Health Regulation & Licensing Administration (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HCA-0078 09/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1220 12TH STREET, SE STE 350 OPEN SYSTEMS HEALTHCARE, INC WASHINGTON, DC 20003 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) H 000 INITIAL COMMENTS H 000 An initial survey was conducted from September 12, 2017, to September 25, 2017, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency Regulations). The home care agency provides home care services to seven (7) patients and employs twenty (20) staff. The findings of the survey were based on a H335 3914,3 (d) The corrective 10/25/17 review of administrative records, five (5) active action to address the identified patient records and seven (7) employee records. deficiant practice has been put into place. The descriptions of the services to be provided by the The findings were also based on four (4) home visits, one (1) patient telephone interview and interviews with patients/family and staff. SN have been included in the up dated POC's. A copy of the revised POC and the POC addresum Please note. Listed below are abbreviations used throughout this report. to be utilized with Patients #1. POC --- Plan of Care #2, #3, #4, #5 and all other SN --- Skilled Nurse Correct and future patients can be viewed in attachmente 1+2. DON --- Director of Nursing HCA --- Home Care Agency PCA --- Personal Care Aide The measure that will be put into place to prevent a recurrence will be to ensure the use of the H 355 3914.3(d) PATIENT PLAN OF CARE H 355 updated por form which includes The plan of care shall include the following: a description of SN sorvices to be provided. (d) A description of the services to be provided. The corrective action will be including: the frequency, amount, and expected monitored by conducting a weekly internal andit of all new Poxis duration; dietary requirements; medication administration, including dosage; equipment; and

Health Regulation & Licensing Administration

supplies;

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

Based on record review and interview, the agency

failed to ensure that POCs included a description

of SN services to be provided for five (5) of five

(5) patients in the sample (Patients #1, #2, #3,

This Statute is not met as evidenced by:

TITLE

for correction.

to ensure the description of services to be provided including

frequery, amount, and expected duration is clarimeted. Otherwise, POC's will

be andited during auntaly QA.

Discrepancies in compliance will be

reported to the DON'or designer

(X6) DATE

STATE FORM

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ HCA-0078 B. WING 09/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1220 12TH STREET, SE STE 350 OPEN SYSTEMS HEALTHCARE, INC WASHINGTON, DC 20003 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 355 Continued From page 1 H 355 #4, and #5). The finding includes: On September 12, 2017 and September 13, 2017, starting at 10:30 a.m., review of the clinical H363 3914.3(1) The POCS 10/25/17 records for Patients #1, #2, #3, #4, and #5 have been updated and include revealed POCs with certification periods from identification of employees in charge of managing energercy situations. A copy of the revised POL and the POL addendum to be May 31, 2017 through October 28, 2017. The POCs, however, failed to describe the services the SN was to provide. whilized for Patriate #1, #2, #3, #4, #5 and all other current and hime On September 13, 2017, at 2:00 p.m., interview the DON/SN revealed that she conducts head-to-toe assessments, medication reviews, patients can be wewed in attachnows 1+2, and supervision of personal care aides at least monthly. The DON/SN stated that she would The measure put in place to present ensure SN services are described on all POCs going forward. of the updated POC form which At the time of the survey, the HCA failed to includes identification of employees include SN services on POCs for Patients #1, #2, incharge of manying energency #3, #4 and #5. situations. H 363 3914.3(I) PATIENT PLAN OF CARE H 363 The corrective action will be monitored by conducting weekly The plan of care shall include the following: audity of all new Pocs to ensure the industrification of (I) Identification of employees in charge of employees in charge of managing managing emergency situations; other wise POCs will be

Health Regulation & Licensing Administration

#3, #4, and #5).

situations for five (5)

This Statute is not met as evidenced by:

Based on record review and interview, the agency failed to ensure that POCs included identification

of employees in charge of managing emergency

of five (5) patients in the sample (Patients #1, #2,

STATE FORM

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If continuation sheet 2 of 6

