STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HSA-0014	A. BUILDING: _____ B. WING _____	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HHA HOME CARE, LLC D/B/A SMITHLIFE HOME	4000 ALBERMARLE STREET, NW WASHINGTON, DC 20016

(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 208	Continued From page 11 (c) Functional limitations of the client; Based on record review and staff interview, the home support agency (HSA) failed to include relevant data in the "functional limitations" section of the client service plan for four of six client records reviewed (Clients #2, #3, #4, and #5). Findings included: 1. On 06/08/2021 at 10:30 AM, review of Client #2's Assessment & Care Plan showed that the client had diagnoses that included high cholesterol and a pacemaker. Continued review of the form showed that the client ambulates with a walker and is at risk for falls. Further review of the form showed a section titled "functional limitations." This section included the following options: amputation, bowel/bladder (Incontinence) contracture hearing, paralysis, endurance, ambulation, speech, legally blind, and dyspnea with minimal exertion, however, the section was left blank. Additionally, the home support agency failed to direct the home health aide in ensuring client safety by failing to identify the client's functional limitations. 2. On 06/08/2021 at 12:10 PM, review of Client #3's Assessment & Care Plan showed that the client had diagnoses that included high cholesterol and Urinary tract infection. Continued review of the form showed that the client ambulates with a walker and had a recent fall with a cracked sacrum. Further review of the form showed a section titled "functional limitations." This section included the following options: amputation, bowel/bladder (Incontinence), contracture hearing, paralysis, endurance, ambulation, speech, legally blind, and dyspnea with minimal exertion, however, this section was left blank. Additionally, the home support agency	R 208	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information.	7/06/2021

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R 208	Continued From page 12 failed to direct the home health aide in ensuring client safety by failing to identify the client ' s functional limitations. 3. On 06/09/2021 at 8:30 AM, review of Client #4's Assessment & Care Plan showed that the client had diagnoses documented in her record. The client uses a wheelchair for ambulation. Further review of the form showed a section titled "functional limitations." This section included the following options: amputation, bowel/bladder (Incontinence), contracture hearing, paralysis, endurance, ambulation, speech, legally blind, and dyspnea with minimal exertion, however, this section was left blank. Additionally, the home support agency failed to direct the home health aide (HHA) in ensuring client safety by failing to identify the client's functional limitations. 4. On 06/09/2021 at 10:35 AM, review of Client #5's Assessment & Care Plan showed that the client had diagnoses that included high cholesterol, hypertension Diabetes mellitus. Continued review of the form showed that the client ambulates with a walker. Further review of the form showed a section titled "functional limitations." This section included the following options: amputation, bowel/bladder (Incontinence), contracture hearing, paralysis, endurance, ambulation, speech, legally blind, and dyspnea with minimal exertion, however, this section was left blank. Additionally, the home support agency failed to direct the home health aide (HHA) in ensuring client safety by failing to identify the client's functional limitations. On 06/10/2021 at 3:00 PM during an interview with the Clinical Director, she acknowledged the deficient practice and stated that the agency will review and update the care plan to reflect the	R 208	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information.	7/06/2021

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R 208	Continued From page 13 functional limitations of all clients.	R 208	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary.	
R 209	9913.3d Client Service Plan (d) Activities permitted; and Based on record review and staff interview, the home support agency (HSA) failed to include relevant data on the "activities permitted" section of the client service plan for one of six client records reviewed (Client #4) Findings included: On 06/09/2021 at 8:30 AM, review of Client #4's Assessments & Care Plan showed that the client had diagnoses documented in her record. Continued review of the form showed that the client uses a wheelchair for ambulation. Further review showed a section titled "activities permitted." This section identifies the activities allowed during care such as transfers, ambulation, weight bearing, bedrest, up as tolerated, or no restrictions. This section was left blank. Review of the plan also revealed that the registered nurse failed to identify client centered activities, to direct the home health aide (HHA) in assisting the client to achieve their highest practicable quality of life. On 06/10/2021 at 3:00 PM during an interview with the Clinical Director, she acknowledged the deficient practice and stated that the agency will review and update the care plan to reflect the activities permitted for the client.	R 209	2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information. 7/06/2021	
R 211	9913.4 Client Service Plan 9913.4 A registered nurse shall review and evaluate the service plan at least every ninety	R 211		

