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 07/25/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
H 000	INITIAL COMMENTS	H 000		

On July 5, 2012, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received a telephone call from the District of Columbia Fire Department (DCFD) requesting an investigation of the group home providing services for Patient #1 for possible negligence.

The complainant identified the following concern:

Allegation #1: An unidentified elderly man (Patient #1) was discovered on the top floor at an alleged group home covered in fecal matter and food. Patient #1 was transported via ambulance by the Fire and Emergency Medical Services Department (FEMS) to a local hospital for further assessment and evaluation. Subsequently Patient #1 was admitted to the hospital with diagnoses that included dehydration and emaciation.

Findings:

Based on interview and record review with Home Health Aide (HHA #1) it was revealed that on July 5, 2012, when he/she arrived on duty at approximately 8:00 a.m., to serve Patient #1 breakfast, Patient #1 complained of fainting and blacking out due to the heat in the bedroom. HHA #1 acknowledged that the patient's room was extremely hot. Later when HHA #1 returned to the facility from the grocery store (time unknown) he/she observed Patient #1 lying in the same position on the bed. HHA #1 further noted that Patient #1 had not eaten the food that had been prepared. HHA #1 then called 911. HHA # explained that the DCFD personnel did observe fecal matter on Patient #1's body, adult protective undergarment and bed linens and that food particles where on Patient #1's body. HHA #1

The Provider acknowledges the surveyor's interpretation of the events that triggered this report but respectfully denies any intentional neglect by the Premier Health Services Staff.

Plan

Premier Health Services will complete the retraining for the staff on the following topics by 8/31/12:

- The roles and responsibilities of the Case Manager.
- The roles and responsibilities of the Registered Nurse.
- The roles and responsibilities of the Personal Care Aide. (Delayed until two weeks after her return from Jamaica. Return date TBD)
- Handling of Medical Emergencies
- Dealing with Difficult Patients.
- Reviewed with the staff the reasons for utilization of Adult Protective Services.
- Premier Health Services has continued to support the patient family in obtaining needed

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H 000	Continued From page 1 revealed the FEMS transported Patient #1 to the hospital for evaluation and treatment. Conclusion: This allegation was substantiated as there was evidence that the patient's bed and body were soiled with fecal matter and food. The patient was also dehydrated and emaciated. On July 6, 2012, an onsite visit was initiated to determine if there were any health and safety issues related to the care of Patient #1. It was discovered that the facility was a rooming house licensed by the Department of Consumer and Regulatory Affair (DCRA). Home care services were being provided by a home care agency licensed by the DOH/HRLA. An investigation was initiated off site on July 10, 2012, to ascertain compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the investigation were based on interviews with the home health aide (HHA), registered nurse (RN) and the director of the nursing as well as a review of patient, administrative records and incident reports.	H 000	information and seeking a more appropriate housing arrangement for the patient.	
H 148	3907.2(d) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (d) Documentation of current CPR certification, if required. 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 current CPR certification for	H 148	The Provider acknowledges and accepts this tag with the following plan of correction: Plan • Completing revision of the Agency's procedure for handling new and continuing employee's file maintenance by August 31, 2012. Plan	

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H 148 Continued From page 2

one (1) of three (3) employees in the investigation. (Home Health Aide #1 (HHA #1)

The finding includes:

Review of home health aide #1's (HHA #1's) personnel file on July 20, 2012, at approximately 3 30 p.m., revealed the CPR certification in the personnel file had expired on March 25, 2012.

On July 5, 2012, there was no evidence HHA #1 assessed the need for first aid or the need to call 911 timely when Patient #1 complained of fainting and blacking out due to the heat in the bedroom. HHA #1 left Patient #1 and went to the grocery store

H 163 3907.7 PERSONNEL

Each employee shall be screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease.

This Statute is not met as evidenced by:
Based on record review and interview, it was determined that the agency failed to ensure each employee was screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and was certified free of communicable disease for two (2) of three (3) employees in the investigation.]Home Health Aide #1 (HHA #1) and Independent Clinical Social Worker #1 (ICSW #1)]

The findings include:

H 148

- Created an audit tool for new records to ensure that all required elements are in the new hire chart. (See addendum 1&2)
- Utilize the computerized system to track chart compliance on a monthly bases to remind staff of the need to update document elements.
- Utilize the computerized system to track and remove from the service lines any employees, who remain out of compliance with the regulatory guidelines.
- The agency will conduct bi-weekly 100% audits of the computerized system against the payroll system to ensure continued compliance of all active employees.
- Resubmission of the SW medical documentation (See Addendum3)
- HHA is out of the country indefinitely and will be addressed upon her return.

