			periodically reviewed by the		
		s: make [sic] him/her a			physician, dentist, chiropracto	or,	
		d he/she took sugar and it was			optometrist or podiatrist. 2. T		
		himself/herself a [sic] insulin			medical plan of care shall me		
		npid Release)" There was no			the following: be developed in		
	documentation in th	ne clinical record that this			consultation with the agency		
	blood sugar was rep	ported to the RN or the			include all services to be prov	/ided	
	physician. An ager	ncy document titled "Personal			if a skilled service is being		
	Care/Companion C	are Note and Timesheet",			provided, cover all pertinent		
	dated 5/4/16, stated " Comments/Remarks:				diagnoses, and include the following: mental status, type	of	
	Client is a [sic] dial	betic situation. Called			services and equipment requ		
	ambulance". There	was no documentation			frequency and during of visits		
		ent record that these events			prognoses, rehabilitation	',	
	were reported to the	e patient's physician.			potential, functional limitation	S.	
					activities permitted, nutritional		
		the clinical record for patient			requirements, medications ar		
		ency document titled			treatments, any safety measu	ıres	
		dated 9/29/16. The document			to protect against, injury,		
		d "Vital Signs" with a pulse of			instructions for timely dischar	-	
		was no documentation			or referral, therapy modalities		
		al record #3 that the skilled			specifying length of treatmen		
		d the physician regarding a			any other appropriate items.		
	pulse of 54.				The total medical plan of care		
	6 Review of the of	linical record for patient #4 on			shall be reviewed by the atter physician, dentist, chiropracto		
		an agency document titled			optometrist or podiatrist and	л,	
		t" dated 6/1/16 with "Initial"			home health agency persona	l as	
		title. The skilled nurse failed			often as the severity of the	. 40	
		tal signs on patient #4's initial			patient's condition requires, b	ut at	
	assessment.	2-5m on partent " 10 million			least once every sixty (60) da		
					4. A written summary for each		
	7. Review of the cl	linical record for patient #5 on			patient shall be sent to the		
		an agency documents titled			physician, dentist, chiropracto		
		t" and "Supervisory Visit" both			optometrist of podiatrist at lea	st	
		both signed by a RN. The			every sixty (60) days. 5. The	_	
	agency document titled "Client Assessment"				health care professional staff		
		e of 110, the agency document			the home health agency shal		

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		AT) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING		COMPLETED 07/27/2017	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
1110		Visit" had an area subtitled	1110	promptly alert the person	5.112	
		so had a pulse of 110. There		responsible for the medical		
		on evidenced in the clinical		component of the patient's car		
		ed nurse ever contacted the		any changes that suggest a no		
		the elevated pulse of 110		to alter the medical plan of car 6. Home health agency person		
	beats per minute.			shall promptly notify a patient's		
	8 Review of the ali	nical record for patient #6 on		physician or other appropriate		
		n agency document titled		licensed professional staff and		
		' dated 3/2/16 and signed by a		legal representatives (if any),		
		evidenced an area subtitled		any significant physical or mei		
	"Vital Signs". The s	skilled nurse recorded the		changes observed or reported	by	
		s as 25, shallow and labored.		the patient. 7 In the case of a medical emergency, the home		
		nentation in the clinical record		health agency must know in	,	
		eted the physician or notified		advance which emergency		
	-	31 of the patient's respiratory		system to contact. 8. The age	ency	
	status at the time of	his/her assessment.		may accept written orders fror	n a	
				physician, a dentist, a		
				chiropractor, a podiatrist, or ar		
				optometrist licensed in Indiana		
				in any other state. 9. If the age receives an order from a	ency	
				physician, dentist, a chiroprac	tor	
				podiatrist or an optometrist wh		
				licensed in another state, the		
				home health agency shall take	e	
				reasonable steps to determine		
				that the order complies with th		
				laws of the state where the ord		
				originated and the individual was issued the order examined the		
				patient is licensed to practice		
				that state. 10. All orders issue		
				a physician, a dentist, a	´	
				chiropractor, podiatrist or an		
				optometrist for home health		
				services must meet the same		
				requirements whether the order		
				originated in Indiana or another state. 11. Orders issued from		
				another state may not exceed		
				another state may not exceed	uic	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THE TEAM	or conduction	ESERTIFICATION NOMBER.	B. WING	<u>uu</u>	07/27/2017
			CTDEET	ADDRESS, CITY, STATE, ZIP COI	
NAME OF P	ROVIDER OR SUPPLIER	8		NDIANAPOLIS BLVD, SUIT	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322	•
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	**************************************	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	CHON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				authority allowed under o	
				from the same profession Indiana under IC 25. 12.	
				medications, treatments	
				skilled nursing services p	
				to patients must be order	-
				physician including patie name, physician's name,	
				the order and signature of	
				RN/LPN taking the order	
				orders may be initially ob	-
				telephone and confirmed writing by the physician i	
				timely/manner. 14. Order	
				be received by fax, howe	
				agency will attempt to ob	
				original signatures for ea signed order whenever	ich
				possible.15. Verbal order	rs mav
				be taken by licensed age	· I
				personnel in accordance	
				applicable state and fede	
				and organization policy. stamped signatures are	10. NO
				permitted. 17. The medic	cal plan
				of care will be used as the	
				plan and will include reas	
				measurable and realistic determined by the patien	_
				assessment. 18. The car	
				will also address rehabili	tation
				potential and discharge p	
				The care plan will also be reviewed, evaluated and	
				as needed at least every	
				(60) days and/or as need	-
				Agency staff caring for th	· ·
				will be made aware of the	
				plan and any changes will communicated to approp	
				staff members. 21. The a	
				will perform an annual au	
			I	i	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
ANDILAN	51 CORRECTION	IDENTIFICATION NUMBER.	B. WING	00	07/27/2017
			_	ADDRESS OF OTATE ZID CORE	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322	- •
(X4) ID		TATEMENT OF DEFICIENCIES	ID	, <u>-</u>	(X5)
				PROVIDER'S PLAN OF CORRECT. (EACH CORRECTIVE ACTION SHOULD	ION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	DATE DATE
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	order y 02.24 lition to ns will eport care and lich rd goals ar tablish hysician oriate ng lient's chly or nt's anges the ber 30, will be eir lig did ding
				elimination, skin, and abno	
				findings.	
				ADDENDUM: All employe to have access to their em a requirement to work for company to be kept appris situations of policies and	nails as our
			1	1	

State Form Event ID: VQEX11 Facility ID: 012189 If continuation sheet Page 87 of 123

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING		COMPLETED	
			B. WING		07/27/2017	
	PROVIDER OR SUPPLIER STAR OF LAKE CO		9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	DECLIDED OF ALL OF CORRECTION	(X5)	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
N 0584	410 IAC 17-14-1(g	3)		procedures. ERISA form is on stating they will do this and the compliance of being in receipt these notices. A letter and in-service was sent on conditional to look for an abnormal report conditions. This in-service is a now a mandatory basic in-servat the time of hire and annuall thereafter. Care Notes are being reviewed by nursing supervisor nursing designee to see if any change of condition was noted and not reported to the office.	eir of ons able also vice y ng or or	
Bldg. 00	be supervised by a to ensure competer Supervision of ser scope of practice of professional provides Based on record revision of care in reviewed. (#1, #3, #4) The findings included the included the included to be supervision of care in reviewed. (#1, #3, #4) The findings included the incl	Home health aides shall a health care professional ent provision of care. vices must be within the of the health care ding the supervision. view the home health aides sed by a health care 30 days to ensure competent 5 out of 6 clinical records (4, #5, #6)	N 0584	By 9/30/17 the Administrator a Nursing Supervisor will meet vall Nursing Case Managers ar review our Policy Section 03.0 - Supervisory Visits. Policy: By observing the day to day activ of the care giving staff, the RN able to verify compliance with Plan of Care, Protocols and Standards, Quality of Services being provided, and the degre satisfaction with the services. During these visits, the RN will also collect data to implement	with nd 16A / ities I is	
	CARE, PROTOCO QUALITY OF SER AND THE DEGRE WITH THE SERVI	ANCE WITH PLAN OF LS AND STANDARDS, EVICES BEING PROVIDED, E OF SATISFACTION CES. DURING THESE VILL ALSO COLLECT		performance improvement activities to solve and prevent future problems, provide immediate feedback to care giving staff and gather		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPI	
			B. W	/ING		07/27	/2017
NAME OF I	DDOMDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIER	C		9521 IN	IDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CO	OUNTY INDIANA		HIGHL	AND, IN 46322		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID	T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
1710		MENT PERFORMANCE	+	1710	suggestions to improve		DATE
		ACTIVITIES TO SOLVE			processes.		
		UTURE PROBLEMS,			For skilled care provided by a	1	
		DIATE FEEDBACK TO			Licensed Practical Nurse (LP		
		AFF AND GATHER			supervisory visits are perform	•	
		O IMPROVE PROCESSES.			every fourteen (14) days. For		
		vided by a Licensed Practical			personal/support services		
		visory visits are performed			(attendant, companion,		
		days. For personal/support			homemaking, transportation)		
					supervisory visits are perform		
	services (attendant, companion, homemaking, transportation), supervisory visits are performed				every thirty (30) days.		
	every sixty (60) days. Elements of a Supervisory Visit: Supervisory visits need to include but are				Supervisory visits need to inc	lude	
					but are not limited to the		
	not limited to the following: Ensure care giving staff have implemented care and are following the				following: Ensure care giving		
					have implemented the care a		
	•	late that staff perform care			are following the POC, valida	te	
		e of practice as defined by the			that staff perform care within		
		zation's policies. Observation			his/her scope of practice as		
		n infection control including			defined by the state and the		
	_	mpletion of the Hand Hygiene			organization's policies. Observation for compliance v	vith	
	Observation Form,	as indicated for sampling			infection control including har		
	needs; Observation	for compliance with universal			hygiene, completion of the Ha		
	precautions under (OSHA's [Occupational Safety			Hygiene section, Observation		
	and Health Admini	stration] Bloodborne			compliance with universal		
	Pathogens Standard	l; Ongoing evaluation of staff			precautions under OSHA's		
	competency; Adhe	rence to agency's policies and			Bloodborne Pathogen's Stand	dard,	
	procedures; Provid	e instruction/teaching to staff			Ongoing evaluation of staff		
		ssion with client/family about			competency, adherence to		
	the quality of care b	peing provided and the			agency's policies and proced		
		re staff. Verification that			provide instruction/teaching to		
		nealth status has been reported			staff as indicated, discussion		
		fursing or supervising RN; If			client/family about the quality	of	
		ges to the Plan of Care; and If			care being provided and the		
	needed, perform a c	elient reassessment."			compatibility of care staff,		
					verification that changes in	n	
		al record #1 on 7/25/17			client's health status has bee reported to the Director of	11	
		locuments titled "Supervisory			Nursing and Supervising RN,	and	
		no evidence of supervisory			if needed changes to the PO		
		ted in February 2016, April			On going compliance will be	.	
	I	d October 2016. The agency			monitored as 10% of active		
	failed to ensure the	home health aides were	I		I III III III III II II II II II II II		I

