GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Immaculate Health Care Services Inc.	1818 New York Ave. N.E., Suite 228	3/27/09 – 4/22/09
	Washington, D.C. 20002	Follow-up Dates(s):

Citation from the DCMR	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
Title 22 Chapter 39	The Health Regulation Licensing Administration (HRLA) received a telephone complaint from an employee of Immaculate Health Care Services on March 27, 2009. The complaint alleged the following: (1) Employees were fraudulently certified by a training school. This allegation was **referred to the Office of Inspector General.** (2) Employees were inappropriately asked to sign training attendance sheets when they came for their paycheck . This allegation was **partially substantiated.** (3) A majority of employees were not qualified. This allegation was **partially substantiated.**	Title 22 Chapter 39 1. 2. 3.	All employees' certificate is being reviewed prior to being employed by the agency. The agency has reviewed all personnel files and verified all employee certificate and all verified with their schools as valid. An ongoing verification system is in place and the new administrator will randomly review 10% of personnel files to ensure that clinicians, contracted employees have a valid license or certificate. Employees are mostly giving hand outs on pay days. The new administrator will ensure that all in-services are conducted as schedule by the human resources monthly calendar dates. All employees' certificate is being reviewed prior to being employed by the agency.	06/10/09 06/10/09 06/10/09 June 10 2009

Theresa Waters, Ronald Tyson, Rolland Follot
Name of Inspector

Date Issued

Johnson Komolafe
Facility Director/Designee

5/15/09
Date

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	(4) The complainant's daughter (also an employee) was issued a CPR certification card without having taken a test . This allegation was **not substantiated.** (5) The complainant's mother (a patient) was asked to sign a nurse's time sheet for dates when services were not rendered. This allegation was **not substantiated.** Based on the nature of the complaint two investigators from HRLA initiated an onsite investigation on March 27, 2009. The findings and conclusion of the investigation were based on review of clinical records, personnel files, and staff, patient and caregiver interviews. The findings were also based on three home visits. A sample of 9 adult patient records was selected based on 10% of 85 adult patients served. [Note: The HCA also provides services for 41 children.] In addition to the investigation , a follow up survey was also conducted to verify compliance with deficiencies cited during the July 2008 initial licensure survey. The results of the follow-up revealed new and continued deficiencies.	4. 5.	The agency do not issue CPR certificate to workers, the agency only refers their workers to appropriate CPR instructors for recertification purposes. The agency verify and validate CPR cards for all current employees and then on an ongoing basis for all new potential employees. It is the policy of IHCSI that all timeslips be signed by the client at the end of every shift.	06/10/09 06/10/09

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3911.1	**3911** **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 practice.**			
	Based on record reviews and interviews, it was determined that accuracy of clinical records could not be verified for one (1) of nine (9) records reviewed. The findings include: 1. Patient #1's care plans dated 8/8/08-2/7/09 and 2/8/09-8/7/09 directed the RN to: *"teach dietary modifications as it relates to the* <patient's diagnosed> *diseases,"* such as hypertension, diabetes mellitus and end stage renal disease (assigned to the RN). The nursing monthly note for November and	3911.1 1.	An extensive in-service training is ongoing with the new administrator to ensure that all IHCSI staff are clinically competent in Instructing/teaching client measurable goals with client's disease process, diet modification, physical assessment, documenting feedback	June 1st 2009

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	December 2008 indicated that teaching of diabetic care was provided to the patient; however there was specific training on diabetic care indicated since December 2008. On 4/6/09 Patient #1 was interviewed at his home. He was asked about education/ training about diabetes management, Patient #1 stated that neither the current RN nor the previous RN had done so. He recalled that one woman had *"lectured"* him *"a long time ago."* The HHA on duty at the time stated that he had not observed a nurse educating Patient #1 about diabetes during the past 2 – 3 months that he had worked with the client (Mon.-Fri.).	3911.1	from client as it relates to client disease process. A review of all clinical records is in progress and measures have been implemented to those client found to have been affected with non educational training with disease process. Upon completion of training, acknowledgement of training form will be placed in their personnel files.	
3911.2 3911.2 (h)	**3911** **CLINICAL RECORDS** **Each clinical record shall include the following information related to the patient:** **(h) Clinical, progress, and summary notes, and activity records, signed and dated as**			

