Health Reaulation & Licensma Administration

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0086	A. BUILDING: _____ B. WING _____	02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECIALTY HOME CARE LLC	6120 KANSAS AVENUE, NW WASHINGTON, DC 20011

Received 3/23/18

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H 0001	INITIAL COMMENTS An annual survey was conducted from 02/22/18 through 02/23/18 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 to seven patients and employs five staff. The findings of the survey were based on a review of seven active patient records, four discharged patient records, and five employee records. The findings were also based on three home visits, four telephone interviews, and interviews with patients and staff. Listed below are abbreviations used throughout the body of this report. CPR – Cardiopulmonary Resuscitation DON – Director of Nursing HCA – Home Care Agency HTN – Hypertension POC – Plan of Care **PRN – As Needed** SOC – Start of Care T2DM – Type 2 Diabetes Mellitus	H 000	Initial Comments Specialty Home Care has reviewed the deficiencies noted in the survey conducted from Feb.22nd,2018 through Feb23rd,2018. Plan of Correction has been developed for review and approval and to ensure that the agency maintains compliance with professional standards and licensure regulations.	
H 098	3905.2(h) POLICIES AND PROCEDURES Written policies and procedures shall be developed for, at a minimum, the following: (h) The provision of each service offered; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to have an effective Ongoing Assessment policy.	H 098	H 098 3905.2(h) POLICIES AND PROCEDURES Corrective Actions: Agency Policy and Procedure was revised on the provision of each services offered and an ongoing assessment policy reflecting that during each home visit, the clinician would re-evaluate the patient according to problems identified during the initial visit and subsequent visits.	03/30/18 and ongoing

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chan Dems MD | TITLE: CEO/Administrator | (X6) DATE: 3/22/18

Health Regulation & Licensing Administration

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H 098	Continued From page 1 Findings included: Review of the HCA's policy titled, "Ongoing Assessment," undated, showed that during each home visit, the clinician or another discipline would re-evaluate the patient according to problems identified during the initial visit and subsequent visits. 1. Review of Patient #1 's clinical record on 02/22/18 at 11:00 AM, showed an initial assessment dated 01/10/18, which documented the patient had problems with Cardiac Arrhythmias and T2DM. Further review of the record showed nursing notes dated 01/11/18, 01/16/18, 01/19/18, 01/22/18, 01/25/18, and 01/29/18 that lacked documented evidence the nurse assessed the patient's circulatory system. Additionally, the nursing notes dated 01 /19/18, 01/22/18, 01/25/18, and 01/29/18 lacked documented evidence the nurse assessed the patient's endocrine system. 2. Review of Patient #2's clinical record on 02/22/18 at 12:00 PM, showed an initial assessment dated 01/11/18, which documented the patient had a problem with T2DM. Further review of the record showed nursing notes dated 01/19/18, 01/22/18, 01/25/18, and 01/29/18, which lacked documented evidence that the nurse assessed the patient's endocrine system. 3. Review of Patient #3's clinical record on 02/22/18 at 1:00 PM, showed an initial assessment dated 01/11/18, which documented the patient had a problem with T2DM. Further review of the record showed nursing notes dated 01/15/18, 01/19/18, 01/22/18, 01/25/18, and 01/29/18 that lacked documented evidence the nurse assessed the patient's endocrine system.	H 098	Agency's Patient Record folder`s content (both at Patient`s home & at the the agency will be updated to include an"Active Problem List" form to document all active problems identified during the initial assessment and/or Re-evaluation assessment. In-service will be provided to all current and new hire clinicians. The Agency's chart audit checklist was also updated to reflect the item(problems identified and documented evidence of clinician`s assessment of the identified problem related systems on subsequent visits) and will be utilized for all patients to ensure compliance on ongoing basis. Quality Assurance RN will utilize the updated chart audit checklist to audit charts to ensure continued compliance going forward with Quantitative goal/measure of success >90% The QA Nurse and/or Director of Nursing will be responsible for monitoring of the implementation of the updated policy. Clinicians will also be actively involved in self-auditing their visit notes. The Quality assurance RN will provide audit report on all audited charts to the QA committee on a quarterly basis to monitor ongoing compliance. Outcome below the set goal would trigger referral to the agency`s professional advisory board for further recommendation and action. **Random Sampling methodology.** The monthly sampling size is based on average daily census(ADC). For a census size of 30 or less, sample of 10(1% of the cases. For a census size of 31 to 100, sample of 30 cases For a census size of 101 to 500, sample of 50cases. etc ...	3/30/18 and Ongoing

