GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
INTERMIEDIATE CARE FACILITIES DIVISION

Home Care Agencies
Title 22 DCMR 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Health Care Agency:	Street Address, City, State, ZIP Code:	Survey Date:
Home Management Inc. (HMI)	1025 Vermont Ave, NW WASHINGTON DC 20005-3516	01/15/2009 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An initial licensure survey was conducted from January 15, 2009 through January 16, 2009. The sample size selected for the clinical record review was fourteen (14) clinical records based on a census of one hundred forty (140) patients and seventeen (17) staff records based on a census of approximately 170 employees. The findings of the survey were based on interviews, clinical and administrative record review.		Received 4/6/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	3903 **GOVERNING BODY**			
3903.2(a)	***The governing body shall do the following:***			
	(a) Establish and adopt by-laws and policies governing the operation of the home care agency;			
	Based on record review, the facility failed to implement a comprehensive set of policies and procedures to manage and ensure the implementation of the regulator requirements set forth in this chapter.			
	The findings include:			
	Review of the records presented on 1/15/2009 and on 1/16/2009 revealed the HCA failed to implement a set of policies and procedures that would ensure			

Alma Brannum & Jude Jules — Name of Inspector(s)

01/15/2009 — Date Issued

Facility Director/Designee

April 6, 2009 — Date

Revised 3-20-09 Laura A. Hunter, Supervisor

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	the provisions of this chapter. The HCA failed to implement policies and procedures to address the local regulatory requirements as cited below in Sections 3905, 3906, 3907, 3908, 3909, 3910, 3912, 3913, 3916, and 3520.		
3903.2(c)(1)	***The governing body shall do the following:*** ***(c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following:*** ***(1) The evaluation shall include feedback from a representative sample consisting of either ten percent (10%) of total District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patients.*** Based on record review and staff interview, the HCA failed to ensure at least 10% patient feedback to ensure they were providing appropriate, adequate, effective and efficient services as required by this section. The finding includes: Review of the records presented on 1/15/2009 and again on 1/16/2009 revealed there was no evidence presented or on file to substantiate that an effective system of information gathering and review had been implemented to ensure that at least 10% of the HCA's patient base provided feedback regarding their service delivery. Interview with the HCA's Director on 1/16/2009 at 11:50am revealed he was only able to gather about 2% response from their active patients.	3903.2(c)(1) HMI conducts at least one full patient satisfaction survey annually. The last full written survey was conducted in December 2007 and the last telephonic survey was in August of 2008. Results are evaluated and reported to the HMI Board of Directors. The last report was on December 8, 2008. It was available at the time of the inspection. The 2009 written survey was distributed on March 15, 2009 and was supplemented telephonically on April 3, 2009. Results will be analyzed in April 2009 and reported to the HMI Executive Committee on April 16, 2009 The statement that responses are received from only 2% of active patients is incorrect. Responses to the written survey are over 20% and the response rate for the telephonic survey is over 80%.	16, APRIL 2009
3903.2(c)(2)	***The governing body shall do the following:*** ***(c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services***		

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	promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: ***(2) The evaluation shall include a review of all complaints made or referred to the agency, including the nature of each complaint and the agency's response thereto.*** Based on record review and staff interview, the HCA failed to ensure the implementation of an effective system to monitor and review of all agency complaints. The finding includes: Review of the records presented on 1/15/2009 and again on 1/16/2009 revealed there was no evidence presented or on file to substantiate that an effective system was in place to properly monitor, review, and respond to all agency wide complaints. Interview with the HCA's Director on 1/16/2009 at 11:52am revealed he was responsible for managing all of the complaints generated through the agency. Additional record review failed to reflect that the nature of each complaint was also being assessed and addressed accordingly.	3903.2(c)(2) HMI has and effective system to monitor, review and respond to complaints. Prior to April 1, 2009, complaints were recorded on the Accident/Incident Form. The forms are kept in the Executive Director's office. Effective April 1, 2009, a separate *Complaint* From was created to facilitate identifying and sorting complaints by type. In addition to complaints that reach the written stage, telephonic complaints are recorded in the HHC system and are reviewed at the Administrative Staff meeting. Effective April 1, 2009, these reviews will be recorded in the minutes of the meeting. Complaints are evaluated as part of the risk management process and are reported to the Board of Directors. The last report to the HMI Board of Directors was on December 8, 2008.	APRIL 1, 2009
3903.2(c)(3)	***The governing body shall do the following:*** ***(c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following:*** ***(3) A written report of the results of the evaluation shall be prepared and shall include recommendations for modifications of the agency's overall policies or practices, if appropriate.***	3903.2(c)(3) HMI conducts a review of all polices and procedures annually. The review date for each policy is recorded on the last page of the policy. Results are discussed at the HMI Executive Committee and the HMI Board of Directors meeting and recorded in the minutes. The last report was on December 8, 2008. The next full annual review will be recorded and reported to the Board of Directors in December 2009. Polices reviewed and revised are reviewed by the HMI Executive Committee and then at the next meeting of the HMI Board of Directors. The next Executive Committee Meeting will be April16, 2009. The next HMI Board of Directors meeting will be in May 2009.	

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	Based on record review and staff interview, the HCA failed to ensure the creation of a written report of the evaluation of the agency's policies, procedures with regards to service delivery as required by this section. The finding includes: Review of the records presented on 1/15/2009 at 11:05am revealed there was no evidence presented or on file to substantiate that a written report of the annual review of the agency's policies and procedures was drafted. Interview with the HCA's Director on 1/16/2009 at 12:01pm revealed the agency keeps tracking and trending information on file and that this information is reviewed every Tuesday during the administrative staff meetings, but compiling a written report was not part of the process.		
3903.2(c)(4)	***The governing body shall do the following:*** ***(c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following:*** ***(4) The evaluation report shall be presented to, and acted upon, by the governing body at least annually. The results of the action taken by the governing body shall be documented, maintained, and available for review by government officials.*** Based on record review, the HCA failed to ensure an annual review of their policies and practices and failed to maintain effective documentation of their annual meetings. The finding includes: Review of the records presented on 1/15/2009 and again on 1/16/2009	3903.2(c)(4) HMI conducts an annual review of policies and procedure. The review is reported to the HMI Board of Directors for review and recommendations if appropriate. The review is recorded in the minutes of the Board meeting. The last board meeting was on December 8, 2008. The next Board meeting will be in June of 2009. The next annual review will be presented to the HMI Board of Directors in December 2009. New or revised policies are submitted to the HMI Executive Committee for review and approval. The committee meets twice a month.	April 30 2009

