

## Health Regulation &amp; Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2312 RHODE ISLAND AVE, NE WASHINGTON DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	INITIAL COMMENTS  An annual survey was conducted on March 14, 2013 through March 15, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). A random sample of 15 clinical records based on a census of 456 patients, 33 personnel files based on a census of 420 employees (11 clinical field nurses plus 409 aides), 3 discharge records and 4 home visits were utilized to conduct the survey. Another 11 patients were interviewed by telephone after the survey. The findings of the survey were based on observations in the corporate office and four patients' homes, interviews with agency staff and patient interviews as well as a review of patient and administrative records.	R 000	<p><i>Received 4/1/13</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT  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.  This Statute is not met as evidenced by: Based on interview and record review, the home care agency failed to ensure criminal background checks for all jurisdictions in which the employee had worked or resided within the 7 years prior to the check, for 1 of the 17 unlicensed employees. (Staff #5)  The finding includes:  On March 14, 2013, beginning at 3:07 p.m., review of the personnel record for Staff #5 revealed that background checks had been	R 125	<b>4701.5 BACKGROUND CHECK REQUIREMENT</b>  The agency HR and QA departments will review all pre-existing applications to ensure criminal background checks for all jurisdictions in which employee had worked or resided within the 7 years prior to the check is completed.  A background check for the jurisdiction has been completed in respect of staff #5.  To forestall a reoccurrence, it is now part of the application process that a national background check should be conducted for all prospective employees.	<b>4/1/13</b>	

Health Regulation &amp; Licensing Administration

TITLE *Administrator*

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE


*03/29/13*

## Health Regulation &amp; Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVE, NE WASHINGTON DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	'PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 125	Continued From page 1  obtained at the time of hire. The background checks covered the District of Columbia and Maryland. Her employment application form, dated November 29, 2012, indicated that she had been employed in California from 2009 through 2010. There was no evidence that a background check had been obtained in that jurisdiction.  On March 14, 2013, at approximately 1:30 p.m., the director of nursing (Staff #28) and the administrator (Staff #29) both confirmed that a background check was not done for California.	R 125	Continued From page 2  Cross Reference 4701.5 for Staff #5		4/1/2013

Health Regulation &amp; Licensing Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



Administrator

03/29/13

STATE FORM

5899

V21111

If continuation sheet 2 of 2

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVE, NE WASHINGTON DC 20018</b>		
(X4) ID PREFIX, TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	INITIAL COMMENTS  An annual survey was conducted on March 14, 2013 through March 15, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). A random sample of 15 clinical records based on a census of 456 patients, 33 personnel files based on a census of 420 employees (11 clinical field nurses plus 409 aides), 3 discharge records and 4 home visits were utilized to conduct the survey. Another 11 patients were interviewed by telephone after the administrative review. The findings of the survey were based on observations in the corporate office and four patients' homes, interviews with agency staff and patient interviews as well as a review of patient and administrative records.	H 000		
H 1501	3907.2(f) PERSONNEL  Each home care agency shall maintain accurate personnel records, which shall include the following information:  (f) Verification of previous employment;  This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to maintain accurate personnel records, to include documentation verifying previous employment, for 23 of the 27 employees in the sample. (Staff #1-15 and #17 home health aides; and, Staff #19 and #21-27 skilled nurses)  The findings include:  The HCA's personnel records were reviewed on March 14, 2013, beginning at 3:07 p.m. There	H 150	3907.2 (f) PERSONNEL  The agency HR department in conjunction with the QA Manager under the supervision of the Administrator will review all personnel's records to ensure that previous employments are verified.  The verification of employments in respect of Staff #1-15 and #17 home health aides; and, Staff #19 and #21-27 skilled nurses have been completed	4/1/13