andited during anorthly QA. Discrepancies will be reported

to the DON or designee for

Correction

Health F	Regulation & Licensin	ng Administration			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	3:	COMP	PLETED
		HCA-0078	B. WING		09/2	25/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ODEN S	YSTEMS HEALTHCAR	1220 12Ti		SE STE 350		
OPLNS	TOTEWIS REALTROAT	WASHING	STON, DC 2	20003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
H 363	Continued From pa	ge 2	H 363			
	The finding include:	S.				
H 364	2017, starting at 10 records for Patients revealed POCs with May 31, 2017 throu POCs, however, fairesponsible for mar On September 13, 2 DON/SN stated dur responsible for eme on POCs going for At the time of this s include employees for the patient record 3914.3(m) PATIENT The plan of care shown Emergency professed on record regalied to ensure that protocols for five (5) sample (Patients #1 The finding includes On September 12, 2 2017, starting at 10:	urvey, the HCA failed to responsible for emergencies ds sampled. PLAN OF CARE all include the following: cocols; and met as evidenced by: view and interview, the agency POCs included emergency of five (5) patients in the , #2, #3, #4, and #5).	H 364	H364 3914.3 Lm) The correction to address the idultion deficiant practice will be revise and applicated to include energency protocol. The Phave boken applicated to include energency protocol along wanderdown to correct Poes for #1, #2, #3, #4, #5 and a current and future patients. See attachments I +2, The measure that will be into place to prevent recurre will be to ensure the use the updated POL which income energency protocol. Ach staff were in-serviced on energency protocol will be of HHA/PCA new hire ori and reviewed annually. Any non-active staff not inwill not be assigned to account the energy protocol inchas been completed. See Affect the source of the energy protocol inchas been completed. See Affect the corrective action will be month conducting weekly internal and its of all Pocs to essure energy protocol rare otherwise Poes will be and fed an anatory QA. Discrepancies will reported to the DON or designed Correction—	to to clude to clude to clude to clude to clude to clude the club the club the club that the contract of the contract of the contract of the contract of the club the	16/25/17

Health Regulation & Licensing Administration

STATE FORM

If continuation sheet 3 of 6

Health Regulation & Licensin	a Administration		FORM APPROVEL
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING:	(X3) DATE SURVEY COMPLETED
	HCA-0078	B. WING	09/25/2017
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZIP CODE	
OPEN SYSTEMS HEALTHCAR	E. INC	H STREET, SE STE 350 GTON, DC 20003	
(VA) ID SUMMARY STAT	TEMENT OF DEFICIENCIES	DROVIDEDIO DI ANI OE CODDECT	ION

OPEN S	TOLENIO DEALIBUARE INC.	TON, DC 2	20003	
(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 364	Continued From page 3	H 364		
Н 399	showed POCs with certification periods from May 31, 2017 through October 28, 2017. The POCs, however, failed to include emergency protocols. On September 13, 2017, starting at 2:00 p.m., interview with the DON/SN revealed that she would include emergency protocols on all POCs going forward. At the time of this survey, the HCA failed to include emergency protocols on POCs for Patients #1, #2, #3, #4 and #5. 3915.10(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Personal care 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 agency failed to ensure PCAs observed and recorded the patient's physical condition, behavior or appearance for five (5) of five (5) patients in the sample (Patients #1, #2, #3, #4, and #5). The finding includes: On September 12, 2017 and September 13, 2017, starting 11:30 a.m., review of the clinical records for Patients #1, #2, #3, #4, and #5 revealed a lack of documented evidence the PCA(s) observed and recorded the patient's	H 399	H399 3915, 10 (f) The activity log sheet has been updated to include provisions for the PCA/HHA to record observed patriats physical Condition, behavior or appropriate. Active PCAs were in-serviced on 16/23/17 + 10/24/17 on appropriate documentation and siven a sample guide document. All new hires and current non-active employees will be in-serviced of proper record Keeping moving forward at initial orientation or prior to bein assigned to acase. Please see attached copy of the applicated activity log and sample document in attachnate 4+5. The necessress that will be put into place to prevent recurrence include weekly review of the activity log sheet for proper documentation by SN or designese, and initial and continued education for the RA/HHA no less than annually. The corrective action will be monitored by conducting weekly intendant audit and review of the activity los sheet prior to charting to each intended audit on a review of the activity los sheet prior to charting to each office each completed shift. Deficial activity loss will be submitted to the DON or designee for review with the corresponding RAN/HHA. Re-education will be provided as necessary.	10/25/17

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STATE FORM

If continuation sheet 4 of 6

Health F	Regulation & Licensin	a Administration			FORM	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A, BUILDING	LE CONSTRUCTION		SURVEY
		HCA-0078	B. WING		09/2	25/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OPEN S	YSTEMS HEALTHCAR	E. ING	H STREET, S	SE STE 350		
04.0.15	CUBARA DV CTA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
H 399	Continued From page	ge 4	H 399			
	physical condition, t	pehavior or appearance.				
H 459	interview with the Diwould ensure all PC patients' physical coappearance going for At the time of the surensure PCAs obserphysical condition, beatients #1, #2, #3, 3917.2(i) SKILLED II Duties of the nurse sthe following:	orward. Irvey, the HCA failed to ved and recorded behavior or appearance for	H 459	1459 3917.2(i) The coire action implemented to address deficient practice was to pe and document the re-instruction of the re-infor putient #2 on 9/25/17. Petithas not been re-educated due hospitalization. Petith #1 will re-educated and evaluated withours of patient #1's discharge the home. The measure that will be purplicate to prevent recoverage be to ensure documentation of the patients instead evaluation of the patient understanding of instruction	sthe form than stratum to be 48 to wing raction to	10/25/17
	Based on record rev nurse failed to evalu two (2) of five (5) pa # 1 and #2). The findings include 1. On September 12 of Patient #1's clinical Comprehensive Assa 2017, which indicate medication adherence however, lacked evice	, 2017, at 11:30 a.m., review al record revealed a essment dated August 24, d that the SN instructed on		The corrective action will monitored by conducting mon internal and its and will be reviewed during courtary a Assurance Andits and an a on-soing basis to ensure documentation of the evidence that SN evaluated the patient undustanding of teaching provided the provi	thly weliky ce this	

Health Regulation & Licensing Administration

provided.

