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-0078	A. BUILDING: _____ B. WING _____ Received 10/27/17	09/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN SYSTEMS HEALTHCARE, INC	1220 12TH STREET, SE STE 350 WASHINGTON, DC 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 000	INITIAL COMMENTS 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. Please note. Listed below are abbreviations used throughout this report. POC --- Plan of Care SN --- Skilled Nurse DON --- Director of Nursing HCA --- Home Care Agency PCA --- Personal Care Aide	H 000		
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; This Statute is not met as evidenced by: 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,	H 355	H 335 3914.3 (d) The corrective action to address the identified deficient practice has been put into place. The descriptions of the services to be provided by the SN have been included in the updated POC's. A copy of the revised POC and the POC addendum to be utilized with Patients #1, #2, #3, #4, #5 and all other current and future patients can be viewed in attachments 1+2. The measure that will be put into place to prevent a recurrence will be to ensure the use of the updated POC form which includes a description of SN services to be provided. The corrective action will be monitored by conducting a weekly internal audit of all new POC's to ensure the description of services to be provided including frequency, amount, and expected duration is documented. Otherwise, POC's will be audited during quarterly QA. Discrepancies in compliance will be reported to the DON or designee for correction.	10/25/17

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10/27/17

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H 355	Continued From page 1 #4, and #5). The finding includes: On September 12, 2017 and September 13, 2017, starting at 10:30 a.m., review of the clinical records for Patients #1, #2, #3, #4, and #5 revealed POCs with certification periods from May 31, 2017 through October 28, 2017. The POCs, however, failed to describe the services the SN was to provide. On September 13, 2017, at 2:00 p.m., interview the DON/SN revealed that she conducts head-to-toe assessments, medication reviews, and supervision of personal care aides at least monthly. The DON/SN stated that she would ensure SN services are described on all POCs going forward. At the time of the survey, the HCA failed to include SN services on POCs for Patients #1, #2, #3, #4 and #5.	H 355	H363 3914.3(1) The POCs have been updated and include identification of employees in charge of managing emergency situations. A copy of the revised POC and the POC Addendum to be utilized for Patients #1, #2, #3, #4, #5 and all other current and future patients can be viewed in attachments 1 + 2. The measure put in place to prevent recurrence is to ensure the use of the updated POC form which includes identification of employees in charge of managing emergency situations.	10/25/17
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 agency failed to ensure that POCs included identification of employees in charge of managing emergency situations for five (5) of five (5) patients in the sample (Patients #1, #2, #3, #4, and #5).	H 363	The corrective action will be monitored by conducting weekly audits of all new POCs to ensure the identification of employees in charge of managing emergency situations are included. otherwise POCs will be audited during Quarterly QA. Discrepancies will be reported to the DON or designee for Correction	

Administrator 10/27/17

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H 363	Continued From page 2 The finding includes: On September 12, 2017 and September 13, 2017, starting at 10:30 a.m., review of the clinical records for Patients #1, #2, #3, #4, and #5 revealed POCs with certification periods from May 31, 2017 through October 28, 2017. The POCs, however, failed to include the employees responsible for managing emergency situations. On September 13, 2017, at 2:00 p.m., the DON/SN stated during interview that employees responsible for emergencies would be included on POCs going forward. At the time of this survey, the HCA failed to include employees responsible for emergencies for the patient records sampled.	H 363		
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, the agency failed to ensure that POCs included emergency protocols 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 at 10:30 a.m., review of the clinical records for Patients #1, #2, #3, #4, and #5	H 364	H364 3914.3(m) The corrective action to address the identified deficient practice will be to revise and update POCs to include emergency protocol. The POCs have been updated to include the emergency protocol along with an addendum to correct POCs for patients #1, #2, #3, #4, #5 and all other current and future patients. See attachments 1 + 2, The measure that will be put into place to prevent recurrence will be to ensure the use of the updated POC which includes an emergency protocol. Active staff were in-serviced on emergency protocol procedures and policy on 10/23/17 + 10/24/17. Emergency protocol will be part of HHA/PCA new hire orientation and reviewed annually. Any non-active staff not in-serviced will not be assigned to a case until the emergency protocol in-service has been completed. See Attachment 3. The corrective action will be monitored by conducting weekly internal audits of all new POCs to ensure emergency protocols are included. Otherwise POCs will be audited during Quarterly QA. Discrepancies will be reported to the DON or designee for correction.	10/25/17