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	revealed the HCA failed to conduct an annual review of its policies and practices. There was also no evidence that the resulting actions had been recorded as they were not available for review at the time of survey. 3905 POLICIES AND PROCEDURES		
3905.2(c)	***Written policies and procedures shall be developed for, at a minimum, the following:*** ***(c) Admission and denials of admission;*** Based on record review and staff interview, the HCA failed to ensure the creation and implementation of written policies to provide clear direction on how to manage and document the denials of admission. The finding includes: Review of the records presented on 1/15/2009 at 1:50pm revealed there was no evidence on file to substantiate that written policies and/or procedures were drafted to govern the "denials of admission". Interview with the facility's Director on 1/15/2009 at 4:00pm revealed there was no written policy on file to manage the "denials of admission" but that they have clear understanding on how they would deny admission.	3905.2(c) Policy 3050, initially written in September, 1997 and last reviewed in January, 2008 titled *Patients Not Taken Under Care*, governs "denials of admissions". Additional guidance is in Policy 3010 titled *Referring A Patient to Home Care Services.* Both polices were available at the time of the inspection and were given to the Inspector by the Executive Director.	March 15 2009
3905.2(e)	***Written policies and procedures shall be developed for, at a minimum, the following:*** ***(e) Records retention and disposal;*** Based on record review and staff interview, the HCA failed to enact a written policy to address the disposal of records as required by this section.	3905.2(e) Paragraph 11 of Policy 5020 titled *Clinical Record Security,* states: "Records older than two years are sorted, boxed and and stored in a secure site operated by an approved contractor. Destruction dates are included in each box and are in accordance with appropriate guidelines to include JCAHO, Medicare and Medicaid. In the event of a conflict, the most stringent guidelines will be followed". This policy was amended on February 15, 2009 to add that, at a minimum, records will be retained for five years.	March 15 2009

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	The finding includes: Review of the records presented on 1/15/2009 at 1:55pm revealed there was no written policy on file to address the disposal of records. Interview with the facility's Director on 1/15/2009 at approximately 4:09pm revealed they have not destroyed any records to date and currently do not have a plan in place to destroy any old records. The Director further indicated that their storage capacity far exceeded their needs at this time. 3907 PERSONNEL		
3907.1(a)	***Each home care agency shall have written personnel policies that shall be available to each staff member and shall include the following:*** ***(a) The terms and conditions of employment, including but not limited to wage scales, hours of work, personal and medical leave, insurance, and benefits;*** Based on record review, the HCA failed to enact a written policy to detail the procedure for establishing wage scales, hours of work, personal and medical leave offerings, insurance and employee benefits as required by this section. The finding includes: Review of the records presented on 1/15/2009 at 3:19pm revealed the agency's policy and procedures failed to detail the wage scales, hours of work, personal and medical leave provisions, insurance, and benefits for its employees. Additional Review of the records presented on 1/16/2009 at 2:25pm revealed the personnel records reflected that a "Professional Services Agreement" was on file which detailed the terms of agreement, but the document does not	3907.1(a) HMI has personnel policies for the subjects mentioned in the report. They are listed below: Hours of work—HMI Personnel Policy Manual Section 200, Policy number 201.0 and the Employee Handbook, paragraph 1.7 Personal and Medical Leave—HMI Personnel Policy Manual numbers 205.0 through 210.0 and the Employee Handbook, paragraphs 2.6 and 2.7 Insurance and benefits—HMI Personnel Policy Manual Section 400 and the Employee Handbook, paragraph 2.11 Wage scale—HMI does not have a wage scale. Pay rates for salaried staff are negotiated individually and recorded on the *Payroll Change Status Form.* Pay rates for Personal Care Aides are per hour and are set by District of Columbia law.	APRIL 1, 2009

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	include provisions for wage scales, or detailed information on personal and medical leave.		
3907.1(b)	***Each home care agency shall have written personnel policies that shall be available to each staff member and shall include the following:*** ***(b) Provisions for an annual evaluation of each employee's performance by appropriate supervisors;*** Based on record review, the HCA failed to enact a written policy to detail the procedure for the annual evaluation of an employee's performance. The finding includes: Review of the records presented on 1/15/2009 at 3:25pm revealed there was no written policy or procedures on file to ensure the all staff received an annual review of their performance. [Reference Licensure Citation 3907.2(h)]	3907.1(b) Procedures for the annual review of an employee's performance are covered in the HMI Personnel Policy Manual, Policy 701.0 and the Employee Handbook, paragraph1.8. Both documents were available at the time of the inspection. In addition, the schedule for evaluations is maintained in the Archer system which is monitored on a monthly basis. All employees currently due an annual evaluation will have one no later than April 22, 2009	APRIL 23 2009
3907.1(c)	***Each home care agency shall have written personnel policies that shall be available to each staff member and shall include the following:*** ***(c) Provisions pertaining to probationary periods, promotions, disciplinary actions, termination and grievance procedures;*** Based on record review and staff interview, the HCA failed to enact a written policy to establish the probationary period, promotion, disciplinary action(s), and the termination of an employee. The finding includes: Review of the records presented on 1/15/2009 at 3:33pm revealed there was no written policy on file to ensure a consistent implementation of the agency's	3907.1(c) HMI has personnel policies which are available to all staff. The items listed in the report are in the documents listed below. These documents were available at the time of the inspection. Probationary Period—HMI Personnel Policy Manual, 108.0 and the Employee Handbook paragraph 1.4 Promotion—HMI Personnel Policy Manual, Policy 701.0 and the Employee Handbook, paragraph 1.10. Disciplinary Procedures—HMI Personnel Policy Manual, Policy 502.0. Termination—HMI Personnel Policy Manual, Section 1000 and the Employee Handbook, paragraph 1.12.	APRIL 1, 2009

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	procedures with regards to establishing the probationary period for an employee; the methodology for promoting an employee; the causes where by disciplinary action could be enforced against an employee; and the reasons why an employee would be terminated.	
3907.2(b)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(b) Current professional license or registration number, if any;*** Based on record review, the HCA failed to enact an effective system to ensure that all professional staff had obtained a current and valid License issued by the District of Columbia. The finding includes: Review of the personnel records presented on 1/16/2009 at 10:05am revealed one of eight professional staff currently employed by the agency did not have a current license on file.	3907.2(b) Prior to being hired, all professional staff must present a current, valid license. The license renewal date is entered into the Archer system. Licenses are verified electronically on the HRLA web site. A check of that site on February 15, 2009 revealed that one LPN had a valid Maryland license but not one issued by the District of Columbia. The Clinical Director was notified immediately. He called the DC Board of Nursing and was told the LPN had a valid DC license. License verification was faxed to HMI on March 20. 2009. As of April 1, 2009, all clinical staff have a current, valid license on file in their personnel record. APRIL 1, 2009
3907.2(c)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(c) Resume of education, training certificates, skills checklist, and prior employment, and evidence of attendance at orientation and in-service training, workshops or seminars;*** Based on record review, the HCA failed to enact an effective system to secure a resume of education, training certificates, and a skills checklist for all currently employed staff. (Staff #3, #4, #5, #8, #9, #16, and #18) The finding includes: Review of the personnel records presented on 1/16/2009 at 10:30am revealed	3907.2(c) Prior to hired, all prospective clinical employees must present the following documents as required by DC law.: 1. Certificate or license as appropriate 2. Skills checklist if required 3. Current CPR certificate 4. Current chest X-ray or PPD 5. Current criminal background check 6. In-services ((CA/HHA) 7. Proof of eligibility to work in the USA. Once verified, this information is entered into the electronic personnel records system and monitored on a monthly basis. At least quarterly, personnel are notified of impending due dates. Those personnel found to not have a complete set of current documents have been notified and have until April 15, 2009 to submit them. APRIL 15, 2009