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		 UILDING	00	(X3) DATE COMPL 07/27 /	ETED	
	PROVIDER OR SUPPLIER		9521 IN	ADDRESS, CITY, STATE, ZIP CODE IDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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
	supervised every 30 3. Review of clinic evidenced agency d Visit". There was n visits being conduct 2016, and Decembe ensure the home heavery 30 days. 4. Review of clinic evidenced agency d Visit". There was n visits being conduct 2016, October 2016 agency failed to enswere supervised every 5. Review of clinic evidenced agency d Visit". There was n visits being conduct 2016, November 20 March 2017. 6. Review of clinic evidenced no agency of care on 3/2/16 to 4/27/16. The agency health aides were supervised.	al record #3 on 7/25/17 ocuments titled "Supervisory o evidence of supervisory ed in May 2016, August r 2016. The agency failed to alth aides were supervised al record #4 on 7/25/17 ocuments titled "Supervisory o evidence of supervisory ed in July 2016, September and December 2016. The ure the home health aides ery 30 days. al record #5 on 7/25/17, ocuments titled "Supervisory o evidence of supervisory ed in July 2016, September 16, December 2016 and al record #6 on 7/25/17, y supervisory visits from start patient/family discharge of y failed to ensure the home upervised every 30 days.		patient charts are audited ever quarter. ADDENDUM: Supervisory visit policy was revised showing that supervis visits needs to be done on personal care employees (attendant, companion, perso care, etc.) This policy was approved by the Governing B on 9/25/17 and given to all nu case managers meeting on 9/27/17 or emailed. Nursing Supervisor will over see this.	ory nal	
N 0586 Bldg. 00	receive continuing continuing educati twelve (12) hours December 31, incl eight (8) hours in a following subject a	Home health aides must education. Such on shall total at least from January 1 through usive, with a minimum of any eight (8) of the				

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PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

AND PLANO E CORRECTION DENTIFICATION NUMBER: A BILLIDING BUILD STREET ADDRESS, CITY, STATE, ZIP CODE. 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322 HIGHLAND, IN 46322 ID PROVIDER OR SUPPLIER PREFIX (FACH DEFICIENCY MUST BE RECEBED BY FULL TAG BUILD TO THE COUNTY INDIANA ABILITY OF THE COUNTY INDIANA BUILD TO THE COUNTY OR LSC IDENTIFYING INFORMATION) ABILITY OF THE COUNTY OR LSC IDENTIFYING INFORMATION ABILITY OF THE COUNTY OR LSC IDENTIFYING INFORMATION ABILITY OF THE COUNTY OR LSC IDENTIFYING INFORMATION ABILITY OR THE COUNTY OR LSC IDENTIFY OR THE COUNTY O	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF LAKE COUNTY INDIANA (C4) ID SUMMARY STATEMENT OF DEFICIENCES REQUITED AND SUMMARY STATEMENT OF DEFICIENCES RECUIT DEFICIENCES REQUITED AND SUMMARY STATEMENT OF DEFICENCES REQUITED AND SUMMARY STATEMENT OF DEFICENC	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322 (X4) JD SIMMARY STATEMENT OF DETICINCIES PRIETX (ACH DEPICIENCY MIST BE PRECEDED BY FULL ABILITY AG Ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance.				B. W	ING		07/27	/2017
BRIGHTSTAR OF LAKE COUNTY INDIANA (X4)ID SUMMARY STATEMENT OF DEFICIENCIES (IACI DEFICIENCY MIST BE PRECEDED BY FULL TAG BRIGHT OF LAKE COUNTY INDIANA (X5) REGULATORY OR LSE DESTITYING INFORMATION) TAG BILLY OR TO THE ACTION OR LSE DESTITYING INFORMATION Accurate oral presentations to patients. caregivers, and other home health agency starff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nall and skin care. (E) Oral hygiene. (F) Toileting and elimination. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance.								
BRIGHTSTAR OF LAKE COUNTY INDIANA	NAME OF P	ROVIDER OR SUPPLIEF	₹					
SUMMARY STATEMENT OF DEFICIENCIES PREFEX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake.					1	·		
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(13) Medication assistance.								
(14) Any other tack that the home health								
(14) Any other task that the home health		(14) Any other ta	ask that the home health					
agency may choose to have the home								
health aide perform.		health aide perfor	m.					

State Form Event ID: VQEX11 Facility ID: 012189 If continuation sheet Page 91 of 123

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPL	ETED
			B. W	B. WING			/2017
						017217	2017
NAME OF I	PROVIDER OR SUPPLIEF	8		STREET .	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KO VIDEK OK SUI I EIEF			9521 IN	NDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		HIGHL	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on record rev	view and interview the agency	N 0	586	It is the Administrator's		09/30/2017
		home health aides had the	1,0		responsibility to make sure pro	per	05/20/2017
		ours of continuing required by			policies and procedures are being		
		epartment of Health in 1 of 1			followed. During survey it was		
		s D, E, F, G, H, I, J, O, R, S)			found that not all of the		
	agency. (employees	5 D, E, F, G, H, I, J, O, K, S)			employees had all of their		
	Tri (* 1				required 12 in-services. At the	2	
	The findings includ	e:			time of hire and annually	•	
					thereafter all employees will		
		ency policy titled "Section			complete 8 mandatory in servi	000	
		alth Aide Inservices" stated			-	Ces	
	"Note: Each home	health aide must receive			and then more than 100		
	continuing education totaling at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in				in-services are available to the		
					to make sure required in-servi	ces	
					are achieved through out the		
		wing subject areas: Annual			year. Up to and including		
		nication skills (including the			required in-services are as		
	_	e and make brief and accurate			follows: Infection		
	-	o clients, caregivers and other			Control/Universal Precautions		
	_	_			Communication Documentation	n,	
		staff). 2. Observing and			Elements of Body Functions,		
		ure, pulse and respiration. 3.			Maintaining a clean and safe		
		trol procedures and universal			environment, Fire Safety, Elde	er	
	_	sic elements of body			Abuse and Neglect,		
	_	anges in body function that			Confidentiality and HIPPA,		
	must be reported to	an aide's supervisor. 5.			Personal Hygiene and grooming	ng,	
	Maintaining a clean	, safe and health environment.			Safety transfer techniques,		
	Recognizing em	ergencies and knowledge of			Range of Motion, Nutrition, an	d	
	emergency procedu	res. 7. The physical,			Medication Assistance.		
	emotional and deve	lopmental needs of and way to			Employees who do not obtain		
		lations served by the home			their 12 required in-services w	ill	
		iding the need for respect for			be removed from providing		
		t's privacy and the client's			patient care. The above is to		
		opriate and safe techniques in			assure the following policy is		
		nd grooming: Bed bath Bath:			followed, "STAFF INSERVICE	S	
		-			HOME HEALTH AIDE	,	
	sponge, tube [sic] or shower Shampoo: sink, tub				CONTINUING EDUCATION A	ND	
		n care Oral hygiene Toileting			COMPETENCY EVALUATION		
		Safe transfer techniques and			PROGRAM". To assure	N	
		ormal range of motion and				ro	
		lequate nutrition and fluid			employees delivering client ca		
	intake 12. Medication assistance 13. Any other				or service receive appropriate		
	task that the home h	nealth agency may choose to			training to meet state and fede		
		th aide perform Note: During			regulations. In-service educat	ion	

