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PREMIER HEALTH SERVICES, INC	7600 GEORGIA AVENUE, NW, SUITE 323 WASHINGTON, DC 20012

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H 000	INITIAL COMMENTS An annual licensure survey was conducted from December 8, 2011, through December 12 , 2011, to determine compliance with Title 22 DCMR, Chapter 39. The findings of the survey were based on a random sample of nine (9) active clinical records based on a census of four hundred ninety-one (491) patients, three (3) discharge records, fifteen (15) personnel files based on a census of five hundred fifty-five (555) employees and three (3) home visit. The findings of the survey were based on staff and patient interviews . review of clinical records and observations.	H 000	The Provider acknowledges and accepts the findings of this report. Received 1/20/12 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
H 268	3911.2(h) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (h) Clinical, progress, and summary notes, and activity records, signed and dated as appropriate by professional and direct care staff; This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency (HCA) failed to ensure activity records in the file were signed and dated for two(2)of twelve (12) patients. (Patients #4, #11) The findings include: 1. On December 9, 2011, a review of patient #4 ' s record at approximately 9:12 a.m. revealed documents entitled "Missed Visits Reports" for the following dates: September 29, and 30, 2011, October 6, and 7, 2011, October 22, and 23, 2011 and November 18, 2011. There was no	H 268	The Provider acknowledges and accepts this tag with the following plan of correction: • Both of the Scheduler's, who receives calls for missed visits and tracks the completion of the visits was re-oriented to the process for handling and documentation of missed visits. • The Registered Nurses and Case Managers received re-orientation to the handling and documentation of missed visits.(See Addendum 1) • Data Entry technician was re-oriented on the process for entering a Missed Visit documentation into the system to facilitate tracking. (see addendum 2) • The Quality assurance staff members were re-oriented to the process for	

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H 268	Continued From page 1 documented evidence of a signature on the aforementioned documents. During a face to face interview with the Director of Nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned "Missed Visits Reports" did not have a signature at the time of this survey. 2. On December 9, 2011, a review of patient #11's record at approximately 1:00 p.m., revealed a POC with certification period June 8, 2011 through August 8, 2011 in which the physician ordered physical therapy services three (3) visits a week for three (3) weeks, then two (2) visits a week for two (2) weeks. There was no documented evidence of physical therapy progress note for June 20, 2011 through June 30, 2011. During a face to face interview with the DON on December 9, 2011 at approximately 1:39 p.m., she indicated there was no documented evidence of physical therapy progress notes in the record for June 20, 2011 through June 30, 2011 in the record at the time of this survey.	H 268	auditing and handling incomplete documentation related to Missed visits. (See Addendum 3)	
H 271	3911.2(k) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (k) Discharge summary, including the reason for termination of services and the effective date of discharge; This Statute is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure a	H 271	The Provider acknowledges and accepts this tag with the following plan of correction:	

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H 271	Continued From page 2 discharge summary, including the reason for termination of services and the effective date of discharge, was in the clinical record for one (1) of four (4) clinical records. (Patient # 9) The findings include: On December 9, 2011, a review of patient #9's record at approximately 10:44 a.m., revealed a POC with the certification period of May 9, 2011 through July 7, 2011 in which the physician ordered skilled nurse to administer cefepiem 2g IV every 12 hours and Daptomycin 6mg/kg IV daily... Further review of the record revealed there was no documented evidence of a discharge summary in the record available for review at the time of this survey. During a face to face interview with the DON on December 9, 2011 at approximately 1:15 p.m., she indicated indicated the patient had been discharge from the agency and there was no documented evidence of a discharge summary for review at the time of this survey.	H 271	• The nurses will meet with the Director of Nursing on a Monthly basis to discuss their case loads, issues and plan for discharges, which will be communicated to the schedulers for tracking. • The schedulers will call their assigned clinicians each week to track with patients have been admitted or discharged. • The QA department and Medical record will be notified of all discharges as they occur by tracking it on the scheduler's white board. • On a weekly basis the Quality Improvement team will meet to review all admissions, transfers and discharges to ensure that the medical record is complete. • The Quality department will refer all non-compliant staff members to the Director of Nursing for one to one counseling and initiation of disciplinary action if necessary. (see Addendum 4)	
H 300	3912.2(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (d) To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care; This Statute is not met as evidenced by:	H 300		

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Based on record review and interview, it was determined the Home Care Agency (HCA) failed to have an effective policiy to ensure that patients receive services according to their plan of care ur (7) of twelve (12)patients record at the time of this survey. (Patients #4, #5, #6,#7, #8, #9,#10)

The findings include:

1. On December 9, 2011, a review of patient #4's record at approximately 9:12 a.m. revealed a plan of care (POC) for the certification period of August 24,2011 through February 24, 2012 in which the physician ordered personal care aide visits eight (8)hours a day seven days a week for six (6)months.