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	eight out of fourteen staff records reviewed failed to reflect that a training certificate or a skills checklist was obtained and placed on file.	Attendance at orientation is recorded on a sign-in sheet but that sheet was not kept in the employee's record. Effective April 1, 2009 a copy of the sign-in sheet will be kept in the employee's file.	
3907.2(d)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(d) Documentation of current CPR certification, if required;*** Based on record review, the HCA failed to enact an effective system to ensure that all staff had secured a current CPR certification. (Staff #4, #8, #12 and #16) The finding includes: Review of the personnel records presented on 1/16/2009 at 10:45am revealed four out of fourteen staff did not have a current CPR certification on file.	3907.2(d) CPR certification is monitored in the system mentioned in 3907.2(c). Personnel are notified at least quarterly that their CPR due date is approaching. Those who fail to submit a valid CPR certificate are pulled from the field. As of April 1, 2009, all field staff have a current CPR card in their personnel folder.	APRIL 1, 2009
3907.2(e)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(e) Health certification as required by section 3907.6;*** Based on record review, the HCA failed to enact an effective system to ensure that all staff secured a current health certificate. (Staff #4 and #14) The finding includes: Review of the personnel records presented on 1/16/2009 at 11:00am revealed two out of fourteen staff did not have a current health certificate on file.	3907.2 (e) Health certification is monitored as listed above. The two staff cited in the finding have been instructed to obtain a current health certificate. A complete audit of suspense dates for health certificated will be completed by April 15, 2009. Personnel who do not submit a current health certificate will be pulled from the field.	APRIL 15, 2009
3907.2(f)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:***		

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	(f) Verification of previous employment; Based on record review, the HCA failed to enact an effective system to ensure the verification of previous employment for all currently employed staff. (Staff #6, #8, #9, #10, #11, #12, #14, #17 and #18) The finding includes: Review of the personnel records presented on 1/16/2009 at 11:15am revealed the HCA failed to secure verification of previous employment for nine out of fourteen staff records reviewed.	3907.2(f) The *Application for Employment Form* records previous employment, however, a form to record verification of previous employment did not exist at the time of the inspection. A verification form for previous employment was created and effective March 31, is used for all new hires. Where possible, previous employment will Be verified for current employees by April 22, 2009.	APRIL 23 2009
3907.2(g)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(g) Documentation of reference checks;*** Based on record review, the HCA failed to enact an effective system to secure reference checks for all currently employed staff. (Staff #6, #8, #9, #10, #11, #12, #14, #17 and #18) The finding includes: Review of the personnel records presented on 1/16/2009 at 11:30am revealed the HCA failed to secure the review of reference checks for nine out of fourteen staff records reviewed.	3907.2 (g) Reference checks are recorded on the *Reference Form* which is included in The personnel record. All newly hired staff have this form in their record. No later than May 15, 2009 all personnel charts will be audited to identify those without a completed *Reference Form* and forms will be obtained for those lacking one.	APRIL 15, 2009
3907.2(h)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(h) Copies of completed annual evaluations;*** Based on record review, the HCA failed to enact an effective system to secure	3907.2(h) Annual evaluation dates are maintained In the Archer system and monitored on a quarterly basis. Several of those cited in the report have been with HMI less than a year and did not require an evaluation. A 100% audit of records will be conducted no later than May 1, 2009 and anyone who needs an evaluation will receive one.	APRIL 23 2009

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	annual evaluations for all currently employed staff. The finding includes: Review of the personnel records presented on 1/16/2009 at 11:45am revealed the HCA failed to secure signed and completed annual evaluations for fourteen out of fourteen employee records reviewed.		
3907.2(l)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(l) Results of any competency testing;*** Based on record review, the HCA failed to enact an effective system to secure competency testing for all professional staff. (Staff #3, #5, #6, #7) The finding includes: Review of the personnel records presented on 1/16/2009 at 11:55am revealed the HCA failed to secure competency tests for four of eight of its professional staff.	3907.2(l) The Clinical Director is responsible for competency testing of professional personnel. No later than April 15, 2009 the records of all professional staff will be screen to identify any requiring evidence of competency testing. The Clinical Director will be notified and all will complete competency testing no than May 1, 2009.	APRIL 15, 2009
3907.2(m)	***Each home care agency shall maintain accurate personnel records, which shall include the following information:*** ***(m) Documentation of acceptance or declination of the Hepatitis Vaccine; and*** Based on record review, the HCA failed to enact an effective system to secure Hepatitis B vaccination documentation for all currently employed staff. (Staff #8, #9, #15, #17) The finding includes:	3907.2(m) Documentation of acceptance or declination of the Hepatitis B vaccination is required before a clinician is allowed to begin seeing patients. The four cited in the inspection have been notified they must provide the document no later than April 15, 2009. The 100% of audit of personnel charts will include a review to ensure that this documentation is in all records.	APRIL 15, 2009

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	Review of the personnel records presented on 1/16/2009 at 11:55am revealed the HCA failed to secure the documentation of Hepatitis B vaccinations for four of fourteen staff records as reviewed.		
3907.3	***Each home care agency shall comply with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, D.C. Law 12-238, and subsequent amendments thereto, D.C. Official Code § 44-551 et seq.*** Based on record review, the HCA has failed to ensure that all staff and their respective histories of domicile have been assessed with regards to securing a comprehensive criminal background check prior to employment. The finding includes: DCMR 22-4701.5 states "The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check." Record review on 1/16/2009 at 2:22pm revealed there was evidence which reflected that three out of the fourteen staff employed by the HCA's have lived or are currently living outside of the District, but the criminal background checks on file do not cover those jurisdictions as required by 22-4701.5.	3907.3 Criminal background checks are required for all personnel prior to employment. However, prior to the inspection, only one background check was required. Effective March 1, 2009, all new staff are required to submit the number of criminal background checks required by law will be obtained for all staff. Additional required background checks will be obtained for existing staff no later than April 30, 2009.	APRIL 23, 2009
3907.7	***Each employee shall be screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease.*** Based on record review, the HCA failed to ensure that all staff have been screened and are free of communicable diseases over the past certification year. (Staff #4 and #14)	3907.7 Obtaining and monitoring currency of health certificates is part of the record tracking system described in earlier responses. The two staff who did not have a current certificate have been notified. The 100% audit which will be competed by May 1, 2009 will include a check to ensure that all staff have current certification.	APRIL 15, 2009

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	The finding includes: Review of the personnel records presented on 1/16/2009 at 1:15pm revealed two out of fourteen staff did not have a current health certificate on file.		
3907.8(a)	***No employee may provide home care services, and no agency may knowingly permit an employee to provide home care services, if the employee:*** ***(a) Is under the influence of alcohol, any mind-altering drug or combination thereof; or*** Based on record review, the HCA failed to establish any written direction for managing staff that have been found providing services under the influence of alcohol or any mind-altering drug or combination thereof. The finding includes: Review of the records presented on 1/16/2009 at 1:33pm revealed there was no written policy, procedure or any written directive to govern the management of a staff who has been found providing services under the influence of drugs or alcohol. Interview with the Director on 1/16/2009 at 1:35pm revealed this situation has only occurred once with an employee dealing with alcohol. The Director explained that if they suspect that a staff is under the influence of a mind altering substance, he/she would be terminated. Further record review failed to show that anything has been written to support this agency's practice.	3907.8(a) Written directions for managing staff suspected of being under the influence of alcohol or mind altering drugs are in the HMI Personnel Policy Manual in Policy 510.0 and the HMI Employee Handbook, paragraph 3.10	APRIL 1, 2009
3908.1(c)	***Each home care agency shall have written policies on admissions, which shall include, at a minimum, the following:***		

