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-0005	A. BUILDING: _____ Received 2/21/18 B. WING _____	01/29/2018

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

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H 000	INITIAL COMMENTS An annual survey was conducted from 01/23/18 through 01/29/18 to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22 B DCMR Chapter 39). The home care agency provides home care services for three hundred eighty-seven (387) patients and employs six hundred eighty (680) staff including professional and administrative staff. The findings of the survey were based on a review of administrative records, complaint and incident reports, fifteen (15) active patient records, five (5) discharged patient records, twenty-five (25) employee records, five (5) home visits and (10) telephone interviews with patients/family and staff. An additional patient was added to the sample due to an allegation of patient neglect. The following are abbreviations that may appear throughout the body of this report. DON - Director of Nursing HCA - Home Care Agency PAC - Professional Advisory Committee POC - Plan of Care RN - Registered Nurse SN - Skilled Nurse	H 000		
H 054	3903.2(c)(2) GOVERNING BODY 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: (2) The evaluation shall include a review of all	H 054		

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H 054	Continued From page 1 complaints made or referred to the agency, including the nature of each complaint and the agency's response thereto. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to provide evidence that the governing body had reviewed all complaints received and documented the agency's response for seven (7) of seven (7) complaints during the governing body's annual evaluation of the HCA for 2017. Findings included: On 01/23/18 at 10:34 AM, a review of the HCA's complaints showed that the agency had received seven (7) complaints since the previous survey on 02/21/17. At 10:40 AM, the surveyor was provided with a copy of HCA's Professional Advisory Committee (PAC) meeting minutes held on 10/17/17. On 01/23/18 at 10:40 AM, the agenda for the HCA's PAC meeting was reviewed and failed to include a review of the agency's complaints as a part of the meeting agenda.. On 01/25/18 at 9:40 AM during interview with the HCA' Administrator, s/he stated that the PAC reviews all of the complaints received by the HCA, but this activity was not included in the annual board meeting minutes. The Administrator said that in the future, s/he would ensure that the PAC would document any complaints evaluated and include the review of the agency's complaints in the annual board meeting minutes. At the time of the survey, the annual board meeting minutes lacked documented evidence	H 054	KBC acknowledges the surveyor's finding that the agency did not provide evidence that the governing body had reviewed the seven complaints received by the agency. The Administrator had a meeting with the management team and discussed the result of the survey, and explored how KBC could prevent the deficiency from recurring. KBC has an existing policy on the governance of the agency and it requires that all complaints be reviewed by the governing body. The Professional Advisory Committee reviews all complaints, and advises the agency about the appropriate way to resolve such complaints The exclusion of that activity from the agenda, and the minutes was an oversight. Going forward, the administrator or her designee will ensure that all complaints made to the agency will be presented to governing body/Professional Advisory Committee during the annual evaluation, and the resolution will be documented in the minutes. KBC has added the missing information so at the next meeting, the minutes will be read and ratified. The agency has developed a permanent agenda with topics that must be discussed at the annual meeting. Other topics will be added whenever other matters are brought to the attention of the agency. Going forward, the Quality Assurance Team will review the agenda and minutes for completeness.	1/26/18 1/26/2018 1/26/18 and ongoing Annually

