		_					FORM APPROVED		
STATEMENT	egulation & Licensin FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		A. BUILD	NG	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		HCA-0027		B WING			07/25/2012		
NAME OF P	ROVIDER OR SUPPLIER	<b></b>		DRESS, CITY, STATE, ZIP CODE					
	PREMIER HEALTH SERVICES, INC WASHIN			RGIA AVENUE, NW, SUITE 323 ITON, DC 20012					
rX4) ID PREFIX TAG	ALACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE		
	On July 5, 2012. the Regulation and Lice (DOH/HRLA) receipostrict of Columbia requesting an inverse providing services negligence.  The complainant in Allegation #1: An ure #1) was discovered group home cover Patient #1 was transfer and Emergen Department (FEM assessment and ereceipostrice).  Based on interview that included dehy Findings:  Based on interview Health Aide (HHA 5, 2012, when he/approximately 8:0 breakfast, Patient blacking out due to #1 acknowledged extremely hot. Lat facility from the gransfer #1 had no prepared. HHA #1	TS  TE Department of Heatensing Administration ived a telephone call a Fire Department (Distinguished a telephone call a Fire Department (Distinguished a telephone call a Fire Department (Distinguished a telephone call a for Patient #1 for possible dentified the following unidentified elderly midentified elderly midentified elderly midentified elderly midentified elderly midentified elderly midentified a formation and ambular cy Medical Services  S) to a local hospital evaluation. Subseque to the hospital with district and record review with the hospital with district and record review with the service of the heat in the bedict that the patient of the telephone to the heat in the bedict that the patient's rooter when HHA #1 returned the telephone that the food that the called 911. HH then called 911. HH then called 911.	alth/Health of from the oCFD) home ssible concern: an (Patient an alleged of food, noce by the for further on the form that on July at the foom. HHA of m was urned to the known) esame ted that had been that the food the food that the food that the food the food that the food t	IH 000		The Provider acknowledges interpretation of the events this report but respectfully dintentional neglect by the Proservices Staff.  Plan  Premier Health Services will retraining for the staff on the by 8/31/12:  The roles and response Registered Nurse. The roles and response Registered Nurse. The roles and response Personal Care Aide. two weeks after her Jamaica. Return date Handling of Medical Dealing with Difficul Reviewed with the staff on the by 8/31/12:	that triggered lenies any emier Health complete the e following topics insibilities of the insibilities of the (Delayed until return from e TBD) Emergencies t Patients. taff the reasons alt Protective ices has t the patient		
	explained that the fecal matter on P	I then called 911. HH DCFD personnel did atient #1's body, adul d bed linens and that	l observe t protective		940	family in obtaining n	64 Sept.		

Health Regulation & Licensing Administration

betteller RN MBN/ TITLE BIRECTOR of NURSUSPATE

particles where on Patient #1's body. HHA #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  HCA-0027		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		TION	(X3) DATE SURVEY COMPLETED C 07/25/2012	
NAME OF PE	ROVIDER OR SUPPLIER	I		DRESS, CITY,				
PREMIER	HEALTH SERVICES	S, INC		DRGIA AVENUE, NW, SUITE 323 GTON, DC 20012				
(X4) ID PRILLIX TAG	PRICIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PRICIAL ATTORY OF LIST DENTIFYING INFORMATION)			ID PREFIX TAG	10 to	(EACH C	VIDER'S PLAN OF CORRECTOR SHOP CORRECTIVE ACTION SHO EFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
Н 000	Conclusion: This at there was evidence body were soiled we patient was also de On July 6. 2012, ar determine if there was related to the discovered that the licensed by the De Regulatory Affair (I were being provide licensed by the DC initiated off site on compliance with Ti (Home Care Agency of the investigation the home health ai (RN) and the directions and the rectangle of the investigation that the directangle of the investigation the home health ai (RN) and the directangle of the investigation the directangle of the in	transported Patient	ntialed as ad and food. The afed. ated to safety It was no house er and services gency gation was pertain er 39 ne findings views with I nurse well as a	H 000	2000 0 0 0 0		ition and seeking a riate housing arrang ent.	
H 148	H 148 3907.2(d) PERSONNEL  Each home care agency shall maintain accurate personnel records, which shall include the following information:		H 148		The Provider acknowledges and accepts this tag with the following plan of correction:  Plan			
	(d) Documentation required.	of current CPR cert	ification, if		6	pro- emp	npleting revision of the cedure for handling n ployee's file maintena	ew and continuing
	Based on record redetermined that the	t met as evidenced be eview and interview, e agency failed to me el records, which incl current CPR certifica	it was aintain uded			201 <u>Pla</u> i		