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	appropriate by professional and direct care staff. Based on record review and interview, it was determined that the agency failed to provide signed and dated activity records for one (1) of nine (9) patients. The finding includes: A record review on April 10, 2009 at approximately 1 pm revealed the following: Patient #6's clinical record contained a Plan of Care with certification period from September 8, 2008 to March 7, 2009 which ordered: Personal Care Aides (PCA) 7 visits per week for 8 hours for 6 months. There was no documented evidence that PCA services had been provided seven (7) days a week as evident by signed "PCA Timesheets" which indicated that patient was only provided PCA services for five (5) days a week (Mon.-Fri.) from September 8, 2008 to March 7, 2009. During face to face interview with Director on April 10, 2009, at approximately 2:00 PM, she	3911.2 (h)	The agency has reinforced its policy on physician orders. Clinical staff have been in-serviced on the requirements for compliance with the prompt notification of any change with the plan of treatment such as change of hours especially when complete ordered hours are not allowed by family members. The clinical director will review the PCA hours of work to ensure compliance with the physician orders. The new administrator will audit 10% of client's chart on a random monthly basis to ensure accurate implementation of client's physician care plan. Acknowledgement of physician orders policy training by the clinical nurse staff will be place in staff personnel folders.	June 1st 2009 accepted

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	stated "The patient only wanted PCA services from the PCA he/she had during the week. We can not pay that person overtime on weekends so the patient refused services on the weekends. I should have gotten an order to decrease Home Health Aide services to five (5) days a week."			
3911.2 (s)	**(s) Documentation of training and education given to patient and the patient's caregivers.** Based on record review and interview, it was determined the agency failed to provide education to caregiver and patient as ordered for one (1) of nine (9) patient's. The findings include: A record review on April 10, 2009 at approximately 1 pm revealed the following : (a) Patient #6 clinical record contained a Plan of Care with certification period from September 8, 2008 through March 7, 2009 ordered for PCA (7 visit per week for 8 hours for 6 months), RN to visit monthly/PRN for 6 months to teach factors that aggravate and ameliorate pain…	3911.2 (s)	All IHCSI staff have been reminded about the pain management policy through in-services by a contracting clinical nurse with a BSN and has 7years of home care instructions. Pain management acknowledgement of training by the staff will be documented on each employees file. Measures have also been implemented for those client found to have been affected with these condition of participation.	May 30th 2009

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	There was no documented evidence in patient's record that teaching had been provided for PCA as evident by forms named "Nursing Visits Notes" and "Supervisory Visit Forms" dated monthly from September 15, 2008 through March 18, 2009. There was no documented evidence in the patient's record that the patient was taught about factors the aggravate and ameliorate pain as evident by "Nursing Visit Notes" dated monthly from September 15, 2008 through March 18, 2009. During a face to face interview on April 10, 2009 at approximately 2pm, the Director acknowledged the above findings.		SEE PLAN OF CORRECTION ON PAGE 6	
3912.2 3912.2 (c)	**3912** **PATIENTS RIGHTS AND RESPONSIBILTIES** **Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights:** **(c) To be informed orally and in writing of the following:**	3912.2 (c)	The clinical nurses and social workers have been counseled and trained on the need for compliance with this condition of participation with the admission policies, that every client has the right to be advised of the availability of the toll-free HHA hotline number in the District of Columbia and the agency hours of operation including educating the client about the purpose of the hotline number in case the client want to lodge complaints or questions about the agency. Acknowledgement of the training by all immaculate clinical staff will be placed on their personnel folders.	May 30th 2009

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3912.2 (c)(7)	**(7) The telephone number of the Home Health Hotline maintained by the Department of Health.** Based on telephone interview on April 10, 2009 with patient #2 husband at approximately 3pm, revealed the agency failed to provide patient with Department of Health Hotline phone number. The surveyor asked the husband if he was made aware by the agency of how to contact the Department of Health for a compliant. He denied being given any information of how to contact the Department of Health. The Home Health Hotline for Department of Health phone number was given to the husband by the surveyor at the time.	3912.2 (c)(7)	Corrective measurement has been carried out for all client found to have been affected with not receiving the DC Medicaid hotline telephone numbers. The clinical director of nursing is randomly contacting client at home to ensure that immaculate clients are knowledgeable about the hotline number and they are being provided with the numbers as well.	?? → How long will manager do this?
	3912 **PATIENT RIGHTS AND RESPONSIBILITIES**			
3912.6	**The home care agency shall take appropriate steps to ensure that all information is conveyed, pursuant to these rules, to any patient who cannot read or who otherwise needs accommodations in alternative language or communication method. The home care agency shall document in the patient's record the steps**			