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R 211	Continued From page 14 (90) days. Based on record review and interview the home support agency (HSA) failed to ensure that the registered nurse (RN) reviewed and evaluated the service plan at least every ninety (90) days for three of the six clients in the sample (Clients #2, #4, and #6). Findings included: 1. On 06/08/2021 at 10:30 AM, review of Client #2's Service Agreement and Assessment & Care Plan showed a start of care date of 02/11/2021. Further review of the record showed that at the time of survey, the nurse had not reviewed and evaluated the service plan as required by the regulation, at least every ninety (90) days. 2. On 06/09/2021 at 8:30 AM review of Client #4's Service Agreement and Assessment & Care Plan showed a start of care date of 02/11/2021. Further review of the record showed that at the time of survey, the nurse had not reviewed and evaluated the service plan as required by the regulation, at least every ninety (90) days. 3. On 06/09/2021 at 1:30 PM review of Client #6's Service Agreement and Assessment & Care Plan showed a start of care date of 10/20/2020. Further review of the record showed that at the time of survey, the nurse had not reviewed and evaluated the service plan as required by the regulation, at least every ninety (90) days. During interview on 06/10/2021 at 3:00 PM, the Clinical director stated that the home support agency (HSA) will follow-up with the RN to ensure that service plans are reviewed and evaluated every 90 days as required by the regulation.	R 211	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information. 7/06/2021	

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R 211	Continued From page 15 At the time of survey, the home support agency failed to ensure that the RN conducted an on-site supervision of the home health aide for three of the six clients in the sample (#2, 4 and #6).	R 211	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information.	7/06/2021
R 217	9914.2a Client Records (a) Admission data, including name, address, date of service inquiry, date of birth, sex, next of kin, name and contact information of the client representative (if applicable), date accepted by the home support agency to receive services, and source of payment; Based on record review and interview, the home support agency (HSA) failed to ensure that client records contained date of service inquiry, date accepted by the home support agency to receive services for six of six clients in the sample (Clients #1, #2, #3, #4, #5 and #6). Findings included: 1. On 06/08/2021 at 8:35 AM review of Client #1's records including the Assessment & Care Plan" form, showed the client was admitted to the agency on 05/07/2021. The form failed to provide evidence of the date of service inquiry, and the date accepted by the home support agency (HSA) to receive services. 2. On 06/08/2021 at 10:30 AM, review of Client #2's records including the Assessment & Care Plan form, showed the client was admitted to the agency on 02/11/2021. The form failed to provide evidence of the date of service inquiry, and the date accepted by the home support agency to receive services. 3. On 06/08/2021 at 12:10 PM, review of Client	R 217		

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R 217	Continued From page 16 #3's records including the Assessments & Care Plan form, showed the client was admitted to the agency on 03/30/2021. The form failed to provide evidence of the date of service inquiry, and the date accepted by the home support agency to receive services. 4. On 06/09/2021 at 8:30 AM, review of Client #4's records including the "Assessments & Care Plan" form, showed the client was admitted to the agency on 02/11/2021. The form failed to provide evidence of the date of service inquiry, and the date accepted by the home support agency to receive services. 5. On 06/09/2021 at 10:35 AM, review of Client #5's records including the Assessments & Care Plan form, showed the client was admitted to the agency on 05/06/2021. The form failed to provide evidence of the date of service inquiry, and the date accepted by the home support agency to receive services. 6. On 06/09/2021 at 1:30 PM review of Client #6's records including the Assessments & Care Plan form, showed the client was admitted to the agency on 10/20/2020. The form failed to provide evidence of the date of service inquiry, and the date accepted by the home support agency to receive services. During an interview on 06/10/2021 at 3:00 PM, the Clinical Director said that the dates on the forms were the date they began providing services to the clients. At the time of survey, the home support agency failed to ensure that the client records contained date of service inquiry, and date accepted by the home support agency to receive services for six	R 217	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information.	7/06/2021

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R 217	Continued From page 17 of the six clients in the sample, #1, 2, 3, 4, 5, and #6.	R 217	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary.	
R 218	9914.2b Client Records (b) Source of referral; Based on record review and interview, the Home Support Agency (HSA) failed to ensure that client records contained the source of referral to the Home Support Agency for one of six clients in the sample (Client #5). Findings included: 1. On 06/09/2021 at 10:35 AM, review of Client #5's records including the Assessments & Care Plan form failed to provide evidence of the client's source of referral. Further review of the client's record showed that the Assessments & Care Plan form was completed on 5/07/2021, which was also the date that the client's services began. There was no documented evidence of the client's source of referral to the agency. During an interview on 06/10/2021 at 3:00 PM, the Clinical Director stated that the HSA will review their documentations and ensure that the nurses capture all the required client information during their assessments to include the source of client referral to the agency. At the time of survey, the home support agency failed to ensure that the client's records contained the source of referral to the agency for one of six clients in the sample, (Client #5).	R 218	2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information. 7/06/2021	
R 225	9914.2i Client Records	R 225		