Health Re	agulation & Licensi	ng Administration	*	·····		
STATEMENT	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  HCA-0027		(X2) MULTII A BUILDING B WING		(X3) DATE SURVEY COMPLETED C 07/25/2012	
NAME OF P	ROVIDER OR SUPPLIER	1			STATE, ZIP CODE	
	7600 GEO			RGIA AVEN		
(X4) ID PREFIX 1 AG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETE
	Investigation. (Hon The finding include Review of home horsonnel file on J 3:30 p.m., reveale personnel file had.  On July 5, 2012, the assessed the needed of the second blacking out of the HHA #1 left Patier store.  3907.7 PERSONNE Each employee shoommunicable discommunicable discommunicable and solutions.	B) employees in the me Health Aide #1 (H. es: nealth aide #1's (HHA July 20, 2012, at approduce the CPR certification expired on March 25 there was no evidence of for first aid or the nealth and went to the next #1 and went to the NEL thall be screened for sease annually, according the measurement #1 are sease annually, according the Health and screened for sease annually, according the Health Aiden and the screened for sease annually, according the Health Aiden and the screened for sease annually, according the Health Aiden and	#1's) eximately in in the 2012. HHA #1 eed to call of fainting bedroom. grocery	H 148	compliance on a month staff of the need to upd elements.  Utilize the computerize remove from the servic who remain out of com regulatory guidelines.  The agency will conduct	d elements are in the ddendum 1&2) ed system to track chart hly bases to remind date document ed system to track and ce lines any employees, inpliance with the ct bi-weekly 100% rized system against the cre continued e employees. W medical
	guidelines issued Disease Control, communicable dis	rs for free of	Н163	be addressed upon her The Provider acknowledges with the following plan of co	return. and accepts this tag	
	Based on record a determined that the employee was so disease annually, issued by the feducation, and was disease for two (2 investigation, 1Ho	ot met as evidenced by review and interview, the agency failed to entreened for communic, according to the guideral Centers for Disease certified free of communication of three (3) employme Health Aide #1 (4) Clinical Social Works	it was insure each cable delines ase inunicable ees in the HHA #1)		Plan- Target completion date  Revising the Agency's pascreening for communication and continuing employee  Created an audit tool for ensure that all required new hire chart. (see Additional Agency 2015)	rocedure for handling cable disease in new se's file. r new records to elements are in the

The findings include:

Utilize the computerized system to track chart

Health R	Regulation & Licensin	ng Administration			
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  HCA-0027			(X2) MULT A BUILDII B WING	
MANAE OL D	ROVIDER OR SUPPLIER	1107-0027	STREET ADD	RESS. CITY.	Y, STATE. ZIP CODE
	R HEALTH SERVICES	s, INC		RGIA AVE	ENUE, NW, SUITE 323
(X4) ID PREFIX FAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY)
H 163	Continued From pa			H 163	compliance on a monthly bases to remind
	at approximately 4: last PPD was performed and communicable disest that the communicable disest that p.m., it was stretcheck that the communicable disest that th	interview with the Di July 25, 2012, at app ated that the agency personnel file to asc	HA #1's 11. There ree of rector of rector of roximately would ertain if  worker uly 20, led ICSW led ICSW levidence se.  rector of roximately id le results		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)
Н 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; as supplies;			н355	The Provider acknowledges and accepts this tag with the following plan of correction:  Plan- Target completion date 8/31/12  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)

