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-0027	A. BUILDING: ______ B. WING ______	R 03/15/2013

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

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H 411	Continued From page 35	H 411	H411	
	This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency's home health aide failed to report a patient was missing, for one of fifty-nine patients in the sample. (Patient #59) The finding includes: On March 12, 2013, at approximately 10:30 a.m., review of Patient #59's record revealed an incident report dated February 21, 2012. According to the report, Employee #29 (HHA) documented, "on 02/17/13 when I came to work for [Patient #59] at 8 a.m., my client was not present at [his/her] apartment. I stayed there looking until 2 p.m. then I called the police and filed a missing person report. I have being looking for [him/her] everywhere... I reported the situation to the building security officer on duty." During a telephone interview with Employee #29 on March 15, 2013, at approximately 1:55 p.m., he/she stated, "I can't remember if I called the agency on the day the patient was missing." Further discussion was held with Employee #29 to ascertain information regarding the employee's actions during the aforementioned incident. Employee #29 revealed that he/she did not call the agency to report Patient #59 was missing, instead the employee reported, "I just left at 9:15 a.m." Continued discussion with Employee #29 revealed that he/she did however, call the staffing agency for whom he/she worked on February 18, 2013, after being contacted by the police. According to Employee #29, the police informed him/her that Patient #59 was found dead in Rock Creek Park.		Agency accepts and acknowledges this citation with the following plan of corrections. All PCA's from Staffing Agencies will receive orientation by Agency to re-educate PCA on the duties and responsibilities of a PCA and to orient them on the Agency Policies. PCA will be trained to understand that while they are "employed by Staffing Agencies and receive their payment from Staffing Agency they provide services on behalf of Agency. All issues, incidents, complaints, concerns are to be directed to Agency and not Staffing Agency. PCA's will be instructed that they are supervised by the Agency RN. All PCA's shall receive in-service training on observing , recording and reporting patent behavior and appearance. PCAs will receive training on ethics and consequence of falsifying information. Moving forward Agency shall conduct a more in depth investigation to all complaints and incidents to include; supporting documents, interviews with both employees and patients, and if warranted, refer to a certified investigator. Human Resources Manager will be responsible to monitor process. Administrator will review on a quarterly basis all incidents to ensure procedure is being followed.	MAY 31 2013

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H 430	3916.1 SKILLED SERVICES GENERALLY	H 430	H430	
	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.		Agency accepts and acknowledges this citation with the following plan of corrections.	
	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 patients at least every sixty-two days and that a summary report of the evaluation was sent to the patient's physician for three (3) of fifty-nine (59) patients in the sample. (Patients #1, #7, and #9)		To achieve more consistent care and continuity of care, Agency will phase out the use of part-time nurses. On 4/1/13 Agency hired three full time RNs. All current and new RN's shall receive In-Service training on the deficiencies on this report on April 16th 2013. During this in-service, all RN's will be re-educated on the requirement of a 62 day summary.	April 16 2013
	The findings include:		All 62 days summaries that were not completed starting January 2013 will be completed and faxed to the physicians for review.	July 12 2013
	1. On January 22, 2013, at approximately 11:10 a.m., review of Patient #1's plan of care (POC), with a documented certification period of July 18, 2012, to January 1, 2013, revealed the skilled nurse was required to complete skilled nursing assessments and an evaluation of systems every thirty days for six months. Continued review of the POC, further ordered six visits for any medical health related issues as needed.		Quality Assurance Team will review at least 50 percent of patient records on a quarterly basis to ensure compliance.	ongoing
	Additional review of Patient #1's record on January 22, 2013, revealed the patient received skilled nursing services monthly from July 24, 2012, through September 19, 2012. The patient's record however, failed to provide evidence that the agency evaluated the patient's skilled nursing services at least every 62 days and reported it to the patient's physician.			
	During an interview with the Director of Nursing			

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(DON) on January 22, 2013, at approximately 1:30 p.m., it was revealed the 62 day summary had not been done.

2. On January 31, 2013, at approximately 12:00 p.m., review of Patient #7's POC, with certification period from September 11, 2012 through March 9, 2013, revealed the skilled nurse was required to complete skilled nursing assessments and an evaluation of systems every thirty days for six months. Continued review of the POC, further ordered six visits for any medical health related issues as needed.

Additional review of Patient #7's record on January 31, 2013, revealed the patient received skilled nursing services monthly from September 11, 2012 through March 9, 2013. The patient's record however, failed to provide evidence that the agency evaluated the patient's skilled nursing services at least every 62 days and reported it to the patient's physician.

3. On February 1, 2013, at approximately 10:00 a.m., review of Patient # 9's record revealed a POC with a certification period from August 2, 2012 through January 28, 2013, revealed the skilled nurse was required to complete skilled nursing assessments and an evaluation of systems every thirty days for six months. Continued review of the POC, further ordered six visits for any medical health related issues as needed.

Additional review of Patient #7's record on February 1, 2013, revealed the patient received skilled nursing services monthly from August 2, 2012 through January 28, 2013. The patient's record however, failed to provide evidence that

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	the agency evaluated the patient's skilled nursing services at least every 62 days and reported it to the patient's physician. NOTE: This is a repeat deficiency.			
H 453 SS=C	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 home care agency's (HCA's) nurse failed to ensure that patient needs were met in accordance with the plan of care (POC), for ten (10) of fifty-nine (59) patients in the sample. (Patient #1, #3, #4, #7, #8, #9, #10, #12, #13, and #14) The finding includes: 1. On January 22, 2013, at approximately 11:10 a.m., review of Patient #1's POC, with a documented certification period of July 18, 2012, to January 1, 2013, revealed the skilled nurse was to visit the patient's home every thirty (30) days to conduct skilled assessments and to evaluate systems. According to the POC, personal care aide (PCA) services were to be provided sixteen hours a day, seven days a week and the nurse was required to provide supervision.	H 453	H453 Agency accepts and acknowledges this citation with the following plan of corrections: 1. Patient 1 received a skilled Nursing assessment and evaluation of systems on January 24, 2013 and has received one every month since then. Agency will notify physician of all deviations to the service ordered from the Plan of Care. Agency will place evidence of notification in patient's chart. 2. Patient 3 is discharged patients. However, Agency will notify physician of the deviation in the service ordered and evidence of such notification will be placed in each patients' chart. Any additional hours billed in excess of physician order will be returned. 3.Patient 4 is discharged patients. However, Agency will notify physician of the deviation in the service ordered and evidence of such notification will be placed in each patients' chart.	