Administrator 10/27/17

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H 364	Continued From page 3 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.	H 364		
H 399	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 patient's physical condition, behavior or appearance. Active PCAs were in-serviced on 10/23/17 & 10/24/17 on appropriate documentation and given a sample guide document. All new hires and current non-active employees will be in-serviced on proper record keeping moving foward at initial orientation or prior to being assigned to a case. Please see attached copy of the updated activity log and sample document in attachments 4+5. The measures that will be put into place to prevent recurrance include weekly review of the activity log sheet for proper documentation by SN or designee, and initial and continued education for the PCA/HHA no less than annually. The corrective action will be monitored by conducting weekly internal audit and review of the activity log sheets prior to charting to ensure that proper documentation is maintained for each completed shift. Deficient activity logs will be submitted to the DON or designee for review with the corresponding PCA/HHA. Re-education will be provided as necessary.	10/25/17

Administrator 10/27/17

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H 399	Continued From page 4 physical condition, behavior or appearance. On September 13, 2017, starting at 2:30 p.m., interview with the DON/SN revealed that she would ensure all PCAs observe and document patients' physical condition, behavior or appearance going forward. At the time of the survey, the HCA failed to ensure PCAs observed and recorded physical condition, behavior or appearance for Patients #1, #2, #3, #4 and #5.	H 399		
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 skilled nurse failed to evaluate the teaching provided for two (2) of five (5) patients in the sample (Patients # 1 and #2). The findings include: 1. On September 12, 2017, at 11:30 a.m., review of Patient #1's clinical record revealed a Comprehensive Assessment dated August 24, 2017, which indicated that the SN instructed on medication adherence. The nursing note, however, lacked evidence that the SN evaluated the Patient #1's understanding of the teaching provided.	H 459	H459 3917.2(i) The corrective action implemented to address the deficient practice was to perform and document the re-instruction and the evaluation of the re-instruction for patient #2 on 9/25/17. Patient #1 has not been re-educated due to hospitalization. Patient #1 will be re-educated and evaluated within 48 hours of patient #1's discharge to the home. The measure that will be put in place to prevent recurrence will be to ensure documentation showing evidence of the patients instruction and evaluation of the patient's understanding of instruction. The corrective action will be monitored by conducting monthly internal audits and will be reviewed during Quarterly Quality Assurance Audits and on an on-going basis to ensure documentation of the evidence that SN evaluated the patients understanding of teaching provided and the provided teaching is notated.	10/25/17

Administrator 10/27/17

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H 459	Continued From page 5 2. On September 12, 2017, at 2:30 p.m., review of Patient #2's clinical record revealed a Comprehensive Assessment dated June 27, 2017, which indicated that the SN instructed on daily weight logs. The nursing note, however, lacked evidence that the SN evaluated the patient's understanding of the teaching provided. On September 13, 2017, at 3:30 p.m., interview with the DON/SN revealed that she would ensure all skilled nurses evaluate and document all teaching provided for patients going forward. At the time of the survey, the agency's skilled nurses failed to provide evidence that evaluations of patient were conducted.	H 459		

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

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:	Street Address, City, State, ZIP Code:	Survey Date:
Open Systems Healthcare, Inc.	1220 12th St. SE, Suite 350 Wash., DC 20003	September 12, 2017- September 25, 2017 **Follow-up Dates(s):**

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	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.		4702.2 Finger printing for the Administrator was completed on 10/10/17. The Administrator is currently under Provisional hire pending the results which are expected in 3-6 weeks. Clinicians and personnel files reviewed to ensure fingerprinting and background checks are complete. All employees needing fingerprinting have completed or are scheduled to complete fingerprinting. The measure that will be put into place to prevent recurrence will be an updated policy requiring criminal Background checks and fingerprinting or live scan for all prospective and/or contract workers who will have direct patient or client access. This will be reviewed at hire and during all subsequent personnel file audits. See Attachment #6. The corrective action will be monitored by conducting monthly internal audits and review of compliance with this standard. Non-compliant findings will be reported to the Regional Human Resource Manager.	10/25/17

C. Hurd RN for Theresa Waters, RN — Name of Inspector
10/10/2017 — Date Issued

Administrator — Facility Director/Designee
10/27/17 — Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	4701 **Background Check Requirement**			
4701.2	**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

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