GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
INTERMIEDIATE CARE FACILITIES DIVISION

Home Care Agencies
Title 22 DCMR 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Health Care Agency:	Street Address, City, State, ZIP Code:	Survey Date:
Human Touch Health Care Agency	1416 9th St., NE Washington, DC 20002	1/26 - 29/09 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An initial licensure survey was conducted from January 26, 2009 through January 29, 2009. The sample size selected for the clinical record review was 17 based on a census of 173 patients and 30 staff records based on a census of 304 employees. The findings of the survey were based on interviews, clinical and administrative record review. 3907 **Personnel**			
3907.2(c)	**Each home care agency shall maintain accurate personnel records, which shall include the following:** **(c) Resume of education, training certificates, skills checklist, and prior employment, and evidence of attendance at orientation and in-service training, workshops or seminars;** Based on record review and interview, the agency failed to ensure that all employees attended orientation and in service training. (Staff # 1 and # 4)			

Name of Inspector(s) _____ Date Issued _____

Facility Director/Designee _____ Date 09 MAR 2009

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	The finding includes: Review of the agency's personnel records on January 28, 2009 revealed two out of thirty staff records reviewed failed to show evidence of orientation and in-service training. Interview with the Director of Nursing on January 28, 2009 confirmed the findings of the surveyor.		By 30 March 2009 1..2 Plan of Correction I. A. Corrective Actions to be accomplished for clients affected by the deficiency. • Both staff [redacted] and [redacted] were given Orientation and In-service training on March 2009 as part of the compliance to the above regulation. • The Orientation and training material is distrivbuted with the attendance signature of the two employees. I.B. Identifying other clients who might be affected by the same deficiency • The Human Resource Officer reviewed all employee personnel files to see if there are any employees who did not receive Orientation and in-service training. • The Personnel Data Base (www.homesolutions.net) and Human Touch Personnel File Checklist has a Master Checklist that allows to frequently review the Orientation and In-service documentation. I.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur. • Update the Personnel Data Base regularly with new orientation and in-service training and utilize the Personnel Data Base and Personnel

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File Master Checklist on a weekly basis and put these data sets on the Human Resources personnel ([redacted]) Weekly Productivity List to be reviewed on a weekly basis by the supervisor ([redacted]).

- Provide Monthly Report on all personnel orientation and in-service training with appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.

I.D. Monitoring the corrective actions to ensure similar deficiencies will not recur.

- Evaluation and Monitoring Methods:
  - Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the human resource personnel ([redacted]) and to be reported by the Supervisor ([redacted])
  - Monthly Tracking. The Personnel Supervisor will report Personnel Productivity Report on a monthly basis to the Quality Improvement Director ([redacted]).
  - Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board.

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3907.2(e)	**Each home care agency shall maintain accurate personnel records, which shall include the following:** **(e) Health certification as required by section 3907.6;** Based on record review and interview, the agency failed to obtain a health certificate for one of the thirty employees. (Staff #3) The finding includes: Review of the agency's personnel records on January 28, 2009 revealed one out of thirty employees did not have a current	Measure of Success: o 95% Compliance to these standards will be considered a successful compliance. o Annual Compliance Report to Professional Advisory Board on this standard & regulations citations. I.E. Quality Assurance Programs to be implemented o Tracking, monitoring and reporting. The above two standards on Orientation and in-service training will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings. By 30 March 2009 2.2 Plan of Corrections: II. A . Corrective Actions to be accomplished for clients affected by the deficiency. • Staff No. 3 [redacted] was asked to produce Health Certification and was given 15 days by 15