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	taken to ensure that the patient has been provided with all required information. Based on a interview and record review, it was determined that the agency failed to provide appropriate steps to ensure that all information provided was conveyed to a patient with an alternative language for one (1) of one (1) patient. (Patient #2) The findings include: On April 9, 2009, Patient #2's husband, who is the caretaker and speaks very little English, was interviewed via phone through an interpreter. The husband revealed that he and his wife could not speak or understand English. He acknowledged that his Home Health Aid was bilingual, and reported that neither the Nurse(s) nor the Social Worker that was assigned to his wife spoke Spanish. When asked who provided him with instructions and training on his wife's health care needs and the administration of medication including insulin, he indicated that he was trained to take care of his wife by the staff at the National Rehabilitation Hospital, when his wife was a patient.	3912.6	Effective June 1st 2009 all immaculate Hispanic speaking client approximately 16 in number have been assigned to a nurse who visit with a Hispanic interpreter. Immaculate has also procured lose leaflet teaching instructions in disease process to be used during nursing visits for educational training purpose. Client feedback will be document. The Director of Nursing will randomly audit 10% of clinical file to ensure that the clinical staff are providing proper documentation and teaching instructions as it relates with client's plan of treatment.	5/18/09 accepted

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	He indicated that he had received no training or instructions from Immaculate. A record review on April 10, 2009 at approximately 2pm revealed a plan of care with certification period of January 22, 2009 through July 21, 2009 with order as follows: Social Worker visit monthly and as needed for 6 months to ensure adequate and timely implementation of plan of care; coordinate client's services to get met. RN visit 1-3 times monthly and as needed for 6 months. Teach management of disease process as it relates to IDDM, HTN, osteoarthritis, dyslipidemia, obesity, CAD and cataract... Further review of the record revealed the following: a). Nurse provided teaching to the patient as evident by "Nursing Visit Notes" dated January 19, 2009, February 19, 2009 and March 15, 2009. Nurse failed to document steps used to ensure	3912.6	The administrator will provide training with the loose leaflet teaching instructions to all IHCSI clinical staff and training acknowledgement will be placed on clinical staff personnel files.T he office RN will review nurses notes on a daily basis to ensure teaching instructions are carried as outlined in client's treatment plan	

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	that Spanish speaking patient was provided with required information. b). Social workers notes dated January 6, 2009, February 9, 2009 and March 9, 2009 all indicate that social worker will ensure that patient's need are met. There is no documented evidence of steps used to ensure that Spanish speaking patient was provided with required information. **3915** **HOME HEALTH AND PERSONAL CARE AIDE SERVICES**		**3912.6** **SEE PLAN OF CORRECTION ON** **PAGE 9 AND 10**	
3915.6	**After the first year of service, each aide shall be required to obtain at least twelve (12) hours of continuing education or in-service training annually, which shall include information that will help maintain or improve his or her performance. This training shall include a component specifically related to the care of persons with disabilities.** Based on record review, interview and observation, it could not be verified that a training session on March 23, 2009 was provided to Home Health Aides/LPN's.	3915.6	The agency has reinforced its policy with staff development training by utilizing the calendar method in scheduling all in-services from May through December	June 10 2009

