Health Regulation & Licensing Administration

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	9900 General Provisions	R 000		

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 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

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

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 identified that the client's functional limitations include the client ambulating with a cane or walker, having vision problems, being forgetful,

R 210 — Provider's plan of correction:

On 11/27/2021 at 4:00PM the HSA's CSC, the registered nurse, visited Client #1 in Client #1's residence and conducted a fresh assessment where and "Special Safety Instructions" section of the "Care Plan" document was completed in addition to other relevant sections of the "Care Plan" document.
Upon completion, the registered nurse went over each detail of the "Special Safety Instructions" with the HHA working with Client #1 and directed the HHA to ensure the client's safety by strictly adhering to the "Special Safety Instructions"

To ensure that this deficient practice does not recur, on 12/3/21, the HSA registered

nurse had a refresher course on the HSA's policies and procedures manual with special emphasis on section 11 of the procedure: Policy on Client Service Plan.

To monitor this action to ensure deficient practice does not recur, the Director will review all "Care Plan" once completed to ensure that all relevant sections have been completed and that the HHA is directed on all relevant instructions including all "Special Safety Instructions" stated, to protect clients from injury. Any findings and action(s) taken will be documented. A summary log will be submitted at the Governing Body Meeting for review

Corrective action was completed on 11/27/21 | 11/27/21

On 11/30/2021 at 11AM the HSA's CSC, the registered nurse, visited Client #2 in Client #2's residence and conducted a fresh assessment where and "Special Safety Instructions" section of the "Care Plan" document was completed in addition to other relevant sections of the "Care Plan" document.
Upon completion of the Care Plan, the registered nurse went over each detail of the "Special Safety Instructions" with the HHA working with Client #2 and directed the HHA to ensure the client's safety by strictly adhering to the "Special Safety Instructions"

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R 210	Continued From page 2 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.	R 210	To ensure that this deficient practice does not recur, on 12/3/21, the HSA registered nurse had a refresher course on the HSA's policies and procedures manual with special emphasis on section 11 of the procedure: Policy on Client Service Plan. To monitor this action to ensure deficient practice does not recur, the Director will review all "Care Plan" once completed to ensure that all relevant sections have been completed and that the HHA is directed on all relevant instructions including all "Special Safety Instructions" stated, to protect clients from injury. Any findings and action(s) taken will be documented. A summary log will be submitted at the Governing Body Meeting for review Corrective action was completed on 11/30/21 On 12/03/2021 at 12PM the HSA's CSC, the registered nurse, visited Client #3 in Client #3's residence and conducted a fresh assessment where and "Special Safety Instructions" section of the "Care Plan" document was completed in addition to other relevant sections of the "Care Plan" document. Upon completion of the Care Plan, the registered nurse went over each detail of the "Special Safety Instructions" with the	11/30/21

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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	HHA working with Client #3 and directed the HHA to ensure the client's safety by strictly adhering to the "Special Safety Instructions To ensure that this deficient practice does not recur, on 12/3/21, the HSA registered nurse had a refresher course on the HSA's policies and procedures manual with special emphasis on section 11 of the procedure: Policy on Client Service Plan. To monitor this action to ensure deficient practice does not recur, the Director will review all "Care Plan" once completed to ensure that all relevant sections have been completed and that the HHA is directed on all relevant instructions including all "Special Safety Instructions" stated, to protect clients from injury. Any findings and action(s) taken will be documented. A summary log will be submitted at the Governing Body Meeting for review Corrective action was completed on 12/03/21	12/03/21
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 12/13/2021 at 6:30PM the HSA's CSC, the registered nurse, visited Client #4 in Client #4's residence and conducted a fresh assessment where and "Special Safety Instructions" section of the "Care Plan" document was completed in addition to other relevant sections of the "Care Plan" document.	

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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	Upon completion of the Care Plan, the registered nurse went over each detail of the "Special Safety Instructions" with the HHA working with Client #4 and directed the HHA to ensure the client's safety by strictly adhering to the "Special Safety Instructions To ensure that this deficient practice does not recur, on 12/3/21, the HSA registered nurse had a refresher course on the HSA's policies and procedures manual with special emphasis on section 11 of the procedure: Policy on Client Service Plan. To monitor this action to ensure deficient practice does not recur, the Director will review all "Care Plan" once completed to ensure that all relevant sections have been completed and that the HHA is directed on all relevant instructions including all "Special Safety Instructions" stated, to protect clients from injury. Any findings and action(s) taken will be documented. A summary log will be submitted at the Governing Body Meeting for review Corrective action was completed on 12/13/21 On 12/30/2021 at 4:30PM the HSA's CSC, the registered nurse, visited Client #5 in Client #5's residence and conducted a fresh assessment where and "Special Safety Instructions" section of the	12/13/21

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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	document was completed in addition to other relevant sections of the "Care Plan" document. Upon completion of the Care Plan, the registered nurse went over each detail of the "Special Safety Instructions" with the HHA working with Client #5 and directed the HHA to ensure the client's safety by strictly adhering to the "Special Safety Instructions To ensure that this deficient practice does not recur, on 12/3/21, the HSA registered nurse had a refresher course on the HSA's policies and procedures manual with special emphasis on section 11 of the procedure: Policy on Client Service Plan. To monitor this action to ensure deficient practice does not recur, the Director will review all "Care Plan" once completed to ensure that all relevant sections have been completed and that the HHA is directed on all relevant instructions including all "Special Safety Instructions" stated, to protect clients from injury. Any findings and action(s) taken will be documented. A summary log will be submitted at the Governing Body Meeting for review Corrective action was completed on 12/30/21	12/30/21