Further review of the record revealed there was no documented evidence the personal care aide (PCA)visited patient #4 from September 5, 2011 through September 7, 2011 and November 4, 2011 through November 6, 2011.

Additionally, there was no documented evidence of a physician order for PCA services not be provided on the aforementioned days.

During a face to face interview with the director of nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated there was no documented evidence personal care aide services were provided on the aforementioned dates in the record at the time of this survey.

2. On December 8, 2011, a review of patient #6's record at approximately 2:30 p.m. revealed a plan of care (POC) for the certification period of May 22, 2011 through November 21, 2011 in which the physician ordered personal care aide (PCA)

The Provider acknowledges and accepts this tag with the following plan of correction:

- We have added an additional scheduler to assist with entering all schedules in our agency operations software, to facilitate tracking and monitoring of all staff members to ensure that the visits are completed. (See Addendum 5)
- Both Schedulers' will attempt to re-staff all call outs based on the patient's wishes and staff availability.
- Both of the Scheduler's, who receives calls for missed visits and tracks the completion of the visits was re-oriented to the process for handling and documentation of missed visits.
- The Registered Nurses and Case Managers received re-orientation to the handling and documentation of missed visits.
- Data Entry technician was re-oriented on the process for entering a Missed Visit documentation into the system to facilitate tracking.
- The Quality assurance staff members were re-oriented to the process for auditing and handling incomplete documentation related to Missed visits. (see addendum 3)

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H 300	Continued From page 4 services eight (8)hours a day, five (5) days a week for six (6) months. Further review of the record revealed there was no documented evidence PCA services were provided May 25, 2011 through May 27, 2011, June 13, 2011, through June 17, 2011, June 20, 2011 through June 24, 2011, August 11, 2011 August 12, and August 15, 2011. Additionally, there was no documented evidence of a physician order for PCA services not be provided on the aforementioned days. During a face to face interview with the DON on December 9, 2011 at approximately 9:45 a.m., she indicated there was no documented evidence PCA services were provided on the aforementioned dates in the record at the time of this survey. 3. On December 9, 2011, a review of patient #7's record at approximately 10:44 a.m. revealed a plan of care (POC) for the certification period of May 18, 2011 through November 16, 2011 in which the physician ordered PCA services eight (8)hours a day five (5) days a week for six (6) months. Further review of the record revealed there was no documented evidence PCA services were provided on November 18 th through November 22, 2011. Additionally, there was no documented evidence of a physician order for PCA services not be provided on the aforementioned days. During a face to face interview with the DON on December 9, 2011 at approximately 11:20 a.m.,	H 300	See previous page.	

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had been provided on the aforementioned skilled nursing notes.

6. On December 9, 2011, a review of patient #8's record at approximately 10:44 a.m., revealed a POC with the certification period of November 24, 2011 through May 24, 2011 in which the physician ordered skilled nursing five (5) visits and as needed, change Mediport dressing every 72 hours, change Huber needle every 72 hours assess site each visit and report any changes to physician immediately...

Further review of the record revealed a skilled nursing note dated November 27, 2011 in which the skilled nurse documented " Mediport Huber needle replaced". Additionally, there were skilled nursing notes for November 28, 2011, and December 1, 2011. There was no documented evidence the skilled nurse changed the Mediport Huber needle on November 30, 2011 (every 72 hours as ordered by the physician.)

During a face to face interview with the DON on December 9, 2011 at approximately 12:20 p.m., she indicated the patient had been admitted to the hospital on December 1, 2011 and there was no documented evidence in the record the skilled nurse changed the Mediport Huber needle as ordered by the physician.

7. On December 9, 2011, a record review of patient #8's record at approximately 10:44 a.m., revealed a POC with the certification period of May 9, 2011 through July 7, 2011 in which the physician ordered the skilled nurse to administer cefepime 2g IV every 12 hours and Daptomycin 6 mg/kg IV daily. Instruct patient or caregiver in signs and symptoms to report to physician, teach on medications to both patient and care giver,

Plan for Assigning and Tracking Skilled visits:

- On receiving orders for skilled care, the scheduler of record for the designated staff member will notify the staff of the ordered requirements.
- The scheduler will then post the skilled patient on the Scheduling white board and the white board of the QA department for tracking.
- The record will be flagged as skilled services on receipt of the admission package.
- The scheduler will call the nurse weekly to validate services provided for that week and track the submission of the paperwork for timely submission.
- The QA department will audit the skilled chart once monthly, using the skilled chart audit tool, follow up the nurse of record for any deficiencies and bring any issues to the bi-weekly QA meeting. (see addendum 6)
- The DON will discuss any outstanding issues during her monthly meeting with the staff.

