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 _____	C 04/22/2013

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 000	INITIAL COMMENTS On April 17, 2013, the Office of Health Care Ombudsman and Bill of Rights notified the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) via e-mail, that Patient #1 receiving services from your agency needed assistance regarding his care. Based on the nature of the complaint, an invetigation was ihitiated on April 22, 2013, at approximately 4:26 p.m. The findings of the investigation were based on observation and interviews whcih revealed the folowing: Allegation #1: The home care agency (HCA) failed to ensure Patient #1 was provided with a glucometer to check his blood sugar twice a day as ordered. Findings: Interview with the patient's nurse confirmed that the agency was aware that the patient did not have a glucometer and did not provide one for his use. Conclusion: This allegation was substaniated. Allegation #2: The home care agency (HCA) failed to ensure Patient #1 received instructions regarding denture adhesive or to refer the patient for further evaluation with his dentist. Findings: The patient was observed to have difficulty keeping the dentures in place while he was talking. Interview and observation of Patient #1 revealed he was edentulous. Continued discussion with the patient revealed he had a complete set of artificial teeth for his upper and lower jaw. The caregiver was observed to get the patient's dentures at 4:27 p.m. and Patient #1	H 000	**H000** **Allegation 1** Agency respectfully disputes this allegation. After interviewing the nurse providing care and speaking with the care giver, it has been validated that the patient did have a glucometer, however it was frequently in the possession of the caregiver who would test patient's blood sugar level and who was regularly at the patient's house. During her visits, nurse used the glucometer that the Agency issued to her. Agency nurse subsequently acquired the patient's glucometer and verified through its memory that the glucometer was being used to test the patient's blood sugar level. Agency does acknowledge that the nurse failed to counsel both patient and caregiver that the glucometer should always be kept readily accessible. Nurse has since counseled patient that glucometer should always be readily accessible and available for use as per doctor's orders; Agency has since provided another glucometer to the patient and the liquid to calibrate it to ensure that a glucometer is always available. Currently there are two glucometers at the patient's house. Agency has reviewed policy regarding supervising diabetes patients with nurse and the need to validate the existence of the glucometer by visualizing it every visit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE

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H 000	Continued From page 1 was observed to place his top and bottom dentures in his mouth. Further observation and interview with the patient revealed he was not able to keep the upper set of his dentures in his mouth while trying to talk. Conclusion: This allegation was substantiated. The statement of deficiencies reflects deficiencies related to the allegation as well as incidental findings.	H 000	**Allegation 2** Agency admits this allegation with the following explanation: After interviewing the nurse, the nurse stated that the patient never complained to the nurse about experiencing any difficulty with patient's dentures. The nurse also noted that during several visits she had observed the patient comfortably eating and observed no difficulty with the dentures while patient ate. Nurse explained that because she was unaware of any problems, no referral was made to a dentist or teaching done on the proper use of denture adhesive Patient has since been sent to a dentist and has been evaluated and fit for another set of dentures. Patient will receive dentures on or about May 23, 2013. Patient has also received teaching on the use of denture adhesive. Agency has counseled nurse on ensuring that the assessment upon admission must include any oral assessment regardless of whether patient complains of any oral issues. Nurse was also counseled that during monthly visits, the nurse must also document any improvement or decline with such oral issues. Agency has also counseled nurse on assessment techniques to illicit more information from patients who may not readily volunteer needed information.	
H 267	3911.2(g) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (g) Medication sheet; This Statute is not met as evidenced by: Based on interview, it was determined that the home care agency (HCA) failed to ensure that relevant information was included on the patient's medication sheet for one (1) of one (1) patients included in the investigation. (Patient #1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 17, 2013, through September 12, 2013, on April 22, 2013, at approximately 4:00 p.m., revealed a list of the patient's medications. During the home visit with Patient #1 on April 22, 2013, beginning at 4:26 p.m. revealed his medications were assessed. When comparing the medications observed to the medications listed on the medication sheet they were not the same. At the time of the investigation, the following medications were not included on the sheet: Amlodipine Besylate 10 milligrams (MG),	H 267		

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H 267	Continued From page 2 Valsart/HCTZ 160-25 mg, Olanzapine, and Loratadine 10 mg. During a telephone conference with the agency's administrator and the patient's nurse on April 23, 2013 beginning at approximately 12:30 p.m., revealed that the failure to update the patient's medication profile was an oversight. The nurse stated that she would contact the patient's physician to obtain an updated order.	H 267	**H267** Upon interview, the nurse stated that the medications listed on the plan of care were what seen in the patient's home at the time of recertification and thus the failure to be on the plan of care was an oversight. The Agency sent the medication list on the plan of care to the physician and asked for the physician to validate the list. The patient's current plan of care covering 3/17/2013 through 9/12/2012 and signed by patient's physician on 4/17/2013 contains all medications listed in this citation. See attached POC. Agency conducted an in-service with all Agency nurses on 4/16/2013 regarding what is expected of them as per Medicaid and the Department of Health. Agency will hold another In-service on 5/24/2013 to specifically discuses medication reconciliation and to reinforce agency policy and procedures on medication management in the home environment which includes but is not limited to; (1) Agency's nurses look for themselves in patient's medication cabinet and bedrooms, if permitted, to ensure that all medications are documented (2) empower the patient/caregiver in the development of and the accuracy of the medication list by reviewing the list with the patient/caregiver and documenting on the record that the list was reviewed with the patient/caregiver and patient/caregiver validated the accuracy, (3) The plan of care including the medication list must be sent to the physician of record for review and approval and the physician's agreement as to the accuracy of the list is evidenced by the physician's signature on the plan of care.	4/17/13 5/24/13
H 409	3915.11(d) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (d) Assisting the patient with self-administration of medication; This Statute is not met as evidenced by: Based on interview, it was determined that the home care agency (HCA) failed to ensure that the home health aide (HHA) assisted the patient with the self-administration of his medications, for (1) of one (1) patients in the investigation. (Patient #1) The finding includes: During a home visit with Patient #1 on April 22, 2013, beginning at 4:26 p.m., a face to face interview was conducted with Patient #1's Caregiver #1. According to the caregiver, she sometimes administers the patient's insulin and sometimes the home health aide ((HHA) administers the insulin. Interview with the patient at approximately 4:35 p.m. revealed he	H 409		

