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-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 000	INITIAL COMMENTS An annual licensure survey was conducted 02/15/2023, 02/16/2023, 02/17/2023, and 02/21/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 21 patients and employed 11 staff. The findings of the survey were based on the review of administrative records, 6 active patient records, four discharged patient records, 11 personnel records, and a review of the agency's response to complaints and incidents received. The survey findings were also based on the completion of two patients ' phone interviews. Listed below are abbreviations used throughout this report: CEO - Chief Executive Officer DON- Director of Nursing HCA - Home Care Agency IADL- Instrumental Activities of Daily Living IV - Intravenous MCG - Microgram PCA - Personal Care Aide POC - Plan of Care PPD - Purified Protein Derivative	H 000		

Tracy Bayer — Director of Compliance — 3/31/23

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 000	Continued From page 1 RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care	H 000		
H 011	3900.5 GENERAL PROVISIONS Each home care agency serving one or more patients in the District of Columbia shall maintain an operating office within the District of Columbia. This office shall be staffed, at a minimum, eight hours per day, Monday through Friday. This Statute is not met as evidenced by: Based on observation and interview, the home care agency (HCA) failed to ensure that the operating office was staffed eight hours per day, Monday through Friday. Findings included: Upon arrival to the agency's operating office on 02/15/2023 at 9:30 AM, for an unannounced annual licensure survey, it was determined the agency was not open for business. Per interview with the building receptionist, it was determined that the home care agency was not open. The agency's Director of Pharmacy answered via telephone on behalf of the agency administrator. The survey team was informed the administrator was on travel and would not be available. An agency staff person, Documentation Specialist, arrived to open the office at 10:58 AM so that the survey could be initiated. The home care agency failed to staff the operating office as per regulatory requirements.	H 011	1.An investigation was initiated to identify the causative factors of the office closure. 2. Employee who was not at facility was contacted by her supervisor to confirm business hours and the employee's responsibilities for maintaining business hours. 3. The Executive Administrator calls the DC office daily to confirm operations are open and staffed by the designated employee.	2/15/23 2/15/23 3/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 147	3907.2(c) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (c) Resume of education, training certificates, skills checklist, and prior employment, and evidence of attendance at orientation and in-service training, workshops or seminars; This Statute is not met as evidenced by: Based on record review and interview the home care agency (HCA) failed to maintain accurate personnel records to include employee's participation in orientation for two of eleven sampled employees (Clinical Managers #2 and #3). Findings included: A review of personnel records on 02/15/2023 at 11:27 AM, revealed the following: The agency's Clinical Managers #2 and #3's personnel files included dates of hire of 03/21/ 2022 and 02/21/2022 respectively, with no documented evidence that the employees participated in the home care agency's orientation. The home care agency's Director of Quality and Compliance provided documentation via email of participation in orientation for Clinical Managers #2 and #3, three to four months post hire, on 06/25/2022. During an interview with the director of nursing (DON) on 02/21/2023 at 1:17 PM, she was asked regarding the date that the Clinical Managers #2	H 147	1. Orientation checklists completed for Clinical Managers #2 and #3. **3/31/23** 2.Orientation checklists are implemented to include evidence of job specific orientation and training during the onboarding process. This checklist requires co-signatures of the department manager and HR director to confirm that all orientation items on the checklist were completed and documented in the employee file before the employee is permitted to work independently. **3/31/23** 3.HR Director will verify compliance by auditing new hire employee files monthly and verifying that all orientation items are completed and documented. Audit results to reported Leadership and P.I. Committee quarterly. **5/1/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 147	Continued From page 3 and 3 started providing services. She commented "I checked their files for documentation, as these dates would have occurred prior to me starting (05/03/2022), I am unable to locate any documentation for this time period." At the time of the survey, the home care agency failed to ensure that two new employees (Clinical Managers #2 and 3) participated in orientation proximal to hire and prior to providing services.	H 147		