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H 098	Continued From page 2 During an interview on 02/23/18 at 10:30 AM, the DON, stated that she had assessed the specific systems of the patients' identified problems during every visit. However, the agency's new electronic nursing note does not allow her to document assessments. At the time of the survey, the HCA failed to have an effective system to for Ongoing Assessments.	H 098	The charts will be randomly selected by running a list of patients, then selecting every 3rd chart until 50 records are identified. This will be monitored monthly for block of three consecutive months. The denominator equals the total number of charts reviewed. The numerator equals the number of charts audited in which there is documented evidence of each problem identified initially was assessed on subsequent follow up visits(compliant)	
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 HCA failed to ensure that their (medical) emergency protocol was patient-specific for seven of seven patients' POCs reviewed (Patients #1, #2, #3, #4, # 5, #6, and #7). Findings included: Review of Patients #1 through #7 current POCs starting on 02/22/18 and 02/23/18 showed that each POCs documented the following: "Clinicians to initiate CPR if appropriate and call 911 in the event of a medical emergency, and then notify the DON, or Administrator at first opportunity." During an interview on 02/23/18 at 12:00 PM, the DON, stated that she was unsure of the patients' code status, but she would ascertain that	H 364	**H 364 1 3914.3(m) PATIENT PLAN OF CARE** **Emergency Protocol** In-service will be provided to all current and new hire clinicians to ensure that the emergency protocol was patient-specific that takes into account patient`s code status and medical conditions. Quality Assurance RN will utilize chart audit checklist to audit POC at SOC/Re-certs/ROC/ to ensure continued compliance going forward using random sampling. **Random Sample.** The monthly sampling size is based on average daily census(ADC). For a census size of 30 or less, sample 10(1% of the cases. For a census size of 31 to 100, sample of 30 cases For a census size of 101 to 500, sample of 50 cases. etc ... The charts will be randomly selected by running a list of patients, then selecting every 3rd chart until 50 records are identified. This will be monitored monthly for block of three consecutive months.	3/30/18 and Ongoing

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H 364	Continued From page 3 information and update the medical emergency protocol section on POCs. At the time of the survey, the Home Care Agency failed to ensure that their (medical) emergency protocol was patient-specific for Patients #1 through #7 POCs.	H 364	The denominator equals the total number of charts reviewed. The numerator equals the number of charts audited in which POC documentation reveals patient specific Emergency protocol (compliant) QA Personnel will report results quarterly to the Quality Committee. Goal/measure of success >90%.Outcome below the set goal would trigger referral to Professional advisory board for further recommendation and action.	
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 nurse failed to provide services per the POC for two of seven patients in the sample (Patients #1 and #2). Findings included: 1. Review of Patient #1 's clinical record on 02/22/18 at 11:00 AM, showed a POC with a SOC date of 01/11/18, and a certification date of 01/11/18 to 03/11/18. The POC showed that the patient had diagnoses of T2DM and Cardiac Arrhythmias. The POC required the nurse to provide services two to three times a week for four weeks, and one to two times a week for five weeks to "check [the]patient's blood sugar during each visit and PRN [as needed]. Also, the nurse was and provide instruction on factors that contribute to shortness of breath." Further review of record lacked documented evidence that the nurse checked the patient's blood sugar during	H 453	**3917.2(c) SKILLED NURSING SERVICES** In-service will be provided to all current and new hire clinicians regarding providing services as per the POC to ensuring that patient needs are met in accordance with the plan of care. Quality Assurance RN will utilize chart audit checklist to audit Patient`s records to ensure continued compliance going forward using random sampling method stated in the previous sections with Goal/ measure of success >90%. The denominator equals the total number of charts reviewed. The numerator equals the number of charts audited in which care documentation reveals services provided per POC (compliant) The QA Nurse and/or Director of Nursing will be responsible for implementing the POC. Clinicians will also be actively involved in self-auditing their visit notes.	**03/30/18 And Ongoing**

