STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF LAKE COUNTY INDIANA	9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322

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N 0000 Bldg. 00	This visit was for a state home health complaint survey. Complaint #: IN00222596 - Substantiated Deficiencies are cited. Survey Date: 7/24/17 - 7/27/17 Facility #: 012189	N 0000		
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview the administrator failed to organize and direct the home health agency's ongoing functions in 1 of 1 agency. The findings include: 1. Record review of the complaint/incident log on 7/25/17 failed to evidence the administrator came to a resolution in 4 of 4 complaint/incidents reviewed. The administrator failed to follow the agency complaint/incident policy. a. Review of agency document titled "Incident Report" with a date reported of 8/30/16	N 0444	By 9/30/17 Administrator, Office Managers, Director of Nursing and Case Management personnel will have met and reviewed the following policies and assure that 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 or	09/30/2017

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

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	for patient #1 failed to evidence a resolution according to agency policy. The last outcome listed on the document was dated 8/30/16 and stated "... I [administrator] followed up with [person #26] in regards to the police report, He/She said he/she was aware. He/She asked why [employee G] called and I told him/her that [patient #1] asked him/her to. He/She said that's what he/she thought. He/She said him/her and him/her [family member] were going to the lawyer's today and will decide what they need to do. He/She said [employee G] is doing a good job and to just please keep him/her in the loop with any changes or cancellations." During an interview on 7/27/17 at 9:21 a.m. person #26 indicated there was no resolution to the complaint. Person #26 indicated that he/she never even received an apology from BrightStar and the only employee he/she spoke with was the administrator. Person #26 indicated that he/she was informed by administrator that BrightStar cannot do anything without a police report. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated that the resolution for patient #1 was the termination of employee F. b. Review of agency document titled "Incident Report" with a date reported of 11/17/16 for patient #2 failed to evidence a resolution according to agency policy. The document stated "... Treatments, Interventions, Outcomes 11/9 @ 2:35p [employee E] called and said he/she spoke with the [family member] and said he/she is good at hiding money all over the place. [Employee E] said they looked and found one envelope of money and then they continued looking and they found another envelope with 100's of dollars in it. He/She said the [family member][person #28] was going to take it to the bank." The agency only received testimony from the home health aide. The agency failed to ensure		family, or a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All initial Incident Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, 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,	

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	patient #2 (complainant) and/or the family member were followed up with concerning the resolution. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated the resolution for patient #2 is in the treatments, resolution, outcomes of the incident report. c. Review of agency document titled "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 reported on the incident report document was dated 7/25/16 and stated "... [employee B] followed up with family." During an interview on 7/25/17 at 2:52 p.m. the administrator stated the resolution was that employee H was terminated and employee B called the family. d. Review of agency document titled "Incident Report" with a date of incident as 8/6/16 for patient #4 failed to evidence a resolution according to agency policy. The document stated "... Plan to Resolve (Immediate and Long Term). Once Police report is received, BrightStar will conduct an investigation...." During an interview on 7/25/17 at 2:58 p.m. the administrator indicated the resolution for patient #4 was they were waiting for a police report. During the interview the administrator and employee B also indicated that there should probably be more documented and that they needed to do a better job with details. 2. The undated agency 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 or family, or a message delivered by the caregiver. BrightStar Care management		suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services (CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age of 18. The initial incident report must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local law	

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	will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of our own family. Procedure 1. When a client complaint is reported to the BrightStar Care office, the information, with as much detail as possible, will be captured and logged onto the Customer Complaint Report. 2. The same information will be placed into the employee file (Caregiver of record) if appropriate. 3. The information will be communicated to the Owner, Director of Nursing or designee. 4. The Owner, Director of Nursing and/or designee will investigate the complaint within 10 calendar days and report the findings to the Owner and Administrator. Collectively, they will reach a resolution of the complaint and will advise the client either verbally or in writing of the planned solution or resolution within 30 calendar days after the agency receives the complaint. 5. The Owner and/or Director of Nursing will then monitor the Client/Caregiver situation over the following (30) thirty days to assure that the issue has been satisfactorily resolved and that the client and/or family is satisfied...." 3. The undated agency 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All initial Incident Report involving an allegation or suspicion of abuse, neglect, exploitation, or the		enforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or	

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	care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or exploitation of the person's personal services, 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 or 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 or more; ... 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for		client, a client's family or guardian, or a client's healthcare provider, regarding treatment of care furnished by the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...." All employees will have a verification from the state they have been registered as a HHA before they have any first patient contact. Performance Improvement Plan will include any customer complaints, incidents, and employee complaints to collaborate all of our services and 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 make sure the needs of our clients are being met as well as their well being and safety.	

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	patient's money or property. Discrepancies between patient's resources and living situation. Reports of demands for goods in 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) The allegation Any injury 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 the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...." 5. Review of personnel records on 7/26/17 evidenced a home health aide that provided care prior to licensure with the state of Indiana. The administrator failed to ensure licensure on the home health aide (employee J). A review of the personnel file of employee J, date of hire 2/23/16, on 7/25/17 evidenced an Indiana home health license with an issue date of 3/11/16. Review of the Indiana State Department of Health document titled "Employee Records", that was partially filled out by the administrator, 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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	patient #6 with no home health aide license on 3/2/16. An agency document dated 3/2/16 titled "Personal Care/Companion Care Note and Timesheet" stated "... Comments/Remarks: [patient #6] got up this morning and wanted to get going. So I [employee J] gave her a sponge bath and change [sic] linen on bed wet from water". 6. A review of the 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 Management and one indicator listed as unusual occurrence reporting. Misappropriation of funds was never addressed. However review of the complaint/incident log evidence 4 cases of misappropriation 3 of which were in a 3 week time frame. The misappropriations evidenced in the agency complaint/incident log are dated 7/28/16, 8/6/16, 8/12/16, and 11/7/16.			
N 0446 Bldg. 00	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on record review and interview the administrator failed to ensure employment of	N 0446	It is the Administrator's responsibility to make sure proper	10/31/2017

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	qualified personnel, adequate staff education and evaluations in 1 of 1 agency. The findings include: 1. Review of personnel record and agency in-service logs on 7/26/17 evidenced 10 of 12 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 an interview on 7/27/17 at 1:00 p.m. the administrator indicated I had the complete records of the in-services for all home health aide employees. 2. Review of personnel records on 7/26/17 evidenced a home health aide that provided care prior to licensure with the state of Indiana. The administrator failed to ensure licensure on the home health aide (employee J). A review of the personnel file of employee J, date of hire 2/23/16, on 7/25/17 evidenced an Indiana home health license with an issue date of 3/11/16. Review of the Indiana State Department of Health document titled "Employee Records", that was partially filled out by the administrator, 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 patient #6 with no home health aide license on 3/2/16. An agency document dated 3/2/16 titled "Personal Care/Companion Care Note and Timesheet" stated "... Comments/Remarks: [patient #6] got up this morning and wanted to get going. So I [employee J] gave her a sponge bath and change [sic] linen on bed wet from water". 3. Review of personnel records on 7/26/17 evidenced 2 home health aides that needed further skill competency assessment which failed to be		policies and procedures are being followed. During survey it was found that not all of the employees had all of their required 12 in-services. At the time of hire and annually thereafter all employees will complete 8 mandatory in services and then more than 100 in-services are available to them to make sure required in-services are achieved through out the year. Up to and including required in-services are as follows: Infection Control/Universal Precautions, Communication Documentation, Elements of Body Functions, Maintaining a clean and safe environment, Fire Safety, Elder Abuse and Neglect, Confidentiality and HIPPA, Personal Hygiene and grooming, Safety transfer techniques, Range of Motion, Nutrition, and Medication Assistance. Employees who do not obtain their 12 required in-services will be removed from providing patient care. The above is to assure the following policy is followed, "STAFF INSERVICES, HOME HEALTH AIDE CONTINUING EDUCATION AND COMPETENCY EVALUATION PROGRAM". To assure employees delivering client care or service receive appropriate training to meet state and federal regulations. In-service education programs will cover those areas required by state and federal	

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	documented as accomplished. Review of employee D personnel record evidenced an agency document dated 4/15/15 titled "Competency Assessment Skill Check List for Home Health Aide" that stated under areas subtitled "Competency for the Home Health Aide" and "Comment""17. Optional Skills: ... Hoyer Lift needs tng [training] depending on type ... 25. Meal preparation ... Diabetic Diet 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 under areas subtitled "Competency for the Home Health Aide" and "Comment""4. Blood Pressure needs tng ... 16. Making occupied beds needs tng ... 17. Optional Skills: Hoyer lift needs tng ... 25. Meal preparation ... Diabetic Diet Low sodium Low cholesterol/fat needs tng...." The administrator failed to ensure all the home health aides had a completed skills competency. 4. The undated agency policy titled "Section 03.05 - Performance Evaluations" stated "... BrightStar Care utilizes a performance evaluation process as a way to promote the development of each employee. The performance evaluation process measures not only performance against objectives, but is also a time for each employee and manager to plan how improvement and better results can be achieved. It is primarily a chance to identify strengths and weaknesses and help the employee develop to their full potential in order to achieve optimal success. This process is a very 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. Day-to-day interaction between the employee and manager should provide the employee a good		guidelines and will be based on identified staff and client needs. The agency should maintain documentation of all in-service education. The 12 hour per calendar year requirement for home health aide in-services may be prorated according to the employee's date of hire and records maintained per calendar year. 10% of employee files will be audited quarterly and findings reported to the Performance Improvement Committee. By October 31, 2017 current employees will meet our Nursing Supervisor or Nurse Designee to have their annual clinical competency performed. All staff members who provide direct client care will have a clinical competency assessment as stated in our policy Section 03.06 - Clinical Competency Program. Established competency assessment will be documented and will be established as based on their staff member's classification. This will be done annually and on going in accordance with laws and regulations, any time there is a concern with a staff member's clinical competency and when introducing new client care procedures, techniques or equipment as well as initially at their orientation. By October 31, 2017 current employees who are eligible will have an annual performance	

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	sense of how their performance is perceived. Forma performance evaluations are conducted to provide employees with the opportunity to discuss job responsibilities, identify and correct weaknesses, encourage new ideas, recognize strengths, and discuss positive, effective approaches for meeting goals. Performance evaluations are an important management tool. Employees should feel comfortable actively participating in the review process and keeping the lines of communication open. BrightStar Care attempts to conduct performance evaluations annually, however an evaluation may also be conducted in the event of a promotion, change in duties and responsibilities or to address any open issues. Performance evaluations may be conducted at any time for any reason including when job requirements are not being met, problems occur, or improvement is needed. PEER REVIEW: Policy: BrightStar Care agency ensures compliance of each professional discipline within their respective practice acts or title acts through peer reporting and peer review. BrightStar Care agency ensures compliance of each professional discipline within their respective practice acts or title acts trough peer reporting and peer review. 1. The Agency requires employees to have a performance evaluation annually. 2. Evaluations will be performed at lease every nine (9) to fifteen (15) months. 3. The Agency may perform an additional employee evaluation at anytime to address areas of concern or exceptional care." 5. Review of the personnel record on 7/26/17 for employee A, date of hire 11/17/14 evidenced an agency document titled "Performance Evaluation" dated 11/13/15. This was the only performance evaluation evidenced in employee A's chart. The administrator and agency management failed to ensure employee A had an annual performance		evaluation complete in accordance to our policy Section 03.05 - Performance Evaluations. Each employee and manager will 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 approaches will be discussed to meet goals. Any change in an employee's duties or responsibilities will be addressed as an open issue. On going performance evaluations may be conducted at any time for any reason when job requirements are not being met, 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, RACE 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,	

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	evaluation. 6. Review of the personnel record on 7/26/17 for employee C, date of hire 8/4/14, evidenced no annual performance evaluation in record. The administrator and agency management failed to ensure employee C had an annual performance evaluation. 7. Review of the personnel record on 7/26/17 for employee D, date of hire 3/26/13, evidenced an agency document titled "Annual Performance Review" dated 6/24/15. This was the only performance evaluation evidenced in employee D's chart. The administrator failed to ensure employee D had an annual performance evaluation. 8. Review of the personnel record on 7/26/17 for employee L, date of hire 9/28/11, evidenced an agency document titled "Performance Evaluation" dated 7/2/15. This was the most current performance evaluation evidenced in employee L's chart. The administrator failed to ensure employee L had an annual performance evaluation.		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 meet 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 year 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 were lacking annual competency	

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			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, washing station, transfer equipment, walkers, canes, etc. for nurse (nurse 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 done prior to the annual due date making us out of compliance. If an employee has a competency are that is not satisfactory, an employee will not be sent to a client with that specific need unless additional training has been done with the nursing supervisor or designee. For example, additional training needed on a mechanical lift. Employee file will have a tag that specifies do not send 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 date this was observed and the tag from employee file will be lifted. This will be monitored by running monthly	

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			reports for compliance. Competency 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 and any employee that does not have an 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 stating 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 had an annual review and when the next one is due. Reports will be ran 30 days prior to the next month and administration will call the employee	

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			to schedule reviews and 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. 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.	
N 0456 Bldg. 00	410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview the administrator failed to ensure the agency	N 0456	By 9/30/17 Administrator, Office Managers, Director of Nursing	09/30/2017

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	objectively and systematically monitored and evaluated the quality and appropriateness of patient care and resolved identified problems in 1 of 1 agency. The findings include: 1. Record review of the complaint/incident log on 7/25/17 failed to evidence the administrator came to a resolution in 4 of 4 complaint/incidents reviewed. The administrator failed to follow the agency complaint/incident policy. a. Review of agency document titled "Incident Report" with a date reported of 8/30/16 for patient #1 failed to evidence a resolution according to agency policy. The last outcome listed on the document was dated 8/30/16 and stated "... I [administrator] followed up with [person #26] in regards to the police report, He/She said he/she was aware. He/She asked why [employee G] called and I told him/her that [patient #1] asked him/her to. He/She said that's what he/she thought. He/She said him/her and him/her [family member] were going to the lawyer's today and will decide what they need to do. He/She said [employee G] is doing a good job and to just please keep him/her in the loop with any changes or cancellations." During an interview on 7/27/17 at 9:21 a.m. person #26 indicated there was no resolution to the complaint. Person #26 indicated that he/she never even received an apology from BrightStar and the only employee he/she spoke with was the administrator. Person #26 indicated that he/she was informed by administrator that BrightStar cannot do anything without a police report. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated that the resolution for patient #1 was the termination of employee F.		and Case Management personnel will have met and reviewed the following policies and assure that 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 or family, or a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All initial Incident	

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	b. Review of agency document titled "Incident Report" with a date reported of 11/17/16 for patient #2 failed to evidence a resolution according to agency policy. The document stated "... Treatments, Interventions, Outcomes 11/9 @ 2:35p [employee E] called and said he/she spoke with the [family member] and said he/she is good at hiding money all over the place. [Employee E] said they looked and found one envelope of money and then they continued looking and they found another envelope with 100's of dollars in it. He/She said the [family member][person #28] was going to take it to the bank." The agency only received testimony from the home health aide. The agency failed to ensure patient #2 (complainant) and/or the family member were followed up with concerning the resolution. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated the resolution for patient #2 is in the treatments, resolution, outcomes of the incident report. c. Review of agency document titled "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 reported on the incident report document was dated 7/25/16 and stated "... [employee B] followed up with family." During an interview on 7/25/17 at 2:52 p.m. the administrator stated the resolution was that employee H was terminated and employee B called the family. d. Review of agency document titled "Incident Report" with a date of incident as 8/6/16 for patient #4 failed to evidence a resolution according to agency policy. The document stated "... Plan to Resolve (Immediate and Long Term). Once Police report is received, BrightStar will conduct an investigation...." During an interview on 7/25/17 at 2:58 p.m. the		Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, 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, suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services (CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age of 18. The initial incident report	

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	administrator indicated the resolution for patient #4 was they were waiting for a police report. During the interview the administrator and employee B also indicated that there should probably be more documented and that they needed to do a better job with details. 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 variety of forms, such as a phone call to the office, a letter or note from the client or family, or a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of our own family. Procedure 1. When a client complaint is reported to the BrightStar Care office, the information, with as much detail as possible, will be captured and logged onto the Customer Complaint Report. 2. The same information will be placed into the employee file (Caregiver of record) if appropriate. 3. The information will be communicated to the Owner, Director of Nursing or designee. 4. The Owner, Director of Nursing and/or designee will investigate the complaint within 10 calendar days and report the findings to the Owner and Administrator. Collectively, they will reach a resolution of the complaint and will advise the client either verbally or in writing of the planned solution or resolution within 30 calendar days after the agency receives the complaint. 5. The Owner and/or Director of Nursing will then monitor the Client/Caregiver situation over the following (30) thirty days to assure that the issue has been satisfactorily resolved and that the client and/or family is		must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local law enforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18	

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	satisfied...." 3. The undated agency 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All initial Incident Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, 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, suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services (CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age of		years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or exploitation of the person's personal services, 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 or 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 or more; ... 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient's resources and living situation.	