H 150	3907.2(f) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (f) Verification of previous employment; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to maintain accurate personnel records to include verification of previous employment for two of eleven employee files sampled (Clinical Managers #2 and #3). Findings included: A review of personnel records on 02/15/2023 at 11:27 AM revealed the following: The personnel files for Clinical Managers #2 and #3's revealed dates of hire of 03/21/ 2022 and 02/21/2022 respectively, however, there was no documented evidence of verification of previous employment. The findings were confirmed with the Director of	H 150	**1.**Verification of previous employment was completed for Clinical Managers #2 and #3 and documented in the employee file. **3/31/23** 2.A pre-employment checklist was implemented and includes verification of previous employment as a requirement. The HR Director will review potential employee applications/resumes to verify and document previous employment provided **3/31/23** **3.** HR Director will verify compliance by auditing new-hire employee files monthly for written documentation of previous employment. Audit results to reported Leadership and P.I. Committee quarterly. **5/1/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 150	Continued From page 4 Quality and Compliance.	H 150		
H 151	3907.2(g) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (g) Documentation of reference checks; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to maintain accurate personnel records to include documentation of reference checks for two of eleven personnel files included in the sample (Clinical Managers #2 and #3). Findings included: A review of personnel records on 02/15/2023 at 11:27 AM revealed the following: The personnel files for Clinical Managers #2 and #3's revealed dates of hire of 03/21/ 2022 and 02/21/2022 respectively, however, there was no documented evidence of reference checks for either employee. The findings were confirmed by the Director of Quality and Compliance.	H 151	**1**. Reference checks were completed for Clinical Managers #2 and #3 and documented in the employee file. **2**. A pre-employment checklist was implemented and includes reference checks as a requirement. The HR Director will will complete and document reference checks during the pre-employment process. **3.** HR Director will verify compliance by auditing new-hire employee files monthly for written documentation of reference checks. Audit results to reported Leadership and P.I. Committee quarterly.	**3/31/23** **3/31/23** **5/31/23**
H 162	3907.6 PERSONNEL At the time of initial employment of each employee, the home care agency shall verify that the employee, within the six months immediately preceding the date of hire, has been screened for	H 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 162	Continued From page 5 and is free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that each employee was free of communicable disease within the six months immediately preceding date of hire for two of eleven employee files sampled. (Human Resource Manager and Director of Nursing). Findings included: A review of personnel files on 02/15/2023 at 11:27 AM revealed the following: 1. The personnel file for the Human Resources Manager included a hire date of 02/13/2023. Further review of her personnel file showed that the agency provided a document, allowing the employee the option to select the choice of a declination for tuberculosis screening. 2. The personnel file for the director of nursing (DON) included a hire date of 05/03/2022. Further review of her personnel file showed that she had a purified protein derivative (PPD) dated 05/02/2022, administered by an individual, without evidence of title or professional discipline and subsequent PPD reading performed by individual without evidence of title or professional discipline. At the time of the survey, the home care agency failed to ensure that all employees were screened and verified free of communicable disease within the six months immediately preceding the employee's date of hire.	H 162	1.HR Director completed TB screening. 2.The TB Testing form was revised and the option for declination removed. 3. TB Testing was added to the Pre-Employment checklist. 4.HR Director will verify compliance by auditing employee files monthly for PPD testing completed within 6 months of date of hire. Proof of testing will be kept in the employee confidential medical file. Audit results will be reported to Leadership and the PI Committee quarterly. 5. The TB Prevention policy was revised stating that TB testing is required for all new employees within six months of date of hire. 6.Nation's Director of Compliance contacted Concentra Medical, our employee health provider to verify PPD results provided for the Director of Nursing. The names, titles, and professional disciplines were verified.	3/20/23 3/21/23 3/31/23 5/1/23 3/21/23 3/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 227	Continued From page 6	H 227		
H 227	3909.2 DISCHARGES TRANSFERS & REFERRALS Each patient shall receive written notice of discharge or referral no less than seven (7) calendar days prior to the action. The seven (7) day written notice shall not be required, and oral notice may be given at any time, if the transfer, referral or discharge is the result of: This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each patient received written or oral notice of discharge prior to the action for four of four discharged patients. (Patients #8, 9, 10, and #11). The findings include... Review of the home care agency's (HCA's) clinical records beginning 02/15/2023 through 02/21/2023 showed that the agency provided intravenous therapy services to its patients but failed to ensure that the registered nurses (RNs) reviewed discharge instructions for Patients #8, 9, 10, and #11. Further review of the clinical records revealed discharge summaries with the following statements: "Discharge instructions reviewed with client: No." There was no documented evidence in the records that the patients received written or verbal notices prior to discharge.	