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	The findings include: A record review on April 10, 2009 at approximately 1pm revealed that the agency had provided training on March 23, 2009 to their Home Health Aides/LPN's. The topic was "Observations to Report to the Supervising Nurse" There was no documented evidence of an agenda for the class or a set time that the class was offered. The only information the record contained was four sign-in sheets with approximately 84 staff members names and a one page document named "Observations to Report to the Supervising Nurse D-170" of the information provided to the class The HCA's Director was interviewed on April 10, 2009, to ascertain information regarding the training requirements for HHA/PCAs' and the corresponding in-service training dates. The director indicated that training occurred often. She stated that the training lasted 90 minutes. She explained that the training class was held at the office's conference room. Due to the small conference room which was observed on April 10, 2009, the Director was asked where the staff trained together. She said that they	3915.6 3915.6	Staff will sign their availability date for in-services. The agency has hired a new administrator to reinforced the changes with the new system related to training polices. The agency has also extended its office conference room to sit approximately 18-20 staff at one classroom session. Training/in-services session materials will be attached to signing sheet for record purposes and filed appropriately in the training folders. Mandatory in-service/training season will be scheduled on an ongoing basis around staff availabilities.	June 10th 2009 On Going

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	were trained as they came into the office to pick-up their payroll check. It should be noted staff arrived at staggered times to pick-up their payroll checks and that the Agency's pay day was on Fridays. The training date on the sign-in sheet was a Monday. On April 10, 2009, at approximately 3:00 PM, an HHA was interview outside of the Agency. The HHA requested anonymity, but stated that they often signed training sheets on Fridays before picking up their payroll checks. The HHA acknowledged that they would on occasion be given a short test with 5 questions. The HHA could not recall attending training with the entire staff being present.		3915.6 SEE PLAN OF CORRECTION ON PAGE 11 AND 12	
	3915 **HOME HEALTH AND PERSONAL CARE AIDE SERVICES**			
3915.11 (g)	**(g) Meal preparation in accordance with guidelines, and assistance with eating.** Based on record reviews and interview, it could not be verified that agency staff prepared meals in	3915.11 (g)	All IHCSI staff is currently undergoing in-service educational training on FOOD, NUTRITION, AND MEAL PLANNING, to ensure competency	June 10th 2009

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	accordance to the guidelines for two (2) of nine (9) patients records reviewed. (Patient's #2 and 6) The findings include: A record review on April 10, 2009 at approximately 1 pm revealed the following: a) Client #2 record contained a Care Plan dated January 22, 2009 through July 21, 2009 which had a diet order low salt, fat and 1800 Diabetic Diet. Further review of the record revealed a form named "Personal Care Instructions" dated January 22, 2009 through July 21, 2009 in which the nurse checked for the PCA to prepare and serve diet . There was no documented evidence that the PCA had knowledge of meal preparation in accordance to the guidelines of a low salt, fat and 1800 Diabetic Diet as ordered for the patient by the physician. b). Patient #6 record contained two (2) Plan of Cares with certification periods dated March 8, 2008 through September 7, 2008 and September 8, 2008 through March 7, 2009 both had the same diet order for low salt, low fat and diabetic diet	3915.11 (g)	with this training each staff will have to pass a post test exam at 85%. Evidence of competencies will be placed in their personnel files by June 10th 2009. IHCSI has also procured core curriculum for home health care nursing from home care university nurses association that also include community oriented practice for the use of the clinical instructor as a reference guide as of June 10 2009. The agency has also purchase home health aide hand books for the home care aide (fifth Edition) All home health aides will use the home health hand book as a clinical reference guide as of June 10th 2009.	06/10/09 #2 How will they identify other? #4 who will check?

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	Further review of the record revealed a form named "Personal Care Instructions" dated March 8, 2009 through March 7, 2009 in which the nurse checked for the PCA to prepare and serve diet . There was no documented evidence that the PCA had knowledge of meal preparation in accordance to the guidelines of a low salt, fat and Diabetic Diet as ordered for the patient by the physician. During a face to face interview with Director on April 10, 2009 at approximately 2pm , she acknowledged findings.	3915.11 (g)	The agency signed up a new contract with quality assurance personnel who will audit 10% of clients chart s on a monthly basis to ensure compliance of field nurses documenting teaching of home health aide about food nutrition, and meal planning including response from home health aides. The administrator will review 10% of client's charts on a random monthly basis to ensure accurate implementation of this condition of participation.	06/10/09
	3926 **SOCIAL SERVICES**			
3926.1	**If social services are provided, they shall be in accordance with the patient's plan of care and in consultation with the patient.** Based on interview and record review, the contracted social worker associate (SWA) failed	3926.1	**All clinical visiting nurses /social workers have been counseled and reoriented on the need for compliance with this condition of participation, such as timely collaboration of any change in clients treatment plan, timely communication on educational needs as related to the client disease process between social workers, Registered nurses, and Primary care physician with any change with clients care, the quality assurance personnel has**	June 10th 2009 not accepted, 11 December 3926.1