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	18. The initial incident report must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local law enforcement agency." 4. The undated agency policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or		Reports of demands for goods in 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) The allegation Any injury 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 the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...." All employees will have a verification from the state they have been registered as a HHA before they have any first patient contact. Performance Improvement Plan will include any customer	

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	exploitation of the person's personal services, 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 or 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 or more; ... 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient's resources and living situation. Reports of demands for goods in 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) The allegation Any injury 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 the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...."		complaints, incidents, and employee complaints to collaborate all of our services and 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 make sure the needs of our clients are being met as well as their well being and safety. ADDENDUM: All office employee 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 this form and given to the Administrator. The Administrator will contact all involved parties (client and/or employee) and complete an investigation. Once complaint is complete it will be entered into our software system 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 our risk management during quarterly Performance Improvement meetings to see how we can grow and improve from these	

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	5. A review of the 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 Management and one indicator listed as unusual occurrence reporting. Misappropriation of funds was never addressed. However review of the complaint/incident log evidence 4 cases of misappropriation 3 of which were in a 3 week time frame. The misappropriations evidenced in the agency complaint/incident log are dated 7/28/16, 8/6/16, 8/12/16, and 11/7/16.		experiences and make sure our clients are protected. They also will be discussed during weekly 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 9/25/17 for approval.	
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review the administrator failed to ensure all personnel records were current and complete in 1 of 1 agency.	N 0458	By October 31, 2017 active employee files will be audited to assure Policy Section 03/07 Personnel File are compliant and	10/31/2017

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	The findings include: 1. Personnel record review conducted on 7/27/17 failed to evidence the following in the employee records: a. Review of the personnel record of employee C evidenced no signed copy of a job description or an annual performance evaluation. b. Review of the personnel record of employee A evidenced no annual performance evaluation. c. Review of the personnel record of employee L evidenced no annual performance evaluation. d. Review of the personnel record of employee D evidenced no annual performance evaluation. e. Review of the personnel record of employee M evidenced no national background check or 2nd step of TB [tuberculosis] test. f. Review of the personnel record of employee E evidenced no national background check, or 2nd step of TB test. g. Review of the personnel record of employee F failed to evidence a current TB test during his/her employment with BrightStar. h. Review of the personnel record of employee R failed to evidence any TB test prior to employment with BrightStar. i. Review of the personnel record of employee S failed to evidence a current TB test, chest x-ray or annual risk assessment.		include the following: References, National Background Check, Discipline specific license, certification or registration and verification of active status, an annual negative TB skin test or chest x-ray, pre employment physical stating they are free and clear of communicable disease, current cpr certification, documentation of their job orientation, documentation of their job description (and signed by employee), qualifications and receipt of their job description, and annual performance evaluations. On going 10% of active employee files will be audited quarterly by the Administrator and Compliance Coordinator. Addendum: We were misguide with the background checks needing to be through the state repository. During our survey we found we were not compliant with all Background checks to be completed as a National Background Checks. Every employee file is being audited to make sure they have all of their credentials. Due to it being a national background check we need to run sometimes it can take up to 10 days for results to come in. Therefore, this time frame was allowing us to get this complete by the end of the month. Going forward every new hire will have a completed National Background Check at the time of their hire.	

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	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 it will go through administration for an audit to double check to make sure all employees are compliant before patient contact. As an on going compliance 10% of active employee volume will be audited for continued compliance. The Administrator will oversee this.	
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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	(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.			
	Based on record review the agency failed to ensure all the employees had a current tuberculin test or a 2 step tuberculin test for new employees with no previous years tuberculin test. (employees E, F, M, R, S)	N 0464	Section 03.04 - "Health Screening", Agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients. When the TB	09/30/2017

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	The findings include: 1. The undated agency policy titled "Section 03.04 - Health Screening" stated "1. All Agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients. ... 4. Tuberculosis testing: All health care workers including direct employees and contract staff who will provide direct patient care must have a baseline two-step Tuberculin skin test (TST) 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 is negative. If the individual does not have documented evidence of a negative Tuberculin skin test within the past twelve months, a Tuberculin skin test may be given at the time of hire and repeated within one to three weeks after the first tuberculin test was administered. Administering, reading and interpreting the results of the Tuberculin skin test will be performed by a licensed nursing professional who is knowledgeable of Tuberculin skin tests. The health care worker will be educated concerning the administration and reading of the Tuberculin skin test. ... 6. Any person with a documented history of tuberculosis; previously positive test result for tuberculosis or newly positive result to the tuberculin skin testing must have a documented negative chest x-ray to exclude a diagnosis of tuberculosis. 8. After baseline testing, tuberculosis screening must be completed annually using the one-step method. ... 10. Employees who are known to have converted to a positive PPD [purified protein derivative] reading, either at the time of hire or after, will be required to complete an annual health questionnaire to verify that no known symptoms of TB [tuberculosis] are present. The form is kept in the employee's health file. By signing the form, the employee indicated that they are aware of the		skin test is administered, it will be read within 48-72 hours and documented as "non-significant" (negative) or "significant" (positive) in millimeters of induration. Recruiter and Nursing Supervisor will be re-educated immediately to make sure the established policy is followed and no employee is hired without a negative TB skin test or chest x-ray supporting a positive TB Skin test or chest x-ray supporting a positive TB Skin test and are okay to work. New Hires will be reviewed by the Compliance Coordinator prior to working their first assignment to make sure that compliance with credentials are met. 10% of employee files will be audited quarterly and findings reported to the Performance Improvement Committee. Addendum - Policy addendum was created and reviewed by the Governing Body on 9/25/17. File audits are being conducted to remove any employee from patient contact until a two-step was complete if they did not have a current TB within the last 12 months. Administrator is over seeing this policy.	

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	need to report any symptoms that might arise...." 2. Review of personnel records on 7/26/17 evidenced a document titled "Tuberculosis Test Form" for employee 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 TB test was evidenced in personnel file. The agency failed to ensure employee E had a two-step tuberculin skin test as per agency policy. 4. Review of personnel records on 7/26/17 evidenced a document titled "Tuberculin Skin Test" for employee F dated 4/19/15, no other TB test was evidenced in personnel file. The agency failed to ensure employee F had an annual TB test. 5. Review of personnel records on 7/26/17 evidenced a document titled "PPD/Tuberculosis Assessment" for employee R dated 6/12/16. Employee R date of hire was 6/21/16, no other TB test was evidenced in personnel file. The agency failed to ensure employee R had a two-step upon hire as per agency policy, and failed to ensure employee R had a current annual TB test. 6. Review of personnel records on 7/26/17 evidenced a documented chest x-ray dated 6/13/16 for employee S. No other TB skin test or chest x-ray was evidenced in personnel record for employee S. The agency failed to ensure employee S had a current annual TB test or chest			

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	x-ray.			
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview the agency failed to ensure the performance improvement program addressed all aspects of the agency with the inclusion of misappropriation of funds and patient rights in 1 of 1 agency. The findings include: 1. A review of the 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 Management and one indicator listed as unusual occurrence reporting. Misappropriation of funds was never addressed. However review of the complaint/incident log evidence 4 cases of misappropriation 3 of which were in a 3 week time frame. The misappropriations evidenced in the agency complaint/incident log are dated	N 0472	By 9/30/17 Administrator, Office Managers, Director of Nursing and Case Management personnel will have met and reviewed the following policies and assure that 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 or family, or a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's	09/30/2017

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	7/28/16, 8/6/16, 8/12/16, and 11/7/16. 2. During an interview on 7/25/17 at 2:40 p.m. the administrator and employee B indicated that they talk about other incident occurrences but they do not document these conversations. 3. The undated policy titled "Section 01.10 - Performance Improvement Plan" stated "1. The Agency shall develop, implement, maintain and evaluate a performance improvement quality assessment plan to measure, assess, and improve the performance of clinical and other processes's as needed. 2. This plan will reflect the complexity of the organization and its services, including those services provided directly or under arrangement. 3. The plan will be designed to use objective measures to improve client outcomes and the perceptions of clients/families about the quality and value of services. 4. The plan will design processes, which through collaboration of all services and disciplines, will meet the needs of clients, staff and the community. 5. The purpose of the plan will be to improve client and agency outcomes through a coordinated collaborative approach to assessing and improving organizational performance. 6. Objectives of the Program are as follows: To assess and evaluate the quality of client care services provided, appropriateness of services, and satisfaction of clients and families. To identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation. To identify, address, track and resolve problems in client care services and satisfaction to insure [sic] resolution and/or improvement. To increase the awareness of each staff member of their role within the organization and foster involvement and participation in agency's performance improvement program. To meet state and federal		satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All initial Incident Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, 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, suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services	

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	regulatory requirements. To reduce factors that contribute to unanticipated adverse events and/or outcomes. 7. The development of the performance improvement plan will be guided by the mission, vision and strategic goals of the organization. Additional activities for performance improvement will be prioritized by the agency's management team. 8. Data will be collected to allow the agency to monitor its performance. Data collection will be prioritized based on the organization's mission, services provided, including those services provided directly or under arrangement, and populations served. Processes tracked may [sic] internal or external. Data that may be used for data collection includes the following: Customer satisfaction (clients, physicians, referral sources, Agency staff, etc. [etcetera]) Clinical outcomes. Utilization of services. Effectiveness of programs in responding to specific concerns such as pain management and medication management. Client diagnosis and demographics. Adverse events/outcomes of processes or services. Infection control surveillance and reporting, including hand hygiene. Chart audit results. Client incident reports and customer complaints. Client safety issues. Track regulatory items that might be out of compliance Human Resources/Risk Management Issues (i.e. [that is to say], Employee incident reports, motor vehicle accidents, endangerment of staff, Worker's Compensation incidents, needle sticks, etc. Education and competency training for staff. Billing and finance issues. 9. Data will be systematically collected to measure process and outcome. 10. Data will be assessed and analyzed to: Identify current level of performance. Identify areas and trends that need to be improved. Identify strategies and action plans to stabilize or improve processes. Evaluate whether outcomes were achieved. Compare results with		(CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age of 18. The initial incident report must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local law enforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical	

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	self and others (as results are available), standards, and best practices, using statistical techniques, whenever possible. ... 12. The plan will target the performance of existing processes and outcomes and identify/design new processes based on priorities, standards and resources...."		or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or exploitation of the person's personal services, property or both.) ... Exploitation: The illegal or improper act or process of a	

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			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 or 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 or more; ... 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient's resources and living situation. Reports of demands for goods in 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) The allegation Any injury 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 the agency or that the agency failed to furnish, or a lack of respect for the client's	

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			property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...." Performance Improvement Plan will include any customer complaints, incidents, and employee complaints to collaborate all of our services and 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 make sure the needs of our clients are being met as well as their well being and safety. Risk Management will include any fund complaints and what the findings 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 data collection, quality management and performance improvement,	

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			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 and evidence-based. Typically, the action plan will be designed to either improve an existing process or create a new one that will enhance care. Persons closest to the activity will be utilized to develop a suggested action plan. Once the action plan is implemented, data will be collected to determine whether the intervention was successful, met reasonable needs and expectations of clients and their families, and was sustained over time. This is overseen by the Nursing Supervisor and Administrator	
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review the agency failed to have coordination of care amongst their team members	N 0484	By 9/30/17 the Administrator and Nursing Supervisor will meet with	09/30/2017

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	and with other agency's that provided care to their patients. (#1, #4, #6) The findings include: 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 client's status and progress and action plans will be formulated as needed when problems are identified. 5. In complex cases, the client, caregivers and/or family members might be invited to attend the case conference with the client's or authorized representative's approval. 6. Care conferences will be documented on the appropriate form or in the progress notes. Subsequent changes to the Plan of Care or Service Plan will be communicated by the Registered Nurse to appropriate staff members, the client and/or family/caregivers and/or physician as needed after the case conference. 7. A Clinical Summary of the client's care, services rendered		all Nursing Case Managers and review our Policy Section: 02.37 Coordination of Care, Clinical Summary and Case Conference. Policy includes 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 goals are evaluated and appropriate responses made. Case conferences may be held in various ways, such as group meeting, by phone, fax or email, and must be documented as such. 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 our agencies and institutions if the need arises, and discharge planning. Ongoing case conferences shall be conducted to evaluate the client's status and progress and action plans will be formulated as needed when problems are identified. In complex cases, the family may be invited to participate. Case conferences should be documented in the appropriate form or in the progress note.	

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	and response to care for each client will be documented on the appropriate form and sent to the physician for signature if applicable at a minimum of every 60 (sixty) days. 8. Case conferences and copies of clinical summaries shall be kept in the client's chart." 2. Record review on 7/25/17 of the agency's complaint/incident log and patient #1's clinical record evidenced lack of coordination of care between the agency, the agency nurse, the agency home health aide, and patient #1 and family member. This was evidenced as follows: a. Record review on 7/25/17 evidenced an agency document titled "Incident Report". In the area of the document subtitled "Action Plan Steps" the following statement was evidenced "... I was made aware of this situation this date as of what was reported by the client [patient #1] on 8/12/16. I called [person #26], the [family member], and was asked why service was stopped. I told him/her we received a call 7/25/16 from [patient #1] that they did not want to continue services effective 7/30/16. I asked him/her why and he/she said he/she did not want to discuss it right now. I asked everyone in the office through an email if anyone knew what was going on. [Employee T], scheduling coordinator, told me that the [family member] had been trying to get [patient #1] to come live with him/her and he/she believes that is what happened. No one else offered any info. When speaking with the [family member] he/she explained that [employee F] had still been going but privately apparently and he/she had no knowledge what so ever that BrightStar services were cancelled [sic]. I told him/her that I would reach [employee F] and tell her he/she is not going to [patient #1's] anymore. He/She said if any services are ever cancelled [sic] by [patient #1] please make him/her		Changes in the Plan of Care will be communicated by the Registered Nurse to appropriate staff members. Case conferences will be documented every 60 days and 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 find out the cause of this was finding out that our 60 day summary was not sufficient enough to cover the case conference requirement. A new form was developed and approved by the governing body on 9/25/17 and is being put in place immediately. Nursing Supervisor and nursing designee 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.	