State Form Event ID: VQEX11 Facility ID: 012189 If continuation sheet Page 92 of 123

PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE COMPL 07/27 /	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a home health aide's	s first year on the state's home			programs will cover those area	as	
	health aide registry,	, the number of hours of			required by state and federal		
	training for that aid	e shall be a prorated portion of			guidelines and will be based o	n	
	the usual twelve (12	2) hours and eight (8) hours."			identified staff and client need	S.	
					The agency should maintain		
		ency policy titled "Section			documentation of all in-service	;	
	03.10 - Staff Inserv	ices, Home Health Aide			education. The 12 hour per		
	_	on And Competency			calendar year requirement for	201	
	_	n" stated "Purpose To assure			home health aide in-services r	nay	
		ng client care or service			be prorated according to the employee's date of hire and		
	receive appropriate training to meet state and federal regulations and are provided with				records maintained per calend	lar	
					year. 10% of employee files v		
	^ ^	ities as deemed necessary by			be audited quarterly and findir		
	the Supervising Nurse and/or Administrator to provide quality care to the Agency's clients.				reported to the Performance	.gc	
					Improvement Committee.		
	· ·	members providing direct			•		
		nd in-service education			Addendum: Persons responsible for		
		as needed or required. 2.			this correction is the Administrator		
		n programs will cover those			and Nursing Supervisor or Nursing		
		ate and federal guidelines and			Designee. Governing Body reviewed		
		entified staff and client needs.			in-services, employee audit list, and		
	be maintained and a	ervice education programs will			in-service logs on 9/25/17.		
		ducational programs may be			PLAN: With the requirements of the		
		with vendor or other health			regulations mandatory in-services		
	-	To receive recognition for			the following will be included at our		
	_	ees who attend staff			8 hour orientation and annually		
		ams outside the agency are			thereafter: Infection		
		nit documentation of			Control/Universal Precautions, RAC	Ē	
		cluded in the employee's			for Fire Safety, Confidentiality &		
		5. Home Health Aide			HIPAA, Red Flag Program,		
		on: According to state			Alzheimer's Disease, Effective		
	_	ents and federal Conditions of			Communication Skills in Healthcare,		
	-	gency must provide Home			Reporting and Documenting Client		
		continuing education on an			Care, Basic Nutrition and Hydration,		
	annual basis as note	ed in the policy entitled:			Passive and Active Range of Motion	,	
	"Competency Evalu	uation for Home Care Agency			Recognizing and Reporting		
	Staff and In-service	Education for Home Health			Abnormal Observations, Performing		
	Aides. 6. All emp	loyees must attend in-service			Safe Transfers, Bathing Tips, and		
	programs determine	ed by the Agency to be			Medication Reminders. These		
	mandatory for all st	aff. There are six minimally			in-services will be overseen by the		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 07/27/2017		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
	required training ca	tegories (three need to be		Nursing Supervisor or the Nursing			
		l regulations and will be in		Designee. An additional 100			
		giving training): i. Sexual		in-services are available through			
	1	AA iii. Elder abuse iv.		each employee's portal to complete	·-e		
	Bloodborne Pathogo	ens v. Other OSHA standards		the additional four required to me			
	1	ty Theft Detection and		their 12 in-services, there are			
	Prevention 7. The	Agency should maintain		disease specific and caregiver tips			
	documentation of al	Il in-service education"		including a wide variety of			
				demonstration through an In The			
	3. Record review of personnel records failed to			Know BrightStar Developed			
	evidence the required 8 out of 12 hours of continuing education hours required by the state of Indiana in the following home health aide			Program. Monthly in-services will			
				also be offered to all employees th	ne l		
				third Wednesday of the month he			
	records reviewed:			in our office featuring different			
				caregiver tips not included in the			
		he personnel file of employee		basic mandatory in-services.			
		/13, on 7/26/17 failed to		Employees are being sent new			
		hours of in-service education		mandatory in-services by 10/5/17			
		ncy. The personnel file only		for completion by the end of the			
		on agency document subtitled		year or they are to be removed fro	ım .		
		ed 10/25/15 which included		their shifts. A log is created showing			
	Infection Control, R			who has done them, how many th	-		
	1	HIPAA [health insurance puntability act] testing, Red		have done, and how many need to			
	1 -	ty Theft, Alzheimer's Disease		be completed by the end of the ye			
	_	d Neglect. No other		to have met their 12 required			
		n documentation was		in-services. If they are not			
	evidenced in emplo	- 4.0 - 0		compliant, they will be placed			
	o vidence di monipro	, o		inactive until credentialing is			
	b. Review of t	the personnel file of employee		completed.			
		/16, on 7/26/17 failed to					
		hours of in-service education		All new hires will have skills			
	provided by the age	ency. The personnel file only		competency, mandatory 8			
	evidenced training of	on agency document titled		in-services at our 8 hour orientation	on,		
	"BrightStar In-Serv	ices" dated 11/2/16 which		take the HHA test, and will be			
		Control, Race for Fire Safety,		registered with the state. New hire	es		
	Confidentiality and HIPAA Testing, Red Flag			will not be scheduled any patient			
	Medical Identity Theft, Elder Abuse and Neglect			contact until we can print out their			
	and Alzheimer's Dis			activeness with the state and place	e it		
		n documentation was		in their file. Administrator will			
	evidenced in emplo	yee E's record.		oversee this.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING 00 B. WING		COMPLETED 07/27/2017		
	ROVIDER OR SUPPLIER			9521 IN	ADDRESS, CITY, STATE, ZIP CODE IDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	F, date of hire 10/23 evidence at least 12 provided by the age to evidence any doc in-service and/or ed agency. d. Review of t G, date of hire 6/21/evidence at least 12 provided by the age evidenced training i Fire Safety, Confide Red Flag Medical Id Neglect and Alzheir in-service/education evidenced in employ e. Review of ti H, date of hire 3/22/evidence at least 12 provided by the age evidenced training of "In The Know" date Infection Control, R Confidentiality and Medical Identity Th Bathing Tips, Build Clients, Dressing and Care, Handling Incotract infections], Im Elderly, Passive and Perineal and Cathete in-service/education evidenced in employed	the personnel file of employee (16, on 7/26/17 failed to hours of in-service education necy. The personnel file only on agency document subtitled at 3/21/16 which included acce for Fire Safety, HIPAA Testing, Red Flag eft, Alzheimer's Disease, ing Trust and Confidence with did Grooming Tips, End of Life ontinence and UTIs [urinary portance of Activity for the I Active Range of Motion and er Care. No other a documentation was yee H's record.			Monitoring: In-Service log has been created for every employee and date of year showing all in-services completed in that time frame. As employee completes in-services will be logged. Quarterly administration will check the logs and call employees advising how many have been completed so far and how many need to be completed by the end of the year. Employees who fail to complete in-services by the end of the year will be removed from all patient contact until it is complete. This will be overseen by the Administrator.		
	I, date of hire 6/6/14	ne personnel file of employee 1, on 7/26/17 failed to hours of in-service education					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 B. WING			COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER			9521 IN	DIANAPOLIS BLVD, SUITE O ND, IN 46322			
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	to evidence any doc	ncy. The personnel file failed ruments pertaining to ucation hours provided by the						
	J, date of hire 2/23/2 evidence at least 12 provided by the age evidenced training of "BrightStar In-Servincluded Infection Confidentiality and Medical Identity The Alzheimer's Disease Understanding Auti	ices" dated 1/14/17, which Control, Race for Fire Safety, HIPAA Testing, Red Flag left, Elder Abuse and Neglect, e, Understanding Hospice and sm. No other						
	O, date of hire 5/17, evidence at least 12 provided by the age evidenced a docume In-Services" dated 5 Infection Control, R Confidentiality and Medical Identity Th and Alzheimer's Dis	HIPAA Testing, Red Flag left, Elder Abuse and Neglect sease. No other a documentation was						
	R, date of hire 6/21/ evidence at least 12 provided by the age evidenced the follow Infection Control, R Confidentiality and Medical Identity Th	ne personnel file of employee /16, on 7/26/17 failed to hours of in-service education ncy. The personnel file wing in-services/education: tace for Fire Safety, HIPAA Testing, Red Flagueft, Elder Abuse and Neglect, et and Catheter Change. No						

State Form Event ID: VQEX11 Facility ID: 012189 If continuation sheet Page 96 of 123