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	to provide social services in accordance with Patient #1's plan of care. The findings include: On 4/2/09, beginning at 2:15 PM, review of Patient #1's Treatment Plan/ Physician's Order (POs) revealed that he had orders for monthly social work visits *"to ensure adequate and timely implementation of plan of care; and coordinate client's services to get needs met."* Patient #1's record reflected monthly social work/ case manager visits had been documented on 7/7/08, 8/13/08, 10/22/08, 11/8/08, 12/12/08 1/2/09, 2/20/09 and 3/20/09.	3926.1	reviewed the job description of the social workers and the Registered nurses job description to ensure that every discipline is aware of their job description. The Personnel care aides are undergoing training with timely reporting of any change in client's care to the office or the supervising nurse. Evidence of such training will be placed in their personnel files.	6-10-09
	1. There was no evidence that the social worker associate (SWA) had determined whether Patient #1's teaching/educational needs were being implemented timely and in accordance with the plan of care. Patient #1's Treat Plans dated 8/8/08-2/7/09 and 2/8/09-8/7/09 directed the RN to: *"teach dietary modifications as it relates to the* <patient's diagnosed> *diseases,"* such as hypertension, diabetes mellitus and end	3926.1 1	The quality assurance nurse is conducting educational training to reinforce the importance of teaching instructions related to client disease process acknowledgement of training will be placed on clinicians personal folders and case manager's folders. To ensure compliance with this condition of participation. The administrator is reviewing all clients' record to ensure compliance with this condition of participation.	6-10-09

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	stage renal disease (assigned to the RN). The survey/investigation findings revealed no evidence that Patient #1 and the Home Health Aide (HHA) who prepared the client's meals had not received training on dietary modifications applicable to his health needs. SWA's monthly reports failed to address the teaching component. When interviewed by telephone on 4/15/09, beginning at 2:05 PM, SWA acknowledged that she had not spoken with the RN. 2. There was no evidence that SWA had determined whether the PCA was reporting *"medical necessities to clinical supervisor at <agency office telephone/MD telephone>"* in accordance with Patient #1's plan of care. SWA's 11/8/08 monthly report indicated that Patient #1's PCA informed her that the client was not taking his insulin. A similar concern was documented in the 2/20/09 report. On 4/6/09, Patient #1 stated that he had been without insulin for 6 months, which was confirmed by the HHA present at the time. On 4/9/09, the administrator stated that all problems or concerns identified by a PCA/HHA should be reported to a nurse at their main office. The survey/investigation revealed that this	3926.12	IHCSI clinicians, PCA/HHA, case managers have been re-oriented on the need for compliance with this condition of participation, such as timely reports of any changes in client's treatment plan, timely communication between social workers,nurses and home health aides, timely communication with any change of client' status to the Primary Physician and not limited to change in medications, non Compliant with medications. The Quality assurance nurse is re-orienting all clinician/case managers with Job their description. Evidence of such training will be placed in their personnel files by 6-10-09	6-10-09

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	information had not been relayed to the RN or the primary care physician (PCP). 3. There was no evidence that SWA ensured that Patient #1's complaints regarding sleepiness and possible medication side effects were addressed timely. SWA's 7/7/08 monthly report included *"patient states that he sleeps a lot during the day. He states that this may be due to some of the side effects of his medications."* One month later, the 8/13/08 report repeated the same 2 sentences about sleepiness and medications; however, there was no evidence that SWA contacted either the RN or the PCP. When interviewed by telephone on 4/15/09, beginning at 2:05 PM, SWA stated that she expected that the RN routinely reviewed Patient #1's medications. She acknowledged, however, that she had not discussed the issue with the RN.	3926.1 3.	The reference social worker has been assigned to be supervised by a license clinical social worker Corrective measures have been implemented to that client found to have been affected by untimely notification of client's medical needs. The new administrator is currently reviewing all clients files to ensure compliance with any client medical needs. The quality assurance nurse is reviewing the records of all client's seen by the reference social worker and corrective measures implemented.	06/10/09