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H 453	Continued From page 39 Further review of the record failed to provide evidence that any skilled nursing assessment or evaluation of systems had been conducted for October 2012, November 2012, December 2012 and January 2013. Additionally, review of the PCA time sheets revealed PCA services were only provided for eight hours on August 6, 2012, August 7, 2012, August 9, 2012, August 10, 2012 and August 18, 2012. During an interview with the administrator and scheduling coordinator on January 22, 2013, at approximately 1:30 p.m., it was revealed that skilled nursing notes were not done because the agency was following updated regulations from another branch of the Department of Health. 2. On January 28, 2013, at approximately 1:10 p.m., review on Patient #3's POC with a documented certification period of June 25, 2012, through December 24, 2012, revealed the physician ordered home health aide (HHA) services ten (10) hours a day seven (7) days a week. Additionally, review of the HHA time sheets revealed the following: Four (4) hours of service was provided on: July 2, 2012 through July 15, 2012; July 16, 2012 through July 20, 2012; July 23, 2012; July 28, 2012 through July 30, 2012; August 6, 2012 through August 10, 2012; August 13, 2012 through August 17, 2012; August 20, 2012 through August 24, 2012; August 27, 2012 through August 31, 2012; September 27, 2012 through September 28, 2012; October 1, 2012 through October 5, 2012; October 8, 2012 through October 12, 2012;	H 453	4. Patient 7- Teaching on hypertensive crisis, cardiac complications and energy conservation techniques were completed by Employee 5 on 2/7/13 and will be reinforced as needed. 5. Patient 8 POC's has since been signed by Physician. RN visited patient in September and November 2012 but completed a Missed visit for October 2012. Agency will notify physician of the deviation in the service ordered and evidence of such notification will be placed in each patients' chart. 6. Patient 9- January 2013 visit was completed by nurse, however nurse did not timely submit her notes to the Agency. Visit to patient occurred on 1/14/13. POC for patient was signed on time on 8/22/12 and was in patient chart. 7. Patient 10- RN visited patient on 1/16/13. However, RN did not timely submit visit notes to Agency. HHA submitted timesheets late. Timesheet covering January 11- March 25 2013 are currently in patient chart. Services were provided as ordered.	

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H 453	Continued From page 40 October 15, 2012 through October 19, 2012; October 2, 2012 through October 26, 2012; November 12, 2012 through November 16, 2012; November 19, 2012 through November 23, 2012; and November 26, 2012 through November 30, 2012. Eight (8) hours of service was provided on September 3, 2012 through September 7, 2012; September 10, 2012 through September 12, 2012; September 17, 2012 through September 21, 2012; and September 24, 2012 through September 26, 2012. Further review of Patient #3's record revealed a physician's order dated July 30, 2012. Review of the order revealed it was signed by the director of nursing (DON) but the physician ordered to "change HHA weekend visit frequency from eight (8) hours for two (2) days to four (4) hours for two (2) days to support the need for functional assistance with activities of daily living as requested by the family as of 08/01/12." Review of HHA time sheets revealed the following: Eight (8) hours of service was provided on the following weekends: August 25, 2012 through August 26, 2012; September 1, 2012 through September 2, 2012; September 8, 2012 through September 9, 2012; September 15, 2012 through September 16, 2012; and September 2, 2012 through September 23, 2012, Additionally, there was no evidence HHA service was provided from October 29, 2012, through November 11, 2012.	H 453	8. Patient 12- There was no visit in December of 2012. RN visited patient on 1/23/13 and every month thereafter but as of time of survey had not submitted her note for January 2013. HHA providing services for this patient completed timesheets incorrectly. Timesheets were returned to the HHA to correct. HHA was since reeducated on the proper way to completed timesheet and timesheets in question were submitted. Moving forward Agency will make copies of timesheets filled incorrectly and place them in chart as place holders until a new correct timesheet is submitted to the office. All current and new RN's shall receive In-Service training on the deficiencies on this report on April 16th 2013. During this in-services, all RN's will be re-educated on timely submission of notes. 9.Patient 13 - Services were initially placed on hold due to the Plan of Care not signed by physician and state plan prior authorization for services had not yet been received by Agency. Agency will notify physician of all deviations to the service ordered from the Plan of Care. Agency will place evidence of notification in patient's chart. PCA submitted timesheets late. PCA Timesheet after January 11- March 25 2013 are currently in patient chart. Services were provided as ordered.	

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H 453	Continued From page 41 During an interview with the scheduling coordinator on February 1, 2013, at approximately 3:27 p.m., she indicated there were physician orders to support the changes in the HHA hours provided. At the time of the survey, however there was no evidence in Patient #3's record of physician's orders to support all the aforementioned changes in the HHA hours. 3. On January 31, 2013, at approximately 10:21 a.m., review of Patient #4's POC, with a documented certification period of July 26, 2012 through January 21, 2013, revealed the physician ordered HHA services ten (10) hours a day seven, (7) days a week, skilled nursing service every thirty (30) days for HHA supervision and skilled assessments and evaluation of systems. Review of the HHA time sheets and skilled nursing notes revealed the following Four (4) hours of HHA service was provided on the following dates; July 26, 2012 through August 24, 2012; August 27, 2012 through August 31, 2012; September 3, 2012 through September 7, 2012; September 10, 2012 through September 14, 2012; September 17, 2012 through September 21, 2012; September 24, 2012 through September 30, 2012; October 3, 2012 through October 4, 2012; and November 4, 2012 through November 9, 2012. Eight (8) hours of HHA service was provided on the following dates: August 25, 2012 through August 26, 2102;	H 453	10. Patient 14 Services were initially placed ~~on hold due to the Plan of Care not signed~~ by physician and state plan prior authorization for services had not yet been received by Agency. Agency will notify physician of all deviations to the service ordered from the Plan of Care. Agency will place evidence of notification in patient's chart. PCA Timesheet after January 11are present in chart. All current and new RN's shall receive In-Service training respective on the deficiencies on this report on April 16th 2013. During this in-services, all RN's will be re-educated on notifying physician on deviation of services. A review of current patient charts will be completed for visits starting January 2013and deviation in PCA services will be faxed to physician. Quality Assurance Team will review 25 percent of patient records for proof of physician notification of a deviation on a quarterly basis beginning with 3rd quarter.	ongoing

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September 1, 2012 through September 2, 2012; October 1, 2012 through October 2, 2012; and October 5, 2012.