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	aware...." b. Record review on 7/25/17 failed to evidence any agency Discharge/Transfer Summary for July 2016, or any nursing note or documentation that patient #1 had canceled services with BrightStar. c. During a record review an agency document dated 7/30/16 and signed by the RN [registered nurse] with initials titled "Nursing Narrative Notes" was evidenced that stated "I called [patient #1] for a supervisory visit, but he/she said he/she was not feeling up for it right now. He/She said he/she has some things going on that are difficult and he/she would like me to wait to come by." No other nursing narrative note was evidenced for the month of July. d. Review of the complaint/incident log evidenced an agency document titled "Incident Report" with a date and time of incident recorded as 8/12/16 3:02 p.m. The incident stated "[Employee P], nurse case manager, received a call from a property manager where [patient #1] lives telling him/her that [patient #1] would like to resume service with us...." e. Review of the clinical record for patient #1 evidenced care being provided by BrightStar employee (employee G) on the following dates: 8/15/16, 8/17/16, 8/19/16, 8/22/16, 8/29/16 and 8/31/16. f. Review of the clinical record for patient #1 evidenced an initial assessment conducted by employee P on 8/31/16 and a supervisory visit conducted by employee P on 8/31/16. There were no documented visits from 7/29/16 - 8/14/16. 3. Review of the clinical record for patient #4 on			

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	7/25/17, start of care 6/1/16, evidenced an agency document titled "Client Medication Profile" dated 8/3/16. This document contained patient's medications two of which were administered by central line. The medications listed were Morphine 2000mg [milligram]/1000 ml [milliliter] per central line continuously, and Cath Flo Activace 2 bottles per central line weekly. There was no coordination of care documented in clinical record #4 for any entity/agency/provider who was monitoring patient #4's central line or administering medications per central line. 4. Review of the clinical record for patient #6 on 7/25/17, start of care 3/2/16, evidenced a document titled "Client Assessment" dated 3/2/16 and signed by employee N. This document had an area subtitled "Others involved in client's care:" which listed a skilled nursing facility [#31]. The clinical record failed to evidence any coordination of care with this facility.			
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review the agency failed to coordinate its services with other health care providers serving the patient in 2 f 6 records reviewed. (#4, #6) The findings include: 1. The undated agency policy titled	N 0486	By 9/30/17 the Administrator and Nursing Supervisor will meet with all Nursing Case Managers and review our Policy Section: 02.37 Coordination of Care, Clinical Summary and Case Conference. Policy includes Care coordination is effectively coordinated by members/disciplines of the health care team by case conferences	09/30/2017

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	documented on the appropriate form or in the progress notes. Subsequent changes to the Plan of Care or Service Plan will be communicated by the Registered Nurse to appropriate staff members, the client and/or family/caregivers and/or physician as needed after the case conference. 7. A Clinical Summary of the client's care, services rendered and response to care for each client will be documented on the appropriate form and sent to the physician for signature if applicable at a minimum of every 60 (sixty) days. 8. Case conferences and copies of clinical summaries shall be kept in the client's chart." 2. Review of the clinical record for patient #4 on 7/25/17, start of care 6/1/16, evidenced an agency document titled "Client Medication Profile" dated 8/3/16. This document contained patient's medications two of which were administered by central line. The medications listed were Morphine 2000mg [milligram]/1000 ml [milliliter] per central line continuously, and Cath Flo Activace 2 bottles per central line weekly. There was no coordination of care documented in clinical record #4 for any entity/agency/provider who was monitoring patient #4's central line or administering medications per central line.		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 find out the cause of this was finding out that our 60 day summary was not sufficient enough to cover the case conference requirement. A new form was developed and approved by the governing body on 9/25/17 and is being put in place immediately. Nursing Supervisor and nursing designee 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.	

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	3. Review of the clinical record for patient #6 on 7/25/17, start of care 3/2/16, evidenced a document titled "Client Assessment" dated 3/2/16 and signed by employee N. This document had an area subtitled "Others involved in client's care:" which listed a skilled nursing facility [#31]. The clinical record failed to evidence any coordination of care with this facility.			
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or			

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	(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review the agency failed to ensure a 15 day discharge policy was in place for 1 out of 1 agency. The findings include: 1. The undated agency policy titled "Section 02.41 - Discharge" stated "... Clients and/or their legal representative or other individual responsible for the Client's care shall be given a notice of discharge of service at least five (5) calendar days before services are stopped. ... The five (5) calendar day period requirement does not apply in the following circumstances: The health, safety and/or welfare of the Agency's employees would be at immediate and significant risk if the Agency continued to provide services to the client, such as the client and/or family have threatened agency staff, have weapons in the home or the home is in some other way an unsafe environment for agency staff. The client refuses the Agency's services or decides to go to another agency. The client's services are no longer reimbursable based on applicable reimbursement requirements and the Agency informs the patient of community resources to assist the client following discharge. The Agency must continue, in good faith, to attempt to provide services through the five (5) day period. If the Agency cannot provide such services during that period, its continuing attempts to provide the services must be documented...." The agency policy failed to reflect the current 15 day discharge policy in accordance with Indiana State Board of Health regulations.	N 0488	By 9/30/17 the Administrator will update Policy titled "Section 02.41 - Discharge" and it will state " Clients and/or their legal representative or other individual responsible for the Client's care shall be given a notice of discharge of service at least fifteen (15) calendar days before services are stopped. ... The fifteen (15) calendar day period requirement does not apply in the following circumstances: The health, safety and/or welfare of the Agency's employees would be at immediate and significant risk if the Agency continued to provide services to the client, such as the client and/or family have threatened agency staff, have weapons in the home or the home is in some other way an unsafe environment for agency staff. The client refuses the Agency's services or decides to go to another agency. The client's services are no longer reimbursable based on applicable reimbursement requirements and the Agency informs the patient of community resources to assist the client following discharge. The Agency must continue, in good faith, to attempt to provide services through the fifteen (15) day period. If the Agency cannot	09/30/2017

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			provide such services during that period, its continuing attempts to provide the services must be documented...." Current clients will receive a letter of this new policy by September 30, 2017. Service Agreements will have an addendum with this change until new copies can be made as part of this agreement. ADDENDUM: Policy was re-written. Governing Body approved this policy on 9/25/17, as well as the letter that was mailed to all clients. Letter was mailed to all clients on 9/25/17 and a copy was placed in their chart. Administrator was responsible for this. Consent for Care in all new Admissions was updated to include discharge notice of 15 days with a signature of receipt of this information going forward. On going monitoring will be done by the Administrator with 10% of chart volume quarterly to assure we have a copy of their consent of this information.	
N 0498 Bldg. 00	410 IAC 17-12-3(b)(2)(A) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (A) Have his or her property treated with respect. Based on record review and interview the agency	N 0498	By 9/30/17 Administrator, Office	09/30/2017

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	failed to ensure the patient's property was treated with respect in 4 out of 6 records reviewed. (#1, #2, #3, #4) The findings include: 1. The undated agency policy titled "Section 02.05 - Bill of Rights" stated "... 11. A summary of complaint reports will be kept and presented to the Governing Body with recommendations and resolution documented, at least annually". a. Review of the agency's performance improvement log and meeting minutes on 7/25/17 failed to evidence any meeting minutes or performance improvement indicators that addressed misappropriations or patient rights in 2016. b. During an interview on 7/25/17 at 2:40 p.m. the administrator and employee B indicated that in the computer where you enter complaint runs reports and chooses things and places them on a graph, and then the agency addresses these indicators. Employee B also indicated that the complaints/compliance they were addressing were indicators that were brought up by Joint Commission such as; hand washing, UTI [urinary tract infection] and infections. The administrator and employee B indicated that the agency talks about other incidents but they do not document such conversations. 2. Review of the agency complaint/incident log on 7/25/17 evidenced 4 complaints in 2016 for loss or theft of property. The complaints/incidents dates reported are: 7/27/16 (patient #3), 8/9/16 (patient #4), 8/30/16 (patient #1) and 11/17/16 (patient #2). The allegations are as follows:		Managers, Director of Nursing and Case Management personnel will have met and reviewed the following policies and assure that 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 or family, or a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of	

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	a. Record review of complaint/incident log evidenced a complaint for loss or theft of property for patient #3 that is recorded as 7/23/16 at 9:00 a.m. This complaint/incident failed to be evidenced in the clinical record for patient #3. Who reported incident is listed as "other". The agency document titled "Incident Report" stated "... Incident Description Received a call from caregiver and then family member advising that there were 4 months of charges of the satellite television bill on their mother's/father's account for our caregiver, an iPhone bought for our caregiver and Amazon orders purchased by or [sic] caregiver for personal items. As well, as his/her children being brought to the home...." The last "action plan steps" evidenced on report was dated 7/25/16 and stated "[Employee B] followed up with family." During an interview with the administrator on 7/25/17 at 2:52 p.m., the administrator indicated that the resolution for this incident was employee B followed up with the family and that employee H was terminated. i. Review of the personnel file of employee H on 7/26/17 evidenced an agency document titled "DISCIPLINARY ACTION FORM" that stated "... Description of Incident: [Employee H] was terminated this date due to violation of BrightStar policies and procedures. On 7/23/16 we were informed that [employee H] was having a client pay for his/her personal satellite bills, buying him/her an iphone, and placing personal Amazon orders for the client to purchase. We were also advised he/she was bringing his/her children to the client's home. [Employee H] was advised his/her employment was terminated immediately and he/she is not to contact any of our clients on the phone or go to their homes...." b. Record review of complaint/incident log evidenced an agency document titled "Incident		the incident. 3. All initial Incident Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, 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, suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services (CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age	

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	Initial Report - Confidential" with a date of incident listed as 08/06/2016 at 5:00 p.m. The incident report listed patient #4 and demographics. An area in the agency document subtitled "Narrative: Details - Standard" stated "Client called to discuss his/her schedule. While on the phone, he/she said OMG [oh my God] where's my money? He/She said that approximately $65 - $70 dollars [sic] missing from his/her change purse. He/She stated that there were two people in the home in addition to two BrightStar employee's-total of four. Client stated he/she had gone into his/her bedroom to talk to the scheduler from BrightStar on the phone on 8/5. [person #29] and two others were in the home from a different agency on the 5th. [Employee R] was there on 8/6. Noticed money missing on 8/9. Client thinks it was [employee R]. Client said [employee R] had worked at a bank and went shopping for him/her and had a list from Walmart he/she was trying to get back and [employee R] wont [sic] return her calls. He/She said a 2 dollar bill was left in the change purse. Client asked what he/she should do, we advised him/her to file a police report. Once that was completed, we could investigate. Client stated that he/she is not going to make a report until his/her [family member], who is an attorney comes into town. Plan to Resolve (Immediate and Long Term). Once Police report is received, BrightStar will conduct an investigation." This resolution fails to follow agency policy. During an interview on 7/25/17 at 2:58 p.m. the administrator indicated the resolution for patient #4 was they were awaiting a police report. The administrator and employee B also indicated that there should probably be more documented and that it sounds like we need to do a better job with details. This document failed to be evidenced in the clinical record for patient #4.		of 18. The initial incident report must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local law enforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows:	

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	c. Record review of complaint/incident log evidenced a complaint listed on agency document titled "Incident Report" as "Incident Type" complaint. The record evidenced a date and time of incident as 8/12/16 3:02 p.m. The incident report listed patient #1 as the client and "customer" as who reported the complaint. The agency document stated "... Incident Description Reported by [employee B]: [Employee P], nurse case manager, received a call from a property manager where [patient #1] lives telling him/her that [patient #1] would like to resume service with us. [Employee B] called him/her back to see if he/she could help him/her. He/She said he/she needs our help but he/she does not want [employee F] back. [Employee B] asked him/her why and he/she explained that [employee F] told him/her the he/she is not going to be working for us anymore. He/She ([employee F]) is starting his/her own business and because of this [employee F] would show up whenever he/she wanted. [Patient #1] has always had shifts Mon [Monday], Wed [Wednesday], and Friday from 9a11a, but when [employee B] looked back in the schedule from July, [employee F] would go Mon, Thur [Thursday], and Friday one week and then another week he/she went Mon, Tues [Tuesday], and Wed. He/She said he/she never knew when [employee F] was going to come or not. [Patient #1] said that [employee F] was going shopping for him/her but also for two other people on his/her time. It would take him/her way longer than it should to do his/her shopping. [Patient #1] told [employee B] that [employee F] was there yesterday and that he/she wants us to call him/her and make sure he/she doesn't go back. There has been no one scheduled with [patient #1] in August. " The agency document titled "Incident Report" under area subtitled "Action Plan Steps" stated "... 8/19/16 Follow-up with Patient Family Completed Received a call from [person #26],		Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or exploitation of the person's personal services, 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 or 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 or more; ... 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient's	

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	[family member] of [patient #1], asking if we were being paid directly or was [patient #1] paying the caregiver. I told him/her that [patient #1] paid us. He/She said he/she went through his/her checking account and he/she has found checks that were written out to [employee F] and [employee D] (previous caregiver). I asked him/her how much and he/she said in the amount of $350, $400, $600. I told him/her to please gather what he/she can find (as he/she only went back to 10/15) and let me know on Monday what else he/she found. 8/22/16 Notify Employee Supervisor Completed Informed [employee B] off [sic] what happened on 8/19/16 with check fraud. 8/22/16 Follow-up with Patient Family Completed I called [person #26] to see what he/she had found out with the check fraud. He/She said he/she found a lot more stuff. He/She said he/she did not know what they were going to do. I told him/her I could initiate a police report but I do not have any evidence to support the police report. I told him/her that [employee D] and [employee F] no longer work with us but we would provide any information we needed to for the police. He/She said he/she and her [family member] would be in town this week and will decide what to do. I told him/her if he/she needed anything to please let us know. He/She thanked me for my help. 8/29/16 Follow up with Employee Completed Received a call from [employee G] that [patient #1] was upset about the checks and he/she wanted [employee G] to call the police so he/she could make a report. [Employee G] made a non emergency report of the check fraud. Case [#32] office [phone number]. He/She said the family was aware of it and they thanked him/her for all of his/her help. 8/30/16 Follow-up with Patient Family Completed I followed up with [person #26] in regards to the police report, He/She said he/she was aware. He/She asked why [employee G]		resources and living situation. Reports of demands for goods in 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) The allegation Any injury 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 the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...." Performance Improvement Plan will include any customer complaints, incidents, and employee complaints to collaborate all of our services and disciplines to meet the needs of	

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	called and I told him/her that [patient #1] asked him/her to. He/She said that's what he/she thought. He/She said him/her and his/her [family member] were going to the lawyer's today and will decide what they need to do. He/She said [employee G] is doing a good job and to just please keep him/her in the loop with any changes or cancellations." This is the last entry for the incident report. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated the 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 property for patient #2 with date and time of incident listed as 11/9/16 1:11 p.m. The agency document titled "Incident Report" stated "... Incident Description [Employee E] caregiver went shopping. When the [family member] came in ([employee E] was still at store) he/she said his/her [family member] told him/her "he/she is a thief" referencing [employee E]. He/She said there were 100's of dollars stolen and that's why he/she was not back yet. Treatments, Interventions, Outcomes 11/9 @ 2:35p [employee E] called and said he/she spoke with the [family member] and said he/she is good at hiding money all over the place. [Employee E] said the looked and found one envelope of money and then they continued looking and they found another envelope with 100's of dollars in it. He/She said the [family member][person #28] was going to take it to the bank." No other resolution was evidenced on agency document. There was no record of the family 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 2:52 p.m. the administrator indicated the resolution for patient #2 complaint was in the		the clients, staff and the community. Risk Management, infection control, and clinical quality will also be part of this quarterly team meeting to make sure the needs of our clients are being met as well as their well being and safety. Risk Management will include any fund complaints and what the findings were as well as ways we can protect our clients. ADDENDUM: Letter was sent to all employee, office and field staff reminding them of our client's right and their responsibility in reporting any incidents, complaints or concerns to the office. Governing body reviewed this letter on 9/25/17. This information is also include in their handbook for all new hires. This will be over seen by the Administrator. Employees have acknowledgement they receive access to the handbook as well as an Erisa Disclosure that they have to have an email address to work for BrightStar and be aware of policies and procedures.	