Health Regulation &amp; Licensing Administration

TITLE

(X6) DAT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



V21111

Administrator

03/29/13

STATE FORM

6899

If continuation sheet 1 of 7

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVE, NE WASHINGTON DC 20018</b>		
(X4) ID PREFIX, TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 150	Continued From page 1  was no documented evidence that the HCA received verification of previous employment for the aforementioned employees. The records showed that verification letters had been sent out but had not been returned to the HCA by former employers. No follow-up actions had been documented.  During a face to face interview with the director of nursing (Staff #28) and the administrator (Staff #29) on March 14, 2013, at approximately 4:50 p.m., it was acknowledged the aforementioned employees did not have verification of previous employment in their personnel records.	H 150	Continued From page 1  The HR manager has been charged to review all active employee files and make sure that the reference checks are done immediately to determine who is fit for employment and can continue in employment	4/1/13
H 152	3907.2(h) PERSONNEL  Each home care agency shall maintain accurate personnel records, which shall include the following information:  (h) Copies of completed annual evaluations;  This Statute is not met as evidenced by: Based on review of personnel records and interviews, the home care agency (HCA) failed to provide documented evidence of current annual evaluations, for 5 of the 5 records of employees who were hired more than 12 months prior to the survey. (Staff #3, #7, #11, #13 and #17)  The finding includes:  The HCA's personnel records were reviewed on March 14, 2013, beginning at 3:07 p.m. Of the 27 V records reviewed, the 5 aforementioned employees had been on staff for 1 year or longer. v There was no documented evidence that the 5 employees had received annual performance	H 152	3907.2 (h) PERSONNEL  The annual evaluation has been done in respect of Staff #3, #7, #11, #13 and #17  The HR department and QA department will review all personnel's files monthly and forward the list of aides due for evaluation to the DON who will in turn forward the information to the appropriate supervisors of the respective personnel.	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

V21111

TITLE

*Administrator*

(X6) DATE

*03/29/13*

If continuation sheet 2 of 7



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVENUE, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 152	Continued From page 2 evaluations within the past 12 months.  On March 14, 2013, at 4:39 p.m., the administrator (Staff #29) stated that she had just spoken with their human resources manager. He reportedly confirmed Staff #17 had not received an annual evaluation. She then stated she would ask him about the other 4 employees. At the time of the survey, there was no evidence that the HCA completed annual evaluations, for inclusion in their employees' personnel records.	H 152	Continued From page 2  Cross reference 3907.2 for Staff #3, #7, #11, #13 and #17	4/1/2013	
H 409	3915.11(d) HOME HEALTH & PERSONAL CARE AIDE SERVICE  Home health aide duties may include the following:  (d) Assisting the patient with self-administration of medication; This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure that each home health aide (HHA) only assisted the patient to the extent of self-administration of medications, for one 1 of the 15 patients in the sample. (Patient #12)  The finding includes: Telephone interview with Patient #12, on March 19, 2013, at 10:32 a.m., revealed that her HHA (Staff #16) routinely administered her medications by placing the medications into her mouth. The patient explained that the aide did this "because my eyes are bad." Before the interview ended,	H 409	<b>3915.11 (d) HOME HEALTH &amp; PERSONAL CARE AIDE SERVICES</b>  The agency has scheduled an In-service training for April 9 <sup>th</sup> 2013, where the DON will re-instruct all aides on their duties and responsibilities and lay emphasis on assisting the patient with self-administration of medications by reminding the patient only  The nurses will re-orientate all patients at April's monthly visit on the policy on self administration of medications and aide responsibilities regarding medication administration.  Staff #16 was re-orientated to only remind patient to take medication by self and not to administer the medication as stated in the scope of practice of HHA duties.	4/1/2013	

Health Regulation &amp; Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

5899

V21111

If continuation sheet 3 of 7

## Health Regulation &amp; Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVENUE, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 409	Continued From page 3  she repeated again that the HHA placed medications in her mouth.  On March 19, 2013, an attempt was made to reach the director of nursing (Staff #28) by telephone. The assistant administrator (Staff #20) indicated that Staff #28 was not available at the time. When Staff #20 was informed that Staff #16 allegedly administered medications to his/her patient, she stated that their HHAs were told in training that they were not allowed to administer medications directly.  At the time of the survey, the HCA failed to make certain that Staff #16 only provided assistance to Patient #12 in order for her to self-administer her medications.  It should be noted that on March 20, 2013, at 12:50 p.m., telephone interview with Staff #28 revealed that the HCA had spoken with Patient #12's son, who had agreed to administer his mother's medications, rather than the HHA.	H 409	A plan of action to correct the incident was initiated and the agency spoke to the son of the patient #12 who accepted the responsibility to assist his mom with medication administration.  The family will be solely responsible henceforth for assisting patient with her medication administrations.	03/20/2013	
H 411:	3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE  Home health aide duties may include the following:  (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance;  This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure a home health aide (HHA) reported the patient's stomach	H 411	3915 (f) HOME HEALTH & PERSONAL CARE AIDE SERVICES  The agency has scheduled an In-service session for April 9 <sup>th</sup> , 2013 where the DON will re-orientate all the aides on the accurate process of documenting, recording and reporting of patient's physical condition, behavior or appearance.	4/1/2013	