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H 054	Continued From page 2 that all 2017 complaints and the corresponding resolutions of the complaints had been evaluated by the governing body.	H 054	KBC acknowledges that the evaluations and Summary Reports of the patients involved in this survey met neither the agency's standard nor that of DCMR. In an effort to comply with the rules and regulations of the regulatory bodies including DCMR, KBC has revised the policy on Documentation. The policy proscribes the use of photocopied documents, but prescribes documentation that reflects accurate assessment and competent knowledge of the subject matter.	2/6/2018
H 430	3916.1 SKILLED SERVICES GENERALLY Each home care agency shall review and evaluate the skilled services 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. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to evaluate the skilled services provided to each patient at least every sixty-two (62) calendar days for three (3) of fifteen (15) active patients in the sample (Patients #7, #9 and #10). Findings included: I. On 01/25/18 at 11:19 AM, review of Patient #9's clinical record showed several documents entitled "60 Day Summary Report" dated 01/16/17, 03/20/17, 05/19/17, and 07/19/17, which were signed by Employee #3. II. On 01/25/18 at 12:34 PM, review of Patient #7's clinical record showed several documents entitled "60 Day Summary Report" dated 05/29/17, 07/24/17, and 09/26/17, which were signed by Employee #3. III. On 01/25/18 at 1:11 PM, review of Patient #10's clinical record showed several documents entitled "60 Day Summary Report" dated 07/24/17, 09/27/17, and 11/17/17, which were signed by Employee #3.	H 430	The clinician, Employee #3 who was implicated in this deficiency was counseled about her documentation and has since been terminated. Patients #7, #9 and #10 have not been adversely affected. They have been reassigned to other clinicians who have done follow up visits. On 1/26/2018, KBC had a meeting with the clinicians. The result of the survey and KBC's plan of correction were discussed. The clinicians have been re-educated on the presentation, and appropriate contents of a Sixty Day Summary, including justification for continued service. The Director of Nursing and the clinical managers will conduct continuing education which includes complete assessment and accurate documentation. Beginning February 6, 2018, the clinical managers will review 100% of Sixty Day Summaries to ensure that the accompanying assessments and contents of the documents meet the agency's standard. Those clinicians whose summaries do not comport with KBC's standard will be counseled and re-educated, one on one, by their clinical managers. Those whose summaries show no improvement within three months will face disciplinary action up to and including termination. The Quality Assurance Director or designee will be responsible for reviewing 100% of Sixty Day Summaries to ensure that they comply with the standards established by the agency and the regulatory bodies including DCMR. The Quality Assurance team will meet on a monthly basis, and will discuss the result of the reviews, and explore strategies for quality improvement as they relate to Sixty Day Summaries.	1/26/2018 2/6/2018 And Monthly 5/6/2018 And Ongoing 3/31/2018 And Ongoing

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H 430	Continued From page 3 The summary report listed patient information, including functional limitations, vital signs, and goals. Further review of the summary reports showed similar information for each patient, as the forms contained the same vital signs for the different aforementioned dates. During an interview with the RN (Employee #3) on 01/25/18 at 1:10 PM, she admitted to photocopying and submitting the summary report with different dates. She stated that she had "a poor understanding" and believed she could "use patient history for notes." At 1:25 PM, the DON said that the HCA provided required training for clinical staff throughout each year, which included documentation training. At the time of survey, the HCA failed to provide documented evidence that patient services were reviewed and evaluated at least every sixty-two days.	H 430	KBC's visit policy requires that patients be fully assessed. The assessment includes vital signs and systems assessment for the creation of Sixty Day Summary. The visit assessment and subsequent Sixty Day Summary will provide documented evidence that patient services are reviewed and evaluated at least every sixty-two days. The summaries will be generated from these assessments The assessment will be added to the spreadsheet that the clinical managers use to keep track of documents that are submitted by the field clinicians. Beginning 1/31/18, clinicians will conduct a full assessment that will generate the Sixty Day Summaries. The clinical managers will have the responsibility of instructing the clinicians on how to use the assessment tool to generate the related summaries. The clinical managers will inspect 100% of documents submitted by field clinicians to ensure that 100% of Sixty Day Summaries are accompanied by the related assessments. The Quality Assurance Director or designee will review 10% of randomly selected charts weekly to ensure all Sixty Day Summaries are accompanied by the related assessments. The Quality Assurance team will meet on a monthly basis, and will discuss the result of the reviews, the extent of noncompliance and strategies to increase compliance.	3/31/2018 And Monthly 2/28/2018 And Ongoing
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the SN failed to ensure that the patient's needs were met in accordance with their POC for one (1) of fifteen (15) active patients in the sample (Patient #5).	H 453	KBC appreciates and understands the surveyor's finding that Patient #5 did not receive wound care in accordance her POC. KBC reviewed Patient #5's record and found that the clinician had not seen Patient #5 according to the patient's POC. The clinician involved and the other clinicians have been educated about the importance of providing care according to the POCs and calendars that are generated electronically from the patients' certification ledgers. (Certification Ledger Calendar) Clinicians will submit the calendars completed with their proposed skilled visits. If a clinician is unable to make the proposed visit, s/he is required to notify KBC via phone immediately and in writing at the clinician's earliest convenience within 48 hours. The clinician will make every effort to see the patient thereafter in an effort to comply with the frequency of care spelled out in the POC. If the patient is not provided with care at the frequency the POC dictates for any reason including but not limited to the patient making a visit to his/her physician, this omission will be documented on the	2/20/2018 And Ongoing 2/20/2018 And Ongoing