H163

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

Plan- Target completion date 8/31/12

- Revising the Agency's procedure for handling screening for communicable disease in new and continuing employee's file.
- Created an audit tool for new records to ensure that all required elements are in the new hire chart. (see Addendum 1 &2)
- Utilize the computerized system to track chart

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H 163	Continued From page 3 1. Review of personnel record on July 20, 2012, at approximately 4:00 p.m., revealed HHA #1's last PPD was performed on April 20, 2011. There is no documented evidence HHA #1 is free of communicable disease. During a telephone interview with the Director of Nursing (DON) on July 25, 2012, at approximately 1:41 p.m., it was stated that the agency would re-check HHA #1's personnel file to ascertain if HHA #1 had a current PPD. 2. Review of independent clinical social worker #1's (ICSW #1's) personnel record on July 20, 2012, at approximately 4:20 p.m., revealed ICSW #1's last PPD was performed on February 22, 2012, however the results of the test was not documented. There is no documented evidence ICSW#1 is free of communicable disease. During a telephone interview with the Director of Nursing (DON) on July 25, 2012, at approximately 1:41 p.m., it was stated the agency would re-check personnel file to ascertain if the results of ICSW #1's PPD was in the personnel file.	H 163	compliance on a monthly bases to remind staff of the need to update document elements. • Utilize the computerized system to track and remove from the service lines any employees, who remain out of compliance with the regulatory guidelines. • The agency will conduct bi-weekly 100 % audits of the computerized system against the payroll system to ensure continued compliance of all active employees. • The QA department will conduct monthly 25% audit of the HR department and report findings to the QA committee. • Resubmission of the SW medical documentation (See Addendum 4)	
H 355	3914.3(d) PATIENT PLAN OF CARE The plan of care shall include the following: (d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies; This Statute is not met as evidenced by:	H355	The Provider acknowledges and accepts this tag with the following plan of correction: <u>Plan- Target completion date 8/31/12</u> • The agency will add the orders for Case Management from the Waiver LOC to the PCA plan of care to provide a clear picture of the services being provided for each client beginning 8/20/12. (See Addendum 5)	

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H 355	Continued From page 4 Based on interview and record review, the facility failed to ensure the plan of care (POC) included the description of the services to be provided and expected duration for a patient that required services of a case manager (CM), all medication to be administered, including dosage, and equipment and supplies for one (1) of one (1) patient in the investigation. (Patient #1) The findings include: 1. Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 10, 2012, at approximately 3:45 p.m., revealed that it did not include the description of the services or the duration of the case management services to be provided. Review of Patient #1's medical record on July 16, 2012, between 11:00 a.m. and 12:00 p.m., revealed documentation of case management services provided to Patient #1 on February 14, 23, 2012, March 1, 2012, April 4, 23 and 26, 2012, May 14, 2012 and June 11, 2012. During a telephone interview with the Director of Nursing (DON) on July 10, 2012, at approximately 6:10 p.m., it was revealed Patient #1 was receiving case management services. 2. Review of Patient #1's POC on July 10, 2012, at approximately 4:35 p.m., revealed that it did not include all medication to be administered, including dosage. Review of Patient #1's medical record on July 20, 2012, at approximately 4:30 p.m., revealed the patient was prescribed insulin that included Humilin (depending on sliding scale) and Lantus 25 units subcutaneous (ss) every evening.	H 355	• The RN, Case Managers and the Quality Assurance Staff were retrained on the management of the client with Diabetes Mellitus and Pancreatitis by 7/27/12. (See Addendum 6) • The RN, Case Managers and the Quality Assurance staff were retrained on how the patient assessment and the process for creation of the Plan of Care must be completed by 7/27/12. • The RN, Case Managers and the Quality Assurance staff were retrained on how to conduct the patient assessment of and for the need of DME supplies by 7/27/12. • The RN and The Quality Assurance staff were retrained on the procedure for removing or adding medication and/or treatment to the medication profile by 8/17/12. (See Addendum 7) • Individual counseling session will be completed for each staff member involved in this case by 8/17/12. • Institute a new level of audit for the QA department where 25% of the intake for each month is reviewed by the Director of Nursing to ensure compliance with the written procedures. • Deficiencies will be reviewed with the staff of record and the QA department.	

