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	HCA-0030	A. BUILDING _____ B. WING _____	09/09/2010

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H 000	INITIAL COMMENTS A complaint investigation was conducted on September 8, 2010 and September 9, 2010 on your agency after HRLA/DOH received a complaint via telephone on August 27, 2010 in which patient #1 indicated that she was not being provided the services ordered by her physician. The complaint was unsubstantiated however there were incidental findings during this investigation based on record reviews and interviews.	H 000	GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 11.17.10	
H 192	3908.1(c) ADMISSIONS Each home care agency shall have written policies on admissions, which shall include, at a minimum, the following: (c) The amount charged for each service; 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 the amount charged for each service in it's Admissions Policy. The finding includes: Review of the "Patient Admission Handbook" on September 8, 2010, beginning at approximately 10:24 a.m. revealed a document in the handbook entitled "Financial Agreement." Continued review of the Financial Agreement form revealed a column entitled "Discipline Service", i.e.. Skilled Nursing, Physical Therapy, etc. Another column entitled "Charge per Visit was reviewed to be blank. Interview with the Branch Administrator on September 8, 2010, at approximately 10:47 a.m.,	H192	**3908.1.2(c) Admissions** **Each home care agency shall have written Policies on admissions, which shall include, at a Minimum, the following:** **(c) The amount charged for each service** **A. Corrective Actions for patient found to be affected by this deficiency:** 1. See attached revised policy 605 revised 11/15/10. 11/15 PK **B. Identification of other patients having the potential to be affected by this deficiency:** 1. Policy 605 will be reviewed with staff 11/17/10 11/17/10 PK **C. Systemic Changes to ensure deficient practice does not recur:** 1. Rates will be communicated to staff and consents for care shall reflect current rates ongoing PK 2. All agency policies will be reviewed annually to assure continued compliance **D. Monitoring of Corrective Action** 1. Consents for care to include current rates will be reviewed by Clinical Manager/Administrator at time of submission. ongoing PK 2. Adherence to policy will be monitored in quarterly clinical record audits. 3. A corrective action plan will be implemented if here is found to be non compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PK Patricia Kelly

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H 192	Continued From page 1 the amount charged for each service was changed on an annual basis, which was the reasoning for not including the amount charged for each service in their Admissions Policy. During a face to face interview with the Branch Administrator on September 8, 2010, beginning at approximately 11:18 a.m., it was acknowledged that the admissions policy did not include the amount charged for each service. At the time of the survey, there was no documented evidence that the agency's admissions policy included the amount charged for each service.	H 192		
H 193	3908.1(d) ADMISSIONS Each home care agency shall have written policies on admissions, which shall include, at a minimum, the following: (c) Policies governing fees, payment and refunds; This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure their admissions policy disclosed a policy or procedure for governing fees, payment and refunds. The finding includes: Interview with the Branch Administrator on September 8, 2010 beginning at approximately 10:47 a.m., revealed the HCA had a separate policy entitled "Fee Setting and Collection." Review of this policy on the aforementioned date revealed although the HCA included procedures	H 193	**3908.1 (d) Admissions** **Each home care agency shall have written Policies on admissions, which shall include, at a minimum, the following:** **(c)Policies governing fees, payment and refunds** **A. Corrective Action for patient found to have been affected by this deficiency:** 1. See attached policy 607 which was not presented at time of survey **B. Identification of other patients having the Potential to be affected by this deficiency:** 2. Policy in place at time of survey **C. Systemic changes to ensure this deficiency does not recur:** 1. All policies will be reviewed and presented to staff annually **C. Monitoring of Corrective Action** 1. The deficiency was not present	