H 227	1. Patient #8 was d/c'd due to hospital admission,#9 was provided discharge info by nursing agency, d/c information for patient #10,#11 on file. Discharge Patient Lists has patients as. #7,8,9,10. 2.The DON is implementing the practice that during every initial nursing assessment and 62-day summary assessment, the the anticipated discharge date and discharge plans discussed with the patient/caregiver will be documented. Patients who are discharged for medical emergency, hospitalization, safety of agency staff, physician determination that the condition that necessitated the service no longer exists and patient refusal of service will be documented in the patient progress note 3.To ensure compliance, 100% of discharged DC nursing patient records will be audited monthly by the DON or designee and results reported to Leadership and the Performance Improvement Committee quarterly.	3/31/23 5/1/23 5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 227	Continued From page 7 On 02/21/2023 at 01:48 PM, the director of nursing (DON) and the Administrator were informed of the findings. At the time of survey, the home care agency failed to ensure that Patients #8, 9, 10, and #11 received written or verbal notices of discharge prior to the action.	H 227		
H 350	3914.1 PATIENT PLAN OF CARE Each home care agency shall develop, with the participation of each patient or his or her representative, a written plan of care for that patient. This Statute is not met as evidenced by: Based on record review and staff interview, the home care agency (HCA) failed to develop a written plan of care (POC) for three of six active clients in the sample (Patients #2, 3, and #6). Findings included: 1. On 02/16/2023 at 11:30 AM, review of Patient #2's record showed a plan of care (POC) with a duration period of 01/20/2023 through 04/20/2023. Further review of clinical records revealed that the skilled nurse (SN) visited the patient on 09/07/2022, 09/08/2022, 09/09/2022, 09/10/2022, 09/11/2022, 09/12/2022, 09/13/2022, 09/14/2022, 09/15/2022, and 09/16/2022 for intravenous therapy. However, the clinical record lacked documented evidence of a plan of care for duration documented above. 2. On 02/16/2023 at 11:00 AM, review of Patient #3's record showed a plan of care (POC) with a duration period of 01/22/2023 through	H 350	1. Patient #2 is no longer on service. Updated Plan of Cares were developed and submitted to physician with the Plan of Treatment for patients #3 and #6 2.The DON/Intake Department will print and attach the POC each time it is updated and assign to the patient medical record to ensure that the entire POC history is documented. 3. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify a POC is on file for all dates of service. Results will be reported to Leadership and the Performance Improvement Committee quarterly.	3/31/23 3/31/23 5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 350	Continued From page 8 04/21/2023. Further review of clinical records revealed that the skilled nurse (SN) visited the patient from 04/22/2022 through 01/20/2023 for intravenous therapy. However, the clinical record lacked documented evidence of a plan of care for duration documented above. 3. On 02/16/2023 at 12:00 PM, review of Patient #6's record showed a plan of care (POC) with a duration period of 12/20/2022 through 03/20/2023. Further review of clinical records revealed that the skilled nurse (SN) visited the patient from 11/01/2022 through 02/07/2023 for intravenous therapy. However, clinical record for Patient #6 lacked documented evidence of a plan of care for duration documented above. On 02/16/2023, the Director of Nursing was made aware of the findings. She stated, "we sent you what we could find. We have done lot of catching up starting in November of 2022, and we cannot find some records." At the time of survey, the agency failed to develop a written plans of care (POC) for Patients #2, 3, and #6.	H 350		
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;	H 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 355	Continued From page 9 This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each patient's plan of care included a description of the services to be provided, including frequency, amount, and duration of services for six of six active clients in the sample (Patients #1, 2, 3, 4, 5, and #6). Findings included: Review of the home care agency's clinical records beginning 02/15/2023 through 02/21/2023 showed that the agency provided intravenous therapy services to its patients but failed to ensure that the plans of care (POC) for Patients #1, 2, 3, 4, 5, and #6 included a description of the services to be provided, E.g., the frequency, amount, and duration. The agency's plans of care and treatments did not include orders for the registered nurse (RN) visits. On 12/08/2021 at 3:30 PM, the director of nursing (DON) was informed of the findings. At the time of the survey, the home care agency failed to ensure that the plans of care for Patients #1, 2, 3, 4, 5, and #6 contained orders for the registered nurse (RN) visits. This is a repeat deficiency from last survey 07/26/2021.	H 355	3914.3(d) continued 1. Patient's #1 and #2 discharged from service. Active POC's were updated to include frequency, amount and expected duration of therapy for patients #3,4,5,and 6.	3/31/23