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H 453	Continued From page 4 Findings included: On 01/23/18 at 11:43 AM., review of Patient #5's POC showed a certification period from 11/28/17 through 01/25/18. Patient #5 had diagnoses of Diabetes with foot ulcer, gait abnormalities, and muscle weakness. According to the POC, the SN was to assess the patient and provide wound care to the patient's left foot two times per week. Review of the SN visit notes showed that two visits had been completed. An initial assessment visit was conducted on 11/28/17, and another visit by the SN was conducted on 12/23/17. On 01/23/18 at 1:13 PM, the DON was asked if there were any visit notes for Patient #5 that were not yet filed. On 01/24/18 at 9:45 AM, the DON presented the surveyor with discharge notification for Patient #5 dated 01/23/18. There were no additional SN visit notes provided. At the time of survey, the SN failed to provide wound care to Patient #5 as ordered by the physician.	H 453	patient's profile and the physician will be notified. The DON/designee will be responsible for ensuring that the patient receive care in the frequency ordered and will notify the physician in writing about the clinician's unsuccessful attempts to provide care according to the POC. Starting 2/20/18, each week, upon submission of clinicians' visit records, the DON/ designee will review the completed Certification Ledger Calendars which clinicians will submit with their proposed visit frequencies and determine whether the visits are in compliance with KBC's policy and practice. The DON will counsel clinicians who fail to comply with the established practice relating to visit frequency. The Quality Management team will review 10% of randomly selected records monthly and discuss its findings at the monthly Quality Management meeting.	2/20/2018 And Ongoing 2/20/2018 And Ongoing
H 454	3917.2(d) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (d) Implementing preventive and rehabilitative nursing procedures; This Statute is not met as evidenced by: Based on interview and record review, the HCA's SN failed to provide evidence that preventive nursing procedures, including nursing	H 454		

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H 454	Continued From page 5 assessment, were performed to patients related to their health conditions, for two (2) of fifteen (15) active patients (Patients #5 and #7). Findings included: I. On 01/25/18 at 11:19 AM, review of Patient #5's clinical record showed several nurse assessment forms dated 02/23/17, 05/19/17, and 09/28/17, which were signed by Employee #3. The documented assessment for the aforementioned dates were the same, including vital signs and patient teaching. II. On 01/25/18 at 12:34 PM, review of Patient #7's clinical record showed nurse assessment forms dated 12/21/16 and 01/19/17. Further review of the assessments showed similar information, as the forms contained the same vital signs and physical assessment data for the different aforementioned dates. During an interview with the RN (Employee #3) on 01/25/18 at 1:10 PM, she admitted to photocopying and submitting the form with different dates. She said that she although she knew how to perform a patient assessment, her focus, when she arrived at a patient's home, was their safety. At 1:25 PM, the DON said that the HCA provided required training for clinical staff throughout each year, which included documentation training. At the time of this survey there was no documented evidence the SN actually performed a patient assessment.	H 454	KBC has reviewed the records of Patients #5 and #7 and acknowledges the surveyor's findings that there was no documented evidence that Employee #3 actually performed patient assessment. KBC has updated its policies on Assessments and Documentation. The policy requires patients to be physically assessed every visit. Assessment includes vital signs, systems review and health condition. Documentation must reflect the implementation of preventive and rehabilitative nursing procedures. In the meeting KBC held with clinicians following the survey on 1/26/18, the clinicians were re-educated on the elements of a physical assessment which includes vital signs and systems review. Clinicians were also reminded of their responsibility to implement preventive and rehabilitative procedures as dictated by the assessment or POC. KBC re-educated the clinicians on the agency's policy on Documentation as outlined in H430 above. The clinical managers will inspect 100% of documents submitted by field clinicians to ensure that assessments and documents are done according to the agency's policy. The Quality Assurance Director will ensure that 10% of randomly selected charts will be reviewed weekly to ensure all visit notes are completed according to agency policy and DC Health regulations. The Quality Assurance team will meet on a monthly basis, and will discuss the result of the reviews, the extent of noncompliance, what effect noncompliance has had on the patients, and strategies to increase compliance.	3/1/2018 And Ongoing 1/26/2018 And Ongoing 2/28/2018 And Monthly