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 07/27/2017	
BRIGHTS	ROVIDER OR SUPPLIER	UNTY INDIANA	9521 IN HIGHL	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	evidenced in employ	cation documentation was yee R's record. ne personnel file of employee			
	S, date of hire 5/4/1 evidence at least 12 provided by the age evidenced the follow Infection Control, R Confidentiality and Medical Identity Th and Alzheimer's Dis	1, on 7/26/17 failed to hours of in-service education ncy. The personnel file wing in-services/education: tace for Fire Safety, HIPAA Testing, Red Flag left, Elder Abuse and Neglect sease. No other in documentation was			
	p.m. the administratin-service document administrator indicated not in the binder or he/she provided the During an interview administrator indicated Control, Race For FHIPAA Testing, Reflect Abuse and Netherland Disease was the online annually by the agent indicated that they control.	nterview on 7/27/17 at 1:00 for indicated that all the ts had been received. The tted that if the in-services were in the electronic printed form in they don't have them. If on 7/27/17 at 2:50 p.m. the tted that only the Infection Tire Safety, Confidentiality and d Flag Medical Identity Theft, eglect, and Alzheimer's y in-services required ney. The administrator do encourage the employees to l do others (in-services).			
N 0594	410 IAC 17-14-1(k Scope of Services				
Bldg. 00	shall maintain suff demonstrate that t requirements are i Based on record rev failed to maintain su	riew and interview the agency afficient documentation to econtinuing education	N 0594	It is the Administrator's responsibility to make sure pr policies and procedures are b followed. During survey it was	eing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/27/2017		
	ROVIDER OR SUPPLIER		9	521 INI	DIRESS, CITY, STATE, ZIP CODE DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
PREFIX	The findings includ 1. The undated age 03.10A - Home Heat "Note: Each home continuing education hours from January inclusive, with a min any (8) of the follow Topics 1. Commun ability to read, write oral presentations to home health agency recording temperate Basic infection comprecautions. 4. Basic infection comprecautions. 4. Basic infection comprecautions and chamust be reported to Maintaining a clean 6. Recognizing ememergency procedure emotional and deverwork with the populational and deverwork with the population and had agency, incluted client, the client property. 8. Appropersonal hygiene are sponge, tube [sic] of or bed Nail and ski and elimination 9. ambulation 10. No positioning 11. Addintake 12. Medicated in the state of th	e: ncy policy titled "Section alth Aide Inservices" stated health aide must receive in totaling at least twelve (12) 1 through December 31, nimum of eight (8) hours in wing subject areas: Annual nication skills (including the e and make brief and accurate of clients, caregivers and other is staff). 2. Observing and are, pulse and respiration. 3. trol procedures and universal sic elements of body inges in body function that an aide's supervisor. 5. It, safe and health environment. ergencies and knowledge of res. 7. The physical, lopmental needs of and way to lations served by the home adding the need for respect for 's privacy and the client's in priate and safe techniques in add grooming: Bed bath Bath: It is shower Shampoo: sink, tub in care Oral hygiene Toileting Safe transfer techniques and dequate nutrition and fluid tion assistance 13. Any other	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ces m ces n, r ng, d sill	COMPLETION
	have the home healt a home health aide's health aide registry, training for that aide	the alth agency may choose to the aide perform. Note: During as first year on the state's home the number of hours of the shall be a prorated portion of the polynomial of the state's home.			training to meet state and feder regulations. In-service education programs will cover those area required by state and federal guidelines and will be based of identified staff and client needs	ion is n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
			B. W	ING	<u> </u>	07/27/	2017
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
DDIGUE	OTAB OF LAKE OF	NI INITA INIDIANIA			IDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CC	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	2. The undated age	ency policy titled "Section			The agency should maintain		
	_	rices, Home Health Aide			documentation of all in-service	;	
		ion And Competency			education. The 12 hour per		
	_	n" stated "Purpose To assure			calendar year requirement for		
	_	ng client care or service			home health aide in-services r	nay	
		training to meet state and			be prorated according to the		
		and are provided with			employee's date of hire and		
	_	ities as deemed necessary by			records maintained per calend		
		rse and/or Administrator to			year. 10% of employee files w		
		e to the Agency's clients.			be audited quarterly and findin	ıgs	
		members providing direct			reported to the Performance		
	-	nd in-service education			Improvement Committee.		
		as needed or required. 2.		Addendum: Persons responsible for			
	In-service education programs will cover those				this correction is the Administrator		
		tate and federal guidelines and			and Nursing Supervisor or Nursing		
		entified staff and client needs.			Designee. Governing Body reviewed	l	
		ervice education programs will		in-services, employee audit list, and			
	be maintained and a	, ,			in-service logs on 9/25/17.		
	documented, 4. Ed	ducational programs may be		PLAN: With the requirements of the			
		with vendor or other health			regulations mandatory in-services		
	-	To receive recognition for			the following will be included at our		
	_	vees who attend staff			8 hour orientation and annually		
	development progra	ams outside the agency are			thereafter: Infection		
		nit documentation of			Control/Universal Precautions, RACI	Ē	
		cluded in the employee's			for Fire Safety, Confidentiality &		
		5. Home Health Aide			HIPAA, Red Flag Program,		
	Continuing Educati	ion: According to state			Alzheimer's Disease, Effective		
	_	ents and federal Conditions of			Communication Skills in Healthcare,		
	Participation, the ag	gency must provide Home			Reporting and Documenting Client		
	Health Aides with o	continuing education on an			Care, Basic Nutrition and Hydration,		
	annual basis as note	ed in the policy entitled:			Passive and Active Range of Motion		
	"Competency Evalu	uation for Home Care Agency			Recognizing and Reporting		
	Staff and In-service	e Education for Home Health			Abnormal Observations, Performing		
	Aides. 6. All emp	loyees must attend in-service			Safe Transfers, Bathing Tips, and	·	
	programs determine	ed by the Agency to be			Medication Reminders. These		
	mandatory for all st	taff. There are six minimally			in-services will be overseen by the		
	required training ca	itegories (three need to be			Nursing Supervisor or the Nursing		
	compliant with loca	al regulations and will be in			Designee. An additional 100		
	addition to job care	giving training): i. Sexual			in-services are available through		
		PAA iii. Elder abuse iv.					
	Bloodborne Pathog	ens v. Other OSHA standards	1		each employee's portal to complete		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		07/27/	′2017
				CENTER	ADDRESS OF A STATE OF CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CC	OUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	vi. Red Flag Identi	ty Theft Detection and			the additional four required to mee	t	
	Prevention 7. The	Agency should maintain			their 12 in-services, there are		
	documentation of all in-service education"				disease specific and caregiver tips		
					including a wide variety of		
	3. Record review of	of personnel records failed to			demonstration through an In The		
	evidence the require	ed 8 out of 12 hours of			Know BrightStar Developed		
	continuing education	on hours required by the state			Program. Monthly in-services will		
		ollowing home health aide			also be offered to all employees the	:	
	records reviewed:				third Wednesday of the month held		
					in our office featuring different		
		the personnel file of employee			caregiver tips not included in the		
		/13, on 7/26/17 failed to			basic mandatory in-services.		
		hours of in-service education			Employees are being sent new		
		ency. The personnel file only			mandatory in-services by 10/5/17		
		on agency document subtitled			for completion by the end of the		
		ed 10/25/15 which included			year or they are to be removed fron	n	
		Race for Fire Safety,			their shifts. A log is created showing		
	I	HIPAA [health insurance			who has done them, how many the		
		ountability act] testing, Red			have done, and how many need to	,	
		ity Theft, Alzheimer's Disease			be completed by the end of the yea	r	
		nd Neglect. No other n documentation was			to have met their 12 required		
					in-services. If they are not		
	evidenced in emplo	yee D's fecold.			compliant, they will be placed		
	h Daview of	the personnel file of employee		inactive until credentialing is			
		/16, on 7/26/17 failed to			completed.		
	· '	hours of in-service education					
		ency. The personnel file only			All new hires will have skills		
	1	on agency document titled			competency, mandatory 8		
	_	rices" dated 11/2/16 which			in-services at our 8 hour orientation	١,	
	1	Control, Race for Fire Safety,			take the HHA test, and will be		
		HIPAA Testing, Red Flag			registered with the state. New hires	;	
	I	neft, Elder Abuse and Neglect			will not be scheduled any patient		
	and Alzheimer's Di				contact until we can print out their		
	in-service/education	n documentation was			activeness with the state and place	it	
	evidenced in emplo	yee E's record.			in their file. Administrator will		
					oversee this.		
	c. Review of t	the personnel file of employee					
	F, date of hire 10/2	3/15, on 7/26/17 failed to			Monitoring: In-Service log has been		
	evidence at least 12	hours of in-service education			created for every employee and		
	provided by the age	ency. The personnel file failed			date of year showing all in-services		