Health Regulation & Licensing	o Administration				FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  HCA-0027			(X2) MULTIPLE CONSTRUCTION A. BUILDING B WING		(X3) DATE SURVEY COMPLETED C 07/25/2012		
NAME OF PROVIDER OR SUPPLIER	11CA-0027	STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
7600 GE				E, NW, SUITE 323			
PRETIN FACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY BC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE		
Based on interview failed to ensure the the description of the expected duration for services of a case in to be administered, equipment and supportient in the investion. The findings includes 1. Review of Patient dated January 30, 2012, at approxionate that it did not include services or the dura services to be provided to 23, 2012, March 1, 2012, May 14, 2012.  During a telephone Nursing (DON) on 6:10 p.m., it was repreceiving case mand 2. Review of Patient #2012, at approximately 4: not include all medical including dosage.  Review of Patient #2012, at approximately 4: not include all medical including dosage.  Review of Patient #2012, at approximately 4: not include all medical including dosage.	and record review, to plan of care (POC) is eservices to be propored a patient that requirements for one (CM), all manager (Patient #1) is:  It #1's plan of care (Fatient #1)  It #1's plan of care (Fatient #1)  It #1's plan of care (Fatient #1)  It mately 3:45 p.m., reserved the case manager (Patient #1 on Febrard 2012, April 4, 23 and 2 and June 11, 2012  Interview with the Day of patient #1 was vealed Patient #	included vided and uired hedication and he (1)  POC) 2, on July evealed the hagement wary 14, d 26, hirector of proximately as 10, 2012, at it did blered.  In July 20, aled the kided and Lantus	H 355	<ul> <li>The RN, Case Manager Assurance Staff were management of the cli Mellitus and Pancreati Addendum 6)</li> <li>The RN, Case Manager Assurance staff were repatient assessment and creation of the Plan of completed by 7/27/12</li> <li>The RN, Case Manager Assurance staff were reconduct the patient as the need of DME supp</li> <li>The RN and The Qualit were retrained on the removing or adding metreatment to the medi 8/17/12. (See Addended Individual counseling secompleted for each stain this case by 8/17/12</li> <li>Institute a new level or department where 25% each month is reviewed Nursing to ensure community of record and the QA decrease.</li> <li>Deficiencies will be revorted.</li> </ul>	etrained on the ent with Diabetes tis by 7/27/12. (See s and the Quality etrained on how the d the process for Care must be s and the Quality etrained on how to sessment of and for lies by 7/27/12. Y Assurance staff procedure for edication and/or cation profile by um 7) session will be aff member involved and the intake for ed by the Director of apliance with the staff		

Health R	legulation & Licensin	ng Administration				
	IENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  HCA-0027		(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SURVEY GOMPLETED  C 07/25/2012	
NAME OF D	ROVIDER OR SUPPLIER	1.31(172)	STREET ADI	DRESS, CITY.	STATE, ZIP CODE	
MAINE OF P	ROVIDER OR SUFFEIGR				NUE, NW, SUITE 323	
PREMIER	R HEALTH SERVICES	S, INC		TON, DC 2	0012	
(X4) ID PREFIX TAG	LEACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETI. THE APPROPRIATE DATE
H 355	Continued From pa	ige 5		H 355	9	
	July 12, 2012, at apstated that Patient	interview with the Doproximately 1:10 p.r #1's medical record vin if the aforemention prescribed.	n., it was would be			
	approximately 4:35 heading durable m	nt 1's POC on July 10 p.m., revealed unde edical equipment (DI evealed Patient #1 o	r the ME) and		ec.	
TE.	2012, at approxima	#1's medical record o ately 4:50 p.m., revea ucometer, glucomete ant supplies.	led the		•	
	Nursing (DON), on approximately 1:45 that the description frequency and exp to be administered equipment and sup the POC during the The agency howey	e interview with the Di July 25, 2012, at 5 p.m., it was acknow n of the services to be ected duration, all me including dosage an oplies were not docur e current recertification for the aforementioned	ledged e provided, edication d all mented on on period.			
H 357	3914.3(f) PATIEN	r PLAN OF CARE	vina:	H 357		wledges and accepts this ing completed correction:
	The plan of care s	Ton morado tro follow			tag with the lonow	ing completed correction;
	services, discharge	ing to the reevaluatio e planning, referral of r renewal of services	services		<u>Plan</u>	