			2. The Plan of Care templates were updated to include frequency, amount and expected duration of therapy.	3/31/23
			3. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify Emergency Protocols are documented in the Plan of Care. Results will be reported to Leadership and the Performance Improvement Committee quarterly	5/1/23
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and...	H 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 364	Continued From page 10 This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to include emergency protocols specific to patient's diagnoses and treatment in the Plan of Care (POC) for six of six active patients included in the sample (Patients #1, 2, 3, 4, 5, and #6). Findings included: Review of the agency's clinical records and interview beginning on 02/15/2023 through 02/21/2023 revealed that the home care agency provided infusion therapy to each of the sampled patients. Continued review of the plans of care (POCs) failed to include evidence of emergency protocols (parameters) related to not only the patients' specific diagnoses but also the prescribed infusion treatments. On 02/16/2023 at 02:58 PM, interview with the director of nursing revealed that the agency had no "established parameters for vital signs." At the time of survey, the home care agency failed to ensure that patient's plans of care included emergency protocols to ensure safety during infusion treatment and to properly manage the patient's diagnoses for Patients #1, 2, 3, 4, 5, and #6.	H 364	3914.3(m) continued 1. Patient's #1 and #2 discharged from service. Active POC's were update to include emergency protocols (parameters) as referenced in the on going assessment policy IDM-5, section II for patients #3,4,5,and 6. **3/31/23** 2. The Plan of Care templates were updated to include emergency protocols that are based on vital sign parameters referenced in the on-going assessment policy IDM-5, section II. **3/31/23** 3. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify Emergency Protocols are documented in the Plan of Care. Results will be reported to Leadership and the Performance Improvement Committee quarterly **5/1/23**	
H 366	3914.4 PATIENT PLAN OF CARE Each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care; provided, however, that a plan of care for personal care aide services only may be	H 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 366	Continued From page 11 approved and signed by an advanced practice registered nurse. If a plan of care is initiated or revised by a telephone order, the telephone order shall be immediately reduced to writing, and it shall be signed by the physician within thirty (30) days. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each patient's plan of care (POC) was approved and signed by a physician and/or designee, within 30 days of the start of care (SOC) for five of six active patients in the sample (Patients #1, 2, 3, 4, and #6). Findings included: Review of the home care agency's (HCA's) clinical records beginning 02/15/2023 through 02/21/2023 showed that the agency failed to ensure that the plans of care (POC) for Patients #1, 2, 3, 4, and #6 were reviewed and signed by a physician and/or designee as of the date of this survey, greater than 30 days of the start of care (SOC). On 02/21/2023 at 01:48 PM, the director of nursing (DON) and administrator were informed of the findings. At the time of survey, the home care agency failed to ensure that the POCs for Patients 1, 2, 3, 4, and #6 were signed within 30 days of the start of care (SOC).	H 366	3914.4 continued 1.Patients #1 & 2 are no longer on service. Updated Plan of Care /Plan of Treatments were developed and submitted to the to physician for signature for patients #3,#4 and #6. **3/31/23** 2.The DON/Intake Department will send the Plan of Care with the POT to the physician for signature. Document return will be tracked for physician signature within 30 days of start of care by the Document Specialist. Document tracking will be documented in the patient progress notes. **3/31/23** 3. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify that a POC/POT is signed by the physician within 30 days and is on file in the medical record. Results will be reported to Leadership and the Performance Improvement Committee quarterly. **5/1/23**	
H 451	3917.2(a) SKILLED NURSING SERVICES	H 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 451	Continued From page 12 Duties of the nurse shall include, at a minimum, the following: (a) Initial assessment and evaluation; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the skilled nurse (SN) conducted the required initial assessment for two of six active patients in the sample (Patients #1 and #3). Findings included: The agency's admission policy titled, "Nursing Admission Visit", dated 06/30/2016 read the following: "D. Vital Signs: 5. Mandatory for all admissions, including height/weight. 6. Complete for full physical assessment. This assessment is the basis for on-going patient needs...B. The physical assessment of the patient is one of the most important functions a nurse performs. The results of the initial assessment develop the baseline for the patients care and plan of treatment. On-going assessment ' s chart the patient ' s response to treatment and provides a relational data base by synthesizing bits of information into a total picture of a patient..." 