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	treatments, resolution, and outcomes of the agency document titled "Incident Report". 3. Review of the agency admission packet on 7/24/17 evidenced an area titled "7. Code of Ethics" which stated "The following ethics and standards are mandatory 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. Not solicit or accept money goods or private service for personal 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 not limited to Power of Attorney, Conservatorship or Guardianship. 17. Not take or borrow anything from the Client or the Client's home, even with permission. 18. Not commit any act of abuse, neglect or exploitation. ... 27. Employees are not to engage in any fraudulent activities such as dishonesty, forgery, alteration of any documents or accounts without proper authorization; misappropriation of funds, medical or office supplies, profiteering as a result of insider knowledge; disclosing to outside persons the activities in or contemplated by the Agency; destruction or disappearance of records or furniture, or any similar irregularities...." 410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on interview the agency failed to			
N 0502 Bldg. 00		N 0502	Effective 9/30/17 the	09/30/2017

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	ensure all client's were informed of how to file a complaint with the Indiana State Department of Health. (#3) The findings include: 1. During an interview on 7/26/17 at 9:16 a.m. with patient #3 he/she indicated that they do not know how to file a complaint with the state and did not have a folder provided by the agency with the state hotline number included. 2. During an interview on 7/27/17 at 10:05 a.m. the administrator was queried on the agency document titled "Admission Packet Acknowledgement Statement" that listed "Emergency Plan Welcome, Scope of Service, Mission Statement & Service Description Criteria for Admission Advance Directives - Your Right to Decide (ISDH [Indiana State Department of Health]) Advance Directives Policy for Agency HIPAA Notice of Privacy Practices Code of Ethics Bill of Rights and Responsibilities Universal Precautions and Patient's Rights Infection Control & Handling Infectious Waste Basic Home Safety Guidelines Emergency Disaster Preparedness in the Home", all entries listed had a pre-marked "X" in front. The administrator was queried as to how does BrightStar ensure patient understands all		Administrator will make sure all new admission packets that include "Admission Packet Acknowledgement Statement" listing "Emergency Plan, Welcome, Scope of Service, Mission Statement & Service Description Criteria for Admission Advance Directives - Your Right to Decide (ISDH [Indiana State Department of Health]) Advance Directives Policy for Agency HIPAA Notice of Privacy Practices Code of Ethics Bill of Rights and Responsibilities Universal Precautions and Patient's Rights 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 a signature line for their full name. Their signature will also indicate that they have been explained all of the above and their questions were answered (if any) at the time of their agreement to start services. A letter will be sent by 9/30/17 informing current clients how they may reach the state if they ever have any concerns or complaints; address, phone number and hours. ADDENDUM: Letter was sent on 9/25/17 to all current client on how they can reach the state. Ongoing this is in all admission	

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	items on signed document. The administrator indicated when [employee C] goes out to meet client he/she leaves the folder and agreement with the client. Then when the nurse admits the client he/she goes over the form with the client and they sign the agency document. The administrator indicated it is ensured that the client understands this document because the nurse lets them ask questions as they go through the document.		packets and will be monitored by the Administrator. During survey it was felt that the pre-checked admission checklist was already answering for the patient that they received this information. The pre checks were removed from this list and now client will have to initial that they receive this information by initialing our their rights and receiving our welcome packet.	
N 0505 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment.			
	Based on record review and interview the patient's failed to be informed of their schedules or caregivers that were to provide care and involved in the plan of care in 3 of 6 records reviewed. (#3, #4, #5)	N 0505	The Administrator and Nursing Supervisor reviewed the Client's Rights and Responsibilities document that is given to all client's at the time of starting service. A meeting will be held by 9/30/17 advising all office personnel including the client service coordinators and nursing	09/30/2017

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	The findings include: 1. Review of the agency admission packet on 7/25/17 evidenced an area subtitled "8. Client's Rights & Responsibilities" this document stated "As a client you have the right to: ... 6. 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 care, and be informed of all treatments the agency is to provide, the disciplines to provide care, and the frequency of the visits/shifts to be furnished. Also, to be informed within reasonable notice of any discharge of services...." 2. Review of clinical record #3 on 7/27/17 evidenced an agency document titled "Supervisory Visit" dated 11/1/16 that stated "... Subjective Data (what patient/family reports): upset not knowing what caregivers are coming next. Wants a schedule...." Another document titled "Supervisory Visit" dated 11/30/16 stated "... Subjective Data (what patient/family reports): Wants a schedule Wants a pill box...." There is not agency documentation that evidence patient received a schedule or was informed of who his/her caregivers would be.		managers of the client's rights and responsibilities including that the clients have the right "to 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 care, and be informed of all treatments the agency is to provide, the disciplines to provide care, and the frequency of the visit/shifts to be furnished. Also, to be informed with reasonable notice discharge of services. Addendum: ADDENDUM: All office employee 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 this form and given to the Administrator. The Administrator will contact all involved parties (client and/or employee) and complete an investigation. Once complaint is complete it will be entered into our software system 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	

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	a. During an interview on 7/26/17 at 9:16 a.m. patient #3 indicated he/she does not know who is going to show up at his/her house. They just come into my house and I don't know who they are, they just come in. I don't know anyone's name, and I was not involved in my plan of care. 3. Review of clinical record #4 on 7/27/17 evidenced an agency document titled "Supervisory Visit" dated 8/31/16 that stated "... Subjective Data (what patient/family reports): Not happy that caregivers always change, wants a permanent schedule...." The clinical record failed to evidence any documentation or resolution if patient #4 had received a schedule from the agency.		monitored by the Administrator and then discussed as part of our risk management during quarterly Performance Improvement meetings to see how we can grow and improve from these experiences and make sure our clients are protected. They also will be discussed during weekly 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 letter on the patient's right and how to report any complaints. Governing Body reviewed Client Complaint/Concern on 9/25/17 for approval.	
N 0508 Bldg. 00	410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records. Based on record review, interview and	N 0508	By 9/30/17 Administrator, Office	07/31/2017

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	observation the agency failed to ensure clinical records were safeguarded in a secure, locked room in 1 of 1 agency. The findings include: 1. The undated agency policy titled "Section 02.21 - Client Medical Record Security and Retention" stated "Policy: Medical records will be retained for each client receiving home care services. Medical record information is considered confidential. All records will be protected against loss, damage, or unauthorized access. ... Retention of Records: ... 4. Clinical record information shall be safeguarded in a locked area when not in use by staff...." 2. During tour of the agency on 7/24/16 at 10:52 a.m. the clinical records were observed on open shelves in an unlocked, lighted room of the agency, with no personnel present in the room. On 7/25/17 at 12:20 p.m. the clinical records were observed in an unlocked room with no personnel present. 3. During an interview on 7/25/17 at 2:30 p.m. employee B stated they were currently under construction and he/she is having a new room built for the clinical records.		Managers, Director of Nursing and Case Management personnel will have met and reviewed the following policies and assure that our policies will be followed as stated: Policy Section 02.21 Client Medical Record Security which states that Medical Records will be retained for each client receiving home care services. Medical record information is considered confidential. All records will be protected against loss, damage, or unauthorized access. Procedure: All copies of paper record necessary for continuity of care will be kept in the client's home. 2. At the time of client discharge all records will be collected from the client's home for proper scanning and subsequent destruction. 3. Client records will be scanned into the BrightStar Corporate record retention system for security and storage. 4. BrightStar Corporate maintains a redundant backup system of all scanned documents. 5. Paper documents are either shredded after scanning or placed into a locked file within the BrightStar office. 6. As a security precaution, BrightStar system log in passwords have been pre-set with a lockout feature that helps to prevent access to the BrightStar system by unauthorized users. If a user tries more than three times to log into the system with an incorrect	

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			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 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview the agency failed to ensure a resolution according to agency policy for 4 of 4 complaints reviewed. (#1, #2, #3, #4) The findings include: 1. Record review of the complaint/incident log on 7/25/17 failed to evidence the administrator came to a resolution in 4 of 4 complaint/incidents reviewed. The administrator failed to follow the agency complaint/incident policy.	N 0514	By 9/30/17 Administrator, Office Managers, Director of Nursing and Case Management personnel will have met and reviewed the following policies and assure that 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	09/30/2017

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	a. Review of agency document titled "Incident Report" with a date reported of 8/30/16 for patient #1 failed to evidence a resolution according to agency policy. The last outcome listed on the document was dated 8/30/16 and stated "... I [administrator] followed up with [person #26] in regards to the police report, He/She said he/she was aware. He/She asked why [employee G] called and I told him/her that [patient #1] asked him/her to. He/She said that's what he/she thought. He/She said him/her and him/her [family member] were going to the lawyer's today and will decide what they need to do. He/She said [employee G] is doing a good job and to just please keep him/her in the loop with any changes or cancellations." During an interview on 7/27/17 at 9:21 a.m. person #26 indicated there was no resolution to the complaint. Person #26 indicated that he/she never even received an apology from BrightStar and the only employee he/she spoke with was the administrator. Person #26 indicated that he/she was informed by administrator that BrightStar cannot do anything without a police report. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated that the resolution for patient #1 was the termination of employee F. b. Review of agency document titled "Incident Report" with a date reported of 11/17/16 for patient #2 failed to evidence a resolution according to agency policy. The document stated "... Treatments, Interventions, Outcomes 11/9 @ 2:35p [employee E] called and said he/she spoke with the [family member] and said he/she is good at hiding money all over the place. [Employee E] said they looked and found one envelope of money and then they continued looking and they found another envelope with 100's of dollars in it. He/She said the [family member][person #28] was going to take it to the		received in a variety of forms, such as a phone call to the office, a letter or note from the client or family, or a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All initial Incident Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, neglect, or exploitation must be suspended immediately after the incident occurs and during the	

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	bank." The agency only received testimony from the home health aide. The agency failed to ensure patient #2 (complainant) and/or the family member were followed up with concerning the resolution. During an interview on 7/25/17 at 2:52 p.m. the administrator indicated the resolution for patient #2 is in the treatments, resolution, outcomes of the incident report. c. Review of agency document titled "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 reported on the incident report document was dated 7/25/16 and stated "... [employee B] followed up with family." During an interview on 7/25/17 at 2:52 p.m. the administrator stated the resolution was that employee H was terminated and employee B called the family. d. Review of agency document titled "Incident Report" with a date of incident as 8/6/16 for patient #4 failed to evidence a resolution according to agency policy. The document stated "... Plan to Resolve (Immediate and Long Term). Once Police report is received, BrightStar will conduct an investigation...." During an interview on 7/25/17 at 2:58 p.m. the administrator indicated the resolution for patient #4 was they were waiting for a police report. During the interview the administrator and employee B also indicated that there should probably be more documented and that they needed to do a better job with details. 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 variety of forms, such as a phone call to the office, a letter or note from the client or family, or		provider's investigation of the incident. Reportable Unusual Occurrences (RUO): a) Alleged, suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services (CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age of 18. The initial incident report must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case	

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	a message delivered by the caregiver. BrightStar Care management will respond to any and all such complaints, making every effort to reach a resolution that meets the client's satisfaction. It is the desire and intent of BrightStar Care to provide the best possible care to each of our clients, and to treat them as if they were a member of our own family. Procedure 1. When a client complaint is reported to the BrightStar Care office, the information, with as much detail as possible, will be captured and logged onto the Customer Complaint Report. 2. The same information will be placed into the employee file (Caregiver of record) if appropriate. 3. The information will be communicated to the Owner, Director of Nursing or designee. 4. The Owner, Director of Nursing and/or designee will investigate the complaint within 10 calendar days and report the findings to the Owner and Administrator. Collectively, they will reach a resolution of the complaint and will advise the client either verbally or in writing of the planned solution or resolution within 30 calendar days after the agency receives the complaint. 5. The Owner and/or Director of Nursing will then monitor the Client/Caregiver situation over the following (30) thirty days to assure that the issue has been satisfactorily resolved and that the client and/or family is satisfied...." 3. The undated agency 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 affects the individual's health, safety and welfare shall submit an initial Incident Report known as Reportable Unusual Occurrence (RUO). 2. All providers are required to report incidents of RUO within forty-eight (48) hours of the time the incident occurred, or from the point of knowledge of the incident. 3. All		manager, APS or CPS, the individual's other service providers, if relevant, a local law enforcement agency." Policy titled "Section 02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or	

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	initial Incident Report involving an allegation or 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. 4. Any staff suspected, alleged, or involved in an incident of abuse, 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, suspected or actual abuse, neglect or exploitation of an individual shall be reported to Adult Protective Services (APS) for a consumer over the age of 18 or Child Protective Services (CPS) for a consumer under the age of 18. ... g) Suspected or observed criminal activity by a staff member, employee or agent of a provider, a family member of an individual receiving services or the individual receiving services. ... p) Inadequate staff support with the potential for endangering the health, safety or welfare of the individual. This includes, but is not limited to, inadequate supervision of an individual and inadequate training of staff. ... 7. If an incident involves suspected or actual abuse, neglect, exploitation, and/or death of a person the reporting entity shall also report the incident to: APS for clients over the age of 18 and CPS for clients under the age of 18. The initial incident report must include the following in regard to the report made to APS or CPS: a. The name of the person contacted b. The telephone number c. The date of contact d. The county of contact 8. The reporting entity shall make available a copy of the initial IR [incident report], at a minimum, to the individual or individual's legal representative, the case manager, APS or CPS, the individual's other service providers, if relevant, a local law enforcement agency." 4. The undated agency policy titled "Section		caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or exploitation of the person's personal services, 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 or 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 or more; ... 7. Criteria to identify victims of exploitation include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient's resources and living situation. Reports of demands for goods in 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) The allegation Any injury or adverse affect Any treatment required	

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	02.45 - Abuse Neglect" Policy: BrightStar recognizes that upon occasion recipients of our care may become subject to physical or mental abuse, neglect, or exploitation. BrightStar requires all staff to be alert for obvious or suspected situations jeopardizing a client's right to considerate, humane treatment and to be free of abuse, neglect, or exploitation whether it be 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 at: 1-800-992-6978 (Toll free in 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. Definitions are defined as follows: Vulnerable Adult: Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of mental or physical function impairment or his/her emotional status. (Note: Indiana law defines endangered adults as those individuals 18 years or older who are incapable of managing their property or caring for themselves because of illness, disability, or other incapacity and are harmed or threatened with harm as a result of abuse, neglect or exploitation of the person's personal services, 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 or 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 or more; ... 7. Criteria to identify victims of exploitation		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 the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...." Performance Improvement Plan will include any customer complaints, incidents, and employee complaints to collaborate all of our services and 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 make sure the needs of our clients are being met as well as their well being and safety. ADDENDUM: All office employee and field case managers were given a Compliant Concerns/Complaint Form on	

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	include: Abuse and/or misuse of patient's money An inability of caregiver/family to account for patient's money or property. Discrepancies between patient's resources and living situation. Reports of demands for goods in 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) The allegation Any injury 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 the agency or that the agency failed to furnish, or a lack of respect for the client's property by anyone furnishing services on behalf of the agency. 15. BrightStar will document the receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint. All components of the investigation will be documented and the entire investigation and documentation will be completed within 30 days after the agency receives the complaint, unless the agency has a documents reasonable cause for delay...."		9/25/17. If any complaint is received it will be written on this form and given to the Administrator. The Administrator will contact all involved parties (client and/or employee) and complete an investigation. Once complaint is complete it will be entered into our software system 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 our risk management during quarterly Performance Improvement meetings to see how we can grow and improve from these experiences and make sure our clients are protected. They also will be discussed during weekly 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 9/25/17 for approval.	
N 0532 Bldg. 00	410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency			

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	personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. Based on record review the skilled nurse failed to notify the physician for significant physical changes in the patient's vital signs and/or blood sugar in 4 of 6 records reviewed. (#1, #3, #4, #6) The findings include: 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...." 2. The undated agency policy titled "Section 02.15 - Skilled Nursing	N 0532	Administrator and Nursing Supervisor reviewed Policy Section 02.01 - Standards of Practice. 1. The agency provides services based on acceptable professional standards for home care and according to state and federal regulations as indicated. 2. All agency staff will perform within the guidelines of their stated discipline. 2. All clients will be provided care based on a Plan of 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 Nurse and reviewed, approved and signed by a physician. 4. Skilled nursing visits are performed as 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 condition is performed upon each nursing visit and reported to the physician if indicated. 6. All plans of care are based on the individualized needs of the clients who are being served by the agency. Administrator and Nursing	09/30/2017