Health Re	egulation & Licensin	g Administration					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  HCA-0027			(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  DDRESS, CITY, STATE, ZIP CODE			(X3) DATE SURVEY COMPLETED C 07/25/2012	
		TIOA-0027	STREET ADD	RESS, CITY.	STATE.	ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		The second secon			W, SUITE 323	
PREMIER HEALTH SERVICES, INC WASHING		WASHING	TON, DC	20012	The state of the s		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO PROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
H 357	Continued From pa	ige 6		H 357	•	Worked with the Depart	ment of Health Care
	This Statute is not met as evidenced by: Based on a record review and interview, it was					Finance to correct the m	
	determined that the	e agency failed to ens	sure the			Care to include the requ	irements of CMS
	plan of care (POC)	included provisions	relating to			concerning discharge pla	nning, referral of
	the re-evaluation o	f services, discharge	planning,			services and continuation	201
	referral of services	and continuation or a	renewal of			services. (See Addendum	PERMENT OF PERMENTANCE FOR DESIGNATION
services for one (1) of one (1) patient in the investigation. (Patient #1)			uie			15 APRIL 10	0.00
	investigation (real	out in 1 7		<ul> <li>Added library text to our comp</li> </ul>			8 9 8
	The finding include					AC-4.	
	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.			•	services and continuation services. Educated our data entry the library text for data e Educated our Quality Ass essentials of using this lib	technician on use of entry. surance staff on the	
	Nursing (DON), on approximately 1:48 that the POC did not the re-evaluation of referral of services services for the pa DON indicated how	5 p.m., it was acknow to tinclude provisions of services, discharge and continuation or tients on the current wever the agency has tware to include the	relating to planning, renewal of POC. The		1 comm	appropriately.	
LL 261	3914.3(j) PATIEN	T DI AN OF CARE	~	H361	. 6	The Provider acknowledg	es and accepts this
17.301						tag with the following pla	inned correction.
	The plan of care s	hall include the follow	ving:		50	<u>Plan</u>	
	(i) Psychosocial ne	eeds of the patient;			*		
	This Statute is no	et met as evidenced b	y.		•	Working with the Depar Finance to correct the n	tment of Health Care nandatory Plan of
1	Based on record r	eview and interview,	ruc.				

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B WING 07/25/2012 HCA-0027 STREET ADDRESS. CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7600 GEORGIA AVENUE, NW, SUITE 323 PREMIER HEALTH SERVICES, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (LACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG AG DEFICIENCY) H 361 Continued From page 7 Care to include the requirements of CMS H361 concerning the psychosocial needs of the psychosocial needs of the patient for one (1) of one (1) patient in the investigation. (Patient #1) patient. Added library text to our computer software The finding includes: to address the psychosocial needs of the Review of Patient #1's plan of care (POC) dated patient. (See Addendum 5) January 30, 2012 to July 30, 2012, on July 10, 2012, at approximately 1:00 p.m., revealed that Educated our data entry technician on use of provisions relating to the psychosocial needs of the library text for data entry. the patient had not been included. Educated our Quality Assurance staff on the During a telephone interview with the Director of essentials of using this library text Nursing (DON), on July 25, 2012, at approximately appropriately. 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. The Provider acknowledges and accepts this tag with the following completed correction: H 363 3914.3(I) PATIENT PLAN OF CARE H363 The plan of care shall include the following: Plan (I) Identification of employees in charge of Continue to work with the Department of managing emergency situations; Health Care Finance to correct the mandatory Plan of Care to include the This Statute is not met as evidenced by: requirements of CMS to address the Based on record review and interview, it was determined that the agency failed to ensure the identification of employees in charge of plan of care (POC) included identification of managing emergency situations employees in charge of managing emergency Add library text to our computer software to situations for one (1) of one(1) patients in the investigation. (Patient #1) address the identification of employees in charge of managing emergency situations. ( The finding includes: See Addendum 5) Review of Patient #1's plan of care (POC) dated

January 30, 2012 to July 30, 2012, on July 10.

Health R	egulation & Licensin	g Administration				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPI A BUILDING B WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		HCA-0027				07/25/2012
NAME OF PE	ROVIDER OR SUPPLIER				TATE. ZIP CODE	
PREMIER	HEALTH SERVICES	S, INC		TON, DC 200	JE, NW, SUITE 323 012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
	However, the POC identification of ememergency situation. During a telephone Nursing (DON) on 1:45 p.m., it was acidentification of ememergency situation. POC. The DON incomposition of the aforementioned 3915.11(a) HOME CARE AIDE SERV. Home health aide of following:  (a) Basic personal grooming, and assi	patient should call sidd not include the ployees in charge of ns. interview with the Di July 25, 2012, at appet throwledged that the ployees in charge of ns was not on the culticated however the accomputer software to direquirements.	managing rector of roximately managing rrent agency include	H363	the library text for Educated our Qua essentials of using appropriately.  The Provider acknowledge interpretation of the this report but base and testimonies of hold final judgment statements provide	lity Assurance staff on the
	Based on record re health aide failed to including bathing, (toileting for one (1) investigation. (Pati The finding include Review of the DCF dated July 5, 2012 approximately 10:3		the home onal care ance with the eport t tent lying		on providing individuals the correct daily PCA till upon her response the personal care.  Retraining of the control of the correct daily PCA till upon her response the personal care.	of the Personal Care Aide g personal care to who are incapacitated and documentation on the mesheet by 10/15/12 or eturn from Jamaica. procedure for providing re by 10/15/12. of the Quality Assurance audit and PCA retraining