Health Regulation &amp; Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

03/29/13

STATE FORM

6899

V21111

If continuation sheet 4 of 7

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVENUE, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H411	Continued From page 4  pain timely, for 1 of the 15 patients in the sample. (Patient #10)  The finding includes:  On March 14, 2013, beginning at 1:06 p.m., review of the "Timesheet" notes in Patient #10's clinical record revealed that an HHA (Staff #5) documented that the patient had stomach pains on September 20, 2012, and again on September 21, 2012. The HHA did not document having notified a nurse of Patient #10's condition. At 1:15 p.m., review of the "Nursing Monthly Visit" note dated October 19, 2012, revealed there was no changes to the patient's physical condition and no pain was verbalized. Continued review of the record failed to show evidence that a nurse had been notified at the time that the patient was complaining of stomach pain.  Interview with the director of nursing (Staff #28) on March 15, 2013, at 9:59 a.m., revealed that an HHA should always call the nurse if/when a patient is experiencing pain. Continued interview revealed that the nurse would then do a "PRN" (as needed) visit.  At the time of the survey, Patient #10's record did not provide documentation to verify that the HHA reported the patient's stomach pains to a nurse.	H 411	The RN monthly nurse met with the patient and aide for a visit and re-instructed the aide and patient to call him if such complaints were to arise in the future.	3/29/2013	
H 453	3917.2(c) SKILLED NURSING SERVICES  Duties of the nurse shall include, at a minimum, the following:  (c) Ensuring that patient needs are met in accordance with the plan of care;	H453	The Quality Assurance Manager & DON will Continue to review all timesheet weekly before charting to ensure compliance with instructions and make sure that Nurse is aware of all complaints as stated by aide on timesheets.          <b>3917.2 (c) SKILLED NURSING SERVICES</b>  The agency will ensure that all clients' needs are met in accordance with the plan of care		

Health Regulation &amp; Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

V21111

If continuation sheet 5 of 7

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HCA-0059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  03/15/2013
NAME OF PROVIDER OR SUPPLIER  AMERICAN QUALITY HOME CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 2312 RHODE ISLAND AVENUE, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 453	<p>Continued From page 5</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) nurse failed to ensure that home health aide services were provided for each patient in accordance with his or her plan of care (POC), for one 1 of the 15 patients in the sample. I (Patient #2)</p> <p>The finding includes:</p> <p>Interview with Patient #2 by telephone on March 19, 2013, at 10:05 a.m. revealed that she had not been receiving home health aide (HHA) services. The patient stated that her assigned HHA (Staff #10) had informed her that she was "going out of town for a week." More than a week passed and no other aide had reported for duty. Further interview revealed that another aide had called her on the day before (March 18, 2013) and informed her that he would be coming to her home later that same day. Neither he nor anyone else came to provide services.</p> <p>[Note: When Patient #2's POC had been reviewed on March 14, 2013, beginning at approximately 10:00 a.m., it was for the current certification period of February 12, 2013 through August 11, 2013, and included an order for HHA services for 7 hours, 5 days a week.]</p> <p>Interview with the assistant administrator (Staff #20) by telephone on March 19, 2013, at 10:12 a.m., revealed that the last day Patient #2 had received HHA services was on March 1, 2013. She acknowledged that there had been an 18-day gap in services, stating further that there should not have been any interruption of services.</p> <p>It should be noted that when the HCA administrator (Staff #29) was interviewed by</p>	H 453	<p>Another HHA has been assigned to the client.</p> <p>A follow up of the clients' status will be carried by the Admission Manager in charge of the staffing department on a weekly basis to ensure that home health aide services are provided for the patients in accordance with their plan of care. This will be done under the supervision of the DON</p> <p>The agency has instituted a plan of action for re-assignment of new HHA latest by 48hrs of old aide stopping work; and also an assurance that a family member or friend will be responsible to care for patient temporarily until new aide is assigned.</p>	3/19/2013	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

03/29/13

STATE FORM

6899

V21111

If continuation sheet 6 of 7



Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  R. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AMERICAN QUALITY HOME CARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2312 RHODE ISLAND AVENUE, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 453	Continued From page 6  telephone on March 19, 2013, at approximately 1:00 p.m., she stated that the HCA was without a written policy or procedure that addressed situations when a substitute aide needed to be assigned.	H 453	Continue from page 6  Cross reference 3917.2 (c) for Patient #2	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

V21111

TITLE

*Administrator*

(X6) DATE

*03/29/13*

If continuation sheet 7 of 7