Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0061	A. BUILDING: _____ B. WING _____	03/09/2015

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JD NURSING & MANAGEMENT SERVICES, INC	6120 KANSAS AVE, NW WASHINGTON, DC 20011

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H 000	INITIAL COMMENTS An annual survey was conducted from March 4, 2015 through March 9, 2015, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provided home care services to five hundred and fourteen (514) patients and employed eight hundred and three (803) employees. The findings of the survey were based on observations, record reviews and interviews with patients, staff and caregivers. Please Note: Listed below are abbreviations used in this report. Department of Health - DOH Director of Nursing - DON District of Columbia - DC Chief Executive Officer- CEO Electronic mail - email Health Regulation and Licensing Administration - HRLA Home Care Agency - HCA Home Health Aide - HHA	H 000	MAR 19 2015	
H 150	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 HCA failed to ensure that all personnel records of HHAs included documentation showing verification of previous employment, for one (1) of seven (7) HHAs in the sample. (HHA #1)	H 150	All personnel files will be checked for all required documents by Human Resources prior to filing the Initial Personnel file at time of hiring including verification of employment. Additionally Personnel files will be randomly selected and reviewed by HR. DON will randomly check files quarterly for completion, compliance and ensure verification. The DON will report findings in PAC meeting.	4/1/15

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H 150	Continued From page 1 The finding includes: The HCA's personnel records were reviewed on March 4, 2015. At 2:40 p.m., review of HHA #1's application form, dated February 10, 2015, revealed that he/she had been employed by another DC-licensed HCA from 2009 until February 10, 2015. Continued review revealed no documented evidence that the HCA received verification of previous employment for HHA #1. During a face to face interview with the DON on March 4, 2015, at approximately 4:15 p.m., the DON indicated that he/she was aware that the agency should check references; however, he/she was "learning something new" regarding the need to verify previous employment. He/she agreed to seek evidence the agency might have verified HHA #1's past employment. On March 4, 2015, the HCA forwarded additional personnel documents via email at 5:32 p.m.; however, no additional information regarding HHA #1 was presented before the survey ended. At the time of the survey, the HCA failed to ensure all staff's personnel records met the requirements outlined in this section.	H 150	Refer to Page #1 H150	4/1/15
H 355	3914.3(d) PATIENT PLAN OF CARE The plan of care shall include the following: (d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies;	H 355	An Inservice will be held with all Nurses on accurate and complete development of the Plan of Care. The office RN's will review assessment for completeness when paper is submitted. Each field RN is assigned to an Office RN for	4/1/15

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H 355	Continued From page 2 This Statute is not met as evidenced by: Based on a record review and interview, the HCA failed to include the description of services to be provided, including: dietary requirements on the POC's for two (2) of twelve (12) patients in the sample. (Patient's #8 and #9) The findings include: Review of POCs of Patient's #8 and #9 on March 4, 2015, between the hours of 11:30 a.m. and 4:00 p.m., failed to include a description of the patients dietary requirements. During a face to face interview with the DON and CEO on March 4, 2015, at approximately 4:45 p.m., it was acknowledged that the POCs failed to include a description of the patients dietary requirements for the aforementioned patients. Further interview revealed that the agency would re-train the staff on how to accurately complete the POCs to include dietary requirements.	H 355	paperwork review. ADON will check assessment for completeness of all items prior to generating the POC. Field Staff will be called into Office for any missed entries. DON will select printed POC's and review for completion of all items quarterly and report in PAC meeting. DON will ensure POC is complete and meets all requirements.	4/1/15
H 357	3914.3(f) PATIENT PLAN OF CARE The plan of care shall include the following: (f) Provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services; This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the HCA failed to ensure	H 357	Refer to page #2 H355.	4/1/15

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H 357	Continued From page 3 discharge planning was documented on the POC for two (2) of twelve (12) patients in the sample. (Patient's #14 and #15) The findings include: Review of POCs of Patient's #14 and #15 on March 4, 2015, between the hours of 3:30 p.m. and 4:00 p.m., failed to include provisions for discharge planning. During a face to face interview with the DON and CEO on March 4, 2015, at approximately 4:45 p.m., it was acknowledged that the POCs failed to include provisions related to discharge planning for the aforementioned patients. Further interview revealed that the agency would re-train the staff on how to accurately complete the POCs to include provisions for discharge planning.	H 357	Refer to page #2 H355	4/1/15
H 359	3914.3(h) PATIENT PLAN OF CARE The plan of care shall include the following: (h) Prognosis, including rehabilitation potential; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to document the prognosis on the POC for seven (7) of twelve (12) patient's in the sample. (Patient's #4, #6, #7, #11, #12, #13 and #15) The findings include: Review of POCs of Patient's #4, #6, #7, #11, #12, #13 and #15, on March 4, 2015, between the hours of 11:00 a.m. and 4:00 p.m., revealed the POCs failed to include provisions for the patient's	H 359	Refer to page #2 H355	4/1/15