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✓ 3926.1	3926 **SOCIAL SERVICES** **If social services are provided, they shall be in accordance with the patient's plan of care and in consultation with the patient.** Based on interview and record review, the contracted social worker associate (SWA) failed to provide social services in accordance with Patient #1's plan of care. The findings include: On 4/2/09, beginning at 2:15 PM, review of Patient #1's Treatment Plan/ Physician's Order (POs) revealed that he had orders for monthly social work visits *"to ensure adequate and timely implementation of plan of care; and coordinate client's services to get needs met."* Patient #1's record reflected monthly social work/ case manager visits had been documented on 7/7/08, 8/13/08, 10/22/08, 11/8/08, 12/12/08 1/2/09, 2/20/09 and 3/20/09.		3926.1 SEE PLAN OF CORRECTION ON PAGE 15	

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	1. There was no evidence that social worker A (SWA) had determined whether Patient #1's teaching/educational needs were being implemented timely and in accordance with the plan of care. Patient #1's Treat Plans dated 8/8/08-2/7/09 and 2/8/09-8/7/09 directed the RN to: *"teach dietary modifications as it relates to the <patient's diagnosed> diseases,"* such as hypertension, diabetes mellitus and end stage renal disease (assigned to the RN). The survey/investigation findings revealed no evidence that Patient #1 and the Home Health Aide (HHA) who prepared the client's meals had not received training on dietary modifications applicable to his health needs. SWA's monthly reports failed to address the teaching component. When interviewed by telephone on 4/15/09, beginning at 2:05 PM, SWA acknowledged that she had not spoken with the RN. 2. There was no evidence that SWA had determined whether the PCA was reporting *"medical necessities to clinical supervisor at <agency office telephone/MD telephone>"* in accordance with Patient #1's plan of care. SWA's 11/8/08 monthly report indicated that Patient #1's PCA informed her that the client was	3926.1 I 3926.1 2.	The quality assurance nurse is conducting educational training to reinforce the importance of teaching instructions related to client disease process acknowledgement of training will be placed on clinicians personal folders and case manager's folders. To ensure compliance with this condition of participation. The administrator is reviewing all clients' record to ensure compliance with this condition of participation. IHCSI clinicians, PCA/HHA, case managers have been re-oriented on the need for compliance with this condition of participation, such as timely reports of any changes in client's treatment plan, timely communication between social workers,nurses and home health aides, timely communication with any change of client' status to the Primary Physician and not limited to change in medications, non Compliant with medications. The Quality assurance nurse is re-orienting all clinician/case managers with Job their description. Evidence of such training will be placed in their personnel files by 6-10-09	6-10-09 06/10/09

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	not taking his insulin. A similar concern was documented in the 2/20/09 report. On 4/6/09, Patient #1 stated that he had been without insulin for 6 months, which was confirmed by the HHA present at the time. On 4/9/09, the administrator stated that all problems or concerns identified by a PCA/HHA should be reported to a nurse at their main office. The survey/investigation revealed that this information had not been relayed to the RN or the primary care physician (PCP). 3. There was no evidence that SWA ensured that Patient #1's complaints regarding sleepiness and possible medication side effects were addressed timely. SWA's 7/7/08 monthly report included *"patient states that he sleeps a lot during the day. He states that this may be due to some of the side effects of his medications."* One month later, the 8/13/08 report repeated the same 2 sentences about sleepiness and medications; however, there was no evidence that SWA contacted either the RN or the PCP. When interviewed by telephone on 4/15/09, beginning at 2:05 PM, SWA stated that she expected that the RN routinely reviewed Patient #1's medications. She acknowledged, however, that she had not discussed the issue with the	3926.1 3.	The reference social worker has been assigned to be supervised by a license clinical social worker Corrective measures have been implemented to that client found to have been affected by untimely notification of client's medical needs. The new administrator is currently reviewing all clients files to ensure compliance with any client medical needs. The quality assurance nurse is reviewing the records of all client's seen by the reference social worker and corrective measures implemented.	6-10-09