(See addendum 6B)

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H 300	Continued From page 5 she indicated there was no documented evidence PCA services were provided on the aforementioned dates in the record at the time of this survey. 4. On December 9, 2011, a review of patient #10's record at approximately 2:30 p.m., revealed a skilled nursing note date September 2, 2011 in which the skilled nurse documented she/he documented "urinary foley changed size 16 foley catheter was inserted, patient tolerated procedure." Further review of the record revealed there was no documented evidence of a physician order for the skilled nurse to change patient's foley catheter. During a face to face interview with the DON at approximately 2:33 p.m. , she indicated the was not a physician order for the skilled nurse to change the patient's foley catheter. 5. On December 9, 2011, a review of patient #7's record at approximately 10:44 a.m., revealed a POC with the certification period of May 18, 2011 through November 16, 2011 in which the physician ordered skilled nursing (SN)services for PCA supervision, teach pain management, signs and symptoms of hypertensive crisis... Further review of the record revealed skilled nursing notes from May 16, 2011 through October 24, 201. There was no documented evidence the SN provided the aforementioned teaching as ordered by the physician. During a face to face interview with the DON on December 9, 2011 at approximately 11:20 a.m., she indicated the SN did not document teaching	H 300	• All IV cases will use the designated flow sheets to guide them as to when line and/or needle changes and measurements are needed. (see Addendum 7 and 7B) • All clinical staff was re-oriented to the Use of this protocol at the December Staff meeting. • Quality Assurance Department will audit on a monthly basis to ensure supporting documentation is present. • Each of these case result in a consultation with the nurse.	

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indication, dosage, scheduling and side effects, teach ostomy care and peri-stomal skin care and dietary consideration of ostomy....

Further review of the record revealed there were no skilled nursing notes for review in the record at the time of this inspection.

During a face to face interview with the DON on December 9, 2011 at approximately 1:15 p.m., she indicated there was no skilled nursing notes for review at the time of this survey. She also indicated the patient had been discharge from the agency.

It should be noted there was documented evidence of the discharge for review at the time of this survey.

8. On December 9, 2011, a review of patient #10's record at approximately 2:30 p.m., revealed a POC with the certification period of August 9, 2011 through October 7, 2011 in which the physician ordered wound measurement weekly's....

Further review of the record revealed the only date the skilled nurse documented the wound was measured was September 21, 2011. There was no documented evidence the skilled nurse measured the wound weekly as ordered by the physician in the record at the time of this survey.

During a face to face interview with the DON on December 9, 2011 at approximately 2:33 p.m., she indicated there was no documented evidence the skilled nurse measured the wound weekly in the record at the time of this survey.

9. On December 8, 2011, a review of patient #5 '

- All wound cases will use the designated flow sheets to guide them as to when wound measurements are needed (see Addendum 8 and 8B)
- Quality Assurance Department will audit on a monthly basis to ensure supporting documentation is present.
- Each of these case result in a consultation with the nurse.

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H 300	Continued From page 8 s record at approximately 1:30 p.m. revealed home health aide (HHA) time sheets for November 28, 2011 through December 4, 2011 in which the HHA documented she provided services to the patient for eight hours daily for each of the aforementioned days. During a face to face interview with patient #5 on December 12, 2011 at approximately 11:00 a.m., it was revealed that the patient was alert and oriented to person, place and time. He stated "I haven't seen the HHA in about a couple of weeks. The last time I saw her she wanted me to sign some time sheets and I didn't want to sign them because she did not like to show up for work but I signed them anyway because I figured she needed the money and that's the last time I saw her." During a face to face interview with the receptionist for the building were the patient resides on December 12, 2011 at approximately 11:00 a.m., she indicated she signs in all visitors to the building. According to the sign-in sheets the last time the HHA was signed-in to visited patient #5 was on November 28, 2011. Additionally, the receptionist indicated the HHA was signed in at 8:40 a.m. and signed out at 8 :50 a.m. The receptionist stated " I would sign- in the aide when she did show up but I looked at the sign-in sheets and the aide has not been signed in for this December at all." During a telephone conference with the DON on December 12, 2011 at approximately 11:20 a.m., she indicated she was not aware the HHA had not been providing service to the patient for the last two weeks. She also indicated she would send a HHA to provide services to patient on December 12, 2011.	H 300	The Provider acknowledges and accepts this tag with the following plan of correction: • After review and investigations into these allegations Premier Health Services is implementing short term plan: a two tier level of monitoring of our field staff though monthly customer services calls from designated individuals within the office and a quarterly visit from one of our QA and/or Staffing Coordinator. A long term goal of implementing electronic monitoring, with documentation for all field staff members.(See addendum 9 and 9B)	