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING				COMPL 07/27/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	'E	(X5) COMPLETION DATE	
	d. Review of the Gyalic evidence at least 12 provided by the age evidenced training in Fire Safety, Confidence at least 12 provided by the age evidenced training in Fire Safety, Confidenced training in Fire Safety, Confidenced training in Fire Safety, Confidenced in employ e. Review of the H, date of hire 3/22/evidence at least 12 provided by the age evidenced training of "In The Know" date Infection Control, R. Confidentiality and Medical Identity The Bathing Tips, Build Clients, Dressing and Care, Handling Incompared tract infections, Immaled Elderly, Passive and Perineal and Cathete in-service/education evidenced in employ for Review of the I, date of hire 6/6/14 evidence at least 12 provided by the age to evidence any doc	the personnel file of employee (16, on 7/26/17 failed to hours of in-service education ney. The personnel file only on agency document subtitled d 3/21/16 which included ace for Fire Safety, HIPAA Testing, Red Flag eft, Alzheimer's Disease, ing Trust and Confidence with d Grooming Tips, End of Life ontinence and UTIs [urinary portance of Activity for the l Active Range of Motion and er Care. No other			completed in that time frame. As employee completes in-services will be logged. Quarterly administration will check the logs and call employees advising how many have been completed so far and how many need to be completed by the end of the year. Employees who fail to complete in-services by the end of the year will be removed from all patient contact until it is complete. This will be overseen by the Administrator.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN B. WING		00	COMPL 07/27/	ETED	
	PROVIDER OR SUPPLIEF		952	21 INDI	ORESS, CITY, STATE, ZIP CODE ANAPOLIS BLVD, SUITE O D, IN 46322	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	J, date of hire 2/23/ evidence at least 12 provided by the age evidenced training. "BrightStar In-Serv included Infection of Confidentiality and Medical Identity The and Alzheimer's Disin-service/education evidenced in emplose h. Review of the confidentiality and Alzheimer's Disease evidenced a docum In-Services" dated of Infection Control, For Confidentiality and Medical Identity The and Alzheimer's Disin-service/education evidenced in emplose i. Review of the R, date of hire 6/21 evidence at least 12 provided by the age evidenced the folloour Infection Control, For Confidentiality and Medical Identity The Alzheimer's Disease other in-service/education j. Review of the S, date of hire 5/4/10 service of the confidentiality and for Confidentiality and Medical Identity The Alzheimer's Disease other in-service/education j. Review of the S, date of hire 5/4/10 service of the confidentiality and the confident	the personnel file of employee /16, on 7/26/17 failed to hours of in-service education ency. There personnel file ent titled "BrightStar 5/17/16, which included Race for Fire Safety, HIPAA Testing, Red Flag neft, Elder Abuse and Neglect sease. No other in documentation was yee O's record. The personnel file of employee /16, on 7/26/17 failed to hours of in-service education ency. The personnel file wing in-services/education: Race for Fire Safety, HIPAA Testing, Red Flag neft, Elder Abuse and Neglect, e and Catheter Change. No acation documentation was read and Catheter Change.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	<u>00</u>	COMPLETED 07/27/2017	
	ROVIDER OR SUPPLIER	UNTY INDIANA	9521 IN	ADDRESS, CITY, STATE, ZIP CODE IDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	evidenced the follow Infection Control, R Confidentiality and Medical Identity Th and Alzheimer's Dis in-service/education evidenced in employ	HIPAA Testing, Red Flag eft, Elder Abuse and Neglect sease. No other documentation was yee S's record.			
	in-service document administrator indica not in the binder or he/she provided ther During an interview administrator indica Control, Race For F HIPAA Testing, Ree Elder Abuse and Ne Disease was the only annually by the ager indicated that they de	or indicated that all the as had been received. The sted that if the in-services were in the electronic printed form in they don't have them. on 7/27/17 at 2:50 p.m. the ted that only the Infection ire Safety, Confidentiality and d Flag Medical Identity Theft, glect, and Alzheimer's y in-services required ney. The administrator to encourage the employees to do others (in-services).			
N 0596 Bldg. 00	shall be responsib to patient contact, furnish home healt behalf meet the re as follows: (1) The home healt (A) have success competency evaluaddresses each of subsection (h) of the Based on personnel.	The home health agency le for ensuring that, prior the individuals who the aide services on its quirements of this section alth aide shall: sfully completed a ation program that	N 0596	By October 31, 2017 current employees will meet our Nursi	10/31/2017
		ted their skills competency		Supervisor or Nurse Designee	

State Form Event ID: VQEX11 Facility ID: 012189 If continuation sheet Page 103 of 123

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETE	ED
			B. Wl	ING		07/27/20	17
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	DUNTY INDIANA			AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	assessment. (employees D, I)				have their annual clinical		
	The findings include:				competency performed. All sta	off	
					members who provide direct		
					client care will have a clinical		
	_	ency policy titled "Section			competency assessment as stated in our policy Section 03	06	
		mpetency Program" stated			- Clinical Competency Program		
		r Care will access and			Established competency	'''	
		cal competency of each staff des direct client care, treatment			assessment will be documented	ed	
		lure: 1. Each staff member			and will be established as bas		
		t client care will have a clinical			on their staff member's		
		ment at defined intervals: a.			classification. This will be done	e	
		on b. Periodic: i. CNAs			annually and on going in		
	_	ssistants], CHHAs [certified			accordance with laws and		
		HHAs [home health aides],			regulations, any time there is		
	_	tants], Attendants and			concern with a staff member's		
	_	nually ii. RNs [registered			clinical competency and when		
	nurses] and LPNs [licensed practical nurses] - At			introducing new client care procedures, techniques or		
	least every 3 years	iii. Medical Social Worker,			equipment as well as initially a	ıt I	
	Physical Therapist,	Occupational Therapist,			their orientation.		
	Speech-Language	Therapist - At least every 3			Addendum: Persons responsible for		
	1 -	ance with laws and regulations			this correction is the Nursing		
		re is concern of staff member's			Supervisor or Nursing Designee.		
		y e. When introducing new			PLAN:		
		res, techniques or equipment.			Files are being audited to make sure		
		assessment will be			that the caregiver has had an initial		
		stablished competency			skills competency and are active		
		established base [sic] on the			with the state registry. Our files		
		classification (i.e. [that is to ing assistant, licensed			were lacking annual competency		
		l nurse, etc [etcetera]). 4.			checks. Staff was notified that they		
	_	ompetencies are maintained			need to come in and schedule		
		igh: a. In-service and/or			competency check off in our office.		
	_	on b. Trends in infection			Our office has a new training room		
		porting and performance			which has a mechanical lift, washing	s	
	_	ities c. Specialty training or			station, transfer equipment,		
		xample of qualified individuals			walkers, canes, etc. for nurse (nurse		
		ompetency assessments may			designee) to perform skills		
		health aide, certified home			competency on a living person		
	health aide, certifie	d nursing assistant:			during this session. Due to the		
		ment performed by registered			equipment being set up in our new		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	ING	 	07/27/	2017
						017217	2017
NAME OF I	PROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVIVIL OF I	KOVIDEK OK SOLI EIEI			9521 IN	IDIANAPOLIS BLVD, SUITE O		
BRIGHT	STAR OF LAKE CC	UNTY INDIANA		HIGHLA	AND, IN 46322		
					,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	nurse. b. Licensed	practical/vocational nurse:			training area check offs are		
	competency assesse	ed by registered nurse d.			scheduled on 10/3, 10/5, 10/6,		
		PT): competency assessed by			10/12, 10/13, 10/20 and 10/21. For		
		apist or PT supervisor e.			anyone that cannot make those		
		pist (OT): competency					
		OT or OT supervisor f.			sessions they will have individual		
		athologist (SLP): Competency			training at their convenience to		
		SLP or SLP supervisor g.			make sure it is done. On going		
					thereafter competencies are being		
		rker: competency assessed by			checked monthly to assure all		
	a peer MSW."				annual competencies are being don	e	
					prior to the annual due date making	;	
		of the personnel record for			us out of compliance. If a client has	a	
		6/17 evidenced an agency			competency are that is not		
	document titled "Co	ompetency Assessment Skill			satisfactory, an employee will not be	۵	
	Checklist for Home	Health Aide" dated 4/15/15.			sent to a client with that specific		
	This document indi	cated that the home health aide			· ·		
	(employee D) requi	red more skill competency			need unless additional training has		
	training in hoyer lif	t and diabetic diet, low sodium			been done with the nursing		
		sterol/fat diet. No other skills			supervisor or designee. For example	2,	
		ment/reassessment was			additional training needed on a		
		yee D's personnel record. The			mechanical lift. Employee file will		
	_	sure the home health aide			have a tag that specifies do not send	t	
		eted the skills competency			to a mechanical lift client. Nursing		
	evaluation.	eted the skins competency			Supervisor or Nursing Designee will		
	Cvaruation.				then schedule additional training		
	2 Danamal manifession	£			and once training is satisfactory		
		f personnel record for			competency will then show the date	,	
		/17 evidenced an agency			this was observed and the tag from		
		ompetency Assessment Skill			<u> </u>		
		ne Health Aide" dated 4/15/15.			employee file will be lifted. This will		
		cated that the home health aide			be monitored by running monthly		
		ed more skill competency			reports for compliance. Competence	y	
		essure, making occupied beds,			skills and due dates are being		
	hoyer lift, diabetic	diet, low sodium diet, and low			entered into our computer system		
	cholesterol/fat diet.	No other skills competency			to track nearing expiration dates.		
	assessment/reassess	sment was evidenced in					
	employee I's persor	nnel record. The agency failed			All new hires will have skills		
	to ensure the home	health aide successfully			competency, mandatory 8		
		s competency evaluation.			in-services at our 8 hour orientation		
		•			take the HHA test, and will be	´	
					registered with the state. New hires		
	I				will not be scheduled any patient		