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	Services" stated "1. Skilled nursing services are performed by Registered Nurses or Licensed Practical Nurses under the supervision of a Registered Nurse in accordance with the Nurse Practice Act. ... 3. Registered Nurses do the following: Perform initial admission assessments and periodically reassess the client's needs and coordinate services as needed. Initiates the plan of care or service plan and necessary revisions and updates when needed. Ensure that the physician 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 other nursing personnel when needed. 4. Skilled nurses prepare clinical notes following each visit the same day care is rendered." 3. The undated agency policy titled "Section 02.01 - Standards Of Practice" stated "... 5. Skilled observation and assessment of the client's condition is performed upon each nursing visit and reported to the physician if indicated...." 4. Review of the clinical record for patient #1 on 7/27/17 evidenced an agency document titled "Supervisory Visit" dated 9/30/16 that had an area subtitled "Vital Signs". The agency nurse (employee P) recorded the blood pressure		Supervisor reviewed Policy Section 02.15 Skilled Nursing Services. 1. Skilled nursing services are performed by Registered Nurses or Licensed Practical Nurse under the supervision of a Registered Nurse 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 and coordinate services as needed. Initiates the plan of care or service plan and necessary revisions and updates when needed, ensure that the physician 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 other nursing personnel when needed. 4. Skilled nurses prepare clinical notes following each visit the same day care is rendered. Administrator and Nursing Supervisor reviewed Policy Section 02.23 Medical Plan of Care, Physician Orders and Medical Supervision. 1. Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. 2. The medical plan of care shall meet	

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	of 130/52. There was no documentation in clinical record #1 that the physician was ever contacted regarding a diastolic blood pressure of 52. 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 clinical record #3 that the physician was ever contacted regarding a pulse of 54. a. Review of the clinical record for patient #3 evidenced an agency document titled "Personal Care/Companion Care Note and Timesheet", dated 5/2/16, that stated "... Comments/Remarks: make [sic] him/her a sandwhich [sic] and he/she took sugar and it was 360 so he/she gave himself/herself a [sic] insulin shot at 7:00 pm (Rapid Release)" There was no documentation in the clinical record that this blood sugar was reported to the RN or the physician. An agency document titled "Personal Care/Companion Care Note and Timesheet", dated 5/4/16, stated "... Comments/Remarks: Client is a [sic] diabetic situation. Called ambulance". There was no documentation evidenced		the following: be developed in consultation with the agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, and include the following: mental status, type of services and equipment required, frequency and during of visits, prognoses, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against, injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment and any other appropriate items. 3. The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist and home health agency personal as often as the severity of the patient's condition requires, but at least once every sixty (60) days. 4. A written summary for each patient shall be sent to the physician, dentist, chiropractor optometrist of podiatrist at least every sixty (60) days. 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	

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	in the client record that these events were reported to the patient's physician. b. Review of the clinical record for patient #3 evidenced an agency document titled "Supervisory Visit" dated 9/29/16. The document had an area subtitled "Vital Signs" with a pulse of 54 recorded. There was no documentation evidenced in clinical record #3 that the skilled nurse ever contacted the physician regarding a pulse of 54. 6. Review of the clinical record for patient #4 on 7/27/17 evidenced an agency document titled "Client Assessment" dated 6/1/16 with "Initial" checked following title. The skilled nurse failed to document any vital signs on patient #4's initial assessment. 7. Review of the clinical record for patient #5 on 7/27/17 evidenced an agency documents titled "Client Assessment" and "Supervisory Visit" both dated 1/25/17 and both signed by a RN. The agency document titled "Client Assessment" documented a pulse of 110, the agency document titled "Supervisory Visit" had an area subtitled "Vital Signs" and also had a pulse of 110. There was no documentation evidenced in the clinical record that the skilled nurse ever contacted the physician for the elevated		licensed professional staff and legal representatives (if any), of any significant physical or mental changes observed or reported by the patient. 7 In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. 8. The agency may accept written orders from a physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana or in any other state. 9. If the agency receives an order from a physician, dentist, a chiropractor, podiatrist or an optometrist who is licensed 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 order originated and the individual who issued the order examined the patient is licensed to practice in that state. 10. All orders issued by 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 the authority allowed under orders from the same profession in Indiana under IC 25. 12. All medications, treatments and skilled nursing services provided to patients must be ordered by a physician including patient's name, physician's name, date,	

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	pulse of 110 beats per minute. 8. Review of the clinical record for patient #6 on 7/27/17 evidenced an agency document titled "Client Assessment" dated 3/2/16 and signed by a RN. The document evidenced an area subtitled "Vital Signs". The skilled nurse recorded the patient's respirations as 25, shallow and labored. There was no documentation in the clinical record that the nurse contacted the physician or notified the staff at facility #31 of the patient's respiratory status at the time of his/her assessment.		the order and signature of RN/LPN taking the order. 13. The orders may be initially obtained by 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 laws and organization policy. 16. No stamped signatures are permitted. 17. The medical plan of care will be used as the care plan and will include reasonable, measurable and realistic goals as determined by the patient assessment. 18. The care plan will also address rehabilitation potential and discharge plans. 19. The care plan will also be reviewed, evaluated and revised as needed at least every sixty (60) days and/or as needed. 20. Agency staff caring for the patient 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 order verification. Administrator and Nursing Supervisor reviewed Policy 02.24 - Reporting Patient's Condition to Physician. Policy: Clinicians will monitor, document, and report the patient's response to care and	

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			treatments provided on each home visit. Progress toward goals will be measured at regular intervals. Clinicians will establish and maintain ongong communication with the physician to ensure safe and appropriate care for the patient. Ongoing communication with the client's physician may occur monthly or more frequently when client's condition is unstable of changes unexpectedly. Administrator and Nursing Supervisor will meet with Registered Nurse Case Managers to review all of the above policies by September 30, 2017. Home health aides will be 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 pain, mental status, nutrition, elimination, skin, and abnormal findings. ADDENDUM: All employees have to have access to their emails as a requirement to work for our company to be kept apprised in situations of policies and procedures. ERISA form is on file stating they will do this and their compliance of being in receipt of these notices. A letter and in-service was sent on conditions to look for an abnormal reportable conditions. This in-service is also now a mandatory basic in-service	

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			at the time of hire and annually thereafter. Care Notes are being reviewed by nursing supervisor or nursing designee to see if any change of condition was noted and not reported to the office.	
N 0534 Bldg. 00	410 IAC 17-13-3(b) Service Plan Rule 13 Sec. 3(b) The personal services agency's manager or the manager's designee shall prepare a service plan for a client before providing personal services for the client. A permanent change to the service plan requires a written change to the service plan. The service plan must: (1) be in writing, dated, and signed by the individual who prepared it; (2) list the types and schedule of services to be provided; and (3) state that the services to be provided to the client are subject to the client's right to: (A) temporarily suspend; (B) permanently terminate; (C) temporarily add; or (D) permanently add; the provision of any service.			
	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: 1. The undated agency policy titled "Section 02.16 - Nursing Plan Of Care/Service Plan" stated "1. A nursing plan of care must be developed by a	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 agency 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	09/30/2017

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	Registered Nurse for the purpose of delegating nursing directed client care provided through the Home Health Agency 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 identifying information The name of the client's physician Services to be provided The frequency and duration of visits Medications, diet and activities Signed and dated clinical notes from all personnel providing services Supervisory visits Sixty (60) day summaries The discharge note The signature of the Registered Nurse who developed the plan 3. A service plan must be developed by a Registered Nurse for each client to define the services provided by the Personal Services Agency. 4. The service plan must contain the following: A service plan and appropriate client identifying information Types and schedule of the services to be provided The signature and ate of the Registered Nurse who developed the plan State that the services to be provided to the client are subject to the client's right to temporarily suspend, permanently terminate temporarily add, or permanently add the provision of any service. A client/family signature and date no later than fourteen (14) days after		identifying information, the name of the client's physician, services to be provided, the frequency and duration of visits, medications, diet, and activities, signed and dated clinical notes from all personnel providing services, supervisory visits, sixty (60) day summaries, the discharge note and the signature of the Registered Nurse who developed the plan. 3. A service plan must be developed by a Registered Nurse or each client to define the services provided by the agency. 4. The service plan must contain the following: a service plan and appropriate client identifying information, types and schedule of the service to be provided, the signature and date of the Registered Nurse who developed the plan, state that the services to be provided to the client are subject to the client's right to temporarily suspend, permanently terminate, temporarily add, or permanently add the provision of any service, a client/family signature and date no later than fourteen (14) days after services begin or after a permanent change to the service plan. The Administrator and Nursing Supervisor added an addition to the policy as follows: 5. Home health aides will indicate on their daily care notes the services (i.e. tasks) that were followed according to the service plan as follows: a check indicating the service was complete, refused (r)	

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	services begin or after a permanent change to the service plan." 2. Review of the clinical record of patient #3 on 7/27/17 evidenced an agency document titled "Personal Care/Companion Plan of Care" dated 7/14/16 and signed by the RN. The document indicated the personal care attendant/home health aide to do med [medication] assistance/reminders, light cleaning, exercise ROM [range of motion] - passive/interactive, Transportation, Errands, Recreational Activities, prepare and clean for meals, and fall precautions. The personal care attendant/home health aide failed to follow the "Personal Care/Companion Plan of Care as follows: a. Review of agency document titled "Personal Care/Companion Care Note and Timesheet" dated 7/24/16 and 7/25/16 evidenced home health aide assisted with toileting. This was not an ordered task on the document titled "Personal Care/Companion Plan of Care". b. Review of agency document titled "Personal Care/Companion Care Note and Timesheet" dated 7/27/16 evidenced home health aide assisted with tub/shower, oral care, skin care, dressing		if the client refused the task that day or previously done (pd) written if the task was not complete because it was done on a previous shift according to the client. A home health aide will not perform any tasks not listed on the service plan unless a Registered Nurse approves it and makes adjustments on the service plan according to the client's request. The updated policy will be sent to current home health aides and will be included in orientation by September 30, 2017. ADDENDUM: This will be the responsibility of the Administrator and Nursing Supervisor. An addendum was created and reviewed by the Governing Body on 9/25/17. A letter was sent to all employees of their responsibility and guidelines. All employees have an ERISA on file 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 will review all timesheet/caregiver notes to make sure the plan of care/service agreement is being followed. Any that are not complete will be brought into the office to correct notes accurately and be counseled/re-advised.	

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	and toileting. This was not an ordered task on the document titled "Personal Care/Companion Plan of Care". 3. Review of the 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 dishes, trash removal, dusting, laundry, ironing, clean range, clean refrigerator, clean bathroom, vacuuming, sweeping, mopping, prepare meal snack, errands, and practice universal precautions and fall precautions. The document titled "Personal Care/Companion Plan of Care" indicated home health aide was to perform tub/shower, sponge bath, shampoo hair, oral care, skin care, nail care (file only), dressing, toileting, med assistance/reminders, linen change, laundry, light cleaning, ambulation assist, transfer assist, errands, recreational activities, prepare and clean meals, and practice universal and fall precautions. The homemaker and personal care attendant/home health aide failed to follow the "Homemaker Service Plan" and the "Personal Care/Companion Plan of Care" as follows:			

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	a. Review of clinical record #3 agency document titled "Homemaker Service Note and Timesheet" dated 6/2/16 evidenced the homemaker failed to follow the "Homemaker Service Plan". The homemaker was not evidenced to have provided ironing, cleaning range, or vacuuming. b. Review of clinical record #3 agency document titled "Homemaker Service Note and Timesheet" and "Personal Care/Companion Care Note and Timesheet" dated 6/3/16 evidenced the homemaker and home health aide failed to follow the plans of care. The homemaker was not evidenced to have provided dusting, laundry, ironing, cleaning range, cleaning refrigerator, vacuuming, and sweeping. The home health aide was not evidenced to have provided shower/tub, sponge bath, shampoo hair, oral care, skin care, nail care, toileting, linen change and transfer assistance. The home health aide was evidenced to have provided incontinence care and exercise ROM which are not listed on the "Personal Care/Companion Plan of Care". c. Review of clinical record #3 agency document titled "Homemaker Service Note and Timesheet" dated			

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	6/5/17 evidenced the homemaker failed to follow the plan of care. The homemaker was not evidenced to have provided dusting, ironing, vacuuming, and preparing meal/snack. 4. Review of the clinical record of patient #5 on 7/27/17 evidenced an agency document titled "Personal Care/Companion Plan of Care" dated 4/12/17 and signed by the RN. This document indicated the home health aide was to perform sponge bath, shampoo hair, oral care, skin care, nail care (file only), dressing, toileting, linen change, laundry, light cleaning, transfer assist, exercise ROM -passive/interactive, transportation, errands, recreational activities, prepare and clean meals, and practice universal and fall precautions. The home health aide failed to follow the "Personal Care/Companion Plan of Care" as follows: a. Review of clinical record #5 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 4/12/17, 4/14/17, 4/24/17, 4/26/17, 4/28/17, 5/1/17, 5/3/17, 5/5/17 and 5/19/17 evidenced the home health aide performed shampoo hair, this task was not ordered on the plan of care. b. Review of clinical record #5			

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	agency document titled "Personal Care/Companion Care Note and Timesheet" dated 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 home health aide performed shampoo hair that was not on the plan of care and did not perform nail care which was on the plan of care. c. Review of clinical record #5 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 5/10/17 evidenced the home health aide performed shampoo hair that was not a task on the plan of care and failed to perform nail care, dressing and toileting that was a task on the plan of care. 5. Review of the clinical record of patient #6 on 7/27/17 evidenced an agency document titled "Personal Care/Companion Plan of Care" dated 3/2/16 and signed by the RN. This document indicated the home health aide was to perform nail care (file only), toileting, record bowel movement, transfer assist, recreational activities, encourage fluids and practice universal and fall precautions. The home health aide failed to follow the "Personal Care/Companion Plan of Care" as follows:			

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	a. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/2/16 evidenced the home health aide perform sponge bath, linen change and ambulation assist which was not ordered as tasks on the plan of care and the home health aide failed to perform record bowel movement, recreation activities and encourage fluids which were tasks ordered on the plan of care. b. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/3/16 evidenced the home health aide perform ambulation assist which was not ordered on the plan of care and failed to perform recreational activities, nail care, toileting, record bowel movement and encourage fluids which were tasks ordered on the plan of care. c. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/4/16 evidenced the home health aide perform turn/reposition which was not ordered as a task on the plan of care and failed to perform nail care, record bowel movement and			

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	recreational activities which were tasks on the plan of care. d. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/5/16 and 3/6/16 evidenced the home health aide failed to perform recreational activities and nail care as ordered on the plan of care. e. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/7/16 evidenced the home health aide had performed oral care and turn/position which was not tasks ordered on the plan of care and failed to perform nail care, transfer assist and recreational activities which were tasks on the plan of care. f. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/8/16 evidenced the home health aide had performed sponge bath, skin care, linen change and turn/reposition which was not ordered on the plan of care and failed to perform nail care and recreational activities which were tasks on the plan of care. g. Review of clinical record #6			

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	agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/9/16 evidenced the home health aide had performed turn/reposition which was not tasks ordered on the plan of care and failed to perform nail care, toileting, record bowel movement and recreational activities which were tasks on the plan of care. h. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/10/16 evidenced the home health aide had performed sponge bath, ambulation assist, turn/reposition, feeding assist which was not tasks ordered on the plan of care and failed to perform toileting, record bowel movement and recreational activities which were tasks on the plan of care. i. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/11/16 evidenced the home health aide had performed turn/reposition which was not tasks ordered on the plan of care and failed to perform nail care or record bowel movement which were tasks on the plan of care. j. Review of clinical record #6			

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	agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/13/16 evidenced the home health aide had performed turn/reposition which was not tasks ordered on the plan of care and failed to perform nail care and record bowel movement which were tasks on the plan of care. k. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/14/16 evidenced the home health aide had performed sponge bath and turn/reposition which was not tasks ordered on the plan of care and failed to perform nail care, toileting, record bowel movement, transfer assist and recreational activities which were tasks on the plan of care. l. Review of clinical record #6 agency document titled "Personal Care/Companion Care Note and Timesheet" dated 3/15/16 evidenced the home health aide had performed sponge bath, oral care, skin care, linen change and turn/reposition which was not tasks ordered on the plan of care and failed to perform nail care, record bowel movement and recreational activities which were tasks on the plan of care.			

