

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2016
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NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF LAKE COUNTY INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9521 INDIANAPOLIS BLVD, SUITE O HIGHLAND, IN 46322
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N 0000 Bldg. 00	<p>This was a State home health re-licensure and complaint investigation survey.</p> <p>Survey Date: 1/25/16, 1/26/16, 6/16/16, 6/17/16, 6/20/16, and 6/21/16.</p> <p>Facility #: 012189</p> <p>Unduplicated 12 month census: 244</p> <p>Clinical Records Reviewed without home visit: 2 Clinical Records Reviewed with home visit: 4 Total Clinical Records Reviewed: 6</p> <p>Complaint ID# IN00187380 was found to be unsubstantiated. Other unrelated deficiencies were cited during this survey.</p>	N 0000		
N 0462 Bldg. 00	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases</p>			

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

TITLE

(X6) DATE

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

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	<p>to patients.</p> <p>Based on interview and record review, the agency failed to ensure that physical examinations indicated the employee's were free of communicable diseases in 2 of 11 (employee A and D) employee records reviewed per their own policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Employee Record A, home health aide, hire date 6/5/14, first patient contact date 6/17/14, was reviewed. A physical examination form failed to evidence if the employee was free of communicable disease. 2. Employee Record D, home health aide, hire date 11/6/15, first patient contact date 11/9/15, was reviewed. A physical health information and release form failed to evidence if the employee appeared to be free of communicable disease. Neither the yes or no box was checked to evidence the employee's status of communicable disease. 3. Interview on 6/17/16, at 10:30 PM with employee G, administrator, confirmed the physical examinations for employee A and D did not document if the employees were free of communicable diseases. 	N 0462	<p>The Administrator is responsible for overseeing the following policy "SECTION 03.04 - HEALTH SCREENING" All Agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients. All Agency employees and personnel working under contract who provide patient care will be free from communicable disease before providing direct patient care... A pre-employment physical examination will be performed by a physician or nurse practitioner no more than 180 days before the date that the employee has direct patient contact ... Repeat testing will be required as deemed necessary by the Administrator or designee or Supervising Nurse or designee for individuals with signs of communicable disease." Recruiter and Supervising Nurse will be re-educated to make sure the established policy is followed immediately and that no employee providing patient care will be hired without indication that they are free of communicable disease. New Hires will be reviewed by the Compliance Coordinator prior to working their first assignment to make sure that compliance with credentials are met. Employee files will be audit every 6 months and findings reported to the Performance Improvement.</p>	07/29/2016			

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N 0464 Bldg. 00	<p>4. Agency policy titled "SECTION 03.04 - HEALTH SCREENING", no date, stated, "1. All Agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients. 2. All Agency employees and personnel working under contract who provide patient care will be free from communicable disease before providing direct patient care... A pre-employment physical examination will be performed by a physician or nurse practitioner no more than 180 days before the date that the employee has direct patient contact ... Repeat testing will be required as deemed necessary by the Administrator or designee or Supervising Nurse or designee for individuals with signs of communicable disease."</p> <p>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</p>			

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	<p>has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(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.</p> <p>(3) Any person with:</p> <p>(A) a documented:</p> <p>(i) history of tuberculosis;</p> <p>(ii) previously positive test result for tuberculosis; or</p> <p>(iii) completion of treatment for tuberculosis;</p> <p>or</p> <p>(B) newly positive results to the tuberculin skin test;</p> <p>must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:</p> <p>(A) be completed annually; and</p> <p>(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).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:</p> <p>(A) working for the home health agency; or</p> <p>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on interview and record review, the agency failed to ensure records of</p>	N 0464	The Administrator is responsible for overseeing the following policy	07/29/2016

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	<p>tuberculosis evaluations were complete and present in the employee record for 1 of 11 (employee D) employee records reviewed per their own policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Employee Record D, home health aide, hire date 11/6/15, first patient contact date 11/9/15, was reviewed. This record failed to evidence the results of a tuberculosis evaluation that was to take place on 3/23/15. 2. Interview on 6/17/16, at 10:30 AM with employee G, administrator, confirmed the results of the tuberculosis evaluation were not documented in the employee D's record. 3. Agency policy titled "SECTION 03.04 - HEALTH SCREENING", no date, stated, "1. All Agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients ...When the TB skin test is administered, it will be read within 48-72 hours and documented as "nonsignificant" (negative) or "significant" (positive) in millimeters of induration." 		<p>"SECTION 03.04 - HEALTH SCREENING", All Agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients ...When the TB skin test is administered, it will be read within 48-72 hours and documented as "nonsignificant" (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 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. Employee files will be audit every 6 months and findings reported to the Performance Improvement.</p>	

