STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HSA-0029	A. BUILDING: _____ B. WING _____	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE SUPPORT AGENCY, INC	7813 GEORGIA AVE, NW WASHINGTON, DC 20012

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R 000	9900 General Provisions 9900 General Provisions An unannounced initial survey was conducted virtually on 11/05/2021, 11/08/2021, and 11/09/2021 to determine compliance with the Home Support Agency Regulations, Title 22B DCMR, Chapter 99. The Home Support Agency provided care for five clients and employed ten personnel, including professional and administrative staff. A sample of five active client records and ten personnel records was selected for review. The findings of the survey were based on client and administrative record reviews and on six client and staff interviews. Listed below are abbreviations used throughout the body of this report: HSA - Home Support Agency HHA - Home Health Aide	R 000		
R 210	9913.3e Client Service Plan (e) Safety measures required to protect the client from injury. Based on record review and staff interview, the HSA failed to include relevant data regarding safety measures to protect the client from injury in the client's care plan for five of five clients care plans reviewed (Clients #1, #2, #3, #4, and #5). Findings included: 1. On 11/05/2021 at 1:00 PM, a review of Client #1's record showed a document titled "Care Plan" that was completed by the registered nurse. Within the document, the registered nurse identified that the client's functional limitations include the client ambulating with a cane or walker, having vision problems, being forgetful,	R 210		

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R 210	Continued From page 1 and sometimes confused. Additionally, the record indicated that the client was receiving Home Health Aide service eight hours a day, three times a week to assist the client with activities of daily living to include bathing, dressing, toileting, and ambulation, and instrumental activities of daily living. Further review of the care plan showed a section titled "Special safety instructions" that was left blank. Additionally, the Home Support Agency (HSA) failed to direct the Home Health Aide (HHA) in ensuring the client's safety by failing to identify safety measures to protect the client from injury. 2. On 11/05/2021 at 2:15 PM, a review of Client #2's record showed a document titled "Care Plan" that was completed by the registered nurse. Within the document, the registered nurse identified that the client's functional limitations include the client being bedbound, needing assistance to transfer from bed to chair, being forgetful, and having a urinary catheter. Additionally, the record indicated that the client was receiving Home Health Aide service four hours a day, three times a week to assist the client with activities of daily living to include bathing, dressing, toileting, and ambulation, and instrumental activities of daily living. Further review of the care plan showed a section titled "Special safety instructions" that was left blank. Additionally, the Home Support Agency (HSA) failed to direct the Home Health Aide (HHA) in ensuring the client's safety by failing to identify safety measures to protect the client from injury. 3. On 11/05/2021 at 3:00 PM, a review of Client #3's record showed a document titled "Care Plan" that was completed by the registered nurse. Within the document, the registered nurse	R 210		

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R 210	Continued From page 2	R 210		

identified that the client's functional limitations include assistance to transfer from bed to chair, is forgetful, and is hard of hearing. Additionally, the record indicated that the client was receiving Home Health Aide service three hours a day, on Saturday and Sunday to assist the client with activities of daily living to include bathing, dressing, toileting, and ambulation, and instrumental activities of daily living. Further review of the care plan showed a section titled "Special safety instructions" that was left blank. Additionally, the Home Support Agency (HSA) failed to direct the Home Health Aide (HHA) in ensuring the client's safety by failing to identify safety measures to protect the client from injury.

4. On 11/05/2021 at 4:10 PM, a review of Client #4's record showed a document titled "Care Plan" that was completed by the registered nurse. Within the document, the registered nurse identified that the client's functional limitations include ambulation with a walker, vision problems, being forgetful, and being hard of hearing. Additionally, the record indicated that the client was receiving Home Health Aide service six hours a day, five days a week to assist the client with activities of daily living to include bathing, dressing, toileting, and ambulation, and instrumental activities of daily living. Further review of the care plan showed a section titled "Special safety instructions" that failed to outline safety instructions. Additionally, the Home Support Agency (HSA) failed to direct the Home Health Aide (HHA) in ensuring the client's safety by failing to identify safety measures to protect the client from injury.

5. On 11/05/2021 at 4:30 PM, a review of Client #5's record showed a document titled "Care Plan" that was completed by the registered nurse.