Health R	egulation & Licensin	a Administration				FORM APPROVED
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HCA-0027		(X2) MULTIPL A. BUILDING B WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/25/2012
NAME OF P	ROVIDER OR SUPPLIER	es es a a trace d	STREET ADD	RESS CITY, ST.	ATE, ZIP CODE	
PREMIER	R HEALTH SERVICES	, INC		RGIA AVENU TON, DC 200	E, NW, SUITE 323 12	
(X4) ID PREFIX FAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE
H 406	has been up there is moved for almost a staff places his food to effectively feed of extremely dehydrat placed onto three (3 (intravenous) fluid to lack of care. At hos (MPD) officer inquire and states that he is investigation in regard During a telephone aide #1 (HHA #1) of approximately 5:28 when HHA #1 arrive approximately 8:00 of fainting and black the bedroom. According to HHA #1 bed and requested, store to purchase sto the facility from to unknown) he/she of same position on the aten the food that the HHA's departuratime called the Dist Emergency Medical (DCFEMS) and Pathospital for evaluate explained that the fecal matter on Pathose stools all through the staff of the particles where on further explained the loose stools all through the staff of the particles where on further explained the loose stools all through the particles where on further explained the loose stools all through the particles where on further explained the loose stools all through the place of the particles where on further explained the particles where the particles w	not and staff states the noted and has not be week. Patient states of tray on him and he report has been and emaciated. Patient and emaciated. Patient and the states of t	een sthat the is unable atient is unable atient is ratient and IV tion and Police ondition  thealth dithat 2012, at a plained was not in any on the are grocery returned any in the are driver to the HA at that and ant and the HA # observe protective cood HA #1 iously has a refuses		process for docum 8/17/12 (See Adde • The QA department 100% chart audit of present a corrective director of nursing accompanying disconting form.	endum 14) nt will conduct a every 30 days and we action plan to the which with the

Health F	Regulation & Licensin	ng Administration	1100000 V = 12000 V M			FORW APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HCA-0027		(X2) MULTIPLE A BUILDING B WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/25/2012
MAANE CE D	ROVIDER OR SUPPLIER	1107 0021	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE	L
	R HEALTH SERVICES	s, INC	7600 GEO		E, NW, SUITE 323	
(X4) ID FREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
H 406	Continued From pa	ge 10	*	H 406		a =
H 411	January 30, 2012 to 2012, at approxima patient was to rece seven (7) days a witimes times six (6) (HHA #1) was to as bathing, grooming, bed linen and meal. There was no evide the patient was nor daily living (ADL).  3915.11(f) HOME HAIDE SERVICE.  Home health aide of following:  (f) Observing, reco.	this plan of care (POro July 30, 2012, on Jately 11:20 a.m., reveive home health care eek for eight hours a months. Home health sist Patient #1 with horal care, toileting, of preparation.  The patient with active HEALTH & PERSON duties may include the right and reporting to notition, behavior, or	uly 11, aled the e services a day h aide #1 hygiene, hanging record that itles of  AL CARE e	H411	The Provider acknowledge interpretation of the eventhis report but based on the and testimonies of the stathold final judgment based statements provided by the agency does not support to presented.	ts that triggered ne documentation ff respectfully with on the fact that the e staff to the
	Based on a record determined that the health aides (HHAs the patient's physic appearance for one investigation. (Patient Funding include Review of Patient Funding 30, 2012 to		, it was sure home rted on r or nt in the C) dated uly 11,	# 0 10 10 10 10 10 10 10 10 10 10 10 10 1	<ul> <li>Discipline specific of management train staff by 10/31/12.</li> <li>Retraining of the p documenting an error to all staff by 10/31.</li> <li>100% audit all PCA 10/31/12</li> </ul>	emergency ing for 100% of the rocess of mergent situation 1/12.