Continued review of Patient #4's record failed to provide evidence that HHA services were provided after November 11, 2012; and failed to provide evidence that the skilled nurse provided services in August 2012.

During an interview with the scheduling coordinator on February 1, 2013, at approximately 11:37 a.m., she indicated there were physician orders to support the changes in the HHA hours provided. Continued discussion with the scheduling coordinator revealed there was not a skilled nursing note for August 2012. At the time of the survey however, there was no evidence in Patient #4's record of physician's orders or provided by the agency to support all the aforementioned changes in the HHA hours.

4. On January 31, 2013, at approximately 12:00 p.m., review of Patient #7's POC, with certification period from September 11, 2012 through March 9, 2013, revealed the physician ordered the skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems. The physician further ordered six (6) visits for any medical health related issues as needed and the following training: (a) teach signs and symptoms of hypertensive crisis; (b) teach signs and symptoms of cardiac complications; and (c) teach energy conservation techniques.

Review of skilled nursing notes dated October 8, 2012, November 7, 2012, December 5, 2012 and January 8, 2013, revealed the skilled nurse did not provide teaching on the aforementioned areas ordered by the physician.

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A discussion with both the assistant administrator and scheduling coordinator at approximately 11:27 a.m. on January 31, 2013, was held to make them aware of the findings. At the time of the survey, the agency failed to provide evidence that Patient #7 received the teaching as ordered.

5. On January 31, 2013, at approximately 12:40 p.m., review of Patient # 8's record revealed a POC with a certification period from September 11, 2012 through March 9, 2013. Continued review of the POC revealed it was not signed and approved by the physician. The POC however, ordered a skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems.

Further review of the record revealed a telephone order, also not signed by the physician, dated September 12, 2012. The physician ordered HHA services six (6) days a week for six (6) hours, to assist with activities of daily living. Continued review of the record revealed no evidence the skilled nurse visited the patient in October 2012 and there was evidence HHA services were provided on the following dates: October 15, 2012, October 22, 2012, October 29, 2012, October 30, 2012, and November 17, 2012.

A discussion with both the assistant administrator and scheduling coordinator at approximately 2:00 p.m. on January 31, 2013, was held to make them aware of the findings. At the time of the survey, the agency failed to provide evidence that Patient #8's orders were signed by a physician as required and carried out as prescribed.

6. On February 1, 2013, at approximately 10:00 a.m., review of Patient # 9's record revealed a

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POC with a certification period from August 2, 2012 through January 28, 2013. Continued review of the POC revealed it was not signed and approved by the physician. The POC however, ordered a skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems.
Further review of the record failed to provide evidence that the skilled nurse visited the patient in January 2013.

During an interview with the assistant administrator and scheduling coordinator at approximately 11:00 a.m., on February 1, 2013, they were made aware of the findings. At the time of the survey, the agency failed to provide evidence that Patient #9's orders were signed by a physician as required and carried out as prescribed.

7. On February 1, 2013, at approximately 12:30 p.m., review of Patient # 10's record revealed a POC, with a certification period from October 17, 2012 through April 14, 2013, that ordered the skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems. The physician further ordered an HHA four (4) hours a day, five (5) days a week, for six (6) months to assist with ADL's. Further review of the record failed to provide evidence that a skilled nurse visited the patient in January 2013 and also failed to provide evidence that HHA services were provided after January 11, 2013.

During an interview with the assistant administrator on February 1, 2013, at approximately 2:45 p.m., he was made aware of the finding. At the time of the survey, the agency failed to provide evidence that Patient #10's orders were carried out as prescribed.

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8. On February 1, 2013, at approximately 12:30 p.m., review of Patient # 12's record revealed a POC, with a certification period from November 28, 2012 through May 26, 2013, that ordered the skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems. The physician further ordered an HHA six (6) hours a day, five (5) days for six (6) months to assist with ADL's. Further review of the record failed to provide evidence that a skilled nurse visited the patient in December 2012 and January 2013.
Additionally, there was no evidence the HHA visited the patient from November 28, 2012 through January 1, 2013 and after January 6, 2013. (It should be noted the only HHA time sheet in the record was dated for January 2nd through 6 th 2013).

During an interview with the assistant administrator on February 1, 2013, at approximately 2:45 p.m., he was made aware of the finding. At the time of the survey, the agency failed to provide evidence that Patient #12's orders were carried out as prescribed.

9. On February 1, 2013, at approximately 1:30 p.m., review of Patient # 13's record revealed a POC, with a certification period from November 15, 2012 through May 13, 2013, that ordered the skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems. The physician further ordered an HHA five (5) hours a day, five (5) days a week, for six (6) months to assist with ADL's. Further review of the record failed to provide evidence that HHA services were provided from November 15, 2012 through January 1, 2013. The record further failed to provide evidence of HHA services after

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January 11, 2013. Additionally, there was no evidence the skilled nurse visited the patient in December 2012.

During a interview with the assistant administrator on February 1, 2013, at approximately 2:45 p.m., it was revealed Patient #13's services were on hold due to payment issues.

10. On February 1, 2013, at approximately 2:00 p.m., review of Patient # 14's record revealed a POC, with a certification period from November 28, 2012 through May 28, 2013, that ordered the skilled nurse to visit every thirty (30) days for skilled assessments and evaluation of systems. The physician further ordered an HHA eight (8) hours a day, five (5) days a week for six (6) months to assist with ADL's. Further review of the record failed to provide evidence that HHA services were provided from November 28, 2012 through January 1, 2013 . The record further failed to provide evidence of HHA services after January 11, 2013. Additionally, there was no evidence the skilled nurse visited the patient in in December 2012 and January 2013.

During a interview with the assistant administrator on February 1, 2013, at approximately 2:45 p.m., it was revealed Patient #14's services were on hold due to payment issues.

NOTE: This is a repeat deficiency.