1. On 02/15/2023 at 02:38 PM, review of Patient #1's clinical record showed plans of care (POC) with duration periods of 11/11/2022 through 02/09/2023 and 02/10/2023 through 05/10/2023 with a start of care (SOC) date of 11/11/2022, for skilled nursing (SN) visits once every seven days to infuse intravenous (IV) Blyncito (cancer therapy) and perform weekly blood work as ordered. The patient's diagnoses included acute lymphoblastic leukemia, anxiety, and left breast	H 451	3917.2(a) 1.The DON will conduct in-service training for all nursing staff. The training will include following the Plan of Care as ordered by the physician for completing initial and follow-up assessments, completing assessments to include complete vital signs every visit. Any nursing visits completed without documentation will be subject to disciplinary action and required to repeat the visit for documentation of complete assessment. 2. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify the nursing assessments are documented in the patient record as ordered by the physician and assessments are complete with vital signs. Results will be reported to Leadership and the Performance Improvement Committee quarterly.	5/1/23 5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 451	Continued From page 13 cancer status post lumpectomy. Continued review showed a "late entry progress note" dated 11/12/2022 for "hospital hook up 11/11/2022" from the registered nurse (RN) indicating that the patient "successfully connected to Blyncito... Currently no rigors but patient encouraged to call if rigors occur. Reviewed pump functions and potential issues that may develop. Encouraged to call agency. Tolerated hookup well." In addition, there was no evidence of a documented full set of vital signs except the temperature. Interview with the director of nursing (DON) on 02/15/2023 at 03:22 PM revealed that the "patient was initially seen in 07/18/2022 and put on hold on 07/28/2022." Further review of the clinical records lacked documented evidence of a skilled nurse initial (comprehensive) or resumption of care assessment. 2. The surveyor reviewed the clinical record for Patient #3 on 02/16/2023 at 11:00 AM. The patient ' s diagnoses included Chest pain, Shortness of breath, Chronic heart failure with cardiomyopathy, and chronic kidney disease stage three. The agency provided Skilled Nursing, (SN) for Intravenous Treatment, visits dated 04/22/2022 through 01/20/2023, and a Plan of Care, (POC), and Plan of Treatment (POT) duration of 01/22/2023 through 04/21/2023 start of care 04/21/2022, showing Skilled Nursing visits one to two times a week. Further review of the clinical record lacked documented evidence of a completed assessment on the patient's first SN visit, dated 04/22/2022. On 02/21/2023 at 01:48 PM, the director of nursing (DON) and Administrator were informed	H 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 451	Continued From page 14 of the findings. At the time of the survey, the home care agency failed to ensure that the registered nurse completed an accurate initial assessment to include vital signs enabling the clinical staff to identify any variances in the patient's condition that would warrant attention.	H 451		
H 490	3920.1 INTRAVENOUS THERAPY SERVICES If intravenous therapy services are provided, they shall be provided in accordance with the patient's plan of care and administered by a registered nurse or licensed practical nurse who shall have training or experience in intravenous therapy. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure intravenous therapy services were provided in accordance with the patient's plan of care (POC) for three of six active patients in the sample (Patients #1, 2, and #4). Findings included: 1.On 02/15/2023 at 02:38 PM, review of Patient #1's clinical record showed plans of care (POCs) with duration periods of 11/11/2022 through 02/09/2023 and 02/10/2023 through 05/10/2023 for skilled nursing (SN) visits once every seven days to infuse intravenous (IV) Blyncito and perform weekly blood work as ordered. The patient's diagnoses included acute lymphoblastic leukemia, anxiety, and left breast cancer status post lumpectomy. Continued review of the clinical record lacked evidence that the SN visited Patient	H 490	1.The DON will conduct in-service training for all nursing staff. The training will include following the Plan of Care as ordered by the physician for completing initial and follow-up assessments, completing assessments to include complete vital signs every visit. Any nursing visits completed without documentation will be subject to disciplinary action and required to repeat the visit for documentation of complete assessment. **5/1/23** 2. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify the nursing assessments are documented in the patient record as ordered by the physician and assessments are complete with vital signs. Results will be reported to the Improvement Committee quarterly. **5/1/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 490	Continued From page 15 #1 as ordered during the treatment weeks of 12/16/2022, 1/08/2023, 01/23/2023, and 01/30/2023. 2. On 02/15/2023 at 01:38 PM, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 01/20/2023 through 04/20/2023 for skilled nursing (SN) visits one time a week for each infusion, to obtain vital signs and assess/obtain per established order, for each infusion, and [the] registered nurse (RN) will stay with patient throughout Cytarabine Infusion. Additionally, the physician's order dated 09/06/2022 read, "Administer 1 dose via slow IV (Intravenous), push over at least 3-5 minutes once per day via port on the following dates: 9/7, 9/8, 9/9, then 9/14, 9/15, 9/16 [2022]." The patient ' s diagnosis included Acute Lymphoblastic Leukemia. Skilled Nurse documentation showed home visits occurred with vital signs of temperature and weight only, on 09/07/2022, 09/09/2022, 09/14/2022, and 09/16/2022. There was no documented evidence of Skilled Nurse visits on 09/08/2022 and 09/15/2022. 