	health certificate on file. Interview with the DON on January 28, 2009 confirmed that staff #3 health certificate was dated December 6, 2007.		March 2009 to complete the task at which point the Health Certificate will be placed in the Personnel File. • The Completed Health Certificate will be put in file and the information documented into www.homesolutions.net and reported to the Supervisor ([redacted]) via Weekly Productivity Report. II.B. Identifying other clients who might be affected by the same deficiency • The Human Resource Officer reviewed all employee personnel files to see if there are any employees who did not have their Health Certificates in file. • The Personnel Data Base (www.homesolutions.net) and Human Touch Personnel File Checklist has a Master Checklist that allows to frequently review the Health Certification on file documentation. II.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur. • Update the Personnel Data Base regularly with Health Certification record and utilize the Personnel Data Base and Personnel File Master Checklist on a weekly basis and put these data sets on the Human Resources personnel ([redacted]) Weekly Productivity Report to be reviewed on a weekly basis by the supervisor ([redacted]).	

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- Provide Monthly Report on all personnel Health Certifications by developing an appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.

II.D. Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

- Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on Health Certification Record by the human resource personnel ([redacted]) and to be reported by the Supervisor ([redacted])
- Monthly Tracking. The Personnel Supervisor will report Personnel Productivity Report on a monthly basis to the Quality Improvement Director ([redacted])
- Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board.

Measure of Success:

- 95% Compliance to these standards will be considered a successful compliance.
- Annual Compliance Report to

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				Professional Advisory Board on this standard & regulations citations. II.E. Quality Assurance Programs to be implemented • Tracking, monitoring and reporting. The above standards on Health Certification Record maintenance will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings.		

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3907.2(m)	**Each home care agency shall maintain accurate personnel records, which shall include the following:** **(m) Documentation of acceptance or declination of the Hepatitis Vaccine** Based on interview and record review, the agency failed to ensure that documentation in the acceptance or declination of the hepatitis vaccine were maintained for two out of thirty employees . (Staff #2 and #4) The finding includes: Review of the agency's personnel records on January 28, 2009 revealed that the agency failed to provide evidence that documentation regarding staff #2 and #4 acceptance or declination of the hepatitis vaccine was maintained. Interview with the DON on January 28, 2009 confirmed the finding of the surveyor.	By 30 March 2009 3.2 Plan of Correction (A-E) 3.A. Corrective Actions to be accomplished for clients affected by the deficiency. • Both staff No.2 [redacted] and staff no. 4 ([redacted]) were given two weeks by 15 March 2009 to provide documentation in the acceptance or declination of the Hepatitis Vaccine. as part of the compliance to the above regulation. • The acceptance or declination of the Hepatitis Vaccines for the two employees will be documented and entered into the digital database and hard copies will be placed in the personnel 3.B. Identifying other clients who might be affected by the same deficiency • The Human Resource Officer reviewed all employee personnel files to see if there are any

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				employees who did not have documentation of the acceptance or declination of the hepatitis vaccines. • The Personnel Data Base (www.homesolutions.net) and Human Touch Personnel File Checklist has a Master Checklist that allows to frequently review the Hepatitis Vaccine acceptance and declination. 3.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur. • Update the Personnel Data Base regularly with new documentation of Hepatitis Vaccine acceptance and declination and utilize the Personnel Data Base and Personnel File Master Checklist on a weekly basis and put these data sets on the Human Resources personnel ([redacted]) Weekly Productivity List to be reviewed on a weekly basis by the supervisor ([redacted]). • Provide Monthly Report on all personnel orientation and in-service training with appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation. 3.D. Monitoring the corrective actions to ensure similar deficiencies will not recur. Evaluation and Monitoring Methods:	

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					• Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the human resource personnel [redacted] and to be reported by the Supervisor [redacted] • Monthly Tracking. The Personnel Supervisor will report Personnel Productivity Report on a monthly basis to the Quality Improvement Director [redacted] • Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board. Measure of Success: • 95% Compliance to these standards will be considered a successful compliance. • Annual Compliance Report to Professional Advisory Board on this standard & regulations citations. 3.E. Quality Assurance Programs to be implemented • Tracking, monitoring and reporting. The above two standards on Orientation and in-service training will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings.	