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	RN. 4. There was no evidence that social worker A coordinated "client's services to get needs met", in accordance with Patient #1's plan of care. SWA's 11/8/08 monthly report indicated *"PCA reports that patient is refusing to take his insulin. The CM educated patient about the importance of taking his medication. Patient was rebellious and states that he does not need to take his insulin; and that he is tired of taking it."* A similar concern was documented in her 2/20/09 report. On 4/6/09, Patient #1 stated that he had been without insulin for 6 months, this was confirmed by the HHA present at the time. Review of SWA's monthly reports in the period 6/08-3/09 revealed the following: *"Case manager will collaborate with RN regarding the client's medical care."* The reports did not, however, indicate any actions taken to coordinate services. As was later determined through interviews with the PCP, nurse and SWA, and further review of Patient #1's record, no collaboration with the RN had been achieved. Surveyors brought the issue to the attention of the PCP (and the HCA) following the 4/6/09 interview with Patient #1 and his HHA. On 4/9/09, at 2:50 PM, telephone interview with the PCP revealed that he had	3926.1 4	The reference social worker has been counseled by the quality assurance nurse. The new administrator and the quality assurance nurse have completed in-service training on timely reporting of client's medical problems. Acknowledgement of training has been documented in employees personnel file.	June 10th 2009

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	counseled the patient earlier that day about diabetes management and he had also written a new prescription for the client to resume taking insulin.			
3921.2	**3926** **SOCIAL SERVICES** **Social Services shall be provided by order of a physician by a license independent clinical social worker, a license independent social worker, or a licensed graduate social worker, in accordance with the health Occupation Revision Act (Title 2 Chapter 33).** Based on interview and record review, the HCA failed to ensure that social services were provided by a licensed social worker in accordance with HORA, for seven (7) of nine (9) patients records reviewed. The findings include: A record review on 4/2/09, beginning at 2:15 PM, revealed Care Plans for seven (7) patients had orders for monthly social work visits and visits as needed for 6 months to ensure adequate and timely implementation of plan of care; coordinate client's	3921.2	The services provided to the referenced clients Were case management services under the Elderly Physical disabilities (EPD) Waiver and not social Services under home health agency Regulations. Waiver services are not traditional Medicaid services. Section 19159 (c) of the social Act was waived to provide case management Services under the EPD Waiver. Per the approved EPD waiver regulations as approved by centers for Medicare and Medicaid services (CMS), a case Manager can be a registered nurse, social worker, Psychologist, gerontologist (see regulations Attachment # 9034 & 9035.The reference Social worker is a registered social worker and Holds a Bachelor degree of science in Social work, See enclosed her degree information. The agency has assigned the reference social worker To be supervised by a License clinical social Worker who will review all clients notes upon Turning her monthly evaluations of client notes Immaculate Agency has also contracted with a Quality assurance nurse who is conducting Re-orientation training with all case workers Working with the agency on timely communication About client's complaints and medical problems. The quality assurance nurse is also re-orienting all case Managers, field nurses on diabetic management policy And clinical procedures.	6-10-09

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	services to get needs met. Further review of the records revealed that all list patients had been provided services by the same social worker whose holds a license as an "Social Worker Associate" (Patient 's #1, #2, #3, #4. #7. #8. #9) On 4/15/09, beginning at 2:05 PM, telephone interview with SWA revealed that she had received a bachelor's degree and carried a Social Work Associate license. She stated that she worked "totally independent " and did not have a supervisory licensed clinical social worker reviewing her work. Further interview revealed that she was providing services for 35 Immaculate Health Care Services patients at the time of the interview. Subsequent review of the District's on line registry of licensed. professionals confirmed that SWA was licensed at the associate level.	3921.2	The agency is undergoing training with the nurses, Social workers, Personal Care aides, Home health Aides on timely reports of clients concerns. Upon completion of each training, the Acknowledgement of training will be placed in each Personnel file. The new administrator will ensure that all clients Concerns must be communicated via phone Or email in a timely manner. The office nurse ongoing will review nurse's notes And case management notes on a daily basis To ensure compliance with the treatment plan As ordered by the physician. The administrator will review 10% of clients Records randomly to ensure compliance with Client's instructions/education as it relates to Their disease process, dietary instructions, Diabetic management instructions and Prompt notification to physicians for any client Concerns, such as non compliant with medications Corrective measurement have been implemented To all the clients found to have been affected by the Untimely notification of medical problems.	6-10-09

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