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 07/27/2017
	PROVIDER OR SUPPLIER		9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322	l
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				contact until we can print out their activeness with the state and place in their file. Administrator will oversee this.	
				Monitoring of the above is being maintained in our software system showing when employee have had competency checks and when they are due. Reports will be ran 30 day prior to the next month and administration will call the employ to schedule competencies that are due. Those that do not get them complete prior to their annual due date will be removed from any patient contact until it is complete Administrator will oversee this.	ee
N 0597 Bldg. 00	shall: (B) be entered on on the state aide r Based on record rev home health aide to the home health aide the Indiana state reg	and be in good standing egistry. iew the agency assigned a perform patient care prior to e being licensed and placed on gistry. (employee J)	N 0597	Effective immediately no hom health aide will have any conwith any patient's prior to receiving a verification from the state showing they are an action.	tact he tive
	evidenced a home h prior to licensure an	nnel records on 7/26/17 ealth aide that provided care d registration with the state of histrator failed to ensure		home health aide. Administra will make sure 10% of employ files are audited quarterly to assure this procedure has be followed. ADDENDUM: All new hires will have skills competency, mandatory in-services at our 8 hour orientation.	yee's en y 8

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		07/27/	2017
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					DIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	licensure on the hor	ne health aide (employee J).			take the HHA test, and will be		
	A review of the pers	sonnel file of employee J, date			registered with the state. Recruiter		
	of hire 2/23/16, on 7	7/25/17 evidenced an Indiana			will make sure we are in compliance	,	
	home health license	with an issue date of 3/11/16.			at the day of orientation for these		
	Review of the Indiana State Department of Health document titled "Employee Records", that was				things. Administrator will double		
					check the file by auditing and		
	partially filled out b	y the administrator, evidenced			printing out the aide registry		
	•	et date of 2/29/16. This is 11			verification for the file. New hires		
		ee J was issued a home health			will not be scheduled any patient		
	•	yee J provided patient care			contact until we can print out their		
	-	no home health aide license on			activeness with the state and place i	it	
	3/2/16. An agency document dated 3/2/16 titled				in their file. Administrator will		
		npanion Care Note and			oversee this.		
		Comments/Remarks:					
		his morning and wanted to get					
		yee J] gave him/her a sponge					
		c] linen on bed wet from					
	water".						
N 0604	410 IAC 17-14-1(r	m)					ļ
14 0004	Scope of Services	•					
Bldg. 00	•	The home health aide					
Blug. 00		nanges observed in the					
		s and needs to the					
	supervisory nurse						
	•	riew the home health aide	N 0	604	Administrator and Nursing		09/30/2017
	failed to report chan	iges in a patient's condition to			Supervisor reviewed Policy		
	the supervisory nurs	se. (employee U)			Section 02.01 - Standards of		
					Practice. 1. The agency provide	les	
	The findings include	e:			services based on acceptable		
					professional standards for hon		
		he clinical record for patient			care and according to state an		
	•	ency document titled			federal regulations as indicate		
		npanion Care Note and			2. All agency staff will perform		
		/2/16, that stated "			within the guidelines of their stated discipline. 2. All clients	will	
		s: make [sic] him/her a			be provided care based on a F		
		he/she took sugar and it was			of Care or Service Plan that is		
		himself/herself a [sic] insulin			prepared by the Registered		
		pid Release)" There was no			Nurse. A home health agency		
	documentation in th	e clinical record that this			Skilled Plan of Care will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER		NDIANAPOLIS BLVD, SUITE O		
	STAR OF LAKE C			AND, IN 46322		
BRIGHT	STAR OF LAKE CO	JON I F INDIANA	півпь	AND, IN 40322		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	_	eported to the RN [registered		prepared by a Registered Nu	rse	
		sician. An agency document		and reviewed, approved and		
		are/Companion Care Note and		signed by a physician. 4. Skil		
	Timesheet", dated			nursing visits are performed a		
		ks: Client is a [sic] diabetic		ordered by the physician on t		
		imbulance". There was no		Home Health Plan of Care ar additional orders as needed.		
		denced in the client record that		Skilled observation and	J.	
		reported to the patient's		assessment of the client's		
	physician.			condition is performed upon e	each	
				nursing visit and reported to t		
				physician if indicated. 6. All p		
				of care are based on the		
				individualized needs of the cl	ents	
				who are being served by the		
				agency.		
				Administrator and Nursing		
				Supervisor reviewed Policy		
				Section 02.15 Skilled Nursing		
				Services. 1. Skilled nursing services are performed by		
				Registered Nurses or License	ad	
				Practical Nurse under the	,	
				supervision of a Registered N	urse	
				in accordance with the Nurse		
				Practice Act. 2. Skilled nursin		
				care is performed in accordar	nce	
				with the doctor's orders in a		
				medically approved plan of ca	are	
				for a home agency client. 3.		
				Registered nurses do the		
				following: perform initial	,	
				assessments and periodically reassess the client's needs a		
				coordinate services as neede		
				Initiates the plan of care or	u.	
				service plan and necessary		
				revisions and updates when		
				needed, ensure that the phys	ician	
				is contacted when there are		
				changes in the client's conditi	on,	
				perform skilled nursing care a		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/27/2017
			-		
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
ррісцта	STAD OE LAVE CO			NDIANAPOLIS BLVD, SUIT	ΕU
DRIGHTS	STAR OF LAKE CO	ON IT INDIANA	HIGHL	AND, IN 46322	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	COMPLETION ROPRIATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	·	DATE
				needed for home health a clients, supervise and tea	-
				nursing personnel when r	
				4. Skilled nurses prepare	
				notes following each visit	
				same day care is rendere	
				Administrator and Nursing Supervisor reviewed Police	-
				Section 02.23 Medical Pla	_
				Care, Physician Orders a	
				Medical Supervision. 1. M	
				care shall follow a written	
				plan of care established a	
				periodically reviewed by t physician, dentist, chiropr	
				optometrist or podiatrist. 2	
				medical plan of care shall	
				the following: be developed	ed in
				consultation with the ager	
				include all services to be	·
				if a skilled service is being provided, cover all pertine	
				diagnoses, and include th	
				following: mental status, t	
				services and equipment r	
				frequency and during of v	risits,
				prognoses, rehabilitation potential, functional limita	tions
				activities permitted, nutriti	
				requirements, medication	
				treatments, any safety me	
				to protect against, injury,	
				instructions for timely disc	_
				or referral, therapy modal specifying length of treatn	
				any other appropriate iten	
				The total medical plan of	
				shall be reviewed by the a	
				physician, dentist, chiropr	
				optometrist or podiatrist a	
				home health agency pers	
				often as the severity of the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
11.212111			B. WING	<u> </u>	07/27/2017
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	L		NDIANAPOLIS BLVD, SUITE	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA	HIGHL	AND, IN 46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	OBE COMPLETION COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	patient's condition requires	DATE : but at
				least once every sixty (60)	
				4. A written summary for e	ach
				patient shall be sent to the physician, dentist, chiropra	
				optometrist of podiatrist at	l l
				every sixty (60) days. 5. Th	ne
				health care professional st the home health agency sl	
				promptly alert the person	Iali
				responsible for the medica	l l
				component of the patient's any changes that suggest	l l
				to alter the medical plan of	l l
				6. Home health agency pe	rsonnel
				shall promptly notify a patie	l l
				physician or other appropr licensed professional staff	
				legal representatives (if an	y), of
				any significant physical or	l l
				changes observed or repo the patient. 7 In the case of	- I
				medical emergency, the ho	ome
				health agency must know i	
				advance which emergency system to contact. 8. The	
				may accept written orders	
				physician, a dentist, a	
				chiropractor, a podiatrist, contometrist licensed in Ind	
				in any other state. 9. If the	
				receives an order from a	
				physician, dentist, a chirop podiatrist or an optometris	
				licensed in another state, t	
				home health agency shall	
				reasonable steps to determent that the order complies with	
				laws of the state where the	
				originated and the individu	
				issued the order examined patient is licensed to practi	
				patient is ildensed to practi	CE III