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H 355	Continued From page 5	H 355		

During a telephone interview with the DON on July 12, 2012, at approximately 1:10 p.m., it was stated that Patient #1's medical record would be checked to ascertain if the aforementioned medications were prescribed.

3. Review of Patient 1's POC on July 10, 2012, at approximately 4:35 p.m., revealed under the heading durable medical equipment (DME) and supplies the POC revealed Patient #1 only utilized a cane.

Review of Patient #1's medical record on July 20, 2012, at approximately 4:50 p.m., revealed the patient utilizes a glucometer, glucometer test strips and incontinent supplies.

During a telephone interview with the Director of Nursing (DON), on July 25, 2012, at approximately 1:45 p.m., it was acknowledged that the description of the services to be provided, frequency and expected duration, all medication to be administered including dosage and all equipment and supplies were not documented on the POC during the current recertification period. The agency however, has updated their computer software to include the aforementioned requirements.

H 357 3914.3(f) PATIENT PLAN OF CARE

H 357

The plan of care shall include the following:

(f) Provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services;

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

Plan

Health Regulation & Licensing Administration

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H 357	Continued From page 6 This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to ensure the plan of care (POC) included provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services for one (1) of one (1) patient in the investigation. (Patient #1) The finding includes: Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 10, 2012, at approximately 1:40 p.m., revealed that provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services were not included. During a telephone interview with the Director of Nursing (DON), on July 25, 2012, at approximately 1:45 p.m., it was acknowledged that the POC did not include provisions relating to the re-evaluation of services, discharge planning, referral of services and continuation or renewal of services for the patients on the current POC. The DON indicated however the agency has updated their computer software to include the aforementioned requirements.	H 357	• Worked with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS concerning discharge planning, referral of services and continuation or renewal of services. (See Addendum 5) • Added library text to our computer software to address discharge planning, referral of services and continuation or renewal of services. • Educated our data entry technician on use of the library text for data entry. • Educated our Quality Assurance staff on the essentials of using this library text appropriately.	
H 361	3914.3(j) PATIENT PLAN OF CARE The plan of care shall include the following: (j) Psychosocial needs of the patient; This Statute is not met as evidenced by: Based on record review and interview, the agency's plan of care (POC) failed to include the	**H361**	The Provider acknowledges and accepts this tag with the following planned correction: Plan • Working with the Department of Health Care Finance to correct the mandatory Plan of	

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psychosocial needs of the patient for one (1) of one (1) patient in the investigation. (Patient #1)

The finding includes:

Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 10, 2012, at approximately 1:00 p.m., revealed that provisions relating to the psychosocial needs of the patient had not been included.

During a telephone interview with the Director of Nursing (DON),on July 25, 2012, at approximately 1.45 p.m., it was acknowledged that the psychosocial needs of the patient were not on the current POC. The DON indicated however that the agency has updated their computer software to include the aforementioned requirements.

H361

Care to include the requirements of CMS concerning the psychosocial needs of the patient.

- Added library text to our computer software to address the psychosocial needs of the patient. (See Addendum 5)
- Educated our data entry technician on use of the library text for data entry.
- Educated our Quality Assurance staff on the essentials of using this library text appropriately.

H 363 3914.3(I) PATIENT PLAN OF CARE

The plan of care shall include the following:

(I) Identification of employees in charge of managing emergency situations;

This Statute is not met as evidenced by:
Based on record review and interview, it was determined that the agency failed to ensure the plan of care (POC) included identification of employees in charge of managing emergency situations for one (1) of one(1) patients in the investigation. (Patient #1)

The finding includes:

Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 10, 2012, at approximately 1:20 p.m., revealed " in

H363

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

Plan

- Continue to work with the Department of Health Care Finance to correct the mandatory Plan of Care to include the requirements of CMS to address the identification of employees in charge of managing emergency situations
- Add library text to our computer software to address the identification of employees in charge of managing emergency situations. (See Addendum 5)