PK agrees

PK Patricia Kelly

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H 193	Continued From page 2 for governing fees and payment, the policy did not evidence a procedure for refunds. During a face to face interview with the Branch Administrator on September 8, 2010, at approximately 11:30 a.m., it was acknowledged the HCA did not ensure the admission policy disclosed a procedure for refunds. At the time of the survey, there was no documented evidence the HCA ensured their admission policy disclosed a policy and procedure to include refunds.	H 193		
H 223	3909.2(c) DISCHARGES TRANSFERS & REFERRALS (c) A determination by the home care agency that the referral or discharge is necessary to protect the health, safety or welfare of agency staff; This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure their Discharge Planning policy disclosed a statement to address a determination of a referral or discharge is necessary to protect the health, safety or welfare of agency staff. The finding includes: Interview with the Branch Administrator and record review on September 8, 2010, beginning at approximately 10:44 a.m., revealed the HCA had a policy and procedure entitled "Discharge Planning." Review of the policy revealed no evidence of a statement regarding the determination of a referral or discharge		**H 223 3909.2 (c) Discharges Transfers and Referrals** **(c) A determination by the home care agency that the referral or discharge is necessary to protect the health, safety or welfare of agency staff.** **A. Corrective Action for patient found to be affected by deficiency:** 1. See attached policies 285 and 289 which were updated on 10/1 to reflect standard. 2. The policy was presented to the staff on 11/3 3. Practice was compliant with policy **B. Identification of other patients having the potential to be affected by this deficiency:** 1. Practice compliant with policy **C. Systemic changes to ensure deficiency does not recur:** 1. Annual review of all policies with staff **D. Monitoring of Corrective Action;** 1. The Administrator is responsible for staff compliance with all policies 11/13 AC PL	

PK Patricia Kellef

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H 223	Continued From page 3 necessary to protect the health, safety or welfare of agency staff. During a face to face interview with the Branch Administrator on September 8, 2010, at approximately 11:30 a.m., it was acknowledged that the HCA did not ensure there was a statement regarding the determination of a referral or discharge necessary to protect the health, safety or welfare of agency staff was included in their Discharge Planning policy. At the time of the survey, there was no documented evidence the HCA ensured their Discharge Planning policy and procedures included a statement regarding the determination of a referral or discharge necessary to protect the health, safety or welfare of agency staff was included in their Discharge Planning policy.			
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 interview and record review, the Home Care Agency (HCA) failed to include in their Discharge Policy that each patient would receive written notice of discharge or referral no less than		**H227 3909.2 Discharges Transfers and Referrals** **Each patient shall receive written notice of Discharge or referral no less than seven (7) day unless the conditions outlined in the final rule making are met.** **A. Corrective Actions for patient found to be affected by this deficiency:** 1. See attached revised policy 299-A 11/15/10 11/15 PK 2. The patient was discharged prior to the policy so there was no opportunity to c correct deficiency **B. Identification of other patients having the potential to be affected by this deficiency:** 1. Policy 605 will be reviewed with staff 11/17/10 11/17 PK 2. From 11/17/10 policy regarding 7 day discharge will be in effect 11/17 PK **C. Systemic Changes to ensure deficient practice does not recur:** 1. Policy will be reviewed with staff every week during weekly care conferences to ensure implementation weekly PK 2. The office staff will place reminders on the clinical field staff electronic scheulde 3. All agency policies will be reviewed annually to assure continued compliance **D. Monitoring of Corrective Action** 1. Adherence to policy will be monitored in quarterly clinical record audits. 2. A corrective action plan will be implemented if here is found to be non compliance	

PK Patricia Kelly

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H 227	Continued From page 4 seven (7) days prior to the action. The finding includes: Interview with the Branch Administrator and record review on September 8, 2010, beginning at approximately 10:44 a.m., revealed the HCA had a policy and procedure entitled "Discharge Planning." Review of the policy revealed no evidence of a statement that each of their patients would receive written notice of discharge or referral no less than seven (7) days prior to the action. During a face to face interview with the Branch Administrator on September 8, 2010, at approximately 11:30 a.m., it was acknowledged the HCA did not ensure a statement that each of their patients would receive written notice of discharge or referral no less than seven (7) days prior to the action was included in their Discharge Planning policy. At the time of the survey, there was no documented evidence the HCA ensured their Discharge Planning policy and procedures included a statement that each of their patients would receive written notice of discharge or referral no less than seven (7) days prior to the action was included in their Discharge Planning policy.			
H 277	3911.2(q) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (q) Communications between the agency and all health care professionals involved in the patient's		**H277** **3911.2(q)) Clinical Records** **Communications between the agency and health professional involved in the patient's care–deficiency cited that patient stated all wound care was provided by her surgeon yet agency staff communicated only with the primary attending.** **A. Corrective Actions for patient found to be affected by this deficiency:** 1. Per attached PHRI Policy 288-**Medical Supervision #6** "If a patient is under the care of more than one physician, staff are responsible to the primary physician." The policy later states that other physicians involved in care should be made aware of the services provided and that the home care physician is to be informed of the involvement of other physicians. There is documentation in the clinical record of communication and verification with the primary physician of the surgeon's recommendations and the specific orders of the primary physician. The orders as provided by the primary physician were implemented by agency staff and her wound showed consistent improvement. Staff were compliant with agency policy **B. Identification of other patients having the potential to be affected by this deficiency:** 1. Policy 288 was reviewed with staff 11/10/10 to assure continued compliance 11/10/10 PK	