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		AT) FROVIDENSUFFLIENCLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/27/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O				
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				that state. 10. All orders issue a physician, a dentist, a chiropractor, podiatrist or an optometrist for home health services must meet the same requirements whether the order originated in Indiana or another state. 11. Orders issued from another state may not exceed authority allowed under orders from the same profession in Indiana under IC 25. 12. All medications, treatments and skilled nursing services provide to patients must be ordered by physician including patient's name, physician's name, date the order and signature of RN/LPN taking the order. 13. orders may be initially obtained telephone and confirmed in writing by the physician in a timely/manner. 14. Orders may be received by fax, however the agency will attempt to obtain original signatures for each signed order whenever possible.15. Verbal orders may be taken by licensed agency personnel in accordance with applicable state and federal lay and organization policy. 16. Nestamped signatures are permitted. 17. The medical plate of care will be used as the carplan and will include reasonate measurable and realistic goals determined by the patient assessment. 18. The care plan will also address rehabilitation potential and discharge plans. The care plan will also be	er er the s ed y a , The d by y ne y ws o an e ole, s as		

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		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/27/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O				
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		AND, IN 46322			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				reviewed, evaluated and revis as needed at least every sixty (60) days and/or as needed. 2 Agency staff caring for the pat will be made aware of the care plan and any changes will be communicated to appropriate staff members. 21. The agency will perform an annual audit of staff compliance of verbal ordeverification. Administrator and Nursing Supervisor reviewed Policy 02 - Reporting Patient's Condition Physician. Policy: Clinicians will monitor, document, and report the patient's response to care treatments provided on each home visit. Progress toward gwill be measured at regular intervals. Clinicians will establiand maintain ongong communication with the physician defended and properliate care for the patient. Ongoing communication with the client's physician may occur monthly more frequently when client's condition is unstable of changunexpectedly. Administrator and Nursing Supervisor will meet with Registered Nurse Case Managers to review all of the above policies by September 2017. Home health aides will sent a letter explaining their responsibilities for reporting change in condition to the Registered Nurse and an in-service of what signs and symptoms to look for including	co. cient e cy f er c.24 n to rill t and oals cian e s or es 30, oe		

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMI	E SURVEY PLETED 7/2017
			_	ADDRESS, CITY, STATE, ZIP (_	7/2017
	ROVIDER OR SUPPLIER		9521 IN	NDIANAPOLIS BLVD, S		
	STAR OF LAKE CO			AND, IN 46322		T are
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
				pain, mental status, no elimination, skin, and findings. ADDENDUM: Letter wall aides advised their responsibility with report change of conditions. in-service was also improcedures to follow a look for. This in-service added to the 8 require in-services for new hir employees annually the ERISA form is on file the employees showing the keep their emails up to informed of any change policies and procedure In-Service of reporting changes is in an In The Format. Caregiver not need to report on their anything called into the check that it was done Supervisor or Nursing will contact HHA to as if they did report it to the situation and docu an incident report for it follow-up and report to physician when needed Supervisor is responsi	abnormal vas sent to orting An clude of and what to be was ed es and hereafter. for hey have to o date to be ges in our es. g abnormal he Know hes also r notes he office and e. Nursing Designee k questions he office, hement it as hecessary of the ed. Nursing	
N 0606 Bldg. 00	therapist in therap the initial visit to the make a supervisor					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	JILDING	00	COMPL 07/27	LETED	
	PROVIDER OR SUPPLIER			9521 IN	ADDRESS, CITY, STATE, ZIP CODE NDIANAPOLIS BLVD, SUITE O AND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	assess relationship whether goals are Based on record revialled to be supervisionally assess to observe relationships, and to being met in 5 out of (#1, #3, #4, #5, #6). The findings included the findings included to the findings included the findings included to the findings included	view the home health aides sed by a registered nurse every the care, to assess o determine whether goals are of 6 clinical records reviewed.	NO	606	By 9/30/17 the Administrator Nursing Supervisor will meet all Nursing Case Managers a review our Policy Section 03.1 - Supervisory Visits. Policy: B observing the day to day active of the care giving staff, the RI able to verify compliance with Plan of Care, Protocols and Standards, Quality of Service being provided, and the degres at safaction with the services. During these visits, the RN will also collect data to implement performance improvement activities to solve and prevent future problems, provide immediate feedback to care giving staff and gather suggestions to improve processes. For skilled care provided by a Licensed Practical Nurse (LP supervisory visits are perform every fourteen (14) days. For personal/support services (attendant, companion, homemaking, transportation), supervisory visits are perform every thirty (30) days. Supervisory visits need to include the care and are following: Ensure care giving have implemented the care a are following the POC, validat that staff perform care within his/her scope of practice as defined by the state and the organization's policies.	with nd 06A y vities N is see of ill t N), ned lude staff nd	09/30/2017

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R		NDIANAPOLIS BLVD, SUITE C	1	
BRIGHT	STAR OF LAKE C	OLINTY INDIANA		.AND, IN 46322	,	
	1			J 111D, 111 TOULL	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	_	th infection control including		Observation for compliance v		
		ompletion of the Hand Hygiene		infection control including ha	l l	
		, as indicated for sampling		hygiene, completion of the H	l l	
		n for compliance with universal		Hygiene section, Observation compliance with universal	1 101	
	1 ^	OSHA's [Occupational Safety		precautions under OSHA's		
		istration] Bloodborne		Bloodborne Pathogen's Stan	dard	
	_	d; Ongoing evaluation of staff erence to agency's policies and		Ongoing evaluation of staff		
		de instruction/teaching to staff		competency, adherence to		
	_	ussion with client/family about		agency's policies and proced	ures,	
		being provided and the		provide instruction/teaching t	0	
		are staff. Verification that		staff as indicated, discussion	l l	
		health status has been reported		client/family about the quality	of	
	_	Nursing or supervising RN; If		care being provided and the		
	needed, make char	nges to the Plan of Care; and If		compatibility of care staff,		
	needed, perform a	client reassessment."		verification that changes in client's health status has bee	n	
				reported to the Director of	П	
	2. Review of clini	cal record #1 on 7/25/17		Nursing and Supervising RN	and	
		documents titled "Supervisory		if needed changes to the PO	l l	
		no evidence of supervisory		On going compliance will be		
		cted in February 2016, April		monitored as 10% of active		
	-	nd October 2016. The agency		patient charts are audited eve	ery	
		e home health aides were		quarter.		
	supervised every 3	0 days by a registered nurse.		ADDENDUM:		
	2 D C.1;;			Supervisory visit policy was		
		cal record #3 on 7/25/17 documents titled "Supervisory		revised showing that supervis	sory	
		no evidence of supervisory		visits needs to be done on		
		cted in May 2016, August		personal care employees (attendant, companion, personal care)	nnal	
	_	per 2016. The agency failed to		care, etc.) This policy was	, riui	
		ealth aides were supervised		approved by the Governing E	Body	
	every 30 days by a	-		on 9/25/17 and given to all nu		
				case managers meeting on		
	4. Review of clini	cal record #4 on 7/25/17		9/27/17 or emailed. Nursing		
		documents titled "Supervisory		Supervisor will over see this.		
		no evidence of supervisory				
	visits being condu	cted in July 2016, September				
	2016, October 201	6 and December 2016. The				
	agency failed to er	sure the home health aides				
	were supervised ev	very 30 days by a registered				
	nurse.					

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		IDENTIFICATION NUMBER:	A. BUII B. WIN	LDING	<u>00</u>	COMPLETED 07/27/2017	
	PROVIDER OR SUPPLIER			9521 IN	DIANAPOLIS BLVD, SUITE O ND, IN 46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
N 0608 Bldg. 00	5. Review of clinical evidenced agency devisit". There was now visits being conduct 2016, November 20 March 2017. The agnorm health aides with by a registered nurse of care on 3/2/16 to 4/27/16. The agency of care on 3/2/16 to 4/27/16. The agency health aides were suregistered nurse. 410 IAC 17-15-1(at Clinical Records Rule 15 Sec. 1(at Clinical Records Rule 15 Sec. 1(at Clinical Records Rule 15 Sec. 1(at Containing pertinent findings in accordate professional standate for every patient at (1) The medical appropriate identification (2) Name of the chiropractor, podiation of the chiropractor, podiation of the chiropractor of the contributed to by a Clinical notes shall is rendered and in (14) days.	al record #5 on 7/25/17, ocuments titled "Supervisory o evidence of supervisory ed in July 2016, September 16, December 2016 and gency failed to ensure the vere supervised every 30 days e. al record #6 on 7/25/17, y supervisory visits from start patient/family discharge of y failed to ensure the home apervised every 30 days by a supervised every 30 days every supervised every 30		IAG	DEFICIENCE		DATE
	indicate the correct	•	N 06	08	Administrator and Nursing Supervisor reviewed Policy: Al Medication Orders	I	09/30/2017

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE SU	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ED
			B. W	ING		07/27/20	17