H 458 3917.2(h) SKILLED NURSING SERVICES — H 458

Duties of the nurse shall include, at a minimum, the following:

(h) Reporting changes in the patient's condition to the patient's physician;

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H 458	Continued From page 47 This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse failed to report changes in the patient's condition to the patient's physician for one (1) of fifty-nine (59) patients in the sample. (Patient #3) The finding includes: On January 28, 2013, a review of Patient # 3's record revealed a skilled nursing note dated August 7, 2012. The nurse documented that the "patient has a history of gout patient toe was swollen and tender." The skilled nursing note failed to provide evidence that the nurse informed the physician of the change in condition of the Patient #3's toe. During an interview with the director of nursing (DON), on January 28, 2013, at approximately 3:37 p.m., she indicated the nurse did not document that the patient's physician was made aware of the change in condition of the patient toe. Furthermore, the DON revealed that she had " continually " been providing training on reporting to the physician any changes in patient condition.	H 458	~~H458~~ Agency accepts and acknowledges this citation with the following plan of corrections: All current and new RN's shall receive In-Service training on the deficiencies on this report on April 16th 2013. During this in-service, all RN's will be re-educated on notifying physician on change in patient's condition. The clinical manger will review all clinical notes as they are being received to ensure compliance. The Quality Assurance team will audit at least 25% of the total charts quarterly to ensure compliance.	April 16 2013 ongoing
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	H 459		

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H 459	Continued From page 48	H 459	H459	
	This Statute is not met as evidenced by: Based on interview and record review, the home care agency ' s (HCA)skilled nursing staff failed to provide evidence that instructions were afforded to patients related to their health conditions, for one (1) of the fifty-nine (59) patients in the sample (Patient #6). Additionally, the HCA failed to provide evidence that the instructions given were understood, for thirty-four (34) of the fifty-nine (59) patients in the sample. (Patient #6, #21,#27, #28, #29, #30 #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #52, #53, #54, #55, #56, #57 and #58)		Agency accepts and acknowledges this citation with the following plan of corrections:	March 30 2013
	The findings include:		Patient # 6 received education from Employee 4 on universal precautions in March 2013 and patient verbalized specific understanding of proper hand washing technique before and after wound care and use of gloves.	
	I. The agency failed to provide evidence that Patient # 6 received training on universal precautions as ordered from Employee #4 skilled nurse (SN).		All current and new RN's shall receive In-Service training on the deficiencies on this report on April 16th 2013. During this in-service, all RN's will be re-educated on teaching specific to patient's Plan of Care and disease process, proper documentation of teaching and documenting patient's level of understanding and what the patient specifically understood of the teaching. Client teaching guides/manuals will be provided to all Nursing Staff to use when educating Patients on the disease process.	April 16 2013
	On February 26, 2013, at 11:00 a.m., review of Patient #6's plan of care (POC) dated August 24, 2012, through February, 2013, revealed the patient had diagnoses that included a right leg wound, hypertension, limb problems, urinary incontinence and unspecified schizophrenia. Further review of the POC revealed that Employee #4 (SN) was to instruct Patient #6 on universal precautions of disease transmission.		Thereafter Agency will conduct monthly in-services for Nurses to continually reinforce these trainings.	
			Agency clinical manager will review every supervisory note submitted by Agency RNs to ensure that Agency RNs are teaching as per the plan of care and are documenting specifically what the patient understood of the teaching.	ongoing
	On February 26, 2013, at approximately 11:15 a.m., review of Patient #6's Nurse Quarterly Review dated October 30, 2012, revealed the patient was hospitalized in April 2012 with a diagnosis of an infected right leg ulcer. Continued review of Patient #6's record on February 26, 2013, between 11:07 a.m. and		QA team will review on a quarterly basis 25 percent of all patient records to ensure compliance.	ongoing

Health Regulation & Licensing Administration

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H 459	Continued From page 49 11:21 a.m., revealed registered nurse (RN) Personal Care Aide/Homemaker Supervisory Monthly Visit Forms. According to the forms, the following information was revealed regarding the treatment and services for the patient's right leg ulcer; · September 17, 2012 - The wound was cleaned with normal saline, santyl applied and was covered with a four (4) by four (4). The patient was noted to tolerate care. Employee #4 (SN) however, failed to provide any documented evidence of health teaching instructions given to Patient #6. · October 17, 2012 - Right leg ulcer was cleaned with normal saline, santyl ointment was applied and covered with a 4 by 4. Employee #4 (SN) failed to provide any documented evidence of health teaching instructions given to Patient #6. · October 24, 2012 - Form documented wound care was provided. A skin tear was spotted on the right lower extremity. Area was cleaned with normal saline and santyl ointment was applied. Employee #4 (SN) failed to provide any documented evidence of health teaching instructions given to Patient #6. · November 19, 2012 - Patient's leg ulcer was cleaned with normal saline and santyl ointment was applied. Further review revealed SN #4 instructed the patient and caregiver on maintaining "standard precautions". Employee #4 (SN), however, failed to document Patient #6's specific level of understanding with the aforementioned health teaching. · December 17, 2012 - RN instructed the aide to remind the patient to clean the leg ulcer daily	H 459		

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and apply santyl ointment. Employee #4 (SN), however, failed to document Patient #6's specific level of understanding with the aforementioned health teaching.

At the time of the survey, the agency failed to provide evidence that training had been conducted with Patient #6 on universal precautions of disease transmission

II. The agency failed to ensure training and/or the evaluation of the training had been completed as prescribed.

A. Review of Patient # 21's record on February 26, 2013, at approximately 12:00 p.m. revealed a POC with a certification period from July 12, 2012, to January 7, 2013. According to the POC, the patient had diagnoses that included paralysis, cerebral vascular accident, hypertension, bi-polar disorder, cervical spinal stenosis, and Diabetes Mellitus. Further review of the POC revealed that the SN was to assess the patient' s understanding of foot and skin care measures. Continued review of Patient #21's record on February 26, 2013, at approximately 12:15 p.m., revealed a Supervisory Visit Form (SVF) dated September 13, 2012. The form indicated that Employee #18 (SN) provided education on preventing skin breakdown by turning every two hours and whenever necessary; but failed to document Patient #21' s/caregiver's level of understanding with the aforementioned health teaching.

B. Review of Patient # 27's record on February 26, 2013, at approximately 12:21 p.m. revealed a POC with a certification period from October 9, 2012, to April 6, 2013. According to the POC, the patient had diagnoses that include hypertension,

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asthma, and congestive heart failure. Further review of the POC revealed that the SN was to instruct Patient #27 on signs and symptoms of cardiac complications. Review of Patient #27's SVF dated December 15, 2012, on February 26, 2013, at approximately 12:25 p.m., revealed that Employee #18 (SN) instructed the patient and caregiver on the signs and symptoms to report. Furthermore, they were instructed to call 911 in the event of an emergency (severe headache, difficulty breathing and blood in the urine). Continued review of the form revealed that the patient and caregiver responded well and showed understanding. Employee #18 (SN), however, failed to document both Patient #27 and the aide's specific level of understanding with the aforementioned health teaching.