Health Re	egulation & Licensin	g Administration				<del>i</del>
STATEMENT	OF DEFICIENCIES I CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		110 4 0007		B WING		07/25/2012
		HCA-0027	STREET AND	PESS CITY S	TATE, ZIP CODE	01/20/20/2
NVWE OF BE	ROVIDER OR SUPPLIER				JE, NW, SUITE 323	
PREMIER	HEALTH SERVICES	S, INC		TON, DC 20	012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
H411	seven (7) days a was six (6) months. Rev	ive home health care eek for eight hours a view of Patient #1's ti	day for me	H 411		
•	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.			1		
	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 412	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  The Provider acknowledges the surveyor interpretation of the events that triggere this report but based on the documental and testimonies of the staff respectfully hold final judgment based on the fact the				ts that triggered ne documentation ff respectfully with on the fact that the	
	This Statute is not Based on record to	sistance with eating; t met as evidenced b eview and interview, o provide meal prepa	y: the home		statements provided by the agency does not support to presented.	he allegations
1	accordance with d	ietary guidelines for o	one (1) of	,		

Health R	egulation & Licensin	a Administration	A CONTRACTOR OF THE WAY I PROTECT OF THE PARTY.				FORM APPROVED
STATEMEN AND PLAN (	The state of the s		STREET ADI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  T ADDRESS, CITY, STATE, ZIP CODE		E	(X3) DATE SURVEY COMPLETED C 07/25/2012
				RGIA AVENI ITON, DC 20	UE, NW, SUI 012	TE 323	
(X4) ID PRETIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORREC' CORRECTIVE ACTION SHO EFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE.	
H 412	During a telephone aide #1 (HHA #1) or approximately 5:50 Patient #1 was not owned would instruct HHA prepare for breakfarevealed Patient #1 scrambled eggs wit for breakfast, hotdowings or packaged  During a telephone (Skilled Nurse #1) or approximately 6:15 Patient #1 was not or dietary restrictions.  Review of Patient # January 30, 2012 to 2012, at approximately 6:15 Patient #1 with mea POC revealed orders sodium restrictions, and no concentrate  For example on Ju 10:15 a.m., review of dated July 4, 2012, going to the hospital	e investigation. (Patis: interview with home n July 10, 2012, at p.m., it was revealed on a specific diet. Pa #1 daily on the type st. lunch and dinner, would often request h cheese and pork s gs for lunch, and frie stir fry meals for dinr interview with skilled on July 10, 2012, at p.m., it was revealed on a specific diet and 1's plan of care (POG o July 30, 2012, on Ju tely 2:20 p.m., revea 1 (HHA #1) was to as all preparation. Patien rs for a specific diet no added salt, low s	health  that tient #1 of food to HHA #1 ausage d chicken ner.  nurse #1 d that d had no  C) dated uly 11, led that ssist t #1's with codium  eximately Report ent #1 evealed	H 412	Plan- T	arget completion da 100% Retraining of and documentation 8/31/12 (See Add 12 and 13) 100 % Training on Elderly for all PCA Addendum 8,9 10 100% training on all Elderly for all PCA Addendum 8,9 10 100% training on all Managers on the call	on Food handling on for all PCA by endum 8,9 10 11,  Nutrition in the by 8/31/12. (See 11, 12 and 13) Dehydration in the by 8/31/12. (See 11, 12 and 13) II PCA, RN and Case are need ne Diabetic Patient of the PCA on
	cup of ice for lunch.			8			

Health Re	egulation & Licensin	g Administration		т		·
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIP A BUILDING B WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/25/2012	
		HCA-0027		DEGG OITY E	TATE, ZIP CODE	0112012012
NAME OF PE	ROVIDER OR SUPPLIER					
PREMIER	HEALTH SERVICES	s, INC	WASHING	TON, DC 20		700
(X4) ID PREFIX TAG	ACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
H 412	Continued From pa	ige 13		H 412		
	Department (DCFE allegedly admitted dehydration and en	MS) to a local hospit with diagnoses that in naciation.]	al and noluded	が 報 報 数 数 数 数 数 数 数 の の の の の の の の の の の		•
H 452	3917 2(b) SKILLED NURSING SERVICES  Duties of the nurse shall include, at a minimum, the following:			H 452	The Provider acknowledge	500
					tag with the following plan of correction:  Plan- Target completion date 9/15/12	
	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:			of the Supervisory and the document 9/15/12 (See Add) Retraining of the I Manager on the comprocess and its document 9/15/12 (See Add) Revised the Mont notes (See Adden) Retraining of the I Manager on care development, imp	tation of it by endum 15) RN and Case are coordination cumentation by endum 15) hly RN Supervisory dum 16) RN and Case strategies blementation and or patients with reatitis with weight	
	February 28, 2012, "generalized weakness, multiple toose stools".					