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H453	Continued From page 4 the following nursing visits: 01/19/18, 01/22/18, 01/25/18, and 01/29/18. Continued review of the record on the same day showed a nursing note dated 01/25/18, that documented the patient had "dyspnea [difficulty/labored breathing] with moderate exertion, i.e., bathing, dressing." Further review of the nursing note showed that there was no documented evidence that the nurse provided instruction on factors that contribute to shortness of breath, as outlined in the above mentioned POC. 2. Review of Patient #2's clinical record on 02/22/18 at 12:00 PM, showed a Plan of Care (POC) with a start of care date of 01/10/18, and a certification date of 01/10/18 to 03/10/18. The POC showed that the patient had a diagnosis of Type 2 Diabetes Mellitus. The POC required the nurse to provide services two to three times a week for four weeks, and one to two times a week for five weeks to "check [the]patient's blood sugar during each visit and PRN [as needed]." Further review of record showed that there was no documneted evidence that the nurse checked the patient's blood sugar during the following nursing visits: 01/19/18, 01/22/18, 01/25/18, and 01,29118. During an interview on 02/22/18 at 12:00 PM, the nurse, who was also the DON, stated that she had checked the patient's blood sugar on the dates mentioned above, but she could not document the results in the agency's new electronic records. Additionally, the nurse stated that she did not provide instruction on dyspnea. At the time of the survey, the DON failed to provide services per the POC for Patients #1 and	H453	Continued.. QA RN will report results quarterly to the Quality Committee to ensure continued compliance. Outcome below the set goal would trigger referral to Professional advisory board for further recommendation and action.	

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H453	Continued From page 5 #2.	H453		
H4581	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review and interview, the DON failed to inform the physician of a change in the patient's status for one of seven patients in the sample (Patient #3). Findings included: Review of Patient #3's clinical record on 02/22/18 at 1:00 PM, showed a nursing note dated 01/25/18, which the DON documented that the patient complained of burning during urination. Further review of showed that there was no documented evidence that the patient's physician was made aware of the patient's change in status. During an interview on 02/22/18 at 10:30 AM, the DON, stated that she had made the patient's physician aware, but she failed to document it. At the time of the survey, the DON failed to inform the physician of Patient #3's change in status.	H458	**3917.2(h) SKILLED NURSING SERVICES** In-service will be provided to all current and new hire clinicians regarding reporting changes in the patient's condition to the patient's physician and that visit notes need to reflect documented evidence that the patient's physician was made aware if there is patient's change in status. Quality Assurance RN will utilize chart audit checklist to audit Patient`s records to ensure continued compliance going forward using Random Sampling method stated in the previous sections with Goal/ measure of success >90%. The denominator equals the total number of charts reviewed. The numerator equals the number of charts audited in which care documentation reveals evidence of Physician notification for for Patient change of Status(compliant) QA RN will report results quarterly to the Quality Committee to ensure continued compliance. Outcome below the set goal would trigger referral to professional advisory board for further recommendation and action.	**03/30/18 and Ongoing**
H4591	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum,	H459		

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H 4591	Continued From page 6 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 seven of seven patients in the sample (Patients# 1, #2, #3, #4, #5, #6, and #7). Findings included: 1. Review of Patient #1 's clinical record on 02/22/18 at 11:00 AM, showed a POC with a SOC date of 01/11/18, and a certification date of 01/11/18 to 03/11/18. The POC showed that the patient had diagnoses of T2DM and Cardiac Arrhythmias. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to provide instruction on high-risk medication precautions, factors that contribute to shortness of breath, and irritants/allergens that increase shortness of breath ... Further review of the record on the same day showed that the nurse visited the patient as outlined on POC mentioned above from 01/16/18 to 02/15/18. Additionally, the nurse provided instruction on each visit. However, there was no documented evidence that the nurse evaluated the patient's understanding of the instructions she provided. 2. Review of Patient #2's clinical record on 02/22/18 at 12:00 PM, showed a POC with a	H 459	**3917.2(i) SKILLED NURSING SERVICES** In-service will be provided to all current and new hire clinicians regarding documented evidence of patient instruction, and evaluation of patient instruction provided.i.e documented evidence showing that the patient's understanding of the instructions provided is required The Agency's chart audit checklist was also updated to reflect the item (documented evidence of clinicians assessment of patient's understanding of the instructions provided.) and will be utilized for all patients to ensure compliance on ongoing basis. Quality Assurance RN will utilize chart audit checklist to audit Patient`s records to ensure continued compliance going forward using Random Sampling method stated in the previous sections with Goal/ measure of success >90%. The denominator equals the total number cf charts reviewed. The numerator equals the number of charts audited that reveals documented evidence that the Clinician evaluated the patient's understanding of the instructions provided. (compliant) QA RN will report results quarterly to the Quality Committee to ensure continued compliance. Outcome below the set goal would trigger referral to Professional advisory board for further recommendation and action.	03/30/18 and Ongoing