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H 363	Continued From page 8 case of emergency, patient should call 911". However, the POC did not include the identification of employees in charge of managing emergency situations. During a telephone interview with the Director of Nursing (DON) on July 25, 2012, at approximately 1:45 p.m., it was acknowledged that the identification of employees in charge of managing emergency situations was not on the current POC. The DON indicated however the agency has updated their computer software to include the aforementioned requirements.	H363	• Educated our data entry technician on use of the library text for data entry. • Educated our Quality Assurance staff on the essentials of using this library text appropriately.	
H 406	3915.11(a) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (a) Basic personal care including bathing, grooming, and assistance with toileting or bedpan use. This Statute is not met as evidenced by: Based on record review and interview, the home health aide failed to provide basic personal care including bathing, grooming, and assistance with toileting for one (1) of one (1) patient in the investigation. (Patient #1) The finding includes: Review of the DCFEMS Patient Care Report dated July 5, 2012, on July 25, 2012, at approximately 10:31 a.m., revealed "patient lying on back in bed covered in food and feces. The	H406	The Provider acknowledges the surveyor's interpretation of the events that triggered this report but based on the documentation and testimonies of the staff respectfully with hold final judgment based on the fact that the statements provided by the staff to the agency does not support the allegations presented. <u>Plan – Target date 8/20/12</u> • Retraining of the Personal Care Aide on providing personal care to individuals who are incapacitated and the correct documentation on the daily PCA timesheet by 10/15/12 or upon her return from Jamaica. • Review the procedure for providing personal care by 10/15/12. • Retraining of the Quality Assurance staff on the audit and PCA retraining	

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H 406	Continued From page 9			

room is extremely hot and staff states the patient has been up there in bed and has not been moved for almost a week. Patient states that the staff places his food tray on him and he is unable to effectively feed or hydrate himself. Patient is extremely dehydrated and emaciated. Patient placed onto three (3) lead with oxygen and IV (intravenous) fluid bolus due to dehydration and lack of care. At hospital an Metropolitan Police (MPD) officer inquires about patient's condition and states that he is going to start an investigation in regards to neglect".

During a telephone interview with home health aide #1 (HHA #1) on July 10, 2012, at approximately 5:28 p.m., it was revealed that when HHA #1 arrived on duty on July 5, 2012, at approximately 8:00 a.m., Patient #1 complained of fainting and blacking out because it was hot in the bedroom.
According to HHA #1, Patient #1 was lying on the bed and requested, that HHA #1 go to the grocery store to purchase some items. HHA #1 returned to the facility from the grocery store, (time unknown) he/she observed Patient #1 lying in the same position on the bed. Patient #1 had not eaten the food that had been prepared prior to the HHA's departure to the store. The HHA at that time called the District of Columbia Fire and Emergency Medical Services Department (DCFEMS) and Patient #1 was transported to the hospital for evaluation and treatment. HHA # explained that the DCFD personnel did observe fecal matter on Patient #1's body, adult protective undergarment and bed linens and that food particles where on Patient #1's body. HHA #1 further explained that Patient #1 continuously has loose stools all through the day but often refuses to allow the aide to assist in bathing or changing the adult protective garments.

process for documentation by 8/17/12 (See Addendum 14)

- The QA department will conduct a 100% chart audit every 30 days and present a corrective action plan to the director of nursing with the accompanying disciplinary action form.

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H 406	Continued From page 10	H 406		

Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 11, 2012, at approximately 11:20 a.m., revealed the patient was to receive home health care services seven (7) days a week for eight hours a day times times six (6) months. Home health aide #1 (HHA #1) was to assist Patient #1 with hygiene, bathing, grooming, oral care, toileting, changing bed linen and meal preparation.

There was no evidence in the patient's record that the patient was non-compliant with activities of daily living (ADL).

H 411 3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE

H411

Home health aide duties may include the following:

(f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance;

This Statute is not met as evidenced by:
Based on a record review and interview, it was determined that the agency failed to ensure home health aides (HHAs) recorded and reported on the patient's physical condition, behavior or appearance for one (1) of one (1) patient in the investigation. (Patient # 1)

The finding includes:

Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 11, 2012, at approximately 1:20 p.m., revealed the

The Provider acknowledges the surveyor's interpretation of the events that triggered this report but based on the documentation and testimonies of the staff respectfully with hold final judgment based on the fact that the statements provided by the staff to the agency does not support the allegations presented.