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H 359	Continued From page 4 prognosis. During a face to face interview with the DON and CEO on March 4, 2015, at approximately 4:45 p.m., it was acknowledged that the POCs failed to include provisions related to the prognosis of the aforementioned patient's. Further interview revealed that the agency would re-train the staff on how to accurately complete the POCs to include provisions for the patient's prognosis.	H 359	Refer to page 2 #355	4/1/15
H 363	3914.3(l) PATIENT PLAN OF CARE The plan of care shall include the following: (l) Identification of employees in charge of managing emergency situations; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure that the POC included identification of employees in charge of managing emergency situations for one (1) of twelve (12) patients in the sample. (Patient #7). The finding includes: Review of the Patient #7's POC on March 4, 2015, at 2:00 p.m., revealed the POC failed to include the identification of employees in charge of managing emergency situations. During a face to face interview with the DON and CEO on March 4, 2015, at approximately 4:45 p.m., it was acknowledged that the POC failed to include identification of employees in charge of managing emergency situations. Further interview revealed that the agency would re-train	H 363	The emergency protocol states the person to contact in case of Emergency situation is the Assistant Director of Nursing at 202-722-7776 during business and after hours. The Agency will ensure that the POC includes the Emergency protocol. The ADON & Director of Skill Care will review all POCs before printing to make sure that the Emergency Protocol is included on the POC. The Director of Nursing will review POCs quarterly to ensure that POC included the Emergency Protocol.	4/16/15

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H 363	Continued From page 5 the staff on how to include the identification of the employees responsible for managing emergency situations on the POC.	H 363	Refer to page #5 H363.	4/16/15
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to ensure that the POC included an emergency protocol for one (1) of twelve (12) patients in the sample. (Patient #7) The finding includes: Review of the Patient #7's POC on March 4, 2015, at 2:00 p.m., revealed the POC failed to include an emergency protocol. During a face to face interview with the DON and CEO on March 4, 2015, at approximately 4:45 p.m., it was acknowledged that the POC failed to include an emergency protocol. Further interview revealed that the agency would re-train the staff on how to include an emergency protocol on the POC.	H 364	Refer to page #5 #363	4/16/15
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;	H 409	All HHA will be re-educated on the responsibilities of the HHA involving administering medication. All aspects of medication will be discussed. The In-service will be presented by the DON with the assistance of ADON and Intake Coordinator.	5/6/15

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H 409	Continued From page 6 This Statute is not met as evidenced by: Based on interview and record review, the HCA failed to ensure that each HHA only assisted the patient to the extent of self-administration of medications, for one (1) of the eight (8) patients interviewed by telephone. (Patient #16) The finding includes: Patient #16 was interviewed by telephone on March 6, 2015, beginning at 4:48 p.m. The patient indicated that his/her HHA (HHA #8) had already left for the day (shift ends at 3:00 p.m.). Initially, the patient stated that he/she self-administered his/her own medications. Continued interview, however, revealed that "sometimes" the patient's hands trembled to such a degree that he/she could not complete the process independently. Patient #16 stated that his/her hands became "jittery... once or twice a week" so HHA #8 would apply gloves, place the pills in the patient's mouth and hold the bottle of water for the patient as he/she drank to swallow the pills. The patient's family provided this assistance if/when the trembling occurred on Saturdays or Sundays when she was without HHA services. Continued interview with Patient #16 revealed that a supervisory nurse (RN #4) visited the home once a month. When asked if the supervisory RN was aware of the hands trembling and that HHA #8 administered the medications when his/her hands were trembling, Patient #16 replied "yes." This surveyor telephoned the HCA on March 6, 2015, at 5:06 p.m. and spoke with the DON who	H 409	Follow up random visits will be made by the Field Inspector to ask questions of Client and Aide regarding administering medication. Field Inspector will report to DON and recommend staff to be seen by DON. DON will review all notes from Field Inspector, call staff in if needed. To ensure compliance. Report in PAC meeting. Incident was investigated and the report sent to Department of Health Surveyors.	5/6/15

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H 409	Continued From page 7 indicated that he/she would investigate the findings and report back on the results of his/her investigation. At the time of the survey, the HCA failed to ensure that HHA #8 only provided assistance to Patient #16 in order for him/her to self-administer his/her medications.	H 409	Refer to Page #6 H409	5/6/15
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on record review and interview, the HCA skilled nursing staff failed to evaluate the health teaching that was provided for two (2) of twelve (12) patients in the sample. (Patient's #7 and #9) The findings include: 1. On March 4, 2015, at approximately 1:00 p.m., a review of Patient #7's monthly skilled nursing notes for February 18, 2015, and February 24, 2015, revealed that the patient was provided education on medication compliance and increasing fiber in their diet. The nursing notes, however failed to evidence that the skilled nurse evaluated the patient's understanding of the teaching provided. 2. On March 4, 2015, at approximately 1:35 p.m.,	H 459	Nurses were In-serviced and instructed to document evidence of specific instructions given to Patients related to management of the health condition and evidence that the Skill Nurse evaluated the Patients understanding of the teaching provided. Patient verbalize understanding is not acceptable. Staff was instructed not to use those terms. Staff was also instructed to document what was taught and the Clients verbal response or a return demonstration as evidence of understanding. Notes will be checked for appropriate documentation related to teaching by Office RN, DON will review notes quarterly to ensure compliance.	4/1/15

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H 459	Continued From page 8 a review of Patient #9's monthly skilled nursing notes for February 5, 2015, February 16, 2015 and February 24, 2015, revealed that the patient was provided teaching on strategies to promote sleep, medication compliance and instructed to call 911 if experiencing chest pains/difficulty; however, the nursing notes failed to evidence that the nurse evaluated the patient's understanding of the teaching provided. During a face to face interview with the DON and CEO on March 4, 2015, at approximately 4:45 p.m., it was acknowledged that the skilled nurse failed to evaluate the teaching provided to the aforementioned patients. Further interview revealed that the nursing staff would be re-trained on how to accurately document the evaluation of the training provided in the patient's medical records.	H 459	Refer to page #8 H459.	4/1/15