Additional review of Patient # 27's POC (certification period from October 9, 2012, to April 6, 2013) on February 26, 2013, at approximately 12:30 p.m., revealed that the SN was to instruct Patient #27 on the risks of a sedentary lifestyle. According to review Patient #27's SVF dated November 15, 2012, on February 26, 2013, at approximately 12:35 p.m., Employee #18 (SN) instructed the patient on physical limitations. Further review revealed that the personal care aide (PCA) was instructed to assist the patient with difficult tasks. Employee #18 (SN), however, failed to document both Patient #27 and the aide's specific level of understanding with the aforementioned health teaching.

C. Review of Patient #28's record on February 26, 2013, at approximately 1:01 p.m. revealed a POC with a certification period from September 4, 2012, to March 2, 2013. According to the POC, the patient had diagnoses that include Diabetes Mellitus Type II, End Stage Renal Disease, and

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generalized muscle weakness. Further review of the POC revealed that the SN was to assess Patient #28's understanding of foot and skin care measures. Review of Patient #28's SVF dated December 17, 2012, on February 26, 2013, at approximately 1:15 p.m., revealed that Employee #18 (SN) educated the patient on moisturizing the skin daily especially after taking a shower. Employee #18 (SN), however, failed to document Patient #28's specific level of understanding with the aforementioned health teaching.

Further review of the POC on February 26, 2013, at approximately 1:20 p.m., revealed that the SN was to assess Patient #28's response to treatment. Review of Patient #28's SVF dated October 8, 2012, on February 26, 2013, at approximately 1:35 p.m., revealed that Employee #18 (SN) educated the patient on the increased risk for falls as a result of changes in hemodynamic. The aforementioned changes can cause low blood pressure and dizziness. According to the form, the patient verbalized understanding of the instructions but, Employee #18 (SN) failed to document Patient #28's specific level of understanding with the aforementioned health teaching.

D. Review of Patient #29's record on February 26, 2013, at approximately 1:45 p.m., revealed a POC with a certification period from October 8, 2012, to April 5, 2013, on February 26, 2013. According to the POC, the patient had diagnoses that included Diabetes Mellitus Type II, diabetes neuropathy, peripheral vascular disease, reflux esophagitis and abnormality of gait. Further review of the POC revealed that the SN was to teach and reinforce signs and symptoms and management of impaired arterial/venous circulation. Review of Patient #29's Supervisory

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Visit Form (SVF) dated December 2, 2012, on February 26, 2013, at approximately 2:15 p.m., revealed that Employee #18 (SN) encouraged the patient to perform daily exercise to both feet to promote circulation. Additionally, the form documented to monitor daily for bruises and discoloration to feet. An instruction to report any changes to their medical doctor immediately was also noted. Employee #18 (SN), however, failed to document Patient #29's specific level of understanding with the aforementioned health teaching.

Continued review of the POC on February 26, 2013, at approximately 2:30 p.m., revealed that the SN was to instruct Patient #29 on medication. Review of Patient #29's SVF dated November 2, 2012, on February 26, 2013, at approximately 2:35 p.m., revealed that Employee #18 (SN) educated the patient on taking Oxycodone as prescribed. Instructions to drink plenty of water daily to prevent side effects of constipation and stomach upset were also noted. Further review of the form revealed the patient verbalized understanding of the instructions. Employee #18 (SN), however, failed to document Patient #29's specific level of understanding with the aforementioned health teaching.

E. Review of Patient #30's record on February 26, 2013, at approximately 10:45 a.m., revealed a POC with a certification period from October 2, 2012, to April 2, 2013, on March 4, 2013. According to the POC, the patient had diagnoses that included chronic obstructive asthma, joint pain-multiple joints, hypertension, sleep apnea, lumbago and abnormality of gait. Further review of the POC revealed that the SN was to teach signs and symptoms of cardiac complications. Review of Patient #30's SVF dated November 15,

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2012, on March 4, 2013, at approximately 12:15 p.m., revealed that Employee #18 (SN) reviewed the disease process of Chronic Obstructive Pulmonary Disease (COPD) with the patient and the need for required fluid according to the physician. The form further documented the day to day symptoms of COPD that included coughing, increase of phlegm, shortness of breath, wheezing and chest tightness. The form also revealed the patient verbalized understanding of the instructions. Employee #18 (SN), however, failed to document Patient #30's specific level of understanding with the aforementioned health teaching.

F. Review of Patient #31's record on March 4, 2013, at approximately 12:58 p.m., revealed a POC with a certification period from September 19, 2012, to March 17, 2013. According to the POC, the patient had diagnoses that included blindness, Diabetes Mellitis Type II, neuropathy and hypertension. Further review of the POC revealed that the SN was to assess the patient's understanding of hyper/hypoglycemia. Review of Patient #31's SVF dated October 8, 2012, on March 4, 2013, at approximately 1:11 p.m., revealed that Employee #18 (SN) reviewed the signs and symptoms of hypoglycemia that included sweating, hunger, anxiety, and heart palpitations. The form indicated that the signs of hyperglycemia including increased thirst, frequent urination, high blood sugar (above one hundred -eighty) were also reviewed. The need to call the medical doctor in the event of an emergency was additionally noted. Continued review of the SVF revealed the patient verbalized understanding of the instructions. Employee #18 (SN), however, failed to document Patient #31's specific level of understanding with the aforementioned health

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training's.

G. Review of Patient #32's record on March 4, 2013, at approximately 1:22 p.m., revealed a POC with a certification period from August 24, 2012, to February, 2013. According to the POC, the patient had diagnoses that included blindness due to glaucoma, history of arthritis, congestive heart failure (CHF) and hypertension. Further review of the POC revealed that the SN was to teach energy conservation techniques. Review of Patient #32's SVF dated October 29, 2012, on March 4, 2013, at approximately 1:31 p.m., revealed that Employee #18 (SN) provided education on the importance of reserving energy and pacing activity. The methods documented included taking breaths between activities. Further review of the form revealed the patient "verbalized understanding." Employee #18 (SN), however, failed to document Patient #32's specific level of understanding with the aforementioned health training's.

