STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0005	A. BUILDING: _____ B. WING _____	C 07/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KBC NURSING AGENCY & HOME CARE, INC	7506 GEORGIA AVENUE, NW WASHINGTON, DC 20002

Received 8/31/17 CW

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H 000	INITIAL COMMENTS	H 000		

On July 19, 2017, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received information alleging that Patient #1 did not receive HHA services as ordered; and Patient #1 died at home alone during the HHA's scheduled work hours.

Due to the nature of the complaints, on July 19, 2017, DOH/HRLA initiated an off-site investigation to verify compliance with Title 22, Chapter 39 (Home Care Agencies Regulations). The findings of the investigation were based on record reviews and interviews.

Please Note: Listed below are abbreviations used in this report.

DON - Director of Nursing
HR - human resources
HRLA - Health Regulation and Licensing Administration
HCA - home care agency
HHA - Home Health Aide
POC - plan of care
QA - Quality Assurance
RN - Registered Nurse
SN - Skilled Nurse

Allegation #1 - Patient #1 was not receiving HHA services as ordered.

Conclusion - This allegation was substantiated.

Allegation #2 - Patient #1 died at home alone during the HHA's scheduled work hours.

Conclusion - This allegation was substantiated.

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H 000	Continued From page 1 The deficiency report includes direct and incidential findings related to the care of Patient #1.	H 000		
H 149	3907.2(e) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (e) Health certification as required by section 3907.6; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure one (1) of two (2) employees had a current health certification. (Employee #1) The finding includes: On July 20, 2017, at 4:43 p.m., review of Employee #1's personnel record revealed an altered health certificate. The dates of service and physician signature reflected an original date of 3/18/2017, that had been changed to read 8/18/2017. On July 24, 2017, at 12:45 p.m. interview with the agency's HR employee revealed that the original certificate with the altered dates was copied and placed into the employee's record. When asked if the document appeared altered, the HR employee said "no". The HR employee further stated that he was responsible for verifying the accuracy of the documents in each personnel file.	H 149	All HR personnel have been instructed to verify all Annual PPD and Physical with the employee's Physician who performed the test, and to date and initial the Physical/PPD form as being verified. Employee #1 was notified of the altered PPD/Physical and has submitted her Physical and PPD to HR post survey. These documents were verified by HR. Employee #1 has been terminated from KBC effective 07/25/2017. See Attachment #1 Updated and verified PPD/ Physical.	7/27/2017 and ongoing

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H 149	Continued From page 2 On July 25, 2017, at 11:38 a.m., the aforementioned health certificate was faxed to the physician who allegedly signed the certificate. The physician was asked to verify the certificate's authenticity. On July 25, 2017, at 11:44 a.m., interview with the office manager at physician's office revealed that Employee #1 was last seen by the physician on March 18, 2016. After receiving the health certificate, the office manager stated, "This is a fraudulent document." At the time of the investigation, there was no documented evidence that CNA #2 had a current health certificate.	H 149	See response on page 2 of 6	
H 260	3911.1 CLINICAL RECORDS Each home care agency shall establish and maintain a complete, accurate, and permanent clinical record of the services provided to each patient in accordance with this section and accepted professional standards and practices. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure that each clinical record was accurate, for one (1) of (1) patient in the investigation. (Patient #1) The finding includes: On July 19, 2017 at 12:11 p.m., interview with the the complainant revealed that Patient #1 died on June 30, 2017, at approximately 6:00 p.m. On July 19, 2017 at 12:45 p.m., interview with the	H 260	Patient #1 had been receiving 8hrs x 7 days of PCA services as assessed by Delmarva from 10/10/2016 through 12/03/2016. Patient's regular weekend aide had resigned and the staffing coordinator had attempted to staff the weekend with a new aide but patient's phone was not in working order and the assigned aide had shown up at the patient's home on 12/10 and 12/11/2016 but the patient was not available at home. Patient called and informed the staffing coordinator on 12/15/2016 that she would not need the aide on the weekends and would notify the staffing coordinator when and if she needs the weekend aide. To prevent this from recurring, Quality Assurance RN and DON will update all clinical record and will notify the patient's physician and Delmarva of all changes in service hours.	7/27/17 And On-going