Health Re	egulation & Licensir	a Administration		<del></del>		Total T		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIF IDENTIFICATION NU  HCA-0027			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  C  07/25/2012			
MANE OF PE	ROVIDER OR SUPPLIER	L	STREET ADD	RESS, CITY, S	STATE, ZIP CODE			
7600 0				ORGIA AVENUE, NW, SUITE 323 GTON, DC 20012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FO REGULATORY OR LSC IDENTIFYING INFORMATI		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE		
H 452	Continued From pa	nge 14	e.	H 452				
	<ol> <li>March 26, 2012, "generalized weakness. (loose stools) due to pancreatitis".</li> <li>May 24, 2012, "wt" [ weight loss].</li> <li>June 22, 2012, " weakness secondary [to] pancreatitis".</li> </ol>							
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 453	Duties of the nurse	O NURSING SERVIC shall include, at a m		H 453	The Provider acknowledges and accepts this tag with exception that the nursing notes for the months of February (See Addendum 17)			
	(c) Ensuring that p accordance with th	ne following:  b) Ensuring that patient needs are met in ccordance with the plan of care;  this Statute is not met as evidenced by:			and March (See Addendum twice for this surveyor's rev be presented as addendum	18) were provided iew and will again		
I.	This Statute is no	t met as evidenced b	у.					

Health Requiation & Licensing Administration  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIED IDENTIFICATION  HCA-0027		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	X/CLIA (X2) MULTIPLE CONSTRUCTION  A BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 07/25/2012			
PREMIER HEALTH SERVICES, INC  SUMMARY STATEMENT OF DEFICIENCIES  [X4110] SUMMARY STATEMENT OF DEFICIENCIES			7600 GEO WASHING	TULL FREIN an DEFENCIOED TO THE APPROPRIAL					
TAG	Continued From p Based on interview Care Agency's (He that patient needs the plan of care (F patient in the inver- The findings inclu- Review of Patient January 30, 2012 2012, at approxim skilled nurse was and evaluation of CP/CV status, as status, assess cli- medication on ea- months.  1 Review of Nurs 24, 2012, at appro- documented skille February and Ma 2. Review of Patient Monthly Visit Not 2012, on July 24, p.m., revealed no skilled assessment assessment of vi- status, assessment assessment of in assessments of or medication.  During a telepho Nursing (DON), 1:47 p.m., it was re-check Patient if the skilled nurse if the skilled nurse	wand record review, CAs) nurse failed to were met in accordance (PC) for one (1) of or stigation. (Patient #1) de:  #1's plan of care (PC) to July 30, 2012, on a nately 2:34 p.m., revento perform a skilled a systems, assess vital sess hydration and nurse inical status and response to visit monthly, for sessing Monthly Visit Not oximately 2:43 p.m., red nurse visits for the	the Home ensure nce with he (1)  OC) dated July 24, aled the issessment I signs, utrition onse to ix (6)  es on July revealed no months of May 24, ely 2:48 de of systems, t of CP/CV nagement, status, ponse to  Director of oppoximately by would to ascertain s of	H 453	the notes for April 25 (Ad 24 (Addendum 20) and Jul Addendum 21) all of which mental status, and assessing limitations as the episode supervision. The following will be implemented to accept the agency's document Personal Care Assistated documentation will be a more comprehensive to work in conjunction PCA monitoring tool by 8/24/12 (See additional and see a supervision of the agency's document to work in conjunction pCA monitoring tool by 8/24/12 (See additional and see additional and see a supervision of the see additional and see a supervisi	Idendum 19), May y 24, 2012(See th has the vital sign, ment of functional is opened for PCA g plan of correction Idress the deficits: Late 8/30/12 Intation policy for int supervision y revised to include we assessment tool in with the current until further notice endum 16) Il be retrained on the			