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H459	Continued From page 7 SOC date of 01/10/18, and a certification date of 01/10/18 to 03/10/18. The POC showed that the patient had diagnoses of Abnormality of Gait Mobility and T2DM. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to provide instruction on daily weight, measures to detect and alleviate edema, and signs of a heart attack... Further review of the record on the same day showed that the nurse visited the patient as outlined on POC mentioned above from 01/15/18 to 02/12/18. Additionally, the nurse provided instruction on each visit. However, there was no documented evidence that the nurse evaluated the patient's understanding of the instructions she provided. 3. Review of Patient #3's clinical record on 02/22/18 at 1:00 PM, showed a POC with a SOC date of 01/11/18, and a certification date of 01/11/18 to 03/11/18. The POC showed that the patient had diagnoses of Muscle Weakness and HTN. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to provide instruction on factors that contribute to shortness of breath, irritants/ allergens known that increase shortness of breath, and energy conserving measures... 4. Review of Patient #4's clinical record on 02/22/18 at 2:30 PM, showed a POC with a SOC date of 12/29/17, and a certification date of 12/29/17 to 02/26/18. The POC showed that the patient had diagnoses of Muscle Weakness and HTN. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to	H459		

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H459	Continued From page 8	H459		

provide instruction on proper footwear when ambulating, prescribed assistive devices for ambulating, and precautions for high-risk medications...

Further review of the record on the same day showed that the nurse visited the patient as outlined on POC mentioned above from 12/31/17 to 02/15/18. Additionally, the nurse provided instruction on each visit. However, there was no documented evidence that the nurse evaluated the patient's understanding of the instructions she provided.

5. Review of Patient #5's clinical record on 02/23/18 at 9:30 AM, showed a POC with a SOC date of 12/29/17, and a certification date of 12/29/17 to 02/26/18. The POC showed that the patient had diagnoses of Difficulty Walking and Cerebral Infarction. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to provide instruction on proper footwear when ambulating, prescribed assistive devices for ambulating, and pharmacological and non-pharmacological pain management..

Further review of the record on the same day showed that the nurse visited the patient as outlined on POC mentioned above from 12/31/17 to 02/15/18. Additionally, the nurse provided instruction on each visit. However, there was no documented evidence that the nurse evaluated the patient's understanding of the instructions she provided.

6. Review of Patient #6's clinical record on 02/23/18 at 11:30 AM, showed a POC with a SOC date of 12/29/17, and a certification date of 12/29/17 to 02/26/18. The POC showed that the

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H 459	Continued From page 9 patient had diagnoses of Abnormality of Gait and Mobility and Osteoarthritis. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to provide instruction on proper footwear when ambulating, prescribed assistive devices for ambulating, and precautions for high-risk medications... Further review of the record on the same day showed that the nurse visited the patient as outlined on POC mentioned above from 12/31/17 to 02/16/18. Additionally, the nurse provided instruction on each visit. However, there was no documented evidence that the nurse evaluated the patient's understanding of the instructions she provided. 7. Review of Patient #7's clinical record on 02/23/18 at 12:30 PM, showed a POC with a SOC date of 12/29/17, and a certification date of 12/29/17 to 02/26/18. The POC showed that the patient had diagnoses of Abnormality of Gait and Mobility and Essential Hypertension. The POC required the nurse to visit the patient two to three times a week for four weeks, and one to two times a week for five weeks to provide instruction on proper footwear when ambulating, prescribed assistive devices for ambulating, and precautions for high-risk medications... Further review of the record on the same day showed that the nurse visited the patient as outlined on POC mentioned above from 01/02/18 to 02/12/18. Additionally, the nurse provided instruction on each visit. However, there was no documented evidence that the nurse evaluated the patient's understanding of the instructions she provided.	H 459		

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H 459	Continued From page 10 During an interview on 02/23/18 at 12:00 PM, the nurse, who is also the DON, stated that going forward she would ensure that she evaluate and document the patients understanding of instructions she provided. At the time of the survey, the DON failed to provide evidence that evaluations of patient instructions were conducted.	H459		