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H 300	Continued From page 9 During a telephone conference with the Administrator on December 13, 2011 at approximately 2:30 p.m., she indicated the HHA (Employee #5) informed the agency she was in the building doing laundry when the surveyors visited with the patient on December 12, 2011. The Administrator also indicated a new HHA was sent to the patient #5's home on December 13, 2011.	H 300		
H 354	3914.3(c) PATIENT PLAN OF CARE The plan of care shall include the following: (c) The goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient; This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency (HCA) failed to ensure the plan of care (POC) included the goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient for two(2) of twelve(12) patients in the sample. (Patient #4, #5) The findings include: 1. On December 9, 2011, a review of Patient #4's record at approximately 9:12 a.m. revealed a Plan of Care (POC)with certification period August 24, 2011 until February 24, 2012. There was no documented evidence of goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs.	H 354	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS • Add library text to our computer software to address the goals of the services to be provided, including the expected outcome, based upon the immediate and long-team needs of the patients. (see Addendum 10) • Educate our data entry technician on use of the library text for data entry. (see Addendum 11) • Educate our Quality Assurance staff on the essentials of using this library text appropriately. (see Addendum 11)	

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H 354	Continued From page 10 During a face to face interview with the director of nursing (DON) on December 9, 2011, at approximately 10:30 a.m., she indicated the aforementioned POC did not include goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs. 2. On December 8, 2011, a review of Patient #5's record at approximately 1:30 p.m. revealed a Plan of Care (POC)with certification period September 27, 2011 until March 25, 2012. There was no documented evidence of goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs. During a face to face interview with the director of nursing (DON) on December 8, 2011, at approximately 2:29 p.m. she indicated the aforementioned POC did not include goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs.	H 354		
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 record review and interview, the Home Care Agency (HCA)failed to ensure the plan of care (POC)included provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of	H 357	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS • Add library text to our computer software to address the re-evaluation of services,	

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H 357	Continued From page 11 services for two (2) of twelve (12)patients in the sample. (Patient #4, #5) The findings include: 1. On December 9, 2011, a review of patient #4's record at approximately 9:12 a.m. revealed a plan of care (POC)with certification period from September 24, 2011 until February 24, 2012. There was no documented evidence that the aforementioned POC included evidence of provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services. During a face to face interview with the director of nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services. 2. On December 8, 2011, a review of patient #5's record at approximately 1:30 p.m. revealed a plan of care (POC)with certification period from September 27, 2011 until March 25, 2012. There was no documented evidence that the aforementioned POC included evidence of provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services. During a face to face interview with the director of nursing (DON) on December 8, 2011 at approximately 1:30 p.m., she indicated the aforementioned POC did not include provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services.	H 357	• discharge planning, referral of services and continuation of renewal of services. (See Addendum 10) • Educate our data entry technician on use of the library text for data entry. (Addendum 12) • Educate our Quality Assurance staff on the essentials of using this library text appropriately. (Addendum 12)	

Health Regulation & Licensing Administration

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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 home care agency (HCA)failed to ensure the plan of care (POC)included prognosis, including rehabilitation potential for two(2) of twelve(12) patients in the sample. (Patients #4 & #5) The findings include: 1. On December 9, 2011, a review of patient #4's record at approximately 9:12 a.m. revealed a plan of care (POC)with certification period of August 24, 2011 until February 24, 2012. There was no documented evidence that the aforementioned POC included prognosis, including rehabilitation potential . During a face to face interview with the director of nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include prognosis, including rehabilitation potential 2. On December 8, 2011, a record review of Patient #5's record at approximately 1:30 p.m. revealed a Plan of Care (POC)with certification period September 27, 2011 until March 25, 2012. There was no documented evidence that the aforementioned POC included prognosis, including rehabilitation potential . During a face to face interview with the director of	H 359	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS • Add library text to our computer software to address the prognosis, including rehabilitation potential. (See Addendum 10) • Educate our data entry technician on use of the library text for data entry. (See Addendum 13) • Educate our Quality Assurance staff on the essentials of using this library text appropriately.(See Addendum 13)	