PK Patricia Kells

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H 277	Continued From page 5 care; This Statute is not met as evidenced by: Based on interview and record review, the agency failed to ensure communications between the agency and all health care professionals involved in the patient's care for one (1) of one (1) patient in the sample. (Patient #1) The finding includes: During a face to face interview with Patient#1 on September 9, 2010, it was revealed that Patient #1's surgeon provided all care for her wound. Patient #1 indicated that her primary physician had never seen or provided any care for her wound. On September 8, 2010, at approximately 10:35 a.m., a record revealed there was no documented evidence of communication from Patient #1's surgeon. Further review of the record revealed that all wound orders were prescribed by the primary physician.		**C. Systemic Changes to ensure deficient practice does not recur:** 1. There are no systemic changes necessary as agency policy was followed 2. All agency policies will be reviewed annually to assure continued compliance **D. Monitoring of Corrective Action** 1. Documentation of communication and coordination With primary physicians is included as part of the audit process that is performed quarterly 2. Results are reported and published to Administrator, and Vice President of Clinical Outcomes, Professional Advisory Committee and Governing Board 3. A corrective action plan will be generated for any standard found to be deficient	
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following: (g) Physical assessment, including all pertinent diagnoses; This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to include all pertinent diagnoses on the Plan of Care for one (1) of one (1) patient included in the sample. (Patient #1)		**H 358 3914.3(g)Patient Plan of Care** **The plan of care shall include the following** **(g) Physical assessment, including all pertinent diagnoses** **A. Corrective Action for patient found to have been affected by this deficiency:** 1. Diagnosis V 55.3 Attention to colostomy missing from original Plan of Treatment. 2. The 5/13/10 Plan of Care has been updated to include the V code 3. Though the code was missing there was documentation on the Plan of Care in the summary statement of the presence of the colostomy 4. All Plans of Care since that initial have included the diagnosis code V 55.3	11/12PC

P/C Patricia Kelley

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H 277	Continued From page 5 care; This Statute is not met as evidenced by: Based on interview and record review, the agency failed to ensure communications between the agency and all health care professionals involved in the patient's care for one (1) of one (1) patient in the sample. (Patient #1) The finding includes: During a face to face interview with Patient#1 on September 9, 2010, it was revealed that Patient #1's surgeon provided all care for her wound. Patient #1 indicated that her primary physician had never seen or provided any care for her wound. On September 8, 2010, at approximately 10:35 a.m., a record revealed there was no documented evidence of communication from Patient #1's surgeon. Further review of the record revealed that all wound orders were prescribed by the primary physician.	H 277	Corrected **B. Identification of other patients having the Potential to be affected by this deficiency:** 11/3/10 PC 1. The clinical staff in conjunction with the Clinical Manager and Administrator reviewed all current Plans of Care to determine presence of accurate diagnosis codes 2. There were no confirmed additional instances of the deficiency **C. Systemic changes to ensure this deficiency does not recur:** 1. The Quality Assurance Process Events Work Flow process was reviewed with the clinical field staff on October30 10/30 AO 2. The process was also reviewed with the Quality Assurance clinicians on November 11 11/11 PK	
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following: (g) Physical assessment, including all pertinent diagnoses; This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to include all pertinent diagnoses on the Plan of Care for one (1) of one (1) patient included in the sample. (Patient #1)	H 358		