H. Review of Patient #33's record on March 4, 2013, at approximately 1:59 p.m., revealed a POC with a certification period from July 30, 2012, to January 25, 2013. According to the POC, the patient had diagnoses that included cerebral vascular accident (CVA), hypertension, hyperlipidemia and paralysis. Further review of the POC revealed that the SN was to inform the patient and caregiver on risk factors associated with the condition which included a high sodium intake. Review of Patient #33's RN (registered nurse) Personal Care Aide/Homemaker Supervisory Monthly Visit Form dated December 4, 2012, on March 4, 2013, at approximately 2:14 p.m., revealed that Employee #18 (SN) reviewed low sodium methods such as avoiding fast foods,

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canned goods, eating fresh fruits and vegetables, not adding table salts to meals. Additionally, Employee #18 (SN) documented the importance of paying attention to signs of high blood pressure such as, severe headache, heartbeat, and blood in urine. Further review of the form revealed the patient "verbalized understanding". Employee #18 (SN), however, failed to document Patient #33's specific level of understanding with the aforementioned health training's

I. Review of Patient #34's record on March 4, 2013, at approximately 2:24 p.m., revealed a POC with a certification period from August 22, 2012, to February 17, 2013. According to the POC, the patient had diagnoses that included a history of arthritis, gout, hypertension and malignant neoplasm prostate. Further review of the POC revealed that the SN was to assess home safety on each home visit. Review of Patient #34's Supervisory Visit Form (SVF) dated November 8, 2012, on March 4, 2013, at approximately 2:28 p.m., revealed that Employee #18 (SN)reviewed fall precautions with the patient and instructed him/her on how to avoid injury. Further review of the form revealed, the patient was instructed, with the PCA assistance, to closely observe discoloration of skin and body discomfort. Additionally, the form documented to report to medical doctor immediately. Continued review of the form revealed the patient "verbalized understanding." Employee #18 (SN), however, failed to document Patient #34's specific level of understanding with the aforementioned health training's.

J. Review of Patient #35's record on March 4, 2013, at approximately 2:34 p.m., revealed a

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POC with a certification period from August 10, 2012, to February 5, 2013. According to the POC, the patient had diagnoses that included end stage renal disease, hypertension, and thyroid crisis. Further review of the POC revealed that the SN was to review the patient's diet. Review of Patient #35's SVF dated November 7, 2012, on March 4, 2013, at approximately 2:39 p.m., revealed that Employee #18 (SN) provided education on the patient 's renal diet. The form further documented that there was strict reinforcement to prevent hospitalization, changes in laboratory studies and condition. Additional review of the form revealed that education was provided on high potassium foods to limit and to report changes in condition to the medical doctor immediately or call 911 for emergencies. Employee #18 (SN), however, failed to document Patient #35's specific level of understanding with the aforementioned health training's.

K. Review of Patient #36's record on March 7, 2013, at approximately 3:32 p.m., revealed a POC with a certification period from August 20, 2012, to February 15, 2013. According to the POC, the patient had diagnoses that included renal failure, hypertension, Diabetes Mellitus Type II, left foot amputation, Hepatitis C, and schizoaffective disorder. Further review of the POC revealed the SN was to assess the patient's understanding of hyper/hypoglycemia. Review of Patient #36's SVF dated October 23, 2012, on March 7, 2013, at approximately 3:47 p.m., revealed that Employee #18 (SN) reviewed the signs and symptoms of hyperglycemia which included increased thirst, frequent urination and high blood sugar above one hundred-eighty (180). Employee #18 (SN) also reviewed the signs and symptoms of hypoglycemia which included sweating, hunger, anxiety and heart

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palpitations. Continued review of the SVF revealed the patient "verbalized understanding." Employee #18 (SN), however, failed to document Patient #36's specific level of understanding with the aforementioned health training's.

L. Review of Patient #37's record on March 7, 2013, at approximately 4:12 p.m., revealed a POC with a certification period from August 1, 2012, to January 27, 2013. According to the POC, the patient had diagnoses that included a history of arthritis, congestive heart failure (CHF), hypertension and convulsions. Patient #37's medications included Lasix 40 milligrams daily, Agreement 300 milligrams twice a day, Simvastatin 20 milligrams daily, Labetalol 200 milligrams twice a day, Pristiq 50 milligram every day and Tramadol 50 milligrams four times a day whenever necessary. Further review of the POC revealed that the SN was to instruct the patient on medication. Review of Patient #37's SVF dated September 15, 2012, on March 7, 2013, at approximately 4:41 p.m., revealed Employee #18 (SN) reinforced the importance of a strict adherence to the patient's medication regimen. Continued review of the form revealed that the patient was to report any changes in their condition to the medical doctor and call 911. According to the form, the patient "verbalized understanding." Employee #18 (SN), however, failed to document Patient #37's specific level of understanding with the aforementioned health training's.

M. Review of Patient #38's record on March 7, 2013, at approximately 4:59 p.m., revealed a POC with a certification period from August 11, 2012, to February 6, 2013. According to the POC, the patient had diagnoses that included

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Diabetes Mellitus Type II, low vision (diabetic retinopathy) and osteoarthritis. Further review of the POC revealed that the SN was to instruct the patient on medication. Review of Patient #38's SVF dated December 19, 2012, on March 7, 2013, at approximately 5:08 p.m., revealed Employee #18 (SN) reinforced symptoms of hyperglycemia which included increased thirst and frequent urination. Further review of the form revealed training was conducted on low blood sugar which included symptoms of, sweating, anxiety, and heart palpitations. The patient was also instructed to call 911 immediately. Employee #18 (SN) documented that the patient wanted more clarification of their disease process and the patient verbalized understanding of the instructions. Employee #18 (SN), however, failed to document Patient #38's specific level of understanding with the aforementioned health training's.

N. Review of Patient #39's record on March 7, 2013, at approximately 5:24 p.m., revealed a POC with a certification period from August 6, 2012, to February 1, 2013. According to the POC, the patient had diagnoses that included a history of arthritis, angina pectoris, hypertension, asthma and coronary artery anomaly. Further review of the POC revealed the patient had functional limitations including getting in and out of bed. The SN was to assess the home safety. Review of Patient #39's Supervisory Visit Form (SVF) dated September 17, 2012, on March 7, 2013, at approximately 5:39 p.m., revealed Employee #18 (SN) reinforced the importance of fall precautions especially during transfers from the bed to the wheelchair. The SN documented that the patient "verbalized understanding" of the instructions. Employee #18 (SN), however, failed to document Patient #39's specific level of

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understanding with the aforementioned health teaching training.