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H 409	Continued From page 3 self-administers his insulin twice a day. It should be noted that Patient #1's "functional limitations includes blindness. Interview with the patient's HHA #1 on the same evening at 4:37 p.m. revealed that he draws up the Insulin in the syringe, then hands the filled syringe to Patient #1 to self-administer his Insulin. The interview also revealed that the HHA was not licensed to administer medication On April 23, 2013, beginning at 12:30 p.m., interview with the administrator and one of the patient's registered nurses (RN) #1 revealed that the HHA #1 had been instructed during the nurse's home visit that he could not be involved in the administration of any of Patient #1's medications. At the time of the investigation, the home care agency failed to ensure all of Patient #1's home health aides (HHA #1, HHA#2, HHA #3, and HHA#4) were instructed to assist the patient with self-administration of his medications.	H 409	**H409**- After interview the nurse, Agency determined that HHA had been instructed by nurse not to administer insulin (i.e draw the insulin or inject patient with the insulin) or perform finger sticks; rather HHA was instructed to only remind patient and caregiver to administer the insulin and perform the finger sticks twice a day. A review of the then current HHA care plan clearly indicated that the HHA could only remind the patient/caregiver to perform the finger stick and to administer the insulin. HHA has since been disciplined and removed from this patient for failure to follow teachings and the documented HHA care plan. All HHAs providing services to patient have been retrained by Agency nurses on how to properly assist patient with the self-administration of medications. Nurse's notes demonstrating the retraining have previously been sent to nurse investigator. Agency will hold an additional In-service to reinforce with all HHA how to properly assist patient's with self-administration of medication.	5/10/13 6/7/13
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on observation, and interview, the home care agency (HCA) failed to ensure patient instructions for the patient's dentures were provided for one (1) of one (1) patient included in	H 459	**H459** **(1) Dentures** After interviewing the nurse, the nurse stated that the patient never complained to the nurse about experiencing any difficulty with patient's dentures. The nurse also noted that during several visits she had observed the patient comfortably eating and observed no difficulty with the dentures while patient ate. Nurse explained that because she was unaware of any	

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H 459	Continued From page 4 the investigation. (Patient #1) The findings include: 1. On April 22, 2013, beginning at 4:26 p.m. Patient #1 was observed to be edentulous. When asked if he wore dentures, the patient asked his caretaker to retrieve his dentures. The patient was observed to place the dentures in his mouth. Once the dentures were in place, the patient was observed to have difficulty speaking as the upper dentures was slipping out of his mouth. At the time of the investigation, one of the HCA's registered nurses (RN) failed to ensure Patient #1 was provided with assistance/instructions regarding denture adhesive or to refer the patient for further evaluation with his dentist. 2. During a home visit on April 22, 2013, at 4:45 p.m. the home health aide (HHA) and Caretaker #1 were interviewed to ascertain blood sugar level documentation. The caretaker indicated that finger sticks were performed; however, she was unaware of the parameters for monitoring the blood level. She also indicated that the finger stick values were not documented. It should be noted that the glucometer was not available to measure the finger stick until the day of or two days prior to the home visit. When asked if the nurse provided instruction on blood sugar monitoring, Caretaker #1 indicated the nurse visited and instructed them as how to conduct the finger stick monitoring. There was no documented evidence, however, that the nurse provided instruction on how to monitor the blood sugar.	H 459	problems, no referral was made to a dentist or teaching done on the proper use of denture adhesive. Patient has since been sent to a dentist and has been evaluated and fit for another set of dentures. Patient will receive dentures on or about May 23, 2013. Agency has counseled nurse on ensuring that the assessment upon admission must include any oral assessment regardless of whether patient complains of any oral issues. Nurse was also counseled that during monthly visits, the nurse must also document any improvement or decline with such oral issues. Agency has also counseled nurse on assessment techniques to illicit more information from patients who may not readily volunteer needed information. (2) **Blood Sugar Level** Patient did have a glucometer, however it was frequently in the possession of the caregiver who would test patient's blood sugar level and who was regularly at the patient's house. Nurse subsequently acquired the patient's glucometer and verified through its memory that the glucometer was being used to test the patient's blood sugar level. Agency does acknowledge that the nurse failed to counsel both patient and caregiver that the glucometer should always be kept readily accessible. Nurse has since counseled patient that glucometer should always be readily accessible and available for use as per doctor's orders; As of date, caregivers and patient have received multiple teachings regarding blood sugar monitoring, including the importance of it and the consequences of not following teachings; and nurses' notes demonstrating the teachings and the evaluation of teachings have been sent to nurse investigator.	5/23/13 5/10/13