PK Patricia Kelley

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H 358	Continued From page 6 The finding includes: On September 8, 2010, at approximately 10:30 a.m., record review revealed a document from Genesis Physician Services, Inc. entitled "Comprehensive Nursing Facility Assessments" dated April 20, 2010 which indicated that patient #1 had a history of diabetes and a colostomy. Further review of the record revealed a Plan of Care (POC) with a certification period of May 13, 2010 through July 11, 2010, which failed to have documented evidence of the aforementioned diagnoses. During a face to face interview with the Clincal Manager on September 8, 2010, at approximately 11:35 a.m., the finding was acknowledged.		**C. Monitoring of Corrective Action** 1. The Director of Quality Assurance will monitor compliance with the Quality Assurance Process and institute a tracking mechanism to ensure compliance in coordination with the clinical manager and Administrator of the branch 2. This aspect of care is included in the quarterly clinical record audits performed in the bracnch. Results are compiled and presented to the Administrator and Quality Council 3. Plans of Correction will be developed and Implemented for any standard of care that Is not compliant	
H 430	3916.1 SKILLED SERVICES GENERALLY Each home care agency shall review and evaluate the skilled services provided to each patient at least every sixty-two (62) calendar days. A summary report of the evaluation shall be sent to the patient's physician. This Statute is not met as evidenced by: Based on record review and interview, the agency failed to review, evaluate and send a summary report to the physician of the skill services provided for one (1) of one (1) patient . (Patient #1) The finding includes:		**H 430 3916.1 Skilled Services Generally** **Each home care agency shall review and evaluate the skilled services provided to each patient at least every sixty two calendar days. A summary report of the evaluation shall be sent to the patient's physician** **A. Corrective Action for patient found to be affected by deficiency:** 1. The 7/12 recertification did not include a recertification summary of care for the previous 60 days. This summary has now been completed and an updated Plan of Care sent to the primary physician for review and signature. 10/12 PK PK 2. All other subsequent recertification summaries were completed and included on plan of care The patient continues to receive care by the Agency. 3. The staff member involved was counseled regarding this deficiency 10/12/10	

PK Palmukelf

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H 430	Continued From page 7 On September 8, 2010, at approximately 10:30 a.m., record review revealed no documented evidence of a review, evaluation or summary report sent to the physician of the skilled services provided to Patient#1. During a face to face interview with the Clinical Director on September 8, 2010, at approximately 12:40 p.m., the finding was acknowledged. H 453 3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency's(HCAs) nurse failed to ensure that patient needs are met in accordance with the plan of care POC for one (1)of one (1)patient in the sample. (Patient #1) The findings include: 1. On September 8, 2010, at approximately 10:30 a.m., review of Patient #1's Plan of Care (POC)with a certification period of May 13, 2010 through July 11, 2010, revealed the skill nursing goals as follows: "the patient/caregiver will verbalize understanding of disease process, management and intervention and when to notify physician by 10 days, patient/ caregiver will be knowledgeable in all aspects of diabetic care within 10 days, patient/caregiver will be		H4303916.1 Cont'd **B. Identification of other patients having the potential to be affected by this deficiency:** 1. All active patients records who have been recertified since September 1, 2010 were reviewed on November 10 11/10 PK 2. Clinical records found to be missing Recertification summaries were entered at that time and Plans of Care updated and will be resent to physician **C. Systemic changes to ensure deficiency does not recur:** 1. Quality Assurance functions to include review of assessments and all plans of care was centralilzed On October 18, 2010 10/18 PK 2. These nurses communicate to the clinicians and Branch management staff missing documentation criteria such as this aspect of care via Secure Messaging through the electronic medical record 3. Plans of Care are not approved and sent to physicians without complete documentation 4. All documentation requirements will be reviewed bi-annually with clinical staff by the Clinical Manager/Administrator **D. Monitoring of Corrective Action;** 1. The Director of Quality Assurance functions has instituted a checklist for the Quality Assurance nurses to complete with each clinical record review and the Director will review all checklists for completion 10/18 PK 2 The Quality Assurance department will forward a summary of incomplete documentation by clinician to the Branch management staff for staff counseling and education	

PK Patricia Kelley

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H 430	Continued From page 7 On September 8, 2010, at approximately 10:30 a.m., record review revealed no documented evidence of a review, evaluation or summary report sent to the physician of the skilled services provided to Patient#1. During a face to face interview with the Clinical Director on September 8, 2010, at approximately 12:40 p.m., the finding was acknowledged.
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency's(HCAs) nurse failed to ensure that patient needs are met in accordance with the plan of care POC for one (1)of one (1)patient in the sample. (Patient #1) The findings include: 1. On September 8, 2010, at approximately 10:30 a.m., review of Patient #1's Plan of Care (POC)with a certification period of May 13, 2010 through July 11, 2010, revealed the skill nursing goals as follows: "the patient/caregiver will verbalize understanding of disease process, management and intervention and when to notify physician by 10 days, patient/ caregiver will be knowledgeable in all aspects of diabetic care within 10 days, patient/caregiver will be