3. On 2/16/2023 at 01:21PM PM, review of Patient #4's clinical record showed a plan of care (POC) with a duration period of 01/20/2023 through 04/20/2023 for skilled nursing (SN) visits once every six weeks to infuse Remicade (autoimmune treatment)100mg intravenous over two hours as of 11/09/2021. The patient's diagnosis included Crohn's disease. Continued review of the clinical record lacked evidence that the Skilled Nurse visited Patient #4 as ordered during the treatment week of 12/25/2021. On 02/16/2023 at 02:58 PM, the director of nursing (DON) acknowledged the missed visit.	H 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 490	Continued From page 16 She stated the following: "The medication went out, but I could not verify that the patient received the infusion because there is no nurse's documentation." At the time of the survey, the home care agency failed to ensure that skilled nursing services were provided in accordance with the patient's POC for Patients #1, 2, and #4.	H 490		
H 493	3920.2(c) INTRAVENOUS THERAPY SERVICES The intravenous therapy service plan shall include, at a minimum, the following: (c) Type and frequency of laboratory tests to be monitored; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each patient's intravenous service plan included a type and frequency of laboratory tests to be monitored for six of six active clients in the sample (Patients #1, 2, 3, 4, 5, and #6). Findings include... Review of the home care agency's clinical records beginning 02/15/2023 through 02/21/2023 showed that the agency provided intravenous therapy services to its patients but failed to ensure that the plans of care (POC) for Patients #1, 2, 3, 4, 5, and #6 included a type and frequency of laboratory tests to be monitored. On 02/21/2023 at 01:48 PM, the director of nursing (DON) and the Administrator were	H 493	1.Patient's #1 and #2 no longer on service. Active POC's were updated to include type and frequency of laboratory tests to be monitored for patients #3,4,5,and 6 2. The Plan of Care templates were updated to include type and frequency of laboratory tests to be monitored. 3.To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify type and frequency of laboratory tests to be monitored are documented in the Plan of Care. Results will be reported to Leadership and the Performance Improvement Committee quarterly.	**3/31/23** **3/31/23** **5/1/23**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 493	Continued From page 17 informed of the findings. At the time of survey, the home care agency failed to ensure that laboratory orders were included in the patient's intravenous service plan.	H 493		
H 497	3920.3(b) INTRAVENOUS THERAPY SERVICES Each clinical record shall include, at a minimum, the following information related to intravenous therapy: (b) A copy of the consent form for intravenous therapy executed by the provider of the intravenous therapy product, or a copy of the consent form for intravenous therapy executed by the home care agency, including risks, benefits and alternatives; This Statute is not met as evidenced by: Based on record review and interview, the home care agency's (HCA's) clinical records lacked evidence of consent forms, inclusive of risks, benefits and alternatives, authorizing the administration of intravenous therapy for six of six active clients in the sample (Patients #1, 2, 3, 4, 5, and #6). Findings included: 1. On 02/15/2023 at 02:38 PM, review of Patient #1's clinical record showed plans of care (POCs) with duration periods of 11/11/2022 through 02/09/2023 and 02/10/2023 through 05/10/2023 and a start of care (SOC) date of 11/11/2022. The POC included a physician's order for skilled	H 497	1.Patient #1 and #2 no longer on service. Signed written consent obtained for patient's #3 ,4,5 and 6. **3/31/23** 2.The responsibility of obtaining consent is reassigned from the Intake Dept to the Nursing Department. The RN will obtain written consent to treat on the initial visit prior to therapy. **3/31/23** 3.Nation's has initiated adding an electronic signature module to the EMR to expedite placement of signed patient documents to the EMR. **7/1/23** 4.To verify compliance,100% of active DC patients will be audited monthly to ensure a signed patient consent is on file.Results will be reported to Leadership Quarterly. **5/1/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 497	Continued From page 18 nursing (SN) visits once every seven days to infuse intravenous (IV) Blyncito and perform weekly blood work as ordered. The patient's diagnoses included acute lymphoblastic leukemia, anxiety, and left breast cancer status post lumpectomy. Continued review of the clinical record lacked documented evidence of a consent form authorizing the administration of intravenous therapy, including risks, benefits, and alternatives. 