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H 260	Continued From page 3 agency's DON and the QA nurse revealed that they were unaware that the patient was deceased. They reported that, based on the submitted time sheets, HHA #1 last provided services for the patient on July 7, 2017. At 4:37 p.m., review of the HHA #1's time sheets documented that HHA services were provided on the following dates: - June 30, 2017 from 3:00 p.m. to 11:00 p.m.; and - July 3, 2017 through July 7, 2017 from 3:00 p.m. to 11:00 p.m. On July 19, 2017 at 4:43 p.m., interview with HHA #1 revealed that she provided services to Patient #1 on June 30, 2017 for "about three or four hours in the morning". She further stated that on June 30, 2017, Patient #1 pre-signed her time sheets for the following week (July 1, 2017 through July 7, 2017). HHA #1 admitted that she did not provide services from July 1, 2017 to July 7, 2017. She stated that the patient pre-signed the time sheets as a "gift".	H 260	HHA#1 timesheets were reviewed and Patient's signature was validated; however, During the process of Investigating the Complaint made by Patient #1's daughter, HHA admitted that she had not worked the days that she had submitted for payment, 7/3/-7/7/17. HHA #1has been terminated from KBC. KBC reimbursed DHCF for amount paid for 07/3-7/7/17. KBC had already provided in-service for the second quarter to all PCAs on the subject of Medicaid Fraud, Waste and Abuse. KBC has other Mechanisms to monitor the aides to ensure they are at their assigned duties. such measures include: random field visits to patients' homes, random phone calls to patients' homes, and a new system the GPS call-in call-out system that monitors the aides 'whereabouts'. KBC designated personnel will continue to perform all of the aforementioned tasks to prevent Medicaid Fraud, waste and Abuse.	7/25/17 & on-going
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the SN failed to ensure that the patient's needs were met in accordance with their POC for one (1) of (1) patient in the investigation. (Patient #1)	H 453		

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H 453	Continued From page 4 The findings include: I. On July 19, 2017, at 12:11 p.m., interview with the complainant revealed that Patient #1 did not receive HHA services as ordered. The complainant stated that Patient #1's HHA had not provided services since June 13, 2017. On July 19, 2017, at 12:45 p.m., interview with the agency's DON and QA nurse revealed that Patient #1 was ordered to receive HHA services eight (8) hours per day, five (5) days per week. At 4:17 p.m., review of Patient #1's POC revealed that the patient should have received (8) hours of aide services, (7) days per week. At 4:37 p.m., review of the Patient #1's HHA timesheets failed to provide documented evidence the Patient #1 received aide services on the weekends from January 1, 2017 through June 25, 2017. II. On July 19, 2017, starting at 4:17 p.m., review of Patient #1's POC revealed that Patient #1 had a diagnoses of type 2 diabetes with hyperglycemia. According to the POC, the SN was to visit the patient (1) to two (2) times, every sixty (60) days to perform a skilled assessment of the body systems, including the endocrine system. The patient's record revealed that a SN visit was performed on the following days: - January 23, 2017; - February 16, 2017; - March 4, 2017; - April 5, 2017; and - June 2, 2017	H 453	See response on page 3 of 6 for citation H260 KBC has changed the monthly supervisory visit notes to include a section for blood sugar reading. All nurses have received an in-service on nursing notes documentation and what is expected on the nursing notes in regards to total assessment of the body systems. QA nurses and DON will review nurse's notes biweekly to ensure that the nurses are following the right format in documentation, nurses whose notes do not follow the right format will not be reimbursed for the visit until all corrections have been made.	7/25/17 And ongoing

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H 453	Continued From page 5 The nurse notes for the aforementioned SN visits failed to document Patient #1's blood sugar. On July 20, 2017, at 2:36 p.m., interview with Patient #1's nurse (Nurse #1) revealed that he never performed a blood glucose test on the patient. Nurse #1 stated that the patient would take his/her own blood glucose and would report it to the nurse. Additionally, Nurse #1 stated that he never assessed the patient's glucometer, or the previous values, and never recorded the reported values on the nurse notes. At the time of the survey, the agency failed to ensure Patient #1 received all ordered HHA hours; and failed to ensure that the SN performed a complete system assessment as ordered.	H 453		