H453 3917.2(c) Skilled Nursing Services — 5) LETE TE

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

(c) Ensuring that the patient needs are met in accordance with the plan of care

A. Corrective Actions for patient found to be affected by this deficiency:

1. Patient goals stated in Plan of Care specifically Identifying achieving independence in wound care, Ostomy care and all aspects of medication regimen within 10 days. Documentation in 10 days did not specifically state achievement of goals and plan of care was not updated with additional time frames.
2. Further review of the clinical record did provide evidence of achievement of goals within the time frame but clinician did not correctly document per procedure
3. Clinician has been counseled and reviewed with Clinical Manager documentation guidelines 10/15PK

B. Identification of other patients having the potential to be affected by this deficiency:

1. Deficiency was presented to clinical field staff during mandatory staff meeting on October 14 10/14PK
2. The Clinical Manager and Administrator reviewed all current clinical records during the month of October for compliance to standard. There was found to be other records found to be non-compliant with documentation guidelines. There was no evidence that patient care had not been jeopardized 11/1PK
3. All documentation will be updated to be compliant by November 15, 2010 11/15PK

C. Systemic Changes to ensure deficient practice does not recur:

1. The Quality Assurance clinicians have been requested to review Care Plans for appropriateness of visit orders and care plan goals
2. Patient care plans will be reviewed at least monthly with each clinician and Clinical Manager to assure compliance with standard

D. Monitoring of Corrective Action

1 This standard is included in quarterly clinical record Audits. ongoing

2. Results are reported and published to Administrator, and Vice President of Clinical Outcomes, Professional

PK Patricia Kelley

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PROFESSIONAL HEALTHCARE RESOURCES I	1010 WISCONSIN AVENUE, NW, SUITE 300 WASHINGTON, DC 20007

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H 453	Continued From page 8 independent in all aspects of wound care in 10 days, patient/ caregiver will be stable, educated and compliant with ostomy care and return demonstration within 10 days,and patient / care giver knowledgeable in all aspects of oral/injectable/inhalant medication administration within 10 days." Further review of the record revealed a skilled nursing note dated May 21, 2010. The nurse documented "patient teaching wound care procedure and infection prevention. Patient stated understanding." However there was no documented evidence that the aforementioned skilled nursing goals were met. During a face to face interview with the Clinical Director on September 8, 2010, at approximately 11:35 a.m., the finding was acknowledged.			
H 458	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review, the agency's skilled nurse failed to report changes in the patient's condition to the patient's physician for one (1) of one (1) patients. (Patient #1) The finding includes: On September 8, 2010, at approximately 10:30 a.m., record review revealed skilled nursing notes		**H 458 3917.2(h) Skilled Nursing Services** **Duties of the nurse shall include, at a minimum, The following:** **(h)Reporting changes in the patient's condition to the Primary physician** **A. Corrective Action for patient found to have been affected by this deficiency:** 1. It was found that on Saturday, June 26 the weekend nurse documented a change in the wound care description and did not notify the physician at the time of notice. The nurse documented that the patient had a scheduled MD appointment on the following Tuesday, June 29. She notified the case manager to inform the MD on Monday, June28 as the MD was unavailable on Saturday for consultation. 2. Upon review of the clinical record this description was a not a change in the patient wound as had been documented earlier. 3. No change was made in wound care was made after the appointment **B. Identification of other patients having the Potential to be affected by this deficiency:** 1. All staff were reminded to contact the Primary physician to notify the MD of any change in patient's condition upon finding 10/15 PK 2. A review of weekend documentation provided evidence of regular communication with changes in patient's condition **C. Systemic changes to ensure this deficiency does not recur:** 1. Deficiency was found to be an isolated incident but the staff was reminded on the standard on October 30, 2010 10/30 PK 2. The staff member was counseled on September 12 9/27 PK	

PK Patricia Kelly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0030	A. BUILDING _____ B. WING _____	09/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H 458	Continued From page 9 dated 06/26/10, in which the nurse documented "the patient's wound was very deep with a small opening. Inside the wound, it felt like there wa a pocket. MD may have to open wound and debride the wound. Patient had MD appointment June 29, 2010." Further review of the record revealed there was no documented evidence that the skilled nurse informed the physician of the change in the patient's wound. During a face to face interview with the Clinical Director on September 8, 2010, at approximately 12:30 p.m., the finding was acknowledged.	H 458	**D. Monitoring of Corrective Action** 1. This standard is included in quarterly clinical record Audits. Results are compiled centrally and reported Administrator and Quality council 2. The Administrator develop further Plans of Correction any occurrence of non compliance	