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N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) 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 services. Based on record review the skilled nurse failed to coordinate services with a skilled nursing facility and other agency's providing care to their patients in 2 of 6 clinical records reviewed. (#4, #6) The findings include: 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 client's status and progress and action plans will	N 0545	By 9/30/17 the Administrator and Nursing Supervisor will meet with all Nursing Case Managers and review our Policy Section: 02.37 Coordination of Care, Clinical Summary and Case Conference. Policy includes 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 goals are evaluated and appropriate responses made. Case conferences may be held in various ways, such as group meeting, by phone, fax or email, and must be documented as such. 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	09/30/2017

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	be formulated as needed when problems are identified. 5. In complex cases, the client, caregivers and/or family members might be invited to attend the case conference with the client's or authorized representative's approval. 6. Care conferences will be documented on the appropriate form or in the progress notes. Subsequent changes to the Plan of Care or Service Plan will be communicated by the Registered Nurse to appropriate staff members, the client and/or family/caregivers and/or physician as needed after the case conference. 7. A Clinical Summary of the client's care, services rendered and response to care for each client will be documented on the appropriate form and sent to the physician for signature if applicable at a minimum of every 60 (sixty) days. 8. Case conferences and copies of clinical summaries shall be kept in the client's chart." 2. Review of the clinical record for patient #4 on 7/25/17, start of care 6/1/16, evidenced an agency document titled "Client Medication Profile" dated 8/3/16. This document contained patient's medications, two of which were administered by central line. The medications listed were Morphine 2000mg [milligram]/1000 ml [milliliter] per central line continuously, and Cath Flo Activace 2 bottles per central line weekly. There was no documentation/coordination of care in clinical record for any entity/agency/provider who was monitoring patient #4's central line or administering medications per central line. 3. Review of the clinical record for patient #6 on 7/25/17, start of care 3/2/16, evidenced a document titled "Client Assessment" dated 3/2/16 and signed by employee N. This document had an area subtitled "Others involved in client's care:" which listed a skilled nursing facility (#31). The clinical record failed to evidence any		with our agencies and institutions if the need arises, and discharge planning. Ongoing case conferences shall be conducted to evaluate the client's status and progress and action plans will be formulated as needed when problems are identified. In complex cases, the family may be invited to participate. Case conferences should be documented in the appropriate form or in the progress note. Changes in the Plan of Care will be communicated by the Registered Nurse to appropriate staff members. Case conferences will be documented every 60 days and 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 find out the cause of this was finding out that our 60 day summary was not sufficient enough to cover the case conference requirement. A new form was developed and approved by the governing body on 9/25/17 and is being put in place immediately. Nursing Supervisor and nursing designee will be responsible for monitoring this by reviewing all reassessments and post hospitals done by nurse case management which will include	

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	coordination of care with this facility.		these forms every 60 days.	
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review the skilled nurse failed to notify the physician or other appropriate medical personnel of changes in the patient's condition and needs in 5 of 6 clinical charts reviewed. (#1, #3, #4, #5, #6) The findings include: 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...." 2. The undated agency policy titled "Section	N 0546	Administrator and Nursing Supervisor reviewed Policy Section 02.01 - Standards of Practice. 1. The agency provides services based on acceptable professional standards for home care and according to state and federal regulations as indicated. 2. All agency staff will perform within the guidelines of their stated discipline. 2. All clients will be provided care based on a Plan of 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 Nurse and reviewed, approved and signed by a physician. 4. Skilled nursing visits are performed as 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	09/30/2017

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	02.15 - Skilled Nursing Services" stated "1. Skilled nursing services are performed by Registered Nurses of Licensed Practical Nurses under the supervision of a Registered Nurse in accordance with the Nurse Practice Act. ... 3. Registered Nurses do the following: Perform initial admission assessments and periodically reassess the client's needs and coordinate services as needed. Initiates the plan of care or service plan and necessary revisions and updates when needed. Ensure that the physician 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 other nursing personnel when needed. 4. Skilled nurses prepare clinical notes following each visit the same day care is rendered." 3. The undated agency policy titled "Section 02.01 - Standards Of Practice" stated "... 5. Skilled observation and assessment of the client's condition is performed upon each nursing visit and reported to the physician if indicated...." 4. Review of the clinical record for patient #1 on 7/27/17 evidenced an agency document titled "Supervisory Visit" dated 9/30/16 that had an area subtitled "Vital Signs". The agency nurse (employee P) recorded the blood pressure of 130/52. There was no documentation in clinical record #1 that the physician was ever contacted regarding a diastolic blood pressure of 52. 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 clinical record #3 that the physician was ever contacted regarding a pulse of 54.		condition is performed upon each nursing visit and reported to the physician if indicated. 6. All plans of care are based on the individualized needs of the clients 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 Licensed Practical Nurse under the supervision of a Registered Nurse 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 and coordinate services as needed. Initiates the plan of care or service plan and necessary revisions and updates when needed, ensure that the physician 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 other nursing personnel when needed. 4. Skilled nurses prepare clinical notes following each visit the same day care is rendered. Administrator and Nursing Supervisor reviewed Policy Section 02.23 Medical Plan of	

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	a. Review of the clinical record for patient #3 evidenced an agency document titled "Personal Care/Companion Care Note and Timesheet", dated 5/2/16, that stated "... Comments/Remarks: make [sic] him/her a sandwhich [sic] and he/she took sugar and it was 360 so he/she gave himself/herself a [sic] insulin shot at 7:00 pm (Rapid Release)" There was no documentation in the clinical record that this blood sugar was reported to the RN or the physician. An agency document titled "Personal Care/Companion Care Note and Timesheet", dated 5/4/16, stated "... Comments/Remarks: Client is a [sic] diabetic situation. Called ambulance". There was no documentation evidenced in the client record that these events were reported to the patient's physician. b. Review of the clinical record for patient #3 evidenced an agency document titled "Supervisory Visit" dated 9/29/16. The document had an area subtitled "Vital Signs" with a pulse of 54 recorded. There was no documentation evidenced in clinical record #3 that the skilled nurse ever contacted the physician regarding a pulse of 54. 6. Review of the clinical record for patient #4 on 7/27/17 evidenced an agency document titled "Client Assessment" dated 6/1/16 with "Initial" checked following title. The skilled nurse failed to document any vital signs on patient #4's initial assessment. 7. Review of the clinical record for patient #5 on 7/27/17 evidenced an agency documents titled "Client Assessment" and "Supervisory Visit" both dated 1/25/17 and both signed by a RN. The agency document titled "Client Assessment" documented a pulse of 110, the agency document		Care, Physician Orders and Medical Supervision. 1. Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. 2. The medical plan of care shall meet the following: be developed in consultation with the agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, and include the following: mental status, type of services and equipment required, frequency and during of visits, prognoses, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against, injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment and any other appropriate items. 3. The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist and home health agency personal as often as the severity of the patient's condition requires, but at least once every sixty (60) days. 4. A written summary for each patient shall be sent to the physician, dentist, chiropractor optometrist of podiatrist at least every sixty (60) days. 5. The health care professional staff of the home health agency shall	

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	titled "Supervisory Visit" had an area subtitled "Vital Signs" and also had a pulse of 110. There was no documentation evidenced in the clinical record that the skilled nurse ever contacted the physician regarding the elevated pulse of 110 beats per minute. 8. Review of the clinical record for patient #6 on 7/27/17 evidenced an agency document titled "Client Assessment" dated 3/2/16 and signed by a RN. The document evidenced an area subtitled "Vital Signs". The skilled nurse recorded the patient's respirations as 25, shallow and labored. There was no documentation in the clinical record that the nurse contacted the physician or notified the staff at facility #31 of the patient's respiratory status at the time of his/her assessment.		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. 7 In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. 8. The agency may accept written orders from a physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana or in any other state. 9. If the agency receives an order from a physician, dentist, a chiropractor, podiatrist or an optometrist who is licensed 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 order originated and the individual who issued the order examined the patient is licensed to practice in that state. 10. All orders issued by 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 the	

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			authority allowed under orders from the same profession in Indiana under IC 25. 12. All medications, treatments and skilled nursing services provided to patients must be ordered by a physician including patient's name, physician's name, date, the order and signature of RN/LPN taking the order. 13. The orders may be initially obtained by 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 laws and organization policy. 16. No stamped signatures are permitted. 17. The medical plan of care will be used as the care plan and will include reasonable, measurable and realistic goals as determined by the patient assessment. 18. The care plan will also address rehabilitation potential and discharge plans. 19. The care plan will also be reviewed, evaluated and revised as needed at least every sixty (60) days and/or as needed. 20. Agency staff caring for the patient 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	

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			staff compliance of verbal order verification. Administrator and Nursing Supervisor reviewed Policy 02.24 - Reporting Patient's Condition to Physician. Policy: Clinicians will monitor, document, and report the patient's response to care and treatments provided on each home visit. Progress toward goals will be measured at regular intervals. Clinicians will establish and maintain ongong communication with the physician to ensure safe and appropriate care for the patient. Ongoing communication with the client's physician may occur monthly or more frequently when client's condition is unstable of changes unexpectedly. Administrator and Nursing Supervisor will meet with Registered Nurse Case Managers to review all of the above policies by September 30, 2017. Home health aides will be 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 pain, mental status, nutrition, elimination, skin, and abnormal findings. ADDENDUM: All employees have to have access to their emails as a requirement to work for our company to be kept apprised in situations of policies and	

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			procedures. ERISA form is on file stating they will do this and their compliance of being in receipt of these notices. A letter and in-service was sent on conditions to look for an abnormal reportable conditions. This in-service is also now a mandatory basic in-service at the time of hire and annually thereafter. Care Notes are being reviewed by nursing supervisor or nursing designee to see if any change of condition was noted and not reported to the office.	
N 0584 Bldg. 00	410 IAC 17-14-1(g) Scope of Services Rule 14 Sec. 1(g) Home health aides shall be supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision. Based on record review the home health aides failed to be supervised by a health care professional every 30 days to ensure competent provision of care in 5 out of 6 clinical records reviewed. (#1, #3, #4, #5, #6) The findings include: 1. The undated agency document titled "Section 03.06A - Supervisory Visits" stated "POLICY: BY OBSERVING THE DAY-TO-DAY ACTIVITIES OF THE CARE GIVING STAFF, THE RN [REGISTERED NURSE] IS ABLE TO VERIFY COMPLIANCE WITH PLAN OF CARE, PROTOCOLS AND STANDARDS, QUALITY OF SERVICES BEING PROVIDED, AND THE DEGREE OF SATISFACTION WITH THE SERVICES. DURING THESE VISITS, THE RN WILL ALSO COLLECT	N 0584	By 9/30/17 the Administrator and Nursing Supervisor will meet with all Nursing Case Managers and review our Policy Section 03.06A - Supervisory Visits. Policy: By observing the day to day activities of the care giving staff, the RN is able to verify compliance with Plan of Care, Protocols and Standards, Quality of Services being provided, and the degree of satisfaction 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	09/30/2017

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	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 (LPN), supervisory visits are performed every fourteen (14) days. For personal/support services (attendant, companion, homemaking, transportation), supervisory visits are performed every sixty (60) days. Elements of a Supervisory Visit: Supervisory visits need to include but are not limited to the following: Ensure care giving staff have implemented care and are following the Plan of Care; Validate that staff perform care within his/her scope of practice as defined by the state and the organization's policies. Observation for compliance with infection control including Hand Hygiene; Completion of the Hand Hygiene Observation Form, as indicated for sampling needs; Observation for compliance with universal precautions under OSHA's [Occupational Safety and Health Administration] Bloodborne Pathogens Standard; Ongoing evaluation of staff competency; Adherence to agency's policies and procedures; Provide instruction/teaching to staff as indicated; Discussion with client/family about the quality of care being provided and the compatibility of care staff. Verification that changes in client's health status has been reported to the Director of Nursing or supervising RN; If needed, make changes to the Plan of Care; and If needed, perform a client reassessment." 2. Review of clinical record #1 on 7/25/17 evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in February 2016, April 2016, July 2016 and October 2016. The agency failed to ensure the home health aides were		suggestions to improve processes. For skilled care provided by a Licensed Practical Nurse (LPN), supervisory visits are performed every fourteen (14) days. For personal/support services (attendant, companion, homemaking, transportation), supervisory visits are performed every thirty (30) days. Supervisory visits need to include but are not limited to the following: Ensure care giving staff have implemented the care and are following the POC, validate that staff perform care within his/her scope of practice as defined by the state and the organization's policies. Observation for compliance with infection control including hand hygiene, completion of the Hand Hygiene section, Observation for compliance with universal precautions under OSHA's Bloodborne Pathogen's Standard, Ongoing evaluation of staff competency, adherence to agency's policies and procedures, provide instruction/teaching to staff as indicated, discussion with client/family about the quality of care being provided and the compatibility of care staff, verification that changes in client's health status has been reported to the Director of Nursing and Supervising RN, and if needed changes to the POC. On going compliance will be monitored as 10% of active	

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	supervised every 30 days. 3. Review of clinical record #3 on 7/25/17 evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in May 2016, August 2016, and December 2016. The agency failed to ensure the home health aides were supervised every 30 days. 4. Review of clinical record #4 on 7/25/17 evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in July 2016, September 2016, October 2016 and December 2016. The agency failed to ensure the home health aides were supervised every 30 days. 5. Review of clinical record #5 on 7/25/17, evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in July 2016, September 2016, November 2016, December 2016 and March 2017. 6. Review of clinical record #6 on 7/25/17, evidenced no agency supervisory visits from start of care on 3/2/16 to patient/family discharge of 4/27/16. The agency failed to ensure the home health aides were supervised every 30 days.		patient charts are audited every quarter. ADDENDUM: Supervisory visit policy was revised showing that supervisory visits needs to be done on personal care employees (attendant, companion, personal care, etc.) This policy was approved by the Governing Body on 9/25/17 and given to all nurse case managers meeting on 9/27/17 or emailed. Nursing Supervisor will over see this.	
N 0586 Bldg. 00	410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the			

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	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. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform.			