<u>Plan- Target completion date 10/31/12</u>

- Discipline specific emergency management training for 100% of the staff by 10/31/12.
- Retraining of the process of documenting an emergent situation to all staff by 10/31/12.
- 100% audit all PCA timesheets by 10/31/12

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	HCA-0027	A. BUILDING _____ B. WING _____	C 07/25/2012

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H 411	Continued From page 11 patient was to receive home health care services seven (7) days a week for eight hours a day for six (6) months. Review of Patient #1's time sheets dated March 17, 2012, to July 1, 2012, on July 11, 2012, between 12:25 p.m. and 1:40 p.m., revealed home health aide #1 (HHA #1) had recorded twenty (20) to thirty (30) minutes for bathing, fifteen (15) minutes for oral hygiene and ten (10) minutes for reminders to take medication daily. Further review of the timesheets revealed that there was no time documented for the activity of elimination. There was no documented evidence HHA #1 had recorded and reported the patient's physical condition, behavior or appearance to the agency however there was no documentation of that report/communication. During a telephone interview with the Director of Nursing (DON) on July 25, 2012, at approximately 1:45 p.m., it was stated that the HHA had reported Patient #1's, physical condition, behavior and appearance to the agency.	H 411		
H 412	3915.11(g) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (g) Meal preparation in accordance with dietary guidelines, and assistance with eating; This Statute is not met as evidenced by: Based on record review and interview, the home health aide failed to provide meal preparation in accordance with dietary guidelines for one (1) of	H 412	The Provider acknowledges the surveyor's interpretation of the events that triggered this report but based on the documentation and testimonies of the staff respectfully with hold final judgment based on the fact that the statements provided by the staff to the agency does not support the allegations presented.	

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H 412	Continued From page 12 one (1) patient in the investigation. (Patient #1) The finding includes: During a telephone interview with home health aide #1 (HHA #1) on July 10, 2012, at approximately 5:50 p.m., it was revealed that Patient #1 was not on a specific diet. Patient #1 would instruct HHA #1 daily on the type of food to prepare for breakfast, lunch and dinner. HHA #1 revealed Patient #1 would often request scrambled eggs with cheese and pork sausage for breakfast, hotdogs for lunch, and fried chicken wings or packaged stir fry meals for dinner. During a telephone interview with skilled nurse #1 (Skilled Nurse #1) on July 10, 2012, at approximately 6:15 p.m., it was revealed that Patient #1 was not on a specific diet and had no dietary restrictions. Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 11, 2012, at approximately 2:20 p.m., revealed that home health aide #1 (HHA #1) was to assist Patient #1 with meal preparation. Patient #1's POC revealed orders for a specific diet with sodium restrictions, no added salt, low sodium and no concentrated sweets. For example on July 16, 2012, at approximately 10:15 a.m., review of an Incident/Event Report dated July 4, 2012, the day prior to Patient #1 going to the hospital emergency room revealed HHA #1 prepared Patient #1 two hotdogs and a cup of ice for lunch. [Note: On July 5, 2012, Patient #1 was transported via ambulance by the District of Columbia Fire and Emergency Medical Services	H 412	Plan- Target completion date 9/15/12 • 100% Retraining on Food handling and documentation for all PCA by 8/31/12 (See Addendum 8,9 10 11, 12 and 13) • 100 % Training on Nutrition in the Elderly for all PCA by 8/31/12. (See Addendum 8,9 10 11, 12 and 13) • 100% training on Dehydration in the Elderly for all PCA by 8/31/12. (See Addendum 8,9 10 11, 12 and 13) • 100% training on all PCA, RN and Case Managers on the care need requirements for the Diabetic Patient by 9/15/12 • 100 % Retraining of all Nurses and Case Manager on the need for ongoing retraining of the PCA on meeting the patient's dietary needs by 9/15/12	

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H 412	Continued From page 13 Department (DCFEMS) to a local hospital and allegedly admitted with diagnoses that included dehydration and emaciation.]	H 412		
H 452	3917 2(b) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (b) Coordination of care and referrals; This Statute is not met as evidenced by: Based on record review, and interview the agency's nurse failed to ensure coordination of care and to make referrals for one (1) of one (1) patient in the investigation. (Patient #1) The finding includes: During a telephone interview with skilled nurse #1 (SN#1) on July 10, 2012, at approximately 6:28 p.m., it was revealed that Patient #1 had lost weight. However, there was no documented evidence of monthly weight monitoring. There was no documented evidence SN #1 contacted the physician or the registered nurse supervisor and case manager to coordinate care per the POC On July 24, 2012, at approximately 2:13 p.m., review of skilled nurse #1's (SN #1) Personal Care Aide/Homemaker Supervisory Visit Forms revealed a failure to ensure coordination of care and to make referrals to meet Patient #1's needs as evidenced by the following: 1. February 28, 2012, "generalized weakness, multiple loose stools".	H 452	The Provider acknowledges and accepts this tag with the following plan of correction: <u>Plan- Target completion date 9/15/12</u> • Retraining of the RN on the elements of the Supervisory Monitoring Visit and the documentation of it by 9/15/12 (See Addendum 15) • Retraining of the RN and Case Manager on the care coordination process and its documentation by 9/15/12 (See Addendum 15) • Revised the Monthly RN Supervisory notes (See Addendum 16) • Retraining of the RN and Case Manager on care strategies development, implementation and documentation for patients with • Diabetes and Pancreatitis with weight by 8/30/12. (See Addendum 6)	