NAME OF P	ROVIDER OR SUPPLIEI	2			ADDRESS, CITY, STATE, ZIP CODE		
					IDIANAPOLIS BLVD, SUITE O		
BRIGHTS	STAR OF LAKE CO	DUNTY INDIANA		HIGHLA	AND, IN 46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Policy: BrightStar will minimize	,	
	The findings include	le:			errors and misinterpretation of	:	
					written or verbal medication		
	1. Review of clinic	cal record #3 on 7/27/17			orders by assessing that the		
	_	ey document titled "Client			orders are written clearly and		
		dated 4/24/17 and that stated			transcribed accurately. This		
	" Humalog [insu	-			includes vaccines for influenza and pneumonia. Medication	1	
		efore meals on a sliding			orders will be obtained when		
		as no documentation of a			client is receiving skilled service	ces	
		liding scale evidenced in			from the agency. Procedure: 1		
	patient #3's clinical	record.			All medication orders must		
	a Daview of	clinical record #3 on 7/27/17			contain medication name (gen	eric	
		ey document titled "Home			or brand), dosage, route		
	_	n And Plan Of Care", start of			and frequency. 2. Only Brights	Star	
		certification period 1/29/17 -			approved abbreviations,		
		an area subtitled " 10.			acronyms, symbols and dose		
		/Frequency/Route (N)ew			designation will be utilized. 3.		
		ea had a medication that stated			Generic medication names are		
		lin] 0 - 16 units, sliding			discouraged, but may be used		
		as no other documentation of a			when physician specifies a generic medication. 4. "Indica	tion	
		liding scale evidenced in			for use" must be included in P		
	patient #3's clinical	record.			medication orders or if medica		
					is ordered for a condition not		
					usually treated with that		
					medication. 5. Orders for		
					look-alike/ sound-alike		
					medications (See separate		
					policy). 6. BrightStar staff will		
					verify with the physician any		
					incomplete, illegible or unclear		
					medication orders prior to administering the medication		
					and/or providing patient educa	ition	
					about the medication. 7. Spec		
					medication orders include: PF		
					orders must specify dose, rout		
					frequency and indication for us		
					Hold orders must specify		
					parameters (i.e. "hold digoxin		
					pulse less than 60"). • Automa	tic	
			1			I	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		07/27/2017	
			CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	CR.				
DDICUTO	STAD OE LAVE O			NDIANAPOLIS BLVD, SUITE O		
DRIGHTS	STAR OF LAKE CO	JUNIT INDIANA	HIGHL	AND, IN 46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				stop orders must clearly indic	ate	
				the date that the medication is	s to	
				be stopped. The medication		
				profile will reflect the stop dat	e.	
				Resume orders or blanket reinstatement of provious		
				reinstatement of previous medication orders are not		
				acceptable. All medications m	nust	
				be specifically identified when		
				restarted including post		
				hospitalization. • Titrating and		
				taper orders must clearly state	e	
				the specific guidelines for use		
				Orders for medication relate		
				devices must include the devi	ce	
				and any specific rates, e.g.,		
				nebulizers or infusion pump.	4	
				Orders for herbal products name does route		
				contain the name, dose, route and frequency. • Orders for	;	
				investigational medications m	ust	
				include name, dose, route an		
				frequency. BrightStar will obta		
				copy of the medication		
				information sheet from the		
				dispensing pharmacy or		
				physician. BrightStar will revie	ew	
				all documents of the		
				investigational drug to ensure		
				client is completely informed		
				the indications and side effec Orders for compounded	l5.	
				medications or medication		
				mixtures that are not		
				commercially available must		
				include all drugs used in the		
				preparation of the medication	. All	
				compounded medications will		
				prepared by a pharmacy and	will	
				be provided to the client direct		
				BrightStar nurses will not prep	pare	
				compounded drugs. • Range		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/27/2017
			QTDEET.	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		NDIANAPOLIS BLVD, SUITE O	
BRIGHT	STAR OF LAKE CO			AND, IN 46322	
	TAN OF LARE OF	JOHN I HIDIANA		AND, IN 40022	<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				orders are permitted as long	
				range is clearly defined in the order. Specific indications,)
				dosages, and time frames mu	ıet
				be included in the order. 8.	131
				BrightStar does not require a	
				physician's order for a patien	
				medications at time of discha	
				The medication profile will be	
				accurate. Patient/caregiver w	
				demonstrate knowledge of al	
				medications prior to or at till of discharge. Any medication	
				discrepancies will be verified	
				physician prior to patient	With the second
				discharge. 9. Verbal or telep	hone
				orders will be written down a	nd
				read back for verification. 10.	
				Verbal and telephone orders	will
				be signed by the attending	
				physician, dentist, or podiatris	St
				within 30 working days. Administrator and Nursing	
				Supervisor Reviewed Policy:	
				Medication	
				Administration. Policy: To ensu	ıre
				that physician's orders are followe	d
				and that medications are	
				administered safely and accurately	,
				to the correct patient. Drugs and	
				treatments are administered only	as
				ordered by the physician via	
				prescription. Staff, who administe	r
				medications to clients, will have	
				access to the following: age, sex,	
				diagnosis, allergies, sensitivities,	
				current medications, height and	
				weight, pregnancy and lactation.	
				Procedure: 1. Drugs and treatment	
				are administered by BrightStar Car staff only as ordered. Staff	۳
				stan only as ordered. Stan	

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/27/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA		NDIANAPOLIS BLVD, SUITE O AND, IN 46322	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		,		qualifications to administer	
				medications are defined by job	
				descriptions and provincial practice	e
				standards as mandated by regulate	d
				professional colleges. 2. All orders	
				for medications will contain the name of the drug, dosage, frequence	rv.
				and methods or site of injection. 3.	
				All verbal changes in	
				medication orders will be	
				taken by the nurse and signed	d
				by the physician, if original	
				prescription on medication	
				bottle cannot be verified. 4.	
				BrightStar Care staff must use	2
				2 patient identifiers, the	
				patient's name and physical	
				address, prior to the	
				administration of any	
				medication, until staff	
				member is familiar with the	
				patient. Staff must verify tha	t
				the medication to be	
				administered is the correct	
				medication based on the	
				medication order and produc	t
				label. 5. BrightStar Care staff	
				will check all patient	
				medicines to identify possible	2
				ineffective drug therapy or	
				adverse reactions, significant	
				side effects, drug allergies and	d
				contraindicated medication	
				and report any problems to	
				1	

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B. WING	COMPLETED 07/27/2017					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O						
BRIGHTSTAR OF LAKE COUNTY INDIANA HIGHLAND, IN 46322						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE					
the physician. 6. Patients will						
be assessed and reassessed						
on an ongoing basis for						
medication effectiveness and						
actual or potential drug						
related problems. Staff will						
use information from						
medication monitoring to						
assess the medication's						
continued administration and						
will communicate medication						
findings to patient's physician						
and other appropriate staff.						
7. The drugs and drug classes						
which nurses may administer						
to Private Duty in-home care						
cases are defined by List of						
Home IV Drugs and						
Indications, Drugs and						
Solutions Approved for Home						
Administration and Drugs						
Approved for Home						
Administration lists. Orders						
for medications and/or routes						
which vary from the list must						
be approved by the Corporate						
Clinical Director in						
consultation with a						
Professional Advisory						
Committee, Medical Director						
or Board Certified Physician						
Consultant. Input and						
consultation may also occur						

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		IDENTIFICATION NUMBER: A. BUILDING B. WING		00	COMPLETED 07/27/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIGHTS	STAR OF LAKE CO	UNTY INDIANA	9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
TAG	REGULATORT OR	LSC IDENTIFFING INFORMATION)	TAG	with a pharmacist. 8. Persona				
				Support Workers may apply	`			
				topical ointments, creams and	t l			
				shampoos, only if instructed				
				by the Director of Nursing. 9.				
				In the event of a medication				
				error or adverse drug				
				reaction, the patient's				
				physician is to be notified				
				immediately. 10. Prior to the				
				administration of any				
				medication by any route, the				
				nurse will verify: Medication i	s			
				correct by comparing				
				physician order with				
				medication label, Medication				
				stability by performing a				
				visual examination for				
				discoloration and particulates	,			
				Medication has not expired,				
				Medication is the correct				
				dose, route and time, and No				
				contraindications exist for				
				administration. 11. The				
				patient and family will be				
				educated about potential				
				adverse reactions and any				
				other concerns. 12. Any				
				unresolved, significant				
				concerns about medications				
				will be discussed by the nurse				
				with the patient's physician,				
				the patient or their				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
			B. WI	NG		07/27/	/2017	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	ER	9521 INDIANAPOLIS BLVD, SUITE O					
BRIGHTSTAR OF LAKE COUNTY INDIANA			HIGHLAND, IN 46322					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE CROSS-REFERENCE)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					representative and			
					appropriate staff.			
					Administrator and Nursing			
					Supervisor will meet with			
					Registered Nurse Case			
					Managers regarding the			
					above policies before			
					September 30, 2017 to assure	2		
					they understand the			
					requirements.			
					ADDENDUM:			
					It was found that the root cause of			
					this problem was that the nurse wa	S		
					not specific enough with the sliding			
					scale. Nurses were met with on			
					9/27/17 to review policies and their			
					responsibilities. Nursing Supervisor			
					will be responsible for monitoring			
					med profile sheets after a			
					reassessment, post hospital or new admission assessment is complete			
					and on going with chart audits of			
					10% of patient volume quarterly.			
			1					

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