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	(c) The amount charged for each service; Based on record review and staff interview, the HCA failed to establish any written policies to establish the amount charged for services. The finding includes: Review of the records presented on 1/16/2009 at 1:50pm revealed there was no written policy to establish a fee structure for all services being rendered to date. Interview with the Director on 1/16/2009 at 1:55pm revealed the reimbursement structure is established by the payment center (Medicaid, Medicare, private insurances) and that they don't have to set that structure at all. There was no evidence presented or on file to reflect that the HCA had developed a policy to address the amount charged for each service.	3908.1(c) The written procedure on "Billing Information and Financial Responsibilities" is on pages 10 and 11 of the HMI Guide to Home Care. This is provided to all clients. Additional Information on charges is in the HMI Home Health Policy Manual, Section 3020—Verification Of Insurance Coverage. Except for pure private pay cases, HMI does not set rates or charge for services. Services are paid by Medicare, Medicaid or private insurance companies. Prospective clients are informed if they have a deductible or co-pay but this amount is not determined by HMI. Patients are told the amount they would have to pay if their insurance was discontinued or became invalid. The fee schedule for purely private pay cases is in the office and will be included in the Policy Manual no later than April 1, 2009	APRIL 1, 2009
3908.1(d)	***Each home care agency shall have written policies on admissions, which shall include, at a minimum, the following:*** ***(d) Policies governing fees, payments and refunds;*** Based on record review, the HCA failed to establish any written policies to govern the fees, payments and refunds for services rendered. The finding includes: Review of the records presented on 1/16/2009 at 1:57pm revealed there was no written policy to establish fees, payments and/or refunds. Interview with the Director on 1/16/2009 at 1:55pm revealed the fee structure, including payments and refunds is established by the respective payment	3908.1(d) Information on fees, payments and refunds is on pages 10 and 11 of the *HMI Guide to Home Care.* No later than May 1, 2009 this section will be expanded and also included in the Policy Manual.	APRIL 23 2009

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	center (Medicaid, Medicare, private insurances) and that they don't have any control in setting that structure. There was no evidence presented or on file to reflect that the HCA had developed a policy to address the fees, payments and refunds for each service.		
3908.4	***The home care agency shall notify each entity referring a potential patient to the agency, and each individual requesting services from the agency, of the availability or unavailability of service, and the reason(s) therefore, within 48 hours after the referral or request for services.*** Based on record review and staff interview, the HCA failed to ensure the creation and implementation of written policies to ensure that each entity referring patient or requesting services are informed of the availability or unavailability of services within 48 hours. The finding includes: Review of the records presented on 1/15/2009 at 1:52pm revealed there was no evidence on file to substantiate that written policies and/or procedures were drafted to govern the timely response for service requests from outside entities within the required 48 hour time frame. Interview with the facility's Director on 1/15/2009 at 4:00pm revealed there was no written policy on file to manage the "48 hour" requirement. There was no evidence presented or on file to reflect that the HCA ensured the creation and implementation of written policies to ensure that each entity referring patients or requesting services are informed of the availability or unavailability of services within 48 hours.	3908.4 *HMI Policy and Procedure Manual, Section 3010-Referring a Patient to Home Care Services,* addresses the process by which referral sources are told if a case will be accepted and that the initial visit will be made within 48 hours. Section 3050—*Patients Not taken Under Car"* states that if a case is not to be taken under care, the referral source will be notified immediately.	APRIL 1, 2009
3908.5	***A home care agency shall maintain records on each person requesting services whose request is not accepted. The records shall be maintained***		

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	for at least one year from the date of non-acceptance and shall include the nature of the request for services and the reason for not accepting the patient. Based on record review and staff interview, the HCA failed to ensure the creation and implementation of written policies to provide clear direction on how to maintain records for patients who have been denied services. The finding includes: Review of the records presented on 1/15/2009 at 2:34pm revealed the HCA failed to establish written directives on maintaining records on each person who was denied services. In addition, there was also no evidence the HCA established a written procedure ensuring that the denial for services be maintained for at least one year from the date of non-acceptance and included the nature of the request for services and the reason for not accepting the patient. Interview with the facility's Director on 1/15/2009 at 4:00pm revealed there was no written policy on file to manage the "denials of admission" but that they have clear understanding on the criteria they would use to deny admission. There was no evidence presented or on file to reflect that the HCA ensured the creation and implementation of written policies on how to maintain records for patients who have been denied services.	3908.5 Written directives for maintaining records for patients not taken under care is outlined in Policy 3050 of the HMI Policy and Procedure Manual. The statement that an interview with the Director revealed there was no policy on file to manage the denials of admission is incorrect. The policy was available at the time of the inspection and the Director did not say there was no such policy. Hard copy records of patients not accepted for care are kept in the office for at least one year and kept on the electronic referral file for three years.	APRIL 1, 2009
	3910 **RECORDS RETENTION AND DISPOSAL**		
3910.1(b)	***Each home care agency shall maintain a clinical record system that shall include the following:*** ***(b) Written procedures that address the transfer or disposition of clinical***	3910.1(b) Policy 5020 of the HMI Policy and Procedures Manual addresses the disposition of clinical records in the event of dissolution of the home care agency. This policy will be expanded to include additional, specific details. This will be done no later than May 1, 2009.	APRIL 23 2009

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records in the event of dissolution of the home care agency.

Based on record review, the HCA failed to ensure the creation and implementation of written procedures to address the transfer or disposition of clinical records in the event of dissolution of the agency.

The finding includes:

Review of the records presented on 1/16/2009 at 2:26pm revealed there was no evidence on file to establish that a system had been established to address the transfer or disposition of the agency's clinical records in the event of dissolution.

3911
CLINICAL RECORDS

3911.1 ***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.***

Based on record review, the agency failed to establish and maintain a complete, accurate, and permanent clinical record of the services provided for one of fourteen patients in the sample. (Patient # 11)

The findings include:

Review of Patient # 11's clinical record on January 16, 2009 at approximately 3:50 PM revealed Patient # 11 did not have a POC in the record.

Review of Patient # 11's order from the Primary Medical Doctor (PMD) dated December 10, 2008, on January 16, 2009 at approximately 3:55 PM revealed an order for physical therapy treatment for strengthening exercises, range of motion (ROM) and joint mobility exercise, transfer, balance ,stability,

3911.1

All Medicare and Medicaid patient records have a 485 to record the treatment plan. Private insurance plans require a plan of treatment or a specialty specific treatment plan but do not mandate the use of a 485. Patient #11 is a private insurance patient. Her PT plan of care was on file at the time of the inspection.

Prior to the start of care, a 485 or other appropriate document is prepared. It is reviewed by the Clinical Director. Notes are submitted every Monday and are reviewed by a full-time RN to ensure that the record is complete and accurate. Starting no later than April 22, 2009, a monthly audit of 10% of all active charts will be conducted. Errors or omissions will be identified and referred to the Clinical Director for corrective action.