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H 359	Continued From page 13 nursing (DON) on December 8, 2011, at approximately 2:29 p.m. she indicated the aforementioned POC did not include prognosis, including rehabilitation potential .	H 359	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS • Add library text to our computer software to address the psychosocial needs of the patient .(See Addendum 10) . • Educate our data entry technician on use of the library text for data entry.(See Addendum 14) • Educate our Quality Assurance staff on the essentials of using this library text appropriately. (See Addendum 14)	
H 361	3914.3(j) PATIENT PLAN OF CARE The plan of care shall include the following: (j) Psychosocial needs of the patient; This Statute is not met as evidenced by: Based on record review and interview the Home Care Agency (HCA) failed to ensure the plan of care (POC) included the psychosocial needs of the patient for two(2) of twelve(12) patients in the sample. (Patient #4 and #5) The findings include: 1. On December 9, 2011, a review of Patient #4's record at approximately 9:12 a.m. revealed a POC with certification period August 24, 2011 until February 24, 2012. There was no documented evidence the aforementioned POC included psychosocial needs of the patient. During a face to face interview with the director of nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include psychosocial needs of the patient. 2. On December 8, 2011, a review of Patient #5's record at approximately 1:30 p.m. revealed a POC with certification period September 27, 2011 until March 25, 2012. There was no documented	H 361		

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H 361	Continued From page 14 evidence the aforementioned POC included psychosocial needs of the patient. During a face to face interview with the director of nursing (DON) on December 8, 2011 at approximately 2:29 p.m., she indicated the aforementioned POC did not include psychosocial needs of the patient.	H 361	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS. • Add library text to our computer software to address the Safety measures required to protect the patient from injury. (See Addendum 10) • Educate our data entry technician on use of the library text for data entry. (See Addendum 15) • Educate our Quality Assurance staff on the essentials of using this library text appropriately (See Addendum 15).	
H 362	3914.3(k) PATIENT PLAN OF CARE The plan of care shall include the following: (k) Safety measures required to protect the patient from injury; This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure the plan of care (POC) included the safety measures required to protect the patient from injury for two (2) of twelve (12) patients in the sample. (Patients # 4 & #5) The findings include: 1. On December 9, 2011, a review of Patient #4's record at approximately 9:12 a.m. revealed a POC with certification period August 24, 2011 until February 24, 2012. There was no documented evidence of the safety measures required to protect the patient from injury . During a face to face interview with the director of nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include safety measures required to protect the patient from injury .	H 362		

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H 362	Continued From page 15 2. On December 8, 2011, a review of Patient #5's record at approximately 9:12 a.m. revealed a POC with certification period September 27, 2011 until March 25, 2012. There was no documented evidence of the safety measures required to protect the patient from injury . During a face to face interview with the director of nursing (DON) on December 8, 2011 at approximately 1:30 p.m., she indicated the aforementioned POC did not include safety measures required to protect the patient from injury .	H 362	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS • Add library text to our computer software to address the identification of employees in charge of managing emergency situations. (See Addendum 10) • Educate our data entry technician on use of the library text for data entry. (See Addendum 16) • Educate our Quality Assurance staff on the essentials of using this library text appropriately. (See Addendum 16).	
H 363	3914.3(I) PATIENT PLAN OF CARE The plan of care shall include the following: (I) Identification of employees in charge of managing emergency situations; This Statute is not met as evidenced by: Based on record review and interview the home care agency (HCA) failed to ensure the plan of care (POC) included identification of employees in charge of managing emergency situations for two (2) of twelve(12) patients in the sample. (Patients #4 & #5) The findings include: 1. On December 9, 2011, a review of Patient #4's record at approximately 9:12 a.m. revealed a POC with certification period August 24, 2011 until February 24, 2012. There was no documented evidence the aforementioned POC included the identification of employees in	H 363		

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H 363	Continued From page 16 charge of managing emergency situations. During a face to face interview with the DON on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include identification of employees in charge of managing emergency situations. 2. On December 9, 2011, a review of Patient #5's record at approximately 9:12 a.m. revealed a POC with certification period September 27, 2011 until March 25, 2012. There was no documented evidence the aforementioned POC included the identification of employees in charge of managing emergency situations. During a face to face interview with the DON on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include identification of employees in charge of managing emergency situations.	H 363	The Provider acknowledges and accepts this tag with the following plan of correction: • Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS • Add library text to our computer software to address the identification of employees in charge of managing emergency situations. (See Addendum 10) • Educate our data entry technician on use of the library text for data entry. (See Addendum 16) • Educate our Quality Assurance staff on the essentials of using this library text appropriately. (See Addendum 16).	
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 home care agency (HCA) failed to ensure the plan of care (POC) included emergency protocols for two(2) of twelve (12) patients in the sample. (Patients #4 & #5) The findings include: 1. On December 9, 2011, a review of Patient	H 364		