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N 0524 Bldg. 00	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on record review and interview, the agency failed to ensure that medical plans of care listed all required information in 2 of 2 clinical records for patients receiving skilled nursing services, in a total sample of 6 patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #5, start of care date 10/15/12, certification period 4/28/16-6/28/16, was reviewed. 	N 0524	<p>It is the Administrator's responsibility to make sure proper forms are being utilized in compliance with our policy. It is the Nursing Supervisor's responsibility to make sure that the proper forms are being utilized and that the nursing department is re-educated on proper forms. New Assessment forms have been created to add frequency and duration of visits, equipment required, discharge planning, and safety measures to protect the client. It was found</p>	07/29/2016
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	<p>A. This medical plan of care failed to list the frequency and duration of visits, equipment required, discharge planning, and safety measures to protect against injury.</p> <p>B. Interview on 6/20/16 at 4:00 PM with employee G, administrator and employee H , assistant administrator confirm this plan of care failed to list the above mentioned areas.</p> <p>2. Clinical record #6, start of care date 2/3/15, certification period 4/25/16-6/25/16, was reviewed.</p> <p>A. This medical plan of care failed to list the frequency and duration of visits, equipment required, discharge planning, and safety measures to protect against injury.</p> <p>B. Interview on 6/20/16 at 4:00 PM with employee G, administrator and employee H, assistant administrator confirm this plan of care failed to list the above mentioned areas.</p> <p>3. Agency policy titled "Plan of Care Policy", dated, "03/2015, 07/2010", stated, "Policy... Based on the client assessment, the plan of care will include at a minimum as applicable to client type,</p>		<p>that the BrightStar Plan of Care did not include the above mentioned requirements. At this time, we have chosen to start utilizing the CMS Approved 485 forms to include the missing items. Nursing staff will be educated on these forms (CMS 485) and will be utilized with new admissions effective immediately. 485 Forms will be utilized effective within two weeks with reassessments. 10% of the patient chart volume will be audited on a quarterly basis for compliance by the Nursing Supervisor/Nursing Staff. Findings will be reported to the Performance Improvement Committee quarterly.</p>	

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N 0529 Bldg. 00	<p>the following... frequency and duration of service... safety measures... equipment required... diet and nutritional needs."</p> <p>4. Agency policy titled "SECTION 02.41-DISCHARGE", no date, stated, "1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes... ."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure that written clinical summary reports were sent to the physician at least every two months in 2 of 2 clinical records for patients receiving skilled nursing services, in a total sample of 6 patients.</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care date 10/15/12, certification period 4/28/16-6/28/16, was reviewed. This clinical record failed to evidence a</p>	N 0529	It is the Administrator's responsibility to make sure proper forms are being utilized in compliance with our policy. It is the Nursing Supervisor's responsibility to make sure that the proper forms are being utilized and that the nursing department is educated on proper forms. BrightStar policy states "COORDINATION OF CARE, CLINICAL SUMMARY AND CASE CONFERENCE", 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	07/29/2016

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N 0533 Bldg. 00	<p>written clinical summary report was created or submitted to the physician.</p> <p>2. Clinical record #6, start of care date 2/3/15, certification period 4/25/16-6/25/16, was reviewed. This clinical record failed to evidence a written clinical summary report was created or submitted to the physician.</p> <p>3. Interview on 6/21/16 at 12:00 PM with employee G, administrator and employee H, assistant administrator confirm there were no written clinical summaries in the patients records.</p> <p>4. Agency policy titled "SECTION 02.37 - COORDINATION OF CARE, CLINICAL SUMMARY AND CASE CONFERENCE", no date, stated, "1... 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."</p> <p>410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only</p>		<p>physician for signature if applicable at a minimum of every 60 (sixty)days." New Assessment/Reassessment forms have been created to add Coordination of Care, Clinical Summary and Case Conference of the client's care. These new forms have been created and have put in place effective immediately.Coordination will be sent to the physician for signature every 60 days when completed.</p> <p>10% of the patient chart volume will be audited on a quarterly basis for compliance by the Nursing Supervisor/Nursing Staff. Findings will be reported to the Performance Improvement Committee quarterly.</p>				

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	<p>home health aide services in the absence of a skilled service.</p> <p>(b) The nursing plan of care must contain the following:</p> <ol style="list-style-type: none"> (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. <p>Based on record review and interview, the agency failed to ensure that nursing plans of care listed all required information in 3 of 3 clinical records for patients receiving home health aide only services, in a total sample of 6 patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care date 8/15/14, certification period 12/28/15-2/28/15, was reviewed. <p>A. This nursing plan of care failed to list the name of the patient's physician, the frequency and duration of visits, medication, diet, and activities.</p> <p>B. Interview on 6/20/16 at 4:00 PM</p>	N 0533	<p>It is the Administrator's responsibility to make sure proper forms are being utilized in compliance with our policy. It is the Nursing Supervisor's responsibility to make sure that the proper forms are being utilized and that the nursing department is re-educated on proper forms. New Assessment forms have been created to add frequency and duration of visits, equipment required, discharge planning, patient's physician, medication, diet, activities, and safety measures to protect the client. It was found that the BrightStar POC did not include the above mentioned requirements. At this time, we have chosen to start utilizing the CMS Approved 85 forms to include the missing items. Nursing staff will be educated on</p>	07/29/2016