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	Based on record review and interview the agency failed to ensure the home health aides had the minimum 8 of 12 hours of continuing required by the Indiana State Department of Health in 1 of 1 agency. (employees D, E, F, G, H, I, J, O, R, S) The findings include: 1. The undated agency policy titled "Section 03.10A - Home Health Aide Inservices" stated "Note: Each home health aide must receive continuing education totaling at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any (8) of the following subject areas: Annual Topics 1. Communication skills (including the ability to read, write and make brief and accurate oral presentations to clients, caregivers and other home health agency staff). 2. Observing and recording temperature, pulse and respiration. 3. Basic infection control procedures and universal precautions. 4. Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. 5. Maintaining a clean, safe and health environment. 6. Recognizing emergencies and knowledge of emergency procedures. 7. The physical, emotional and developmental needs of and way to work with the populations served by the home health agency, including the need for respect for the client, the client's privacy and the client's property. 8. Appropriate and safe techniques in personal hygiene and grooming: Bed bath Bath: sponge, tube [sic] or shower Shampoo: sink, tub or bed Nail and skin care Oral hygiene Toileting and elimination 9. Safe transfer techniques and ambulation 10. Normal range of motion and positioning 11. Adequate nutrition and fluid intake 12. Medication assistance 13. Any other task that the home health agency may choose to have the home health aide perform Note: During	N 0586	It is the Administrator's responsibility to make sure proper policies and procedures are being followed. During survey it was found that not all of the employees had all of their required 12 in-services. At the time of hire and annually thereafter all employees will complete 8 mandatory in services and then more than 100 in-services are available to them to make sure required in-services are achieved through out the year. Up to and including required in-services are as follows: Infection Control/Universal Precautions, Communication Documentation, Elements of Body Functions, Maintaining a clean and safe environment, Fire Safety, Elder Abuse and Neglect, Confidentiality and HIPPA, Personal Hygiene and grooming, Safety transfer techniques, Range of Motion, Nutrition, and Medication Assistance. Employees who do not obtain their 12 required in-services will be removed from providing patient care. The above is to assure the following policy is followed, "STAFF INSERVICES, HOME HEALTH AIDE CONTINUING EDUCATION AND COMPETENCY EVALUATION PROGRAM". To assure employees delivering client care or service receive appropriate training to meet state and federal regulations. In-service education	09/30/2017

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	a home health aide's first year on the state's home health aide registry, the number of hours of training for that aide shall be a prorated portion of the usual twelve (12) hours and eight (8) hours." 2. The undated agency policy titled "Section 03.10 - Staff Inservices, Home Health Aide Continuing Education And Competency Evaluation Program" stated "Purpose To assure employees delivering client care or service receive appropriate training to meet state and federal regulations and are provided with education opportunities as deemed necessary by the Supervising Nurse and/or Administrator to provide quality care to the Agency's clients. Policy 1. All staff members providing direct client care will attend in-service education programs annually as needed or required. 2. In-service education programs will cover those areas required by state and federal guidelines and will be based on identified staff and client needs. 3. Records on in-service education programs will be maintained and attendance will be documented. 4. Educational programs may be held in conjunction with vendor or other health care organizations. To receive recognition for in-services, employees who attend staff development programs outside the agency are encouraged to submit documentation of attendance to be included in the employee's personnel record. 5. Home Health Aide Continuing Education: According to state licensure requirements and federal Conditions of Participation, the agency must provide Home Health Aides with continuing education on an annual basis as noted in the policy entitled : "Competency Evaluation for Home Care Agency Staff and In-service Education for Home Health Aides. 6. All employees must attend in-service programs determined by the Agency to be mandatory for all staff. There are six minimally		programs will cover those areas required by state and federal guidelines and will be based on identified staff and client needs. The agency should maintain documentation of all in-service education. The 12 hour per calendar year requirement for home health aide in-services may be prorated according to the employee's date of hire and records maintained per calendar year. 10% of employee files will be audited quarterly and findings reported to the Performance Improvement Committee. 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, RACE 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, Recognizing and Reporting Abnormal Observations, Performing Safe Transfers, Bathing Tips, and Medication Reminders. These in-services will be overseen by the	

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	required training categories (three need to be compliant with local regulations and will be in addition to job care giving training): i. Sexual harassment ii. HIPAA iii. Elder abuse iv. Bloodborne Pathogens v. Other OSHA standards vi. Red Flag Identity Theft Detection and Prevention 7. The Agency should maintain documentation of all in-service education...." 3. Record review of personnel records failed to evidence the required 8 out of 12 hours of continuing education hours required by the state of Indiana in the following home health aide records reviewed: a. Review of the personnel file of employee D, date of hire 3/26/13, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training on agency document subtitled "In The Know" dated 10/25/15 which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA [health insurance portability and accountability act] testing, Red Flag Medical Identity Theft, Alzheimer's Disease and Elder Abuse and Neglect. No other in-service/education documentation was evidenced in employee D's record. b. Review of the personnel file of employee E, date of hire 11/2/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training on agency document titled "BrightStar In-Services" dated 11/2/16 which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee E's record.		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 meet 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 year to have met their 12 required in-services. If they are not compliant, they will be placed inactive until credentialing is completed. 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.	

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	c. Review of the personnel file of employee F, date of hire 10/23/15, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file failed to evidence any documents pertaining to in-service and/or education hours provided by the agency. d. Review of the personnel file of employee G, date of hire 6/21/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training in Infection Control, Race for Fire Safety, Confidentiality and HIPAA testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee G's record. e. Review of the personnel file of employee H, date of hire 3/22/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training on agency document subtitled "In The Know" dated 3/21/16 which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Alzheimer's Disease, Bathing Tips, Building Trust and Confidence with Clients, Dressing and Grooming Tips, End of Life Care, Handling Incontinence and UTIs [urinary tract infections], Importance of Activity for the Elderly, Passive and Active Range of Motion and Perineal and Catheter Care. No other in-service/education documentation was evidenced in employee H's record. f. Review of the personnel file of employee I, date of hire 6/6/14, on 7/26/17 failed to evidence at least 12 hours of in-service education		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.	

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	provided by the agency. The personnel file failed to evidence any documents pertaining to in-service and/or education hours provided by the agency. g. Review of the personnel file of employee J, date of hire 2/23/26, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file evidenced training on a document titled "BrightStar In-Services" dated 1/14/17, which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect, Alzheimer's Disease, Understanding Hospice and Understanding Autism. No other in-service/education documentation was evidenced in employee J's record. h. Review of the personnel file of employee O, date of hire 5/17/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. There personnel file evidenced a document titled "BrightStar In-Services" dated 5/17/16, which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee O's record. i. Review of the personnel file of employee R, date of hire 6/21/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file evidenced the following in-services/education: Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect, Alzheimer's Disease and Catheter Change. No			

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		A. BUILDING 00 B. WING	07/27/2017

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	other in-service/education documentation was evidenced in employee R's record. j. Review of the personnel file of employee S, date of hire 5/4/11, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file evidenced the following in-services/education: Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee S's record. k. During an interview on 7/27/17 at 1:00 p.m. the administrator indicated that all the in-service documents had been received. The administrator indicated that if the in-services were not in the binder or in the electronic printed form he/she provided then they don't have them. During an interview on 7/27/17 at 2:50 p.m. the administrator indicated that only the Infection Control, Race For Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect, and Alzheimer's Disease was the only in-services required annually by the agency. The administrator indicated that they do encourage the employees to go on the portal and do others (in-services).			
N 0594 Bldg. 00	410 IAC 17-14-1(k) Scope of Services Rule 14 Sec. 1(k) The home health agency shall maintain sufficient documentation to demonstrate that the continuing education requirements are met. Based on record review and interview the agency failed to maintain sufficient documentation to demonstrate that the continuing education requirements are met in 1 of 1 agency.	N 0594	It is the Administrator's responsibility to make sure proper policies and procedures are being followed. During survey it was	09/30/2017

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	The findings include: 1. The undated agency policy titled "Section 03.10A - Home Health Aide Inservices" stated "Note: Each home health aide must receive continuing education totaling at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any (8) of the following subject areas: Annual Topics 1. Communication skills (including the ability to read, write and make brief and accurate oral presentations to clients, caregivers and other home health agency staff). 2. Observing and recording temperature, pulse and respiration. 3. Basic infection control procedures and universal precautions. 4. Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. 5. Maintaining a clean, safe and health environment. 6. Recognizing emergencies and knowledge of emergency procedures. 7. The physical, emotional and developmental needs of and way to work with the populations served by the home health agency, including the need for respect for the client, the client's privacy and the client's property. 8. Appropriate and safe techniques in personal hygiene and grooming: Bed bath Bath: sponge, tube [sic] or shower Shampoo: sink, tub or bed Nail and skin care Oral hygiene Toileting and elimination 9. Safe transfer techniques and ambulation 10. Normal range of motion and positioning 11. Adequate nutrition and fluid intake 12. Medication assistance 13. Any other task that the home health agency may choose to have the home health aide perform Note: During a home health aide's first year on the state's home health aide registry, the number of hours of training for that aide shall be a prorated portion of the usual twelve (12) hours and eight (8) hours."		found that not all of the employees had all of their required 12 in-services. At the time of hire and annually thereafter all employees will complete 8 mandatory in services and then more than 100 in-services are available to them to make sure required in-services are achieved through out the year. Up to and including required in-services are as follows: Infection Control/Universal Precautions, Communication Documentation, Elements of Body Functions, Maintaining a clean and safe environment, Fire Safety, Elder Abuse and Neglect, Confidentiality and HIPPA, Personal Hygiene and grooming, Safety transfer techniques, Range of Motion, Nutrition, and Medication Assistance. Employees who do not obtain their 12 required in-services will be removed from providing patient care. The above is to assure the following policy is followed, "STAFF INSERVICES, HOME HEALTH AIDE CONTINUING EDUCATION AND COMPETENCY EVALUATION PROGRAM". To assure employees delivering client care or service receive appropriate training to meet state and federal regulations. In-service education programs will cover those areas required by state and federal guidelines and will be based on identified staff and client needs.	

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	2. The undated agency policy titled "Section 03.10 - Staff Inservices, Home Health Aide Continuing Education And Competency Evaluation Program" stated "Purpose To assure employees delivering client care or service receive appropriate training to meet state and federal regulations and are provided with education opportunities as deemed necessary by the Supervising Nurse and/or Administrator to provide quality care to the Agency's clients. Policy 1. All staff members providing direct client care will attend in-service education programs annually as needed or required. 2. In-service education programs will cover those areas required by state and federal guidelines and will be based on identified staff and client needs. 3. Records on in-service education programs will be maintained and attendance will be documented. 4. Educational programs may be held in conjunction with vendor or other health care organizations. To receive recognition for in-services, employees who attend staff development programs outside the agency are encouraged to submit documentation of attendance to be included in the employee's personnel record. 5. Home Health Aide Continuing Education: According to state licensure requirements and federal Conditions of Participation, the agency must provide Home Health Aides with continuing education on an annual basis as noted in the policy entitled : "Competency Evaluation for Home Care Agency Staff and In-service Education for Home Health Aides. 6. All employees must attend in-service programs determined by the Agency to be mandatory for all staff. There are six minimally required training categories (three need to be compliant with local regulations and will be in addition to job care giving training): i. Sexual harassment ii. HIPAA iii. Elder abuse iv. Bloodborne Pathogens v. Other OSHA standards		The agency should maintain documentation of all in-service education. The 12 hour per calendar year requirement for home health aide in-services may be prorated according to the employee's date of hire and records maintained per calendar year. 10% of employee files will be audited quarterly and findings reported to the Performance Improvement Committee. 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, RACE 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, 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	

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	vi. Red Flag Identity Theft Detection and Prevention 7. The Agency should maintain documentation of all in-service education...." 3. Record review of personnel records failed to evidence the required 8 out of 12 hours of continuing education hours required by the state of Indiana in the following home health aide records reviewed: a. Review of the personnel file of employee D, date of hire 3/26/13, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training on agency document subtitled "In The Know" dated 10/25/15 which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA [health insurance portability and accountability act] testing, Red Flag Medical Identity Theft, Alzheimer's Disease and Elder Abuse and Neglect. No other in-service/education documentation was evidenced in employee D's record. b. Review of the personnel file of employee E, date of hire 11/2/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training on agency document titled "BrightStar In-Services" dated 11/2/16 which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee E's record. c. Review of the personnel file of employee F, date of hire 10/23/15, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file failed		the additional four required to meet 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 year to have met their 12 required in-services. If they are not compliant, they will be placed inactive until credentialing is completed. 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. Monitoring: In-Service log has been created for every employee and date of year showing all in-services	

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	to evidence any documents pertaining to in-service and/or education hours provided by the agency. d. Review of the personnel file of employee G, date of hire 6/21/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training in Infection Control, Race for Fire Safety, Confidentiality and HIPAA testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee G's record. e. Review of the personnel file of employee H, date of hire 3/22/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file only evidenced training on agency document subtitled "In The Know" dated 3/21/16 which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Alzheimer's Disease, Bathing Tips, Building Trust and Confidence with Clients, Dressing and Grooming Tips, End of Life Care, Handling Incontinence and UTIs [urinary tract infections], Importance of Activity for the Elderly, Passive and Active Range of Motion and Perineal and Catheter Care. No other in-service/education documentation was evidenced in employee H's record. f. Review of the personnel file of employee I, date of hire 6/6/14, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file failed to evidence any documents pertaining to in-service and/or education hours provided by the agency.		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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	g. Review of the personnel file of employee J, date of hire 2/23/26, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file evidenced training on a document titled "BrightStar In-Services" dated 1/14/17, which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee J's record. h. Review of the personnel file of employee O, date of hire 5/17/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. There personnel file evidenced a document titled "BrightStar In-Services" dated 5/17/16, which included Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee O's record. i. Review of the personnel file of employee R, date of hire 6/21/16, on 7/26/17 failed to evidence at least 12 hours of in-service education provided by the agency. The personnel file evidenced the following in-services/education: Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect, Alzheimer's Disease and Catheter Change. No other in-service/education documentation was evidenced in employee R's record. j. Review of the personnel file of employee S, date of hire 5/4/11, on 7/26/17 failed to evidence at least 12 hours of in-service education			

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	provided by the agency. The personnel file evidenced the following in-services/education: Infection Control, Race for Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect and Alzheimer's Disease. No other in-service/education documentation was evidenced in employee S's record. k. During an interview on 7/27/17 at 1:00 p.m. the administrator indicated that all the in-service documents had been received. The administrator indicated that if the in-services were not in the binder or in the electronic printed form he/she provided then they don't have them. During an interview on 7/27/17 at 2:50 p.m. the administrator indicated that only the Infection Control, Race For Fire Safety, Confidentiality and HIPAA Testing, Red Flag Medical Identity Theft, Elder Abuse and Neglect, and Alzheimer's Disease was the only in-services required annually by the agency. The administrator indicated that they do encourage the employees to go on the portal and do others (in-services).			
N 0596 Bldg. 00	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel record and policy review the agency failed to ensure all home health aides had successfully completed their skills competency	N 0596	By October 31, 2017 current employees will meet our Nursing Supervisor or Nurse Designee to	10/31/2017

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	assessment. (employees D, I) The findings include: 1. The undated agency policy titled "Section 03.06 - Clinical Competency Program" stated "Policy: BrightStar Care will access and document the clinical competency of each staff member who provides direct client care, treatment or services. Procedure: 1. Each staff member who provides direct client care will have a clinical competency assessment at defined intervals: a. As part of orientation b. Periodic: i. CNAs [certified nursing assistants], CHHAs [certified home health aides], HHAs [home health aides], Mas [medical assistants], Attendants and Homemakers - Annually ii. RNs [registered nurses] and LPNs [licensed practical nurses] - At least every 3 years iii. Medical Social Worker, Physical Therapist, Occupational Therapist, Speech-Language Therapist - At least every 3 years c. In accordance with laws and regulations d. At any time there is concern of staff member's clinical competency e. When introducing new client care procedures, techniques or equipment. 2. The competency assessment will be documented. 3. Established competency assessment will be established base [sic] on the staff member's job classification (i.e. [that is to say], certified nursing assistant, licensed practical/vocational nurse, etc [etcetera]). 4. Client care staff's competencies are maintained and improved through: a. In-service and/or continuing education b. Trends in infection control incident reporting and performance improvement activities c. Specialty training or certifications 5. Example of qualified individuals to performs [sic] competency assessments may include: a. Home health aide, certified home health aide, certified nursing assistant: competency assessment performed by registered		have their annual clinical competency performed. All staff members who provide direct client care will have a clinical competency assessment as stated in our policy Section 03.06 - Clinical Competency Program. Established competency assessment will be documented and will be established as based on their staff member's classification. This will be done annually and on going in accordance with laws and regulations, any time there is a concern with a staff member's clinical competency and when introducing new client care procedures, techniques or equipment as well as initially at their orientation. Addendum: Persons responsible for this correction is the Nursing Supervisor or Nursing Designee. PLAN: 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 were lacking annual competency 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, washing station, transfer equipment, walkers, canes, etc. for nurse (nurse designee) to perform skills competency on a living person during this session. Due to the equipment being set up in our new	