2. The surveyor reviewed the clinical record for Patient #2 on 02/16/2023 at 11:30 AM. The agency provided skilled nursing, (SN), visits dated 09/07/2022 through 09/16/2022, along with an unsigned and undated future POC), and plan of treatment (POT). The duration for the POC and POT was dated 01/20/2023 through 04/20/2023. The POC/POT physician ' s order directed that Patient #2 treatment modality included Intravenous (IV), Infusion for Cytarabine, with the patient's diagnosis documented as newly diagnosed b-cell ALL leukemia. Continued review of the clinical record lacked documented evidence of a consent form authorizing the administration of intravenous therapy, including risks, benefits, and alternatives. 3.The surveyor reviewed the clinical record for Patient #3 on 02/16/2023 at 11:00 AM. The agency provided skilled nursing, (SN), visits dated 04/22/2022 through 01/20/2023, along with an unsigned and undated POC, and POT. The patient ' s diagnoses included Chest pain, Shortness of breath, Chronic heart failure with cardiomyopathy, and chronic kidney disease, stage three. The physician prescription shows, "Milrinone 1mg/ml (milligram/Miltier), 306 ml bag	H 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 497	Continued From page 19 plus overfill Intravenous every seven days. The Certification period for the POC and POT was dated 01/22/2023 through 04/21/2023. Continued review of the clinical record lacked documented evidence of a consent form authorizing the administration of intravenous therapy, including risks, benefits, and alternatives. 4. On 02/16/2023 at 01:21PM, review of Patient #4's clinical record showed a POC with a duration period from 01/20/2023 through 04/20/2023 and a SOC date of 12/12/2020. The POC included a physician's order for SN visits once every six weeks to infuse Remicade 100 mg intravenous over two hours as of 11/09/2021 and provide education of disease process, therapeutic regimen, and procedures for monthly port access/flush. Continued review of the clinical record lacked documented evidence of a consent form authorizing the administration of intravenous therapy, including risks, benefits, and alternatives. 5. On 02/17/2023 at 11:42 AM, review of Patient #5's clinical record showed a plan of care (POC) with a duration period of 12/19/2022 through 03/19/2023 and a SOC date of 10/01/2019. The POC included a physician's order for SN visits twice a month for blood work from mediport and heparin flush intravenous push as directed following the sash protocol (Saline, administer the medication, Saline, and Heparin). Continued review of the clinical record lacked documented evidence of a consent form authorizing the administration of intravenous therapy, including risks, benefits, and alternatives. 6. The surveyor reviewed the clinical record for Patient # 6 on 02/16/2023 at noon, with a patient diagnosis of vascular disorder of intestine. The	H 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 497	Continued From page 20 agency provided SN visits dated 11/01/2022 through 02/07/2023, along with unsigned and undated, expired POC and POT. The physician ' s orders showed, "TPN, (total parenteral nutrition) intravenous six times a week." The POC stated the SN visits are one to two times a week and as needed for ongoing training/assessment..." Continued review of the clinical record lacked documented evidence of a consent form authorizing the administration of intravenous therapy, including risks, benefits, and alternatives. On 02/16/2023 at 12:58 PM, the director of nursing (DON) and the Compliance Director were made aware of the findings. The compliance director stated that they did not have a consent form because the form was generated when orders were received and sent out, but they did not have a system of collection. At the time of survey, it was determined the home care agency's (HCA's) clinical records failed to include consent forms for intravenous therapy, including risks, benefits, and alternatives, for Patients #1, 2, 3, 4, 5, and #6. This is a repeat deficiency from last survey 07/26/2021.	H 497		
H 506	3920.3(k) INTRAVENOUS THERAPY SERVICES Each clinical record shall include, at a minimum, the following information related to intravenous therapy: (k) Progress notes at least every thirty (30) calendar days; and...	H 506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 506	Continued From page 21 This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to ensure that the skilled nurse documented progress notes at least once every 30 calendar days for four of six active patients in the sample (Patients # 3, 4, 5, and #6). Findings included: 1.The surveyor reviewed the clinical record for Patient #3 on 02/16/2023 at 11:00 AM. The patient ' s diagnoses included Chest pain, Shortness of breath, Chronic heart failure with cardiomyopathy, and chronic kidney disease, stage three. The agency provided skilled nursing (SN), visits dated 04/22/2022 through 01/20/2023, and a plan of care, (POC), and plan of treatment (POT) certification dated 01/22/2023 through 04/21/2023, showing SN visits one to two times a week. Further review of the clinical record lacked evidence of progress notes at least once every 30 calendar days from 04/22/2022 through 01/20/2023. 2. On 02/16/2023 at 01:21PM, review of Patient #4's clinical record showed a plan of care (POC) with a duration period from 01/20/2023 through 04/20/2023 and a start of care date of 12/12/2020. The POC included a physician's order for skilled nursing visits skilled nursing (SN) visits once every six weeks to infuse Remicade 100 mg intravenous over two hours as of 11/09/2021 and provide education of disease process, therapeutic regimen, and procedures for monthly port access/flush. Further review of the clinical record lacked evidence of a progress note during the month of January 2022.	