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Administrator (0/27/17

If continuation sheet 5 of 6

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A BOILDING.		h		
		HCA-0078	B. WING		09/	25/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
OPEN S	YSTEMS HEALTHCAF	TE IIV.	H STREET, S GTON, DC 20				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
H 459	2. On September 1 of Patient #2's clinic Comprehensive Ass 2017, which indicate daily weight logs. The lacked evidence that patient's understand On September 13, 2 with the DON/SN reall skilled nurses everaching provided for At the time of the sur	12, 2017, at 2:30 p.m., review cal record revealed a sessment dated June 27, ed that the SN instructed on the nursing note, however, at the SN evaluated the ding of the teaching provided. 2017, at 3:30 p.m., interview evealed that she would ensure raluate and document all or patients going forward.	H 459	DEFICIENC			

Health Regulation & Licensing Administration STATE FORM



GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address 899 North Capitol St., NE Washington DC 20002 2nd Floor 202-724-8800

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility: Open Sys	t Facility: Open Systems Healthcare, Inc.	Street Address, City, State, ZIP Code: 1220 12th St. SE, Suite Wash., DC 20003	ate, ZIF ™ St. SI sh., DC	, State, ZIP Code:) 12 th St. SE, Suite 350 Wash., DC 20003	Survey Date: September 12, 2017- September 25, 2017 Follow-up Dates(s):	12, 2017- 25, 2017 ½(s) :
Regulation Citation	Statement of Deficiencies		Ref.	Plan of Correction	on	Completion Date
000	An initial survey was conducted from September 12, 2017, to September 25, 2017, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency Regulations). The home care agency provides home care services to seven (7) patients and employs twenty (20) staff. The findings of the survey were based on a review of administrative records, five (5) active patient records and seven (7) employee records. The findings were also based on four (4) home visits, one (1) patient telephone interview and interviews with patients/family and staff.	from September 12, determine compliance 39 (Home Care Agency ency provides home care l employs twenty (20) were based on a review) active patient records The findings were also the (1) patient telephone tients/family and staff.		4702. 2 Fixer printing for the Administrator was completed on 10/10/17. The Administrator was completed on 10/10/17. The Administrator is curretly under Posvisional hime pending the results which are expected in 3-6 weeks: Clinicians and personnal files reviewed to ensure fixerprinting and background checks are complete. All employees needing fixerprinting have completed on are scheduled to complete fixerprinting. The measure that will be not not place to prevent recurrence will be an applicated policy requires criminal background checks and fixerprinting or live search will be reviewed at him and client access. This will be reviewed at him and the corrective action will be nowhered by conducting mostly internal and to and review of complime with this struction.	for the forth could be result which the conditions of the complete to complete the conditions of the c	10/1

Name of Inspector

Date Issued

Facility Director/Designee

Christoper

|0/27/₁₇ **Date**

for Theresa Water Paul

Rev. 9/02

4701.2

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Background Check Requirement

Each facility...shall cause each prospective employee or contract worker who will have, or foreseeably may have direct patient, resident or client access, to undergo a criminal background check that shall reveal the criminal history, if any, in the District of Columbia and the fifty (50) states. Finger printing or live scan shall be performed in the District of Columbia utilizing the Metropolitan Police Department (MPD) or a private agency. The criminal background check shall be performed, following finger printing or live scan, by the MPD and FBI in an FBI-approved environment. The results of the criminal background checks shall be forwarded to the Department of Health.

Based on the review of personnel records and interview, the agency failed to obtain a fingerprint or live scan for one (1) of seven (7) employees in the sample (Director).



Administrator 10/27/17



GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

The finding includes:

On September 12, 2017, starting at 2:00 p.m., review of the Director's personnel file showed that he was hired on January 3, 2017. The continued review of his personnel file revealed a criminal background check had been conducted by E-verify on January 5, 2017. The file, however, lacked documented evidence of an FBI criminal background check.

On September 12, 2017, at 2:20 p.m., interview with the Director revealed that he visits patients' homes with the DON when a patient starts services. Additionally, he indicated that he had a criminal background check conducted. However, it was not an FBI fingerprinting or live scan.

At the time of the survey, the agency failed to ensure the Director had an FBI fingerprinting or live scan conducted.

It should be noted that Chapter 47 was amended to require FBI fingerprinting, effective December 2012.

Administrator 10/27/17