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	endurance and gait training two times a week for eight weeks. Review of the physical therapy progress note dated December 10, 2008 revealed the patient had a physical therapy evaluation on that same day. Interview with the Clinical Director on January 16, 2009 at approximately 4:00 PM revealed Patient # 11 did have a POC, however it probably was misfiled. There was no evidence in the clinical record that the agency had established and maintained a complete, accurate and permanent clinical record for the patient.		
3911.2(m)	***Each clinical record shall include the following information related to the patient:*** ***(m) Type and frequency of diagnostic services*** Based on interview and record review, the agency failed to ensure types and frequency of diagnostic services ordered were documented on the Home Health Certification and Plan of Care (POC) for one out of fourteen patients in the sample. (Patient # 7) The finding includes: Review of Patient # 7's Home Health Certification and POC dated December 26, 2008 to February 23, 2009 on January 15, 2009, at approximately 3:00 PM revealed an order for skilled nursing services one to two times a week for eight weeks for blood draw. In an interview with the Clinical Director on January 15, 2009, at approximately 3:10 PM it was acknowledged that the type and frequency of diagnostic services to be drawn was not on the Home Health Certification and POC. There was no evidence that the type and frequency of diagnostic services to be drawn was on the Home Health Certification and POC.	3911.2(m) The POC for the one chart cited has been corrected to add the type and frequency of diagnostic services. Effective immediately, 485 or other plans of care are prepared by the Office Manager and reviewed by the Director of Operations prior to being sent to the clinician. This review will ensure that the type and frequency of diagnostic services are recorded in the chart. No later than April 15, 2009, the chart audit tool will be amended to include this item.	APRIL 15, 2009

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3911.2(o)	***Each clinical record shall include the following information related to the patient:*** ***(o) Dates and times of collection of specimens*** Based on interview and record review, the agency failed to ensure the dates and times of collection of specimens ordered were documented on the Home Health Certification and Plan of Care (POC) for one out of fourteen patients in the sample. (Patient # 7) The finding includes: Review of Patient # 7's Home Health Certification and POC dated December 26, 2008 to February 23, 2009 on January 15, 2009, at approximately 3:00 PM revealed an order for skilled nursing services one to two times a week for eight weeks for blood draw. In an interview with the Clinical Director on January 15, 2009, at approximately 3:10 PM it was acknowledged the dates and times of collection of specimens was not on the Home Health Certification and POC. There was no evidence the dates and times of collection of specimens was on the Home Health Certification and POC.	3911.2(0) The process listed above will be instituted to ensure that dates and times of collection of specimens in included in the patient's chart. No later than April 22, 2009 the chart audit tool will be amended to include this item. 3911.2(s) The Clinical Director has instructed the appropriate clinicians to submit documentation of training and education given to patients and caregivers. Effective March 15, 2009, the RN doing the weekly audit will check specifically for this item. It will also be added to the audit tool for the monthly audit of 10% of active charts.	APRIL 22, 2009 APRIL 15, 2009
3911.2(s)	***Each clinical record shall include the following information related to the patient:*** ***(s) Documentation of training and education given to the patient and the patient's caregivers.*** Based on interview and record review, the agency failed to ensure		

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documentation of training and education given to the patient and the patient's caregivers for four of fourteen patients in the sample. Patient # 2, Patient # 4, Patient # 5, Patient #13)

The findings include:

1. Review of Patient # 2's Home Health Certification and POC dated November 7, 2008 to January 5, 2009 on January 21, 2009 at approximately 11:50 AM revealed Patient #2 was to be instructed on signs and symptoms of hypo/hyperglycemia and diabetic care management.

Review of Patient # 2's nursing clinical progress notes dated from December 26, 2008 to December 31, 2008, on January 15, 2009 at approximately 11:58 AM did not reveal documentation of training and education given to the patient and the patient's caregivers related to the signs and symptoms of hypo/hyperglycemia and diabetic care management.

In an interview with the Clinical Director on January 15, 2009 at approximately 12:05 PM, it was acknowledged the agency had noted deficiencies in documenting training and education given to the patient and the patient's caregivers according to their POC. Further interview revealed that training was being provided to correct the deficiencies in documenting training and education given to the patient and the patient's caregivers.

There was no evidence in the clinical record documentation of training and education given to the patient and the patient's caregivers was instructed on the signs and symptoms of hypo/hyperglycemia and diabetic care management.

2. Review of Patient # 4's Home Health Certification and POC dated November 13, 2008 to January 11, 2009 on January 15, 2009 at approximately 2:15 PM revealed Patient # 4 was to be instructed on the diabetic regime including diet preparation, administration of insulin, proper disposal of needles/syringes, rotation of injection sites and the signs and

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symptoms of hypo/hyperglycemia.

Review of nursing clinical progress notes dated from December 1, 2008 to December 31, 2008, on January 15, 2009 at approximately 2:20 PM did not reveal documentation of training and education given to the patient and the patient's caregivers related to the diabetic regime including diet preparation, administration of insulin, proper disposal of needles/syringes, rotation of injection sites and the signs and symptoms of hypo/hyperglycemia.

There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the diabetic regime including diet preparation, administration of insulin, proper disposal of needles/syringes, rotation of injection sites and the signs and symptoms of hypo/hyperglycemia.

3. Review of Patient # 5's Home Health Certification and POC dated November 8, 2008 to January 6, 2009 on January 15, 2009 at approximately 2:18 PM revealed Patient # 5 and caregiver was to be instructed on the signs and symptoms of disease progression, complications pain management.

Review of nursing clinical progress notes dated from November 15, 2008 to December 31, 2008, on January 15, 2009 at approximately 2:35 PM did not reveal documentation of training and education given to the patient and the patient's caregivers related on the signs and symptoms of disease progression, complications and pain management.

There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the diabetic regime including on the signs and symptoms of disease progression, complications and pain management.

4. Review of Patient # 13's Home Health Certification and POC dated August 7, 2008 to February 6, 2009 on January 16, 2009 at approximately 4:10 PM revealed Patient # 13 and caregiver was to be instructed on the signs and

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	symptoms of disease progression, complications and pain management. Review of nursing clinical progress notes dated August 6, September 6, October 3, December 3, 2008 and January 6, 2009 on January 16, 2009 at approximately 4:18 PM did not reveal documentation of training and education given to the patient and the patient's caregivers related on the signs and symptoms of disease progression, medication compliance, complications and safety measures. There was no evidence in the clinical record documenting the training and education the patient on the signs and symptoms of disease progression, medication compliance, complications and safety measures. **3912** **PATIENT RIGHTS AND RESPONSIBILITIES**		
3912.5	***Written policies on patient rights and responsibilities shall be made available to the general public.*** Based on staff interview, the HCA failed to ensure the establishment of a directive to ensure that their policies and procedures on patient's rights were being made available to the public. The finding includes: Interview with the Director on 1/16/2009 at 3:15pm revealed their policy on patient's rights and responsibilities was not currently being disseminated to their patients or being made available to the public.	3912.5 HMI Policy and Procedures Manual Section 2010 titled *Patient Rights and Responsibilities* clearly delineates Patient's rights and responsibilities. Any member of the public who comes to the HMI Home Health offices may read this section. This information is also on page 7 of the HMI *Guide to Home Car* which is given to all patients on admission.. Both documents were available at the time of the inspection.	APRIL 1, 2009
	3913 **COMPLAINT PROCESS**		
3913.3	***The telephone number of the Home Health Hotline maintained by the Department of Health shall be posted in the home care agency's***		