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H 364	Continued From page 17 #4's record at approximately 9:12 a.m. revealed a POC with certification period August 24, 2011 until February 24, 2012. There was no documented evidence the aforementioned POC included the emergency protocol. During a face to face interview with the DON on December 9, 2011 at approximately 10:30 a.m., she indicated the aforementioned POC did not include the emergency protocol. 2. On December 8, 2011, a review of Patient #5's record at approximately 1:30 p.m. revealed a POC with certification period September 27, 2011 until March 25, 2012. There was no documented evidence the aforementioned POC included the emergency protocol. During a face to face interview with the DON on December 8, 2011 at approximately 2:29 p.m., she indicated the aforementioned POC did not include the emergency protocol.	H 364		
H 401	3915.10(h) HOME HEALTH & PERSONAL CARE AIDE SERVICE Personal care aide duties may include the following: (h) Infection control; This Statute is not met as evidenced by: Based on an observation, the Home Care Agency's home health aide failed to maintain infection control for one (1) of two (2) patients. (Patient # 4) The finding includes:	H 401	The Provider acknowledges and accepts this tag with the following plan of correction: • The Staff sighted in this report was counsel about the issues as she had just attended the infection control in-service. (See Addendum 17,17B,17C, 17D) • Add infection control in-services to each of the quarterly in-services provided by Premier Health Services for 2012. (see addendum 18)	

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H 401	Continued From page 18 On December 12, 2011, at approximately 9:30 a.m. the home health aide (HHA -employee #4)answered the door wearing rubber gloves. The HHA attempted to hand this surveyor her ID wearing rubber gloves. During a face to face interview with the HHA (employee #4) on December 12, 2011 at approximately 9:40 a.m., she indicated she put on the gloves earlier to wash dishes and just left them on.	H 401	The Provider acknowledges and accepts this tag with the following plan of correction: • The agency has instituted a new form to be used for the 62 day summary evaluation of the skilled nursing services provided. • All nursing staff was trained on use of this new form (see addendum 1and 19) • The Scheduling department will track the submission of this document by the nurses and remind them to complete it during their weekly call. • The Quality Assurance Department will monitor for completion of this document during the monthly audit and referring unresolved issues to the DON • DON will resolve issues during Monthly Meeting	
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 home care agency (HCA) failed to have documented evidence of reviews and evaluations of the skilled services provided to patient's at least every sixty-two days or that a summary report of the evaluation was sent to the patient's physician for one (2) of four (4) patients in the sample. (Patient #9) The finding includes: On December 9, 2011, a record review of patient #4's record at approximately 12:40 p.m. revealed the patient received skilled nursing services from March 11, 2011 through July 7, 2011. There was no documented evidence of a 62 day summary evaluating the skilled nursing services provided to the patient in the patient's file	H 430		

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H 430	Continued From page 19 at the time of this survey. During a face to face interview with the DON on December 9, 2011 at approximately 1:15 p.m., she indicated there was not a 62 day summary evaluating the skilled nursing services provided to the patient in the file at the time of this survey.	H 430		
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: I. Based on record review and interview, it was revealed the Home Care Agency failed to ensure the patient needs were met in accordance with the plan of care (POC) for four(4)of twelve (12) patients in the sample. (Patient #7, #8, #9, #10) The findings include: 1. On December 9, 2011, a review of patient #7's record at approximately 10:44 a.m., revealed a POC with the certification period of May 18, 2011 through November 16, 2011 in which the physician ordered skilled nursing (SN)services for PCA supervision, teach pain management, signs and symptoms of hypertensive crisis... Further review of the record revealed skilled nursing notes from May 16, 2011 through October 24, 201. There was no documented evidence the SN provided the aforementioned teaching as ordered by the physician.	H 453	The Provider acknowledges and accepts this tag with the following plan of correction: Plan for Assigning and Tracking Skilled visits: • On receiving orders for skilled care, the scheduler of record for the designated staff member will notify the staff of the ordered requirements. • The scheduler will then post the skilled patient on the Scheduling white board and the white board of the QA department for tracking. • The record will be flagged as skilled services on receipt of the admission package. • The scheduler will call the nurse weekly to validate services provided for that week and track the submission of the paperwork for timely submission.	