H 506	3920.3(k)continued 1.A 30 day follow-up was completed for patient #3,4,5 and 6 and included in the medical record. 2. A 30-Day Follow-up template was implemented in the CPR+ progress notes to document on patients who are seen for skilled nursing visits greater than 30 days apart. 3. To ensure compliance, 100% of DC active nursing patients will be audited monthly to verify an assessment and or progress note is completed at least every 30 days. Results will be reported to Leadership and the Performance Improvement Committee monthly.	3/31/23 3/31/23 5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 506	Continued From page 22 3. On 02/17/2023 at 11:42 AM, review of Patient #5's clinical record showed a plan of care (POC) with a duration period of 12/19/2022 through 03/19/2023 and a start of care date of 10/01/2019. The POC included a physician's order for skilled nursing visits skilled nursing (SN) visits twice a month for blood work from mediport and heparin flush intravenous push as directed following the sash protocol (Saline, Administer the medication, Saline, and Heparin). Further review of the clinical record lacked evidence of progress notes at least once every 30 calendar days between the period of May 2022 through January 2023. 4.The surveyor reviewed the clinical record for Patient # 6 on 02/16/2023 at noon. The agency provided documented SN visits dated 11/01/2022 through 02/07/2023, POC, and POT, duration period of 12/20/2022 through 03/20/2023. Further review of the clinical record lacked evidence of progress notes at least once every 30 calendar days from 11/01/22 through 02/07/2023. On 02/21/2023 at 01:48 PM, the director of nursing (DON) and administrator were informed of the findings. At the time of survey, it was determined that the agency failed to ensure that skilled nurses documented monthly progress notes in accordance with the regulatory requirements for Patients #3, 4, 5, and #6.	H 506		
H 507	3920.3(I) INTRAVENOUS THERAPY SERVICES Each clinical record shall include, at a minimum, the following information related to intravenous therapy:	H 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 507	Continued From page 23 (l) A summary report at least every sixty-two (62) calendar days. This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to ensure that the skilled nurse documented a summary report at least every 62 calendar days for three of six active patients in the sample (Patients #1, 5, and #6). Findings included: 1. On 02/15/2023 at 02:38 PM, review of Patient #1's clinical record showed plans of care (POCs) with duration periods of 11/11/2022 through 02/09/2023 and 02/10/2023 through 05/10/2023 that included orders for skilled nursing (SN) visits once every seven days to infuse intravenous (IV) Blyncito and perform weekly blood work as ordered. Further review of the clinical record lacked evidence of 62-day summary notes for Patient #1. 2. On 02/17/2023 at 11:42 AM, review of Patient #5's clinical record showed a POC with a duration period of 12/19/2022 through 03/19/2023 and a start of care (SOC) date of 10/01/2019. The POC included a physician's order for skilled nursing visits (SN) visits twice a month for blood work from mediport and heparin flush intravenous push as directed following the sash protocol (Saline, administer the medication, Saline, and Heparin). Further review of the clinical record lacked evidence of a 62-day progress summary notes between the period of May 2022 through January 2023.	H 507	3920.3(l) continued 1.Patient #1 is discharged from service. Patient #5 sixty-two day summary completed and sent to physician. Patient #6 sixty-two day summary completed and sent to physician. **3/31/23** 2.The DON will conduct in-service training for all nursing staff to review the requirements of documentation of the 62-day summary. The training to include review of DC reg 3920.3(l), location and required content to be included in the summary, and instructions for setting a trigger in the electronic medical record to alert nurse of upcoming 62-day summaries that are due. **5/1/23** 3. To ensure compliance the DON/designee will audit 100% of DC active nursing patients monthly to verify the 62 day summaries are documented in the patient record by the required due date (62 days). Results will be reported to Leadership and the Performance Improvement Committee quarterly. **5/1/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0077	A. BUILDING: _____ B. WING _____	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATION'S INFUSION AT HOME	20 F STREET, NW #741 WASHINGTON, DC 20001

(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) COMPLETE DATE
H 507	Continued From page 24 3.The surveyor reviewed the clinical record for Patient # 6 on 02/16/2023 at noon. The agency provided documented SN visits dated 11/01/2022 through 02/07/2023, POC and plan of treatment, (POT), with a duration period of 12/20/2022 through 03/20/2023. Further review of the clinical record lacked evidence of a 62-day progress summary notes from 11/01/22 through 02/07/2023. Interview with the director on nursing on (DON). 02/16/2023 at 03:22 PM revealed that the agency was "not doing 62 days summaries." On 02/21/2023 at 01:48 PM, the DON and administrator were informed of the findings. At the time of survey, it was determined that the agency failed to ensure that the skilled nurse documented 62-day summary reports in accordance with the regulatory requirements for Patients #1, 5, and #6.	H 507		