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	nurse. b. Licensed practical/vocational nurse: competency assessed by registered nurse d. Physical therapist (PT): competency assessed by a peer physical therapist or PT supervisor e. Occupational therapist (OT): competency assessed by a peer OT or OT supervisor f. Speech language Pathologist (SLP): Competency assessed by a peer SLP or SLP supervisor g. Medical Social Worker: competency assessed by a peer MSW." 2. Record review of the personnel record for employee D on 7/26/17 evidenced an agency document titled "Competency Assessment Skill Checklist for Home Health Aide" dated 4/15/15. This document indicated that the home health aide (employee D) required more skill competency training in hoyer lift and diabetic diet, low sodium diet, and low cholesterol/fat diet. No other skills competency assessment/reassessment was evidenced in employee D's personnel record. The agency failed to ensure the home health aide successfully completed the skills competency evaluation. 3. Record review of personnel record for employee I on 7/26/17 evidenced an agency document titled "Competency Assessment Skill Check List for Home Health Aide" dated 4/15/15. This document indicated that the home health aide (employee I) required more skill competency training in blood pressure, making occupied beds, hoyer lift, diabetic diet, low sodium diet, and low cholesterol/fat diet. No other skills competency assessment/reassessment was evidenced in employee I's personnel record. The agency failed to ensure the home health aide successfully completed the skills competency evaluation.		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 done prior to the annual due date making us out of compliance. If a client has a competency are that is not satisfactory, an employee will not be sent to a client with that specific need unless additional training has been done with the nursing supervisor or designee. For example, additional training needed on a mechanical lift. Employee file will have a tag that specifies do not send 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 date this was observed and the tag from employee file will be lifted. This will be monitored by running monthly reports for compliance. Competency 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	

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			contact until we can print out their activeness with the state and place it 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 days prior to the next month and administration will call the employee 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.	
N 0597 Bldg. 00	410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on record review the agency assigned a home health aide to perform patient care prior to the home health aide being licensed and placed on the Indiana state registry. (employee J) The findings include: 1. Review of personnel records on 7/26/17 evidenced a home health aide that provided care prior to licensure and registration with the state of Indiana. The administrator failed to ensure	N 0597	Effective immediately no home health aide will have any contact with any patient's prior to receiving a verification from the state showing they are an active home health aide. Administrator will make sure 10% of employee's files are audited quarterly to assure this procedure has been followed. ADDENDUM: All new hires will have skills competency, mandatory 8 in-services at our 8 hour orientation,	09/18/2017

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BRIGHTSTAR OF LAKE COUNTY INDIANA	9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322

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	licensure on the home health aide (employee J). A review of the personnel file of employee J, date of hire 2/23/16, on 7/25/17 evidenced an Indiana home health license with an issue date of 3/11/16. Review of the Indiana State Department of Health document titled "Employee Records", that was partially filled out by the administrator, 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 patient #6 with no home health aide license on 3/2/16. An agency document dated 3/2/16 titled "Personal Care/Companion Care Note and Timesheet" stated "... Comments/Remarks: [patient #6] got up this morning and wanted to get going. So I [employee J] gave him/her a sponge bath and change [sic] linen on bed wet from water".		take the HHA test, and will be registered with the state. Recruiter will make sure we are in compliance at the day of orientation for these things. Administrator will double check the file by auditing and printing out the aide registry verification for the file. 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.	
N 0604 Bldg. 00	410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.			
	Based on record review the home health aide failed to report changes in a patient's condition to the supervisory nurse. (employee U) The findings include: a. Review of the clinical record for patient #3 evidenced an agency document titled "Personal Care/Companion Care Note and Timesheet", dated 5/2/16, that stated "... Comments/Remarks: make [sic] him/her a sandwhich [sic] and he/she took sugar and it was 360 so he/she gave himself/herself a [sic] insulin shot at 7:00 pm (Rapid Release)" There was no documentation in the clinical record that this	N 0604	Administrator and Nursing Supervisor reviewed Policy Section 02.01 - Standards of Practice. 1. The agency provides services based on acceptable professional standards for home care and according to state and federal regulations as indicated. 2. All agency staff will perform within the guidelines of their stated discipline. 2. All clients will be provided care based on a Plan of Care or Service Plan that is prepared by the Registered Nurse. A home health agency Skilled Plan of Care will be	09/30/2017

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	blood sugar was reported to the RN [registered nurse] or the physician. An agency document titled "Personal Care/Companion Care Note and Timesheet", dated 5/4/16, stated "... Comments/Remarks: Client is a [sic] diabetic situation. Called ambulance". There was no documentation evidenced in the client record that these events were reported to the patient's physician.		prepared by a Registered Nurse and reviewed, approved and signed by a physician. 4. Skilled nursing visits are performed as 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 condition is performed upon each nursing visit and reported to the physician if indicated. 6. All plans of care are based on the individualized needs of the clients 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 Licensed Practical Nurse under the supervision of a Registered Nurse 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 and coordinate services as needed. Initiates the plan of care or service plan and necessary revisions and updates when needed, ensure that the physician is contacted when there are changes in the client's condition, perform skilled nursing care as	

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			needed for home health agency clients, supervise and teach other nursing personnel when needed. 4. Skilled nurses prepare clinical notes following each visit the same day care is rendered. Administrator and Nursing Supervisor reviewed Policy Section 02.23 Medical Plan of Care, Physician Orders and Medical Supervision. 1. Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. 2. The medical plan of care shall meet the following: be developed in consultation with the agency staff, include all services to be provided if a skilled service is being provided, cover all pertinent diagnoses, and include the following: mental status, type of services and equipment required, frequency and during of visits, prognoses, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against, injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment and any other appropriate items. 3. The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist and home health agency personal as often as the severity of the	

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			patient's condition requires, but at least once every sixty (60) days. 4. A written summary for each patient shall be sent to the physician, dentist, chiropractor optometrist of podiatrist at least every sixty (60) days. 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. 7 In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. 8. The agency may accept written orders from a physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana or in any other state. 9. If the agency receives an order from a physician, dentist, a chiropractor, podiatrist or an optometrist who is licensed 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 order originated and the individual who issued the order examined the patient is licensed to practice in	

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			that state. 10. All orders issued by 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 the authority allowed under orders from the same profession in Indiana under IC 25. 12. All medications, treatments and skilled nursing services provided to patients must be ordered by a physician including patient's name, physician's name, date, the order and signature of RN/LPN taking the order. 13. The orders may be initially obtained by 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 laws and organization policy. 16. No stamped signatures are permitted. 17. The medical plan of care will be used as the care plan and will include reasonable, measurable and realistic goals as determined by the patient assessment. 18. The care plan will also address rehabilitation potential and discharge plans. 19. The care plan will also be	

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			reviewed, evaluated and revised as needed at least every sixty (60) days and/or as needed. 20. Agency staff caring for the patient 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 order verification. Administrator and Nursing Supervisor reviewed Policy 02.24 - Reporting Patient's Condition to Physician. Policy: Clinicians will monitor, document, and report the patient's response to care and treatments provided on each home visit. Progress toward goals will be measured at regular intervals. Clinicians will establish and maintain ongong communication with the physician to ensure safe and appropriate care for the patient. Ongoing communication with the client's physician may occur monthly or more frequently when client's condition is unstable of changes unexpectedly. Administrator and Nursing Supervisor will meet with Registered Nurse Case Managers to review all of the above policies by September 30, 2017. Home health aides will be 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	

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			pain, mental status, nutrition, elimination, skin, and abnormal findings. ADDENDUM: Letter was sent to all aides advised their responsibility with reporting change of conditions. An in-service was also include of procedures to follow and what to look for. This in-service was added to the 8 required in-services for new hires and employees annually thereafter. ERISA form is on file for employees showing they have to keep their emails up to date to be informed of any changes in our policies and procedures. In-Service of reporting abnormal changes is in an In The Know Format. Caregiver notes also need to report on their notes anything called into the office and check that it was done. Nursing Supervisor or Nursing Designee will contact HHA to ask questions if they did report it to the office, the situation and document it as an incident report for necessary follow-up and report to the physician when needed. Nursing Supervisor is responsible for this.	
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide			

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	is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review the home health aides failed to be supervised by a registered nurse every 30 days to observe the care, to assess relationships, and to determine whether goals are being met in 5 out of 6 clinical records reviewed. (#1, #3, #4, #5, #6) The findings include: 1. The undated agency document titled "Section 03.06A - Supervisory Visits" stated "POLICY: BY OBSERVING THE DAY-TO-DAY ACTIVITIES OF THE CARE GIVING STAFF, THE RN [REGISTERED NURSE] IS ABLE TO VERIFY COMPLIANCE WITH PLAN OF CARE, PROTOCOLS AND STANDARDS, QUALITY OF SERVICES BEING PROVIDED, AND THE DEGREE OF SATISFACTION 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 (LPN), supervisory visits are performed every fourteen (14) days. For personal/support services (attendant, companion, homemaking, transportation), supervisory visits are performed every sixty (60) days. Elements of a Supervisory Visit: Supervisory visits need to include but are not limited to the following: Ensure care giving staff have implemented care and are following the Plan of Care; Validate that staff perform care within his/her scope of practice as defined by the state and the organization's policies. Observation	N 0606	By 9/30/17 the Administrator and Nursing Supervisor will meet with all Nursing Case Managers and review our Policy Section 03.06A - Supervisory Visits. Policy: By observing the day to day activities of the care giving staff, the RN is able to verify compliance with Plan of Care, Protocols and Standards, Quality of Services being provided, and the degree of satisfaction 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 (LPN), supervisory visits are performed every fourteen (14) days. For personal/support services (attendant, companion, homemaking, transportation), supervisory visits are performed every thirty (30) days. Supervisory visits need to include but are not limited to the following: Ensure care giving staff have implemented the care and are following the POC, validate that staff perform care within his/her scope of practice as defined by the state and the organization's policies.	09/30/2017

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	for compliance with infection control including Hand Hygiene; Completion of the Hand Hygiene Observation Form, as indicated for sampling needs; Observation for compliance with universal precautions under OSHA's [Occupational Safety and Health Administration] Bloodborne Pathogens Standard; Ongoing evaluation of staff competency; Adherence to agency's policies and procedures; Provide instruction/teaching to staff as indicated; Discussion with client/family about the quality of care being provided and the compatibility of care staff. Verification that changes in client's health status has been reported to the Director of Nursing or supervising RN; If needed, make changes to the Plan of Care; and If needed, perform a client reassessment." 2. Review of clinical record #1 on 7/25/17 evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in February 2016, April 2016, July 2016 and October 2016. The agency failed to ensure the home health aides were supervised every 30 days by a registered nurse. 3. Review of clinical record #3 on 7/25/17 evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in May 2016, August 2016, and December 2016. The agency failed to ensure the home health aides were supervised every 30 days by a registered nurse. 4. Review of clinical record #4 on 7/25/17 evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in July 2016, September 2016, October 2016 and December 2016. The agency failed to ensure the home health aides were supervised every 30 days by a registered nurse.		Observation for compliance with infection control including hand hygiene, completion of the Hand Hygiene section, Observation for compliance with universal precautions under OSHA's Bloodborne Pathogen's Standard, Ongoing evaluation of staff competency, adherence to agency's policies and procedures, provide instruction/teaching to staff as indicated, discussion with client/family about the quality of care being provided and the compatibility of care staff, verification that changes in client's health status has been reported to the Director of Nursing and Supervising RN, and if needed changes to the POC. On going compliance will be monitored as 10% of active patient charts are audited every quarter. ADDENDUM: Supervisory visit policy was revised showing that supervisory visits needs to be done on personal care employees (attendant, companion, personal care, etc.) This policy was approved by the Governing Body on 9/25/17 and given to all nurse case managers meeting on 9/27/17 or emailed. Nursing Supervisor will over see this.	

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	5. Review of clinical record #5 on 7/25/17, evidenced agency documents titled "Supervisory Visit". There was no evidence of supervisory visits being conducted in July 2016, September 2016, November 2016, December 2016 and March 2017. The agency failed to ensure the home health aides were supervised every 30 days by a registered nurse. 6. Review of clinical record #6 on 7/25/17, evidenced no agency supervisory visits from start of care on 3/2/16 to patient/family discharge of 4/27/16. The agency failed to ensure the home health aides were supervised every 30 days by a registered nurse.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review the agency failed to indicate the correct dosage on the medication profile in 1 of 6 clinical records reviewed. (#3)	N 0608	Administrator and Nursing Supervisor reviewed Policy: All Medication Orders	09/30/2017

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	The findings include: 1. Review of clinical record #3 on 7/27/17 evidenced an agency document titled "Client Medication Profile" dated 4/24/17 and that stated "... Humalog [insulin] 10 units subq [subcutaneously] before meals on a sliding scale....". There was no documentation of a physician ordered sliding scale evidenced in patient #3's clinical record. a. Review of clinical record #3 on 7/27/17 evidenced an agency document titled "Home Health Certification And Plan Of Care", start of care date 4/29/17, certification period 1/29/17 - 3/30/17 which had an area subtitled "... 10. Medications: Dose/Frequency/Route (N)ew (C)hanged" this area had a medication that stated "... Humalog [insulin] 0 - 16 units, sliding scale....". There was no other documentation of a physician ordered sliding scale evidenced in patient #3's clinical record.		Policy: BrightStar will minimize errors and misinterpretation of written or verbal medication orders by assessing that the orders are written clearly and transcribed accurately. This includes vaccines for influenza and pneumonia. Medication orders will be obtained when client is receiving skilled services from the agency. Procedure: 1. All medication orders must contain medication name (generic or brand), dosage, route and frequency. 2. Only BrightStar approved abbreviations, acronyms, symbols and dose designation will be utilized. 3. Generic medication names are discouraged, but may be used when physician specifies a generic medication. 4. “Indication for use” must be included in PRN medication orders or if medication 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 education about the medication. 7. Specific medication orders include:• PRN orders must specify dose, route, frequency and indication for use. • Hold orders must specify parameters (i.e. “hold digoxin if pulse less than 60”). • Automatic	

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			stop orders must clearly indicate the date that the medication is to be stopped. The medication profile will reflect the stop date. • Resume orders or blanket reinstatement of previous medication orders are not acceptable. All medications must be specifically identified when restarted including post hospitalization. • Titrating and taper orders must clearly state the specific guidelines for use. • Orders for medication related devices must include the device and any specific rates, e.g., nebulizers or infusion pump. • Orders for herbal products must contain the name, dose, route and frequency. • Orders for investigational medications must include name, dose, route and frequency. BrightStar will obtain a copy of the medication information sheet from the dispensing pharmacy or physician. BrightStar will review all documents of the investigational drug to ensure the client is completely informed of the indications and side effects. • Orders for compounded medications or medication mixtures that are not commercially available must include all drugs used in the preparation of the medication. All compounded medications will be prepared by a pharmacy and will be provided to the client directly. BrightStar nurses will not prepare compounded drugs. • Range	

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			orders are permitted as long as range is clearly defined in the order. Specific indications, dosages, and time frames must be included in the order. 8. BrightStar does not require a physician's order for a patient's medications at time of discharge. The medication profile will be accurate. Patient/caregiver will demonstrate knowledge of all medications prior to or at time of discharge. Any medication discrepancies will be verified with physician prior to patient discharge. 9. Verbal or telephone orders will be written down and read back for verification. 10. Verbal and telephone orders will be signed by the attending physician, dentist, or podiatrist within 30 working days. Administrator and Nursing Supervisor Reviewed Policy: Medication Administration. Policy: To ensure that physician's orders are followed 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 administer 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 treatments are administered by BrightStar Care staff only as ordered. Staff	

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			qualifications to administer medications are defined by job descriptions and provincial practice standards as mandated by regulated professional colleges. 2. All orders for medications will contain the name of the drug, dosage, frequency and methods or site of injection. 3. All verbal changes in medication orders will be taken by the nurse and signed by the physician, if original prescription on medication bottle cannot be verified. 4. BrightStar Care staff must use 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 that the medication to be administered is the correct medication based on the medication order and product label. 5. BrightStar Care staff will check all patient medicines to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication and report any problems to	

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		A. BUILDING 00 B. WING	07/27/2017

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			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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			with a pharmacist. 8. Personal Support Workers may apply topical ointments, creams and 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 is 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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			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 they understand the requirements. ADDENDUM: It was found that the root cause of this problem was that the nurse was 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.	