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H 453	Continued From page 20 During a face to face interview with the DON on December 9, 2011 at approximately 11:20 a.m., she indicated the SN did not document teaching had been provided on the aforementioned skilled nursing notes. 2. On December 9, 2011, a review of patient #8's record at approximately 10:44 a.m., revealed a POC with the certification period of November 24, 2011 through May 24, 2011 in which the physician ordered skilled nursing five (5) visits and as needed, change Mediport dressing every 72 hours, change Huber needle every 72 hours assess site each visit and report any changes to physician immediately... Further review of the record revealed a skilled nursing note dated November 27, 2011 in which the skilled nurse documented " Mediport Huber needle replaced". Additionally, there were skilled nursing notes for November 28, 2011, and December 1, 2011. There was no documented evidence the skilled nurse changed the Mediport Huber needle on November 30, 2011 (every 72 hours as ordered by the physician.) During a face to face interview with the DON on December 9, 2011 at approximately 12:20 p.m., she indicated the patient had been admitted to the hospital on December 1, 2011 and there was no documented evidence in the record the skilled nurse changed the Mediport Huber needle as ordered by the physician. 3. On December 9, 2011, a record review of patient #8's record at approximately 10:44 a.m., revealed a POC with the certification period of May 9, 2011 through July 7, 2011 in which the physician ordered the skilled nurse to administer	H 453	• The QA department will audit the skilled chart once monthly, using the skilled chart audit tool, follow up the nurse of record ensure that all necessary education is being provided with the supporting documentation and bring any issues to the bi-weekly QA meeting. (see addendum 6) • The DON will discuss any outstanding issues during her monthly meeting with the staff. (See addendum 6B)	

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H 453	Continued From page 21 cefepime 2g IV every 12 hours and Daptomycin 6 mg/kg IV daily. Instruct patient or caregiver in signs and symptoms to report to physician, teach on medications to both patient and care giver, indication, dosage, scheduling and side effects, teach ostomy care and peri-stomal skin care and dietary consideration of ostomy.... Further review of the record revealed there were no skilled nursing notes for review in the record at the time of this inspection. During a face to face interview with the DON on December 9, 2011 at approximately 1:15 p.m., she indicated there was no skilled nursing notes for review at the time of this survey. She also indicated the patient had been discharge from the agency. It should be noted there was documented evidence of the discharge for review at the time of this survey. 4. On December 9, 2011, a review of patient #10's record at approximately 2:30 p.m., revealed a POC with the certification period of August 9, 2011 through October 7, 2011 in which the physician ordered wound measurement weekly's.... Further review of the record revealed the only date the skilled nurse documented the wound was measured was September 21, 2011. There was no documented evidence the skilled nurse measured the wound weekly as ordered by the physician in the record at the time of this survey. During a face to face interview with the DON on December 9, 2011 at approximately 2:33 p.m., she indicated there was no documented evidence	H 453	The Provider acknowledges and accepts this tag with the following plan of correction: • We have added an additional scheduler to assist with entering all schedules in our agency operations software, to facilitate tracking and monitoring of all staff members to ensure that the visits are completed. (See Addendum 5) • Both Schedulers' will attempt to re-staff all call outs based on the patient's wishes and staff availability. • Both of the Scheduler's, who receives calls for missed visits and tracks the completion of the visits was re-oriented to the process for handling and documentation of missed visits. • The Registered Nurses and Case Managers received re-orientation to the handling and documentation of missed visits. • Data Entry technician was re-oriented on the process for entering a Missed Visit documentation into the system to facilitate tracking. • The Quality assurance staff members were re-oriented to the process for auditing and handling incomplete	

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H 453	Continued From page 22 the skilled nurse measured the wound weekly in the record at the time of this survey. II. Based on record review and interview, it was determined the agency's nurse staff failed to ensure that person care services were provided as prescribed by plans of care for four (5)of twelve (12)patients record at the time of this survey. (Patients #4, #5, #6,#7, #10) The findings include: 1. On December 9, 2011, a review of patient #4's record at approximately 9:12 a.m. revealed a plan of care (POC) for the certification period of August 24,2011 through February 24, 2012 in which the physician ordered personal care aide visits eight (8)hours a day seven days a week for six (6)months. Further review of the record revealed there was no documented evidence the personal care aide (PCA)visited patient #4 from September 5, 2011 through September 7, 2011 and November 4, 2011 through November 6, 2011. Additionally, there was no documented evidence of a physician order for PCA services not be provided on the aforementioned days. During a face to face interview with the director of nursing (DON) on December 9, 2011 at approximately 10:30 a.m., she indicated there was no documented evidence personal care aide services were provided on the aforementioned dates in the record at the time of this survey. 2. On December 8, 2011, a review of patient #6's record at approximately 2:30 p.m. revealed a plan	H 453	• documentation related to Missed visits. (see addendum 3) The Provider acknowledges and accepts this tag with the following plan of correction: • Please see -Plan for Assigning and Tracking Skilled visits.	