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H 452	Continued From page 14 2. March 26, 2012, "generalized weakness. (loose stools) due to pancreatitis". 3. May 24, 2012,"wt" [weight loss]. 4. June 22, 2012, " weakness secondary [to] pancreatitis". Review of Patient #1's Comprehensive Adult Nursing Assessment dated February 4, 2011, record, on July 24, 2012, at approximately 2:04 p.m., under the heading "Systems Review", Patient #1's reported weight was one hundred-twenty-seven (127) pounds with a reported weight loss of four (4) pounds. Review of the Medical Social Service Re-visit note dated June 22, 2011, on the same date and time revealed Patient #1 weighed one hundred-twenty-two (122) pounds. There was no weight documented after June 22, 2011. [Note: On July 5, 2012, Patient #1 was transported via ambulance by the District of Columbia Fire and Emergency Medical Services Department (DCFEMS) to a local hospital and allegedly admitted with diagnoses that included dehydration and emaciation.]	H 452		
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:	H 453	The Provider acknowledges and accepts this tag with exception that the nursing notes for the months of February (See Addendum 17) and March (See Addendum 18) were provided twice for this surveyor's review and will again be presented as addendums with	

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H 453	Continued From page 15 Based on interview and record review, the Home Care Agency's (HCAs) nurse failed to ensure that patient needs were met in accordance with the plan of care (POC) for one (1) of one (1) patient in the investigation. (Patient #1) The findings include: Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 24, 2012, at approximately 2:34 p.m., revealed the skilled nurse was to perform a skilled assessment and evaluation of systems, assess vital signs, CP/CV status, assess hydration and nutrition status, assess clinical status and response to medication on each visit monthly, for six (6) months. 1. Review of Nursing Monthly Visit Notes on July 24, 2012, at approximately 2:43 p.m., revealed no documented skilled nurse visits for the months of February and March 2012. 2. Review of Patient #1's available Nursing Monthly Visit Notes dated April 25 and May 24, 2012, on July 24, 2012, at approximately 2:48 p.m., revealed no documented evidence of skilled assessments and evaluation of systems, assessment of vital signs, assessment of CP/CV status, assessment pain and pain management, assessment of hydration and nutrition status, assessments of clinical status and response to medication. During a telephone interview with the Director of Nursing (DON),on July 25, 2012, at approximately 1:47 p.m., it was stated that the agency would re-check Patient #1's medical record to ascertain if the skilled nurse visits for the months of February and March 2012, were in the medical	H 453	the notes for April 25 (Addendum 19), May 24 (Addendum 20) and July 24, 2012(See Addendum 21) all of which has the vital sign, mental status, and assessment of functional limitations as the episode is opened for PCA supervision. The following plan of correction will be implemented to address the deficits: <u>Plan- Target completion date 8/30/12</u> • The agency's documentation policy for Personal Care Assistant supervision documentation will by revised to include a more comprehensive assessment tool to work in conjunction with the current PCA monitoring tool until further notice by 8/24/12 (See addendum 16) • 100% of all nurses will be retrained on the agency's documentation procedures by 8/30/12	