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R 210	Continued From page 3 Within the document, the registered nurse identified the client's functional limitations to include the client could be up as tolerated. Additionally, the record indicated that the client was receiving Home Health Aide service five hours a day, five days a week to assist the client with activities of daily living to include bathing, dressing, toileting, and ambulation, and instrumental activities of daily living. Further review of the care plan showed a section titled "Special safety instructions" that was left blank. Additionally, the Home Support Agency (HSA) failed to direct the Home Health Aide (HHA) in ensuring the client's safety by failing to identify safety measures to protect the client from injury. On 11/09/2021 at 12:30 PM, during an interview with the Director and client service coordinator, the deficiency was acknowledged.	R 210		
R 319	9918.4g Personal Care Services (g) Observing, recording, and reporting the client's physical condition, behavior, or appearance; Based on record review and interview, it was determined that the home support agency (HSA) failed to ensure that the home health aide (HHA) observed, recorded, and reported the patient's physical condition, behavior, or appearance for five of five active patients in the sample receiving home health aide services (Patient #1, #2, #3, #4, and #5). Findings included: 1. A review of Patient #1's clinical record on 11/05/2021 at 1:00 PM, showed a client service agreement dated 09/04/2021 indicating that the	R 319	On 12/15/21, a new HHA timesheet was developed and approved by the HSA board on 12/23/21. This new HSA timesheet has provision for the record of client's observed physical condition, behavior and appearance. This new timesheet format will be forwarded to the DC DOH for approval. Once approved, all HHA will go through training on the "Personal Care Services" section of the HAS Policies and Procedures Manual. The Director will review HHA's timesheet	

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R 319	Continued From page 4 client was to receive home health aide services nine hours a day, three to four days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the clinical record showed that the home health aide visited the patient four times a week from 09/04/2021, through 10/30/2021, and provided personal care and light housekeeping. There was no documentation evidencing the aide observed the patient's physical condition, behavior, or appearance. 2. A review of Patient #2's clinical record on 11/05/2021 at 2:15 PM, showed a client service agreement dated 08/16/2021 indicating that the client was to receive home health aide services four hours a day, three days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the clinical record showed that the client reduced the home health aide visits to four hours a day, one day a week from 09/03/2021, through 10/27/2021, to provide personal care and light housekeeping. There was no documentation evidencing the aide observed the patient's physical condition, behavior, or appearance. 3. A review of client #3's record on 11/05/2021 at 3:00 PM, showed a client service agreement dated 10/12/2020 indicating that the client was to receive home health aide services four hours a day, two days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the clinical record showed that the home health aide visited the patient two times a week from 09/04/2021, through 10/23/2021, and provided personal care and light housekeeping. There was no documentation evidencing the aide observed the patient's physical condition, behavior, or	R 319	weekly to ensure that client's physical condition, behavior, or appearance are recorded as appropriate. Any findings and action(s) taken will be documented. A summary log will be submitted at the Governing Body Meeting for review This will apply for Clients#1, #2, #3, #4, And #5. Corrective action will be completed by 2/28/22 (pending DOH approval of new Timesheet)	2/28/22

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R 319	Continued From page 5 appearance. 4. A review of client #4's record on 11/05/2021 at 4:10 PM showed a client service agreement dated 09/03/2021 indicating that the client was to receive home health aide services six hours a day, four days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the clinical record showed that the home health aide visited the patient two times a week from 09/14/2021, through 10/29/2021, and provided personal care and light housekeeping. There was no documentation evidencing the aide observed the patient's physical condition, behavior, or appearance. 5. A review of client #5's record on 11/05/2021 at 4:30 PM showed a client service agreement dated 10/13/2020 indicating that the client was to receive home health aide services five hours a day, five days a week to assist with activities of daily living (ADL)and instrumental activities of daily living (IADL). Further review of the clinical record showed that the home health aide visited the patient two times a week from 08/02/2021, through 10/29/2021, and provided personal care and light housekeeping. There was no documentation evidencing the aide observed the patient's physical condition, behavior, or appearance. On 11/09/2021 at 12:30 PM, during an interview with the Director and client service coordinator, the deficiency was acknowledged.	R 319		