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(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 23 of care (POC) for the certification period of May 22, 2011 through November 21, 2011 in which the physician ordered personal care aide (PCA) services eight (8)hours a day, five (5) days a week for six (6) months. Further review of the record revealed there was no documented evidence PCA services were provided May 25, 2011 through May 27, 2011, June 13, 2011, through June 17, 2011, June 20, 2011 through June 24, 2011, August 11, 2011 August 12, and August 15, 2011. Additionally, there was no documented evidence of a physician order for PCA services not be provided on the aforementioned days. During a face to face interview with the DON on December 9, 2011 at approximately 9:45 a.m., she indicated there was no documented evidence PCA services were provided on the aforementioned dates in the record at the time of this survey. 3. On December 9, 2011, a review of patient #7's record at approximately 10:44 a.m. revealed a plan of care (POC) for the certification period of May 18, 2011 through November 16, 2011 in which the physician ordered PCA services eight (8)hours a day five (5) days a week for six (6) months. Further review of the record revealed there was no documented evidence PCA services were provided on November 18 th through November 22, 2011. Additionally, there was no documented evidence of a physician order for PCA services not be provided on the aforementioned days.	H 453	The Provider acknowledges and accepts this tag with the following plan of correction: • After review and investigations into these allegations Premier Health Services is implementing short term plan: a two tier level of monitoring of our field staff though monthly customer services calls from designated individuals within the office and a quarterly visit from one of our QA and/or Staffing Coordinator. • A long term goal of implementing electronic monitoring, with documentation for all field staff members.(See addendum 9 and 9B)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0027	A. BUILDING _____ B. WING _____	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HEALTH SERVICES, INC	7600 GEORGIA AVENUE, NW, SUITE 323 WASHINGTON, DC 20012

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H 453	Continued From page 24 During a face to face interview with the DON on December 9, 2011 at approximately 11:20 a.m., she indicated there was no documented evidence PCA services were provided on the aforementioned dates in the record at the time of this survey. 4. On December 9, 2011, a review of patient #10's record at approximately 2:30 p.m., revealed a skilled nursing note date September 2, 2011 in which the skilled nurse documented she/he documented "urinary Foley changed size 16 Foley catheter was inserted, patient tolerated procedure." Further review of the record revealed there was no documented evidence of a physician order for the skilled nurse to change patient's Foley catheter. During a face to face interview with the DON at approximately 2:33 p.m. , she indicated the was not a physician order for the skilled nurse to change the patient's Foley catheter. 5. On December 8, 2011, a review of patient #5 ' s record at approximately 1:30 p.m. revealed home health aide (HHA) time sheets for November 28, 2011 through December 4, 2011 in which the HHA documented she provided services to the patient for eight hours daily for each of the aforementioned days. During a face to face interview with patient #5 on December 12, 2011 at approximately 11:00 a.m., it was revealed that the patient was alert and oriented to person, place and time. He stated "I haven't seen the HHA in about a couple of weeks. The last time I saw her she wanted me to	H 453	The Provider acknowledges and accepts this tag with the following plan of correction: Plan for Assigning and Tracking Skilled visits: • On receiving orders for skilled care, the scheduler of record for the designated staff member will notify the staff of the ordered requirements. • The scheduler will then post the skilled patient on the Scheduling white board and the white board of the QA department for tracking. • The record will be flagged as skilled services on receipt of the admission package. • The scheduler will call the nurse weekly to validate services provided for that week and track the submission of the paperwork for timely submission.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0027	A. BUILDING _____ B. WING _____	12/12/2011

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H 453	Continued From page 25 sign some time sheets and I didn't want to sign them because she did not like to show up for work but I signed them anyway because I figured she needed the money and that's the last time I saw her." During a face to face interview with the receptionist for the building were the patient resides on December 12, 2011 at approximately 11:00 a.m., she indicated she signs in all visitors to the building. According to the sign-in sheets the last time the HHA was signed-in to visited patient #5 was on November 28, 2011. Additionally, the receptionist indicated the HHA was signed in at 8:40 a.m. and signed out at 8 :50 a.m. The receptionist stated " I would sign- in the aide when she did show up but I looked at the sign-in sheets and the aide has not been signed in for this December at all." During a telephone conference with the DON on December 12, 2011 at approximately 11:20 a.m., she indicated she was not aware the HHA had not been providing service to the patient for the last two weeks. She also indicated she would send a HHA to provide services to patient on December 12, 2011. During a telephone conference with the Administrator on December 13, 2011 at approximately 2:30 p.m., she indicated the HHA (Employee #5) informed the agency she was in the building doing laundry when the surveyors visited with the patient on December 12, 2011. The Administrator also indicated a new HHA was sent to the patient #5's home on December 13, 2011.	H 453	The Provider acknowledges and accepts this tag with the following plan of correction: • After review and investigations into these allegations Premier Health Services is implementing short term plan: a two tier level of monitoring of our field staff though monthly customer services calls from designated individuals within the office and a quarterly visit from one of our QA and/or Staffing Coordinator. • A long term goal of implementing electronic monitoring, with documentation for all field staff members.(See addendum 9 and 9B)	