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	<p>with employee G, administrator and employee H , assistant administrator confirm this plan of care failed to list the above mentioned areas.</p> <p>2. Clinical record #3, start of care date 10/1/15, certification period 10/1/15-12/1/15, was reviewed.</p> <p>A. This nursing plan of care failed to list the name of the patient's physician, the frequency and duration of visits, medication, and activities.</p> <p>B. Interview on 6/20/16 at 4:00 PM with employee G, administrator and employee H , assistant administrator confirm this plan of care failed to list the above mentioned areas.</p> <p>3. Clinical record #4, start of care date 3/2/16, certification period 5/3/16-7/3/16, was reviewed.</p> <p>A. This nursing plan of care failed to list the name of the patient's physician, the frequency and duration of visits, medication, and activities.</p> <p>B. Interview on 6/20/16 at 4:00 PM with employee G, administrator and employee H , assistant administrator confirm this plan of care failed to list the above mentioned areas.</p>		<p>these forms (CMS 485) and will be utilized with new admissions effective immediately. 485 Forms will be utilized effective within two weeks with reassessments.</p> <p>10% of the patient chart volume will be audited on a quarterly basis for compliance by the Nursing Supervisor/Nursing Staff. Findings will be reported to the Performance Improvement Committee quarterly.</p>				

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N 0534 Bldg. 00	<p>4. Agency policy titled "Plan of Care Policy", dated, "03/2015, 07/2010", stated, "Policy... Based on the client assessment, the plan of care will include at a minimum as applicable to client type, the following... frequency and duration of service... safety measures... equipment required... diet and nutritional needs."</p> <p>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 and interview, the agency failed to ensure that the service plan of care listed all required information in 1 of 1 (#1) clinical record</p>	N 0534	It is the Administrator's responsibility to make sure prope rforms are being utilized in compliance with our policy. It is the Nursing Supervisor's	07/29/2016

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N 0586 Bldg. 00	<p>for patients receiving personal services, in a total sample of 6 patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care date 1/8/16, certification period 1/8/16-3/8/16, was reviewed.</p> <p>A. This service plan of care failed to list the schedule of service to be provided.</p> <p>B. Interview on 6/20/16 at 4:00 PM with employee G, administrator and employee H, assistant administrator confirm this plan of care failed to list the above mentioned area.</p> <p>2. Agency policy titled "Plan of Care Policy", dated, "03/2015, 07/2010", stated, "Policy... Based on the client assessment, the plan of care will include at a minimum as applicable to client type, the following... frequency and duration of service... Service objectives and goals."</p> <p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must</p>		<p>responsibility to make sure that the proper forms are being utilized and that the nursing department is re-educated on proper forms. New Assessment forms have been created to add frequency and duration of visits, equipment required, discharge planning, patient's physician, medication, diet, activities, and safety measures to protect the client. It was found that the BrightStar POC did not include the above mentioned requirements. At this time, we have chosen to start utilizing the CMS Approved 485 forms to include the missing items. Nursing staff will be educated on these forms (CMS 485) and will be utilized with new admissions effective immediately. 485 Forms will be utilized effective within two weeks with reassessments. 10% of the patient chart volume will be audited on a quarterly basis for compliance by the Nursing Supervisor/Nursing Staff. Findings will be reported to the Performance Improvement Committee quarterly.</p>				

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	<p>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:</p> <ol style="list-style-type: none"> (1) Communications skills, including the 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: <ol style="list-style-type: none"> (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. 			

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	<p>(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.</p> <p>Based on record review and interview, the agency failed to ensure home health aides received the adequate amount of in-service hours for 1 of 5 (employee B) home health aide in-service records reviewed.</p> <p>Findings include:</p> <p>1. Employee record B, hire date 12/12/14, first patient contact date 12/13/14, date of termination 9/9/15. This record evidence 1 in-service had been completed for the nine month period employee B was employed with the agency.</p> <p>2. Interview on 6/21/16 at 3:00 PM with employee G, administrator, indicated it was difficult to get employee G in to the office to complete in-services and that ultimately employee G had to be terminated.</p> <p>3. Agency policy titled "SECTION 03.10 - STAFF INSERVICES, HOME HEALTH AIDE CONTINUING EDUCATION AND COMPETENCY</p>	N 0586	<p>It is the Administrator's responsibility to make sure proper policies and procedures are being followed. During survey it was found that not all employees had at all of their 12 required in-services. At the time of hire and annually thereafter all employee will complete 5 mandatory in-services and then more than 100 in-services are available to them to make sure required in-services are achieved through the year. Up to and including required in-services are as follows: Infection Control/Universal Precautions, Communication, Documentation, Elements of Body Function, Maintaining a clean, safe and healthy 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 of patient care. The above is to assure the following policy is followed, "STAFF INSERVICES, HOME HEALTH AIDE CONTINUING</p>	07/29/2016

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	EVALUATION PROGRAM", no date, stated, "PURPOSE 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... 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 pro rated according to the employee's date of hire and records maintained per calendar year."		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... 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."Employee files will be audit every 6 months and findings reporting to the Performance Improvement.		