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	operating office in a place where it is visible to all staff and visitors. Based on observation, the HCA failed to post the telephone number for the Home Health hotline maintained by the Department of Health in an area visible to staff and visitors. The finding includes: Observations on 1/15/2008 at 9:45am and again on 1/16/2009 at 4:33pm revealed the required phone number was not posted anywhere in the receptionist area of the HCA's operating office.	3913.3 The number to the Home Health Hotline was posted in the reception area on February 19, 2009.	FEB 19 2009
3913.5	***The home care agency shall respond to the complaint within fourteen (14) calendar days of its receipt, and shall document the response.*** Based on staff interview, the HCA failed to ensure the establishment of a written directive or procedure to manage the requirement of the 14 day response period for all complaints as required by this section. The finding includes: Interview with the HCA's Director on 1/16/2009 at 11:53am revealed all complaints come to him and that he was responsible for managing all of the complaints generated through the agency. Additional record review failed to reflect that complaints were being responded to within the 14 day time frame allotted by this section.	3913.5 Policy 2050 of the HMI Policy and Procedure Manual was amended to reflect the requirement to respond to complaints within 14 days. The requirement to respond to complaints sent to DCRA remains at 72 hours. Effective April 22, 2009 a formal complaints tracking and trending form will be instituted.	APRIL 22, 2009
3913.6	***If the patient indicates that he or she is not satisfied with the response, the agency shall respond in writing within thirty (30) calendar days from the date of the agency's initial response. The response shall include the telephone number and address of all District government agencies with which a complaint may be filed and the telephone number of the Home Health Hotline maintained by the Department of Health.***	3913.6 HMI Home Health Policy and Procedures Manual, Section 2050 #10 states that clients will be informed that oral complaints may be filed with DCRA or mailed to 825 North Capitol Street and gives the Home Health Hotline number. This information is in the HMI *Guide to Home Care* on page 8. The requirement to respond to complaints within 30 days has been added to Section 2050.	APRIL 1, 2009

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Based on record review, the HCA failed to ensure the establishment of written directives or procedures for the referral of the HCA's complaints to the pertinent District Government agency and the telephone number of the Home Health Hotline maintained by the Department of Health.

The finding includes:

Review of the records presented on 1/16/2009 at 4:41pm revealed there was no evidence on file to substantiate that a written directive or procedure had been established to ensure that the HCA responds within 30 calendar days from the date of the initial complaint from a patient. In addition, there was no evidence on file to reflect that the patient was aware their complaint could be forwarded out to other District agencies, particularly the District's Department of Health.

3914

PATIENT PLAN OF CARE

3914.1 ***Each home care agency shall develop, with the participation of each patient or his or her representative, a written plan of care for that patient.***

Based on record review, the agency failed to ensure the development, with the participation of each patient or his or her representative, a written plan of care for that patient for one of fourteen patients in the sample. (Patient # 11)

The findings include:

Review of Patient # 11's clinical record on January 16, 2009 at approximately 3:50 PM revealed Patient # 11 did not have a POC in the record.

Review of Patient # 11's clinical record on January 16, 2009 at approximately 3:55 PM revealed an order from the Primary Medical Doctor (PMD) dated

3914.1

This case and its resolution was addressed in The response to 3911.1

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	December 10, 2008, for physical therapy treatment foe strengthening exercises, range of motion (ROM) and joint mobility exercise, transfer, balance ,stability, endurance and gait training two times a week for eight weeks. Review of the physical therapy progress note dated December 10, 2008 revealed the patient had a physical therapy evaluation on that same day. There was no evidence in the clinical record that the agency had developed a written POC for the patient.		
3914.3(l)	***The plan of care shall include the following:*** ***(l) Identification of employees in charge of managing emergency situations;*** Based on interview and record review, the agency failed to ensure identification of employees in charge of managing emergency situations on the Home Health Certification and Plan of Care (POC) for fourteen out of fourteen patients in the sample. The finding includes: Review of Home Health Certification and Plan of Care (POC) records from January 15-16, 2009 revealed the identification of employees in charge of managing emergency situations was not documented. Interview with the Clinical Director on January 15, 2009 at approximately 2:00 PM revealed that the agency did not document the identification of employees in charge of managing emergency situations on the Home Health Certification and POC. There was no evidence that the agency documented the identification of employees in charge of managing emergency situations on the Home Health Certification and POC.	3914.3(l) The patient's nurse or other clinician is responsible for managing emergencies. The PCA is to call the clinician or the office in the event of an emergency. When there is no HMI staff in the home, the Caregiver or patient is to call the on-call number or 911. This information will be added to the HMI Policy and Procedure Manual and included in the plan of care. This will commence on April 15, 2009	APRIL 15, 2009

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3914.3(m)	***The plan of care shall include the following:*** ***(m) Emergency protocols*** Based on interview and record review, the agency failed to ensure emergency protocols were documented on the Home Health Certification and Plan of Care (POC) for fourteen out of fourteen patients in the sample. The finding includes: Review of Home Health Certification and POC clinical records from January 15-16, 2009 revealed that emergency protocols were not documented. Interview with the Clinical Director on January 15, 2009 at approximately 2:10 PM revealed that the agency did not document emergency protocols on the Home Health Certification and POC. There was no evidence that the agency documented the emergency protocols on the Home Health Certification and POC.	3914.3(m) Effective April 15, 2009 emergency protocols addressed in 3914.3(l) will be documented in the plan of care.	APRIL 15, 2009
3914.3(n)	***The plan of care shall include the following:*** ***(n) Types and frequency of laboratory tests ordered, if applicable.*** Based on interview and record review, the agency failed to ensure types and frequency of laboratory tests ordered were documented on the Home Health Certification and Plan of Care (POC) for one out of fourteen patients in the sample. (Patient # 7) The finding includes: Review of Patient # 7's Home Health Certification and POC dated December 26, 2008 to February 23, 2009 on January 15, 2009, at approximately 3:00 PM revealed an order for skilled nursing services one to two times a week for eight	3914.3(n) This is the same case addressed in 3911.2(0). The chart audit tool will be amended to include a check for type and frequency of laboratory tests.	APRIL 15, 2009

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	weeks for blood draw. In an interview with the Clinical Director on January 15, 2009, at approximately 3:10 PM it was acknowledged that the type and frequency of laboratory tests to be drawn was not on the Home Health Certification and POC. There was no evidence that the type and frequency of laboratory tests to be drawn was on the Home Health Certification and POC.		
3914.4	***Each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care;*** Based on interview and record review, the agency failed to ensure each plan of care was approved and signed by a physician within thirty (30) days of the start of care for one of fourteen patients in the sample. (Patient # 5) The finding includes: Review of Patient # 5's Home Health Certification and POC dated November 8, 2008 to January 6, 2009 on January 15, 2009 at approximately 2:30 PM revealed the physician signed the POC on December 19, 2008. In an interview with the Clinical Director on January 15, 2009 at approximately 2:50 PM it was acknowledged that the POC was not signed by the physician in 30 days. There was no evidence that the POC was approved and signed by a physician within 30 days of the start of care.	3914.4 Once the Plan of Care is prepared and reviewed, it Is faxed to the doctor's office. Doctors who will not accept faxes receive the POC by certified mail. Prior to the faxing or mailing, the Receptionist calls the doctor's office to inform them that the POC is being sent. If the POC is not returned in one week, the doctor is called. If a response does not arrive in another week. an HMI staff member will visit the doctor to obtain a signature. If a signature still cannot be obtained, the patient, caregiver and doctor are told that if signature is not provided, care will stop. If a patient will be endangered due to the physician not Signing the order, the patient may be moved to a hospital. Physicians who consistently fail to sign the POC will be reported to the appropriate authorities.	APRIL 15 2009
	3916 **SKILLED SERVICES GENERALLY**		
3916.1	***Each home care agency shall review and evaluate the skilled services***		