O. Review of Patient #40's record on March 7, 2013, at approximately 6:01 p.m., revealed a POC with a certification period from September 21, 2012, to March 19, 2013. According to the POC, the patient had diagnoses that included congestive heart failure, atrial fibrillation, a history of arthritis and hypertension. Further review of the POC revealed that the SN was to teach energy conservation techniques. Review of Patient #40's SVF dated October 19, 2012, on March 7, 2013, at approximately 6:10 p.m., revealed that Employee #18 (SN) reinforced the importance of reserving energy during activity and advised the patient to pace herself by taking breaths between activities. Further review of the form revealed that if the patient noted signs of increased shortness of breath, cough and changes in sputum the patient was to call the medical doctor immediately. Continued review of the form revealed the patient "verbalized understanding". Employee #18 (SN), however failed to document Patient #40's specific level of understanding with the aforementioned health training.

P. Review of Patient #41's record on March 8, 2013, at approximately 5:01 p.m., revealed a POC with a certification period from December 16, 2012, to June 13, 2013. According to the POC, the patient had diagnoses that included Diabetes Mellitus Type II, congestive heart failure, psychosis, schizophrenia, a history of arthritis and hypertension. Further review of the POC revealed that the SN was to inform the patient/caregiver on risk factors associated with his/her condition

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including obesity, high sodium, high fat and high cholesterol intake. Review of Patient #41's SVF dated September 26, 2012, on March 8, 2013, at approximately 5:09 p.m., revealed that Employee #18 (SN) reinforced the importance of a proper diet with carbohydrate control, eating fresh fruits, and eating vegetables and grains. There was no documented evidence Employee #18 (SN)evaluated Patient #41's level of understanding with the aforementioned health teaching.

Q. Review of Patient #42's record on March 8, 2013, at approximately 5:20 p.m., revealed a POC with a certification period from August 2, 2012, to February 2, 2013. According to the POC, the patient had diagnoses that included Diabetes Mellitus Type II, above the knee amputation, osteoarthritis and hypertension. Further review of the POC revealed that the SN was to teach the patient about fall precautions. Review of Patient #42's SVF dated October 15, 2012, on March 8, 2013, at approximately 5:28 p.m., revealed Employee #18 (SN) provided health teaching on safety and preventing falls during transfers from the bed, to the wheelchair, to the commode. Further review of the form revealed the importance of a proper diet with carbohydrate control, eating fresh fruits, and eating vegetables and grains was reinforced. There was no documented evidence however, that Employee #18 (SN) evaluated Patient #42's level of understanding with the aforementioned health teaching.

R. Review of Patient #43's record on March 11, 2013, at approximately 1:00 p.m., revealed a POC with a certification period from October 9,

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2012, to April 6, 2013. According to the POC, the patient had diagnoses that included a history of arthritis, cardiomyopathy, diverticulum of bladder, anemia and hypertension. Further review of the POC revealed that the SN was to assess home safety because the patient had functional limitations that included an unsteady gait. Review of Patient #43's SVF dated November 3, 2012, on March 11, 2013, at approximately 1:12 p.m., revealed that Employee #18 (SN) reviewed fall precautions due to weakness, "Link to Life" procedures and keeping the environment clutter free. Employee #18 (SN), however, failed to document Patient #43's specific level of understanding with the aforementioned health teaching.

S. Review of Patient #44's record on March 11, 2013, at approximately 1:29 p.m., revealed a POC with a certification period from November 24, 2012, to May 22, 2013. According to the POC, the patient had diagnoses that included Diabetes Mellitus Type II, glaucoma, hypertension and gout. Further review of the POC revealed that the SN was to teach signs and symptoms of cardiac complications. Review of Patient #44's SVF dated December 15, 2012, on March 11, 2013, at approximately 2:26 p.m., revealed that Employee #18 (SN) educated the patient on preventing the spread of disease, taking a flu shot and reporting signs of changes in symptoms to the medical doctor immediately. Employee #18 (SN)documented the patient verbalized understanding. Employee #18 (SN), however, failed to document Patient #44's specific level of understanding with the aforementioned health teaching.

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T. Review of Patient #45's record on March 11, 2013, at approximately 4:15 p.m., revealed a POC with a certification period from October 11, 2012, to April 8, 2013. According to the POC, the patient had diagnoses that included metastatic lung cancer, peripheral vascular disorder, pancreatic disease, vitamin B deficiency, alcohol abuse and tobacco use disorder. Patient #45 has functional limitations that included endurance, ambulation, dyspnea with minimal exertion and unsteady gait. Further review of the POC revealed that the SN was to teach patient/caregivers about fall precautions. Review of Patient #45's SVF dated November 11, 2012, on March 11, 2013, at approximately 4:26 p.m., revealed that Employee #18 (SN) educated the patient on ambulating with the use of the walker and long trips using the power wheelchair. Further review of the form revealed the patient was encouraged to call the medical doctor in the event of a change in condition immediately. The SN stated the patient and caregiver verbalized understanding of the instructions. Employee #18 (SN), however failed to document Patient #45's specific level of understanding with the aforementioned health teaching.

U. Review of Patient #46's record on March 11, 2013, at approximately 5:05 p.m., revealed a POC with a certification period from September 23, 2012, to March 21, 2013. According to the POC, the patient had diagnoses that included a history of arthritis, Diabetes Mellitus Type II and hypertension. Further review of the POC revealed that the SN was to assess the patient 's understanding of signs and symptoms of hyperglycemia and hypoglycemia. Review of Patient #46's SVF dated November 11, 2012, on March 11, 2013, at approximately 5:18 p.m.,

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revealed that Employee #18 (SN) provided diabetic teaching on differentiating between signs and symptoms of hyperglycemia which included frequent urination, increased thirst, high blood sugar over 180 and severe headaches. Signs and symptoms of hypoglycemia included anxiety, heart palpitations, sweating and hunger. The SN stated the patient verbalized understanding of the instructions. Employee #18 (SN), however, failed to document Patient #46's specific level of understanding with the aforementioned health teaching.

V. Review of Patient #47's record on March 11, 2013, at approximately 5:35 p.m., revealed a POC with a certification period from September 4 , 2012, to March 2, 2013. According to the POC, the patient had diagnoses that included paralysis, convulsions, memory loss and hyperlipidemia. Further review of the POC revealed that the SN was to teach caregivers about methods to prevent pressure ulcerations. Review of Patient #47's SVF dated October 3, 2012, on March 11, 2013, at approximately 5:46 p.m., revealed that Employee #18 (SN) reinforced the need for the caregiver to conduct daily range of motion to prevent contractions, assess all boney areas and report any changes in skin to the medical doctor immediately. The SN stated the caregiver verbalized understanding of instructions. Employee #18 (SN), however, failed to document Patient #47's specific level of understanding with the aforementioned health teaching.