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H 453	Continued From page 16 record. At the time of the investigation, there was no evidence that the aforementioned assessments had been conducted.	H 453		
H 456	3917.2(f) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (f) Supervision of services delivered by home health and personal care aides and household support staff, as appropriate; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to have supervision of services delivered by home health aides (HHAs) as appropriate for one (1) of one (1) patients in the sample. (Patient #1) The finding includes: Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 11, 2012, at approximately 3:20 p.m., revealed the skilled nurse (SN) was to visit once a month for six (6) months to instruct and supervise the home health aide (HHA) about modalities to handle health issues, fall precautions and infection transmission and prevention methods. Review of Personal Care Aide/Homemaker Supervisory Visit Forms on July 24, 2012, at approximately 1:32 p.m., revealed no documented evidence of instruction related to modalities to handling health issues and fall precautions provided by SN #1 to HHA #1 as evidenced by the following:	H 456	The Provider acknowledges and accepts this tag with the following plan of correction: <u>Plan- Target completion date 8/30/12</u> • Retraining of the RN on the elements of the Supervisory Monitoring Visit and the documentation of it by 8/30/12 • Retraining of the RN and Case Manager on the PCA supervision process and its documentation by 8/30/12. • Retraining of the RN and Case Manager on care strategies development, implementation and documentation for patients with Diabetes and Pancreatitis with weight by 8/30/12. (See Addendum 6)	

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H 456	Continued From page 17 1. February 28, 2012. "generalized weakness. multiple loose stools. Personal Care Aide (PCA) is able to assist by providing timely reminders". 2. March 26, 2012. "generalized weakness, (loose stools) due to pancreatic. PCA instructed to remind client couple of hours prior to appointments". 3. May 24, 2012."wt [weight loss]. Instructed PCA on ongoing reminders of appointments". 4. June 22, 2012, " weakness secondary [to] pancreatitis. Instructed PCA on providing reminders of MD (doctors) appointments". During a telephone interview with the Director of Nursing (DON) on July 25, 2012, at approximately 1:44 p.m., it was stated the agency's nursing staff did provide health teaching instructions to the HHAs, however there was no documented evidence of such.	H 456		
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 interview and record review, the facility's skilled nursing staff failed to ensure patient instruction and evaluation of patient instruction for one (1) of one (1) patient in the investigation. (Patient #1)	H 459	The Provider acknowledges and accepts this tag with the following plan of correction: Plan- Target completion date 8/30/12 • Revise the documentation of patient teaching procedures by 8/30/12	

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H 459	Continued From page 18	H 459		

The findings include:

1. During a telephone interview with home health aide #1 (HHA #1) on July 10, 2012, at approximately 5:28 p.m. it was revealed when he/she arrived on duty on July 5, 2012, at approximately 8:00 am, to serve Patient #1 breakfast, Patient #1 complained of fainting and blacking out because it was hot in the bedroom. Patient #1 did not call 911 when the life threatening event occurred.

During a telephone interview with skilled nurse #1 (Skilled Nurse #1) on July 10, 2012, at approximately 6:28 p.m., it was revealed that Patient #1 was taught how to use the glucometer to monitor blood sugar and was able to return the demonstration. However, there was no documented evidence of the aforementioned health teaching instructions and evaluation of the instructions.

Review of Patient #1's plan of care (POC) dated January 30, 2012 to July 30, 2012, on July 24, 2012, at approximately 7:56 a.m., revealed the patient was diagnosed with CVA, Diabetes Mellitus Type II, pancreatic disorder and depressive disorder. The skilled nurse #1 (SN #1) was to review the diet, instruct on medication, assess the patient's ability to manage diabetes including knowledge of and compliance with blood sugar monitoring, understanding of signs/symptoms of hyper/hypoglycemia and foot/skin measures. SN #1 should instruct the patient to call 911 in case of life threatening emergency.

Review of Patient #1's available Nursing Monthly Visit Notes dated April 25 and May 24, 2012, on July 24, 2012, at approximately 12:13 p.m., at the

- Retraining of the RN on the elements of the patient monitoring during the visit and the documentation of it by 8/30/12 (see Addendum 15)
- Retraining of the RN and Case Manager on the patient supervision process and its documentation by 8/30/12. (see Addendum 15)
- Retraining of the RN and Case Manager on care strategies development, implementation and documentation for patients with Diabetes and Pancreatitis with weight by 8/30/12. (see Addendum 6)

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H 459	Continued From page 19 time of the investigation, revealed no documented evidence that any of the aforementioned health teaching instructions were performed. 2. Review of Patient # 1's Nursing Monthly Visit Notes dated April 25, 2012, on July 24, 2012, at approximately 11:53 a.m., revealed under the heading Education and Training "proper handwashing techniques done at all times". Client verbalized understanding of instructions. Reinforced the importance of medication adherence and daily treatment. Client verbally accepts responsibility of medications". However the health teaching instructions were not specific and there was no specific evidence that indicated which aspect of the health teaching instructions were evaluated or understood by the patient.	H 459		