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	provided to each patient at least every sixty-two (62) calendar days. A summary report of the evaluation shall be sent to the patient's physician. Based on interview and record review, the agency failed to review and evaluate the skilled services provided to each patient at least every sixty-two (62) calendar days and failed to send summary reports of the evaluations to the patient's physician for twelve out of fourteen patients in the sample. (Patients # 2, # 3, # 4, # 5, # 6, # 7, # 8, # 9, # 10, t #12 , # 13 and # 14) The finding includes: Review of twelve out of fourteen clinical records revealed that the skilled services provided to each patient was not reviewed and evaluated at least every sixty-two (62) calendar days and a summary report of the evaluations were not sent to the patient's physician. Interview with the Clinical Director on January 16, 2009, at approximately 11:40 AM revealed that skilled services were documented on the clinical record during each home visit. Further interview revealed that summary notes were recorded at the end of the certification period in the clinical records. There was no evidence that the agency reviewed and evaluated skilled services at least every sixty-two (62) calendar days and a summary report of the evaluations were not sent to the patient's physician.	3916.1 Skilled services being provided to patients are reviewed at least every 62 days as required. A summary report in the form of a 485 is sent along with doctors' orders. The 485 provides an update of the patient's condition and is the authority by which treatment continues. If a 485 is not used, a copy of the Case Conference will be sent to the physician.	APRIL 22, 2009
	3917 **SKILLED NURSING SERVICES**		
3917.1	***Skilled nursing services shall be provided in accordance with the patient's plan of care.*** Based on interview and record review, the agency failed to ensure that skilled nursing services were provided in accordance with the patient's plan of care for one out of fourteen patients in the sample. (Patient #1)		

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	The findings include: Review of Patient #1's Home Health Certification and POC dated November 4, 2008 to January 2, 2009 on January 15, 2009 at approximately 11:20 AM revealed Patient # 1 was to be provided skilled nursing services for complete systems assessment one to two times a week for eight weeks. Review of nursing clinical progress notes on January 15, 2009 at approximately 11:25 AM revealed that the skilled nurse only documented skilled visits to Patient # 1 on November 5, 15, 25, 2008, December 17 and 29, 2008. In an interview with the Clinical Director on January 15, 2009 at approximately 11:28 AM, it was acknowledged that nursing services were not provided in accordance with the patient's plan of care. There was no evidence in the clinical record that skilled nursing services were provided in accordance with the patient's plan of care.	3917.1 Scheduled nurse visits are to be recorded on the tracking system. Missed visits are reported to the Clinical Director the day the visit is missed so that appropriate action can be taken.	APRIL 22, 2009
3917.2(g)	***Duties of the nurse shall include, at a minimum, the following*** ***(g) Recording progress notes at least once every thirty (30) calendar days and summary notes at least once every sixty-two (62) calendar days;*** Based on interview and record review, the agency failed to ensure that skilled nurses recorded summary notes at least once every sixty-two (62) calendar days for ten out of fourteen patients in the sample. (Patients # 1, # 3, # 4, # 5, # 6, t # 7, # 9, # 10, #1 2 and # 13)	3917.2(g) All skilled nurses have been reminded of the requirement to record summary notes at least once every 62 days. This item has been added to the monthly chart audit to be completed on 10% of active charts. Omissions will be recorded and reported to the Clinical Director. Over time, omissions will be trended and that information also provided to the Clinical Director.	APRIL 22, 2009

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	The finding includes: Review of ten out of fourteen clinical records from January 15-16, 2009 revealed that skilled nurses did not record summary notes at least once every sixty-two (62) calendar days in the clinical records. Interview with the Clinical Director on January 16, 2009 at approximately 10:50 AM revealed that skilled nursing services were documented on the clinical record during each home visit. Further interview revealed that summary notes were recorded at the end of the certification period in the clinical records. There was no evidence that the agency's skilled nurses recorded summary notes at least once every sixty-two (62) calendar days in the clinical records.				
3917.2(i)	***Duties of the nurse shall include, at a minimum, the following:*** ***(i) Patient instruction, and evaluation of patient instruction*** Based on interview and record review, the agency failed to ensure that skilled nurses provided patient instruction and evaluation of patient instruction for four of fourteen patients in the sample. (Patient #1, Patient # 3, Patient # 7 and Patient # 10) The findings include:				

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	1. Review of Patient #1's Home Health Certification and POC dated November 4, 2008 to January 2, 2009 on January 15, 2009 at approximately 11:30 AM revealed Patient #1 was to be instructed on her diet, safety hydration and signs and symptoms of illness. Review of nursing clinical progress note dated November 25, on January 15, 2009 at approximately 11:35 AM revealed patient instruction related to Patient #1 increasing her fluid intake to two liters a day as tolerated and the signs and symptoms of Urinary Tract infection (UTI). However there was no documentation of the evaluation of patient instruction related to increasing hydration and signs and symptoms of UTI. In an interview with the Clinical Director on January 15, 2009 at approximately 11:45 AM, it was acknowledged the agency had noted deficiencies related to skilled nurses providing patient instruction, and evaluating patient instruction. Further interview revealed that training was being provided to correct the deficiencies related to skilled nurses documenting patient instruction, and evaluating patient instruction. There was no evidence in the clinical record that skilled nurses evaluated the patient instruction related to increasing hydration and signs and symptoms of UTI. 2. Review of Patient # 3's Home Health Certification and POC dated December 17, 2008, 2008 to January 5, 2009 on January 21, 2009 at approximately 11:50 AM revealed Patient #2 was to be instructed on signs and symptoms of UTI. Review of nursing clinical progress note dated to December 5, 2008 on January 15, 2009 at approximately 1:30 PM revealed patient instruction related to signs and symptoms of UTI and perineum care. However there was no documentation evaluating the patient instruction.	3917.2(i) These cases were all referred to the Clinical Director to Ensure that required patient instruction and evaluation of Patient instruction had occurred. Discussions with The involved nurses revealed that such instruction had Occurred however it had not been documented. On February 12, 2009, the Clinical Director called The nurses involved and directed them to conduct the Required patient instruction (if they had not already Done so) and to document it. Effective February 15, 2009, the RN who conducts the Weekly audit of submitted paperwork is to check to Insure that if patient instruction is ordered by the doctor, it is recorded in the chart. If it is not, the Clinical Director is notified. Documentation of patient instruction will be added to the audit tool for the monthly 10% audit. Omissions will be noted and reported to the Clinical Director.	April 15, 2009

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There was no evidence in the clinical record of an evaluation of patient instruction related to signs and symptoms of UTI and perineum care.