W. Review of Patient # 48's POC on March 11, 2013, at approximately 6:00 p.m., revealed a POC with a certification period from August 2 , 2012, to January 28, 2013. According to the POC, the patient had diagnoses that included a history of arthritis, hypertension and depressive disorder.

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Further review of the POC revealed that the SN was to teach the patient pain management methods. Review of Patient #48's SVF dated September 4, 2012, on March 11, 2013, at approximately 6:16 p.m., revealed that Employee #18 (SN) provided education on pain management, drinking water instead of orange soda preventing risks for constipation. Further review revealed the patient was instructed on using their walker at a slow pace in order to prevent injury. The SN stated the patient verbalized understanding of instructions. Employee #18 (SN), however, failed to document specifically the pain management methods taught and Patient #48's level of understanding with the aforementioned health teaching.

It should be noted, that a review of medical records on March 12, 2013, between 10:00 a.m. and 12:10 p.m., for Patients #49, #50, #51, # 52, #53, #54, #55, #56, #57 and #58 revealed similar findings. Employee #18 (SN) failed to document the patient's specific level of understanding with the health teaching that was provided.

At the time of the investigation/survey, the agency failed to ensure an effective system had been orchestrated to make certain ordered training's and/or the evaluation of the training's had been completed

NOTE: This is a repeat deficiency.

Review of last year's statement of deficiencies dated July 25, 2012, on March 18, 2013, revealed the agency would implement a plan to abate the cited deficiency with a completion date of August 30, 2012. According to the plan of correction, the agency indicated that it would " revise the documentation of patient teaching

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H 459	Continued From page 66 procedures." Additionally, the plan documented that the RN would be retrained on the elements of patient monitoring and its documentation. Continued review of the plan also revealed that there would be " retraining of the RN and Case Manager on the patient supervision process and its documentation." Finally, the plan Indicated that the RN and case manager would be retrained on "care strategies development, implementation and documentation for patients with Diabetes and Pancreatitis." At the time of the survey/investigation the agency failed to ensure it's revised plan to address the cited deficiency was effective.	H 459		
H 999	FINAL OBSERVATIONS The following observation was made during the investigation process. It is recommended that this area be reviewed and a determination be made regarding appropriate actions to prevent a reoccurance. Review of Employee #1's personnel record on January 31, 2013, at approximately 11:10 a.m., revealed a letter terminating Employee #1's (HHA) employment as of January 25, 2013. On January 31, 2013, at approximately 2:00 p.m.., Employee #1 (HHA) was interviewed via phone to ascertain why he/she continued to work after January 25, 2013. He/she indicated that he/she was not aware of his/her termination. Also, Patient #1 was interviewed via phone on January 31, 2013, at approximately 1:30 p.m., to ascertain if the agency made him/her aware of the HHA's termination. The patient was not aware and indicated that the HCA had not contacted him/her about the termination. It	H 999	H999 Agency accepts and acknowledges this citation with the following plan of corrections: The Human Resource Manager will manage and oversee the termination process: The HR Manager will summon the Employee to the office to initiate the termination process onsite. Employee will be instructed not to report to work but to report straight to the office. Once the PCA reports to the office PCA will be issued a termination letter and sign to acknowledge receipt of such letter. The HR Manager will notify all departments involved, and the Agency will notify the Patient that employee will no longer be working with him/her. Patient will be assigned a new PCA. Administrator will ensure compliance by receiving and reviewing a quarterly report of all terminated employees	April 8th 2013

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H 999	Continued From page 67 should be noted that the HHA discontinued her services to the patient on January 31, 2013. During an interview with assistant administrator (AA) and Human Resources Manager (HRM) on January 31, 2013, at approximately 3:00 p.m., they both were made aware Employee #1 was observed working with Patient #1 on January 30, 2013. [It should be noted Employee #1 should not have been working with Patient #1 on January 30, 2013 as evident by termination letter date January 25, 2013]	H 999	SEE ADDENDUM E	

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R 000	INITIAL COMMENTS	R 000		
	On January 17, 2013, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received a telephone complaint that identified concerns related to staffing and patient care. An annual survey, in conjunction with a complaint investigation, was conducted at from January 22, 2013, through March 15, 2013, to determine compliance with Title 22, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of fifty-nine (59) clinical records based on a census of four hundred and sixty nine (469) patients, three (3) discharge records, and twenty-nine (29) personnel files based on a census of five hundred and eighty four (584) employees. Observations and interviews were conducted in the patient homes during four (4) home visits and fourteen (14) telephone calls were made to current patients. On February 6, 2013, HRLA forwarded written notification informing the agency of the preliminary survey/investigative findings. Based on the identified egregious practices, coupled with previous survey findings and indicated a repeated failure to comply with local requirements, a determination was made to convert the agency's full license to a restricted license.			
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the	R 125		

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R 125	Continued From page 1 check. This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to maintain accurate personnel records, which included documentation of any required criminal background check for one (1) of one (1) staff in the investigation. Employee #1 (HHA) The finding includes: Review of Employee #1's (HHA) employment application on January 31, 2013, at approximately 11:35 a.m., it was revealed that Employee #1 (HHA) was hired by the Home Care Agency (HCA) on November 7, 2012. Further review revealed Employee #1 (HHA) had a District of Columbia Criminal History Request completed on October 4, 2012. According to Employee #1's (HHA) employment application, dated October 15, 2012, the employee worked in the state of Maryland within the past seven years of being hired by the agency. There was no evidence, however, that a criminal background check had been completed in the State of Maryland prior to being hired as a home health aide. During a face to face interview with the assistant administrator of the HCA on January 31, 2013, at approximately 1:45 p.m., it was revealed that HHA #1's criminal background check for Maryland had not been completed until January 24, 2013. Further interview revealed the HHA did not disclose on the application (dated October 15, 2012) that there were previous convictions of criminal offences in the State of Maryland. The HHA was terminated from the agency on January 25, 2013, for falsifying information on their application.	R 125	R125 Agency accepts and acknowledges this citation with the following plan of corrections: The HR Manager will manage the hiring process of all employees who intend to work for the Agency. Addendum has been attached to the application packet requesting for all candidates to disclose the places they have worked and lived in the last 7 years. HR Manager will review all application packets to ensure that all requirements are met prior to assignment with Patient. Administrator will review a sample of new applicants during monthly HR meetings to ensure compliance. SEE ADDENDUM F	MAY 30 2013 ongoing

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	Note: This is a repeat deficiency.			