Health Re	egulation & Licensin	g Administration		- p			Γ			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/25/2012				
		HCA-0027			. 074	7F 7ID 000F	UTIZOTZ			
NAME OF PE	ROVIDER OR SUPPLIER			DORESS, CITY, STATE, ZIP CODE						
PREMIER	HEALTH SERVICES	S, INC	7600 GEO WASHING	600 GEORGIA AVENUE, NW, SUITE 323 VASHINGTON, DC 20012						
(X4) 1D PREFIX TAG	(I-ACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE			
H 453	Continued From pa	ige 16	ay.	H 453						
	record. At the time no evidence that the assessments had to	of the investigation, t e aforementioned been conducted.	here was		1 21 34		90			
⊞ 456	3917.2(f) SKILLED NURSING SERVICES			H 456	•	The Provider acknowledges and accepts this tag with the following plan of correction:				
	Duties of the nurse shall include, at a minimum, the following:					000 02				
	the following:  (f) Supervision of shealth and persons support staff, as approximately a support staff, as approximately a support staff, as approximately a supervision of servaides (HHAs) as a (1) patients in the supervision of servaides (HHAs) as a (1) patients in the supervision of servaides (HHAs) as a (2) patients in the supervision of Patients and Supervision (SN) six (6) months to inhealth aide (HHA) health issues, fall transmission and support supervision of supervision and supervision of supervision of supervision and supervision of supervision and supervision of supervision of supervision and supervision and supervision and supervision and supervision and supervision of supervision and supervision and supervision and supervision of supervision of supervision of supervision and supervision of sup	c: t was ye ne health ) of one  C) dated uly 11, aled the onth for the home andle stion		a company of the second company	<ul> <li>Retraining of the RN of the Supervisory N and the documenta 8/30/12</li> <li>Retraining of the RN Manager on the PC process and its doct 8/30/12.</li> <li>Retraining of the RN Manager on care st development, imple documentation for Diabetes and Pancr by 8/30/12. (See Acceptable)</li> </ul>	I on the elements Monitoring Visit tion of it by I and Case A supervision umentation by I and Case rategies ementation and patients with eatitis with weight				
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:

Health Re	egulation & Licensin	g Administration		<del></del>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Land History		
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A BUILDING  B WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		8 14				07/25/2012			
NAME OF PR	OVIDER OR SUPPLIER	1	STREET ADD						
7			7600 GEO WASHING	0 GEORGIA AVENUE, NW, SUITE 323 SHINGTON, DC 20012					
(X4) ID PRELIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE			
	<ol> <li>Continued From page 17</li> <li>February 28, 2012, "generalized weakness, multiple loose stools. Personal Care Aide (PCA) is able to assist by providing timely reminders".</li> <li>March 26, 2012, "generalized weakness, (loose stools) due to pancreatic. PCA instructed to remind client couple of hours prior to appointments".</li> <li>May 24, 2012, "wt [weight loss]. Instructed PCA on ongoing reminders of appointments".</li> <li>June 22, 2012, "weakness secondary [to] pancreatitis. Instructed PCA on providing reminders of MD (doctors) appointments".</li> <li>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 HI-IAs, however there was no documented</li> </ol>			H 456	Company of the compan				
H 459	evidence of such.  3917.2(i) SKILLED NURSING SERVICES  Duties of the nurse shall include, at a minimum, the following:  (i) Patient instruction, and evaluation of patient instruction; and			Н 459	0	The Provider acknowledge tag with the following plan Plan-Target completion d  Revise the docum teaching procedures	of correction:  ate 8/30/12  entation of patient		
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)									

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.

HCA-0027

(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING

(X3) DATE SURVEY COMPLETED

> 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

7X4) ID PRECIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

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 not 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)

PRINTED: 08/08/2012 FORM APPROVED

Health F	Regulation & Licensin	ig Administration						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		HCA-0027		B, WING		.   0	7/25/2012	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE			
			DRGIA AVENUE, NW, SUITE 323 STON, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	OTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
H 459	59 Continued From page 19			H 459				
		ation, revealed no do if the aforementioned is were performed.						
	Notes dated April 2 approximately 11:53	t # 1's Nursing Month 5, 2012, on July 24, 2 3 a.m., revealed unde	2012, at : er 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.					÷		
							g K	
			:				î	
		Đ						
			1					
				as .				
			•		ii			
							1	

6899