3. Review of Patient # 7's Home Health Certification and POC dated December 26, 2008 to February 23, 2009 on January 15, 2009, at approximately 3:20 PM revealed an order for Patient # 7 and caregiver to be instructed on the signs and symptoms of disease progression, complications and pain management.

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Review of nursing clinical progress note dated December 28, 2008, on January 15, 2009 at approximately 3:35 PM revealed documentation of training and education given to the patient encouraging the patient to stay on a salt free diet and to continue Coumadin precautions. However there was no documentation evaluating the patient instructions.

There was no evidence in the clinical record of an evaluation of patient instruction related to encouraging the patient to stay on a salt free diet and to continue Coumadin precautions.

4. Review of Patient # 10's Home Health Certification and POC dated September 7, 2008 to January 5, 2009 on January 16, 2009, at approximately 2:50 PM revealed an order for Patient # 10 to be instructed on the signs and symptoms of disease progression and Coumadin precautions.

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Review of nursing clinical progress note dated November 13, 2008, on January 16, 2009 at approximately 3:00 PM revealed documentation of training and education given to the patient related to Coumadin precautions. However there was no documentation evaluating the patient instruction on the Coumadin precautions.

There was no evidence in the clinical record of an evaluation of patient instructions related to Coumadin precautions.

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	3920 INTRAVENOUS THERAPY SERVICES		
3920.5(a)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(a) Patient selection criteria;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures on Intravenous Therapy (IV) services to ensure patient selection criteria. The finding includes: Review of the records presented on 1/16/2009 at 3:30pm revealed there was no evidence on file to establish that a written directive or procedure had been drafted to ensure the criteria for patient selection with regards to IV therapy services.	3920.5(a)(b)(c)(d)(e)(f)(g)(h)(i)(j)(k) No later than May 1, 2009 policies and procedures specific to IV Therapy services will be written and implemented. Policies and procedures for care already exist in the Policies and Procedures Manual, however, there is not currently a set of policies specific to the provision of IV therapy services.	MAY 1, 2009
3920.5(b)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(b) Monitoring of patients and emergency care;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures on Intravenous Therapy (IV) services for the monitoring of patients and the delivery of emergent care. The finding includes: Review of the records presented on 1/16/2009 at 3:35pm revealed there was no evidence on file to establish that a written directive or procedure had been drafted to ensure the monitoring of patients and the delivery of emergent care		

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	for patients receiving IV therapy services.			
3920.5(c)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(c) Availability of care twenty-four (24) hours a day and continuity of care;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures on Intravenous Therapy (IV) services to ensure the availability of care 24 hours a day and to maintain the continuity of care for its patients. The finding includes: Review of the records presented on 1/16/2009 at 3:40pm revealed there was no evidence on file to establish that a written directive or procedure had been written to ensure that continuity of care could be maintained 24 hours a day for patients receiving IV therapy services.			
3920.5(d)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(d) Preparation and storage of intravenous solutions, special nutrition formulas, and medications;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures to ensure the preparation and storage of Intravenous solutions, special nutrition formulas and medications for all patients receiving Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 3:47pm revealed there was no evidence on file to establish that a written directive or procedure had been			

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	written to ensure the preparation and storage of Intravenous solutions, special nutrition formulas and pertinent medications for patients receiving IV therapy services.			
3920.5(e)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(e) Infection control;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures to ensure proper infection control measures for all patients receiving Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 3:50pm revealed there was no evidence on file to establish that a written directive or procedure had been put in place to ensure that effective infection control measures would be implemented for patients receiving IV therapy services.			
3920.5(f)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(f) Disposal of sharps, catheters, tubing and dressings;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures to ensure the proper disposal of sharps, catheters, tubing and dressing for all patients receiving Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 3:55pm revealed there was no evidence on file to establish that a written directive or procedure had been put in place to ensure the proper disposal of sharps, catheters, tubing and			

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	dressings for patients receiving IV therapy services.			
3920.5(g)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(g) Equipment care and maintenance;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures to ensure the proper care and maintenance of medical equipment for all patients receiving Intravenous Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 4:00pm revealed there was no evidence on file to establish that a written directive or procedure had been enacted to ensure the proper care and maintenance of medical equipment for patients receiving IV therapy services.			
3920.5(h)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(h) Administration guidelines, including adverse reaction protocol;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures for administrative guidelines including the management of adverse reaction protocols for all patients receiving Intravenous Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 4:05pm revealed there was no evidence on file to substantiate that a written directive or procedure had been established to ensure administrative guidelines and adverse reaction protocols were created to ensure the health and safety of all patients receiving			

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	IV therapy services.			
3920.5(i)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(i) Obtaining medical supplies;*** Based on record review, the HCA failed to ensure the establishment of policies and procedures for obtaining medical supplies for all patients receiving Intravenous Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 4:10pm revealed there was no evidence on file to substantiate that a written directive or procedure had been established for obtaining medical supplies for all patients receiving IV therapy services.			
3920.5(j)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(j) Blood transfusions; and*** Based on record review, the HCA failed to ensure the establishment of policies and procedures for performing blood transfusions for all patients receiving Intravenous Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 4:17pm revealed there was no evidence on file to substantiate that a written directive or procedure had been established for the procedure of blood transfusions for all patients receiving IV therapy services.			

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3920.5(k)	***The home care agency shall have written policies and procedures concerning intravenous therapy that address the following:*** ***(k) Adverse reactions.*** Based on record review, the HCA failed to ensure the establishment of policies and procedures to address adverse reactions in all patients receiving Intravenous Therapy (IV) services. The finding includes: Review of the records presented on 1/16/2009 at 4:30pm revealed there was no evidence on file to substantiate that a written directive or procedure had been established to manage adverse reactions in all patients receiving IV therapy services. **3923** **PHYSICAL THERAPY SERVICES**		
3923.1	***If physical therapy services are provided, they shall be provided in accordance with the patient's plan of care.*** Based on record review, the agency failed to ensure that physical therapy services were provided in accordance with the patient's plan of care for one of fourteen patients in the sample. (Patient #11) The findings include: Review of Patient # 11's clinical record on January 16, 2009 at approximately 3:50 PM revealed Patient # 11 did not have a POC in the record. Review of Patient # 11's clinical record on January 16, 2009 at approximately	3923.1 HMI has an electronic sign-in system (SANTRAX). The clinician is to submit a schedule every week. That schedule is then entered into the system. If the clinician does not sign in, the office staff makes a coordination call. If it appears that the visit was not made as scheduled, the Clinical Director is notified. Every morning, the Administrative Assistant prepares a PT/OT visit schedule and sends it to the Clinical Director who can thus manage the cases in real time. If a visit is not made on one day, that information is given to the Clinical Director to ensure that action is taken to provide the care ordered by the physician.	APR 15, 2009

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	3:55 PM revealed an order from the Primary Medical Doctor (PMD) dated December 10, 2008, for physical therapy treatment foe strengthening exercises, range of motion (ROM) and joint mobility exercise, transfer, balance ,stability, endurance and gait training two times a week for eight weeks. Review of the physical therapy progress note dated December 10, 2008 revealed the patient had a physical therapy evaluation on that same day. There was no evidence in the clinical record that physical therapy services were provided in accordance with the patient's plan of care.			