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R 225	Continued From page 18 (i) History of sensitivities and allergies; Based on record review and interview, the home support agency failed to ensure that the client's records contained history of sensitivities and allergies for one of six clients in the sample (Client #4). Findings included: 1. On 06/09/2021 at 10:35 AM, review of Client #4's clinical record, showed an Assessment & Care Plan form dated 05/07/2021. Under the section for Allergies, nothing was checked or documented to indicate that the Client had or did not have any allergies. On 06/10/2021 at 3:00 PM during an interview, the Clinical Services Director stated the agency will review their documentation and ensure that the nurses captured all the required client information including sensitivities and allergies during the initial assessment visits. At the time of survey, the home support agency failed to ensure that the client record contained history of sensitivities and allergies for one of seven clients in the sample #4.	R 225	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information.	7/06/2021
R 226	9914.2j Client Records (j) Medication list; Based on record review and interview, the home support agency (HSA) failed to ensure that each client records included a list of the client's current medications, for six of the six clients in the sample (Clients #1, #2, #3, #4, #5, and #6). Findings included: On 03/31/2021, starting at 9:27 AM, review of the records for Clients #1, #2, #3, #4, #5, and #6 was	R 226		

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R 226	Continued From page 19 conducted. The records lacked evidence of a list of medications for each of the clients reviewed. On 06/10/2021 at 2:47 PM, review of the agency's policies was conducted. The policy for documentation in an electronic health record stated that the health record would contain all the client's medications. It should be noted that the agency's assessment and care plans contained a designated area to list medications. Each client's assessment failed to document their current medication list. On 06/10/2021 at 4:00 PM during an interview, the Clinical Services Director acknowledged the findings. At the time of survey, the home support agency failed to ensure that each client's record contained a list of the client's current medications, for six of six clients (Clients #1, #2, #3, #4, #5, and #6)	R 226	1) Our Registered Nurse was informed that additional information was not being captured in her initial assessments of Clients. She added the information that was missing, re-visiting the Clients as necessary. 2) A new RN Admissions policy was written and reviewed with the RN and she signed it acknowledging the training and that she understood. 3) As part of our monthly quality assurance, our DON agreed to spot check at least 5 Client records to ensure that new Initial Assessments capture all the necessary information.	7/06/2021
R 310	9918.2 Personal Care Services 9918.2 Each home health aide shall be supervised by a registered nurse. On-site supervision of personal care services shall take place at least once every ninety (90) days. Based on record review and interview the home support agency (HSA) failed to ensure that the RN conducted an on-site supervision of the home health aides (HHAs) for three of the six clients in the sample (Clients #2, #4 and #6). Findings included: 1. On 06/08/2021 at 10:30 AM, review of Client #2's Service Agreement and Assessment & Care	R 310	1) The RN initiated the 90 day review for the Clients that were found to be missing theirs. In addition, she checked that all New Clients and current Clients were on her Schedule in ClearCare every 90 days for a review. 2) As part of her initial assessment, she is creating a re-occuring shift every 90 days on their schedule for the RN visit. 3) As part of the Clinical Quality Assurance review monthly, the DON will review and spot check Client's charts in ClearCare to ensure they have a supervisory visit completed every 90 days.	07/06/2021

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R 310	Continued From page 20 Plan showed a start of care date of 02/11/2021. The Assessment & Care Plan did not document the client's diagnosis. Further review of the form showed that the client was receiving service for 24hrs/7 days a week. Further review of the record showed that at the time of survey, the nurse had not conducted an onsite supervisory visit since the date of admission. 2. On 06/09/2021 at 8:30 AM, review of Client #4's Service Agreement and Assessment & Care Plan showed a start of care date of 02/11/2021. The Assessment & Care Plan form documented that the client had diagnoses of high cholesterol and a pacemaker. Further review of the form showed that the client was receiving services for 8hrs/ 7 days a week. Further review of the record showed that at the time of survey, the nurse had not conducted an onsite supervisory visit since the date of admission.	R 310	1) The RN initiated the 90 day review for the Clients that were found to be missing theirs. In addition, she checked that all New Clients and current Clients were on her Schedule in ClearCare every 90 days for a review. 2) As part of her initial assessment, she is creating a re-occuring shift every 90 days on their schedule for the RN visit. 3) As part of the Clinical Quality Assurance review monthly, the DON will review and spot check Client's charts in ClearCare to ensure they have a supervisory visit completed every 90 days. 7/06/2021	