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	3911 Clinical Records	
3911.2(b)	**Each clinical record shall include the following information related to the patient:** **(b) source of referral , including date of discharge if from a hospital or extended care facility;** Based on interview and record review, the agency failed to ensure a source of referral for three of the seventeen patients in the sample. (Patients #9, #14 and #17) The findings include: 1. Review of Patient #9's Home Health Certification and Plan of Care dated December 24, 2008 to June 21, 2009 on January 27, 2009 at approximately 2:00 PM revealed no documentation of a source of referral. Interview with the Director of Nursing (DON) on January 27, 2009 at 3:00 PM revealed that most patients are discharged from a hospital.	By 30 March 2009 4.2 Plan of Correction (A-E) 4.A. Corrective Actions to be accomplished for clients affected by the deficiency. • A source of referral was documented for three patient's No. 9 ([redacted]); No. 14 ([redacted]; and No. 17. as part of the compliance to the above regulation. • The documentation for the source of referral was put in the charts of the three respective patients..

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	2. Review of Patient #14's Home Health Certification and Plan of Care dated October 10, 2008 to April 6, 2009 on January 29, 2009 at approximately 2:00 PM revealed no documentation of a source of referral. Interview with the Director of Nursing (DON) on January 29, 2009 at 3:00 PM revealed that most patients are discharged from a hospital. 3. Review of Patient #17's Home Health Certification and Plan of Care dated November 19, 2008 to May 17, 2009 on January 29, 2009 at approximately 3:00 PM revealed no documentation of a source of referral. Interview with the Director of Nursing (DON) on January 29, 2009 at 3:30 PM revealed that most patients are discharged from a hospital. There was no evidence that the agency provided documentation of a source of referral.	4.B. Identifying other clients who might be affected by the same deficiency • The Patient Record Specialist reviewed all patient record system to see if there are any patients who did not have a source of referral documented in their respective charts. • The Patients Records Data Base (www.homesolutions.net) and Human Touch Patient Record Charts has a Master Checklist that allows to frequently review the Referral Source documentation. 4.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur. • Update the Patient Record System regularly such that Patient Referral Source documentation was included in the Patient Record System Master Checklist on a weekly basis and put these data sets on the Patient Records Specialist [redacted]) Weekly Productivity List to be reviewed on a weekly basis by the supervisor (Sheila Ball). • Provide Monthly Report on all Patient Record System for appropriate documentation of Patient Referral Source and reported monthly to the Quality Improvement Director [redacted] on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.	

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4. D Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

- Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the Patient Record System Specialist ([redacted]) and to be reported by the Supervisor ([redacted])
- Monthly Tracking. The Patient Record Specialist will report Patient Referral Source Report on a monthly basis to the Quality Improvement Director ([redacted])
- Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board.

Measure of Success:

- 95% Compliance to these standards will be considered a successful compliance.
- Annual Compliance Report to Professional Advisory Board on this standard & regulations citations.

4.E. Quality Assurance Programs to be implemented

- Tracking, monitoring and reporting. The above standard on Patient Referral Source Recording will be tracked and reported on the Weekly Quality Improvement Meetings via

3911.2(q)	**Each clinical record shall include the following information related to the patient:** **(q) communication between the agency and all health care professionals involved in the patient's care;** Based on interview and record review, the agency failed to provide evidence of communication between the agency and all health care professional involved in the patient's care for one of the seventeen patients in the sample. (Patient #2) The finding includes: Review of Patient #2's Home Health Certification and POC dated December 16, 2008 to February 13, 2009 on January 26, 2008 at approximately 12:00 PM revealed Patient #2 was to have a Physical Therapy (PT) assessment. Review of the Patient's PT progress notes dated December 18, 2008 and January 18, 2009 revealed that the patient refused the assessment. Interview with the DON on January 26, 2009 at approximately	Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings. By 30 March 2009 5.2 Plan of Correction (A-E) 5.A. Corrective Actions to be accomplished for clients affected by the deficiency. • The PT involved in the patients care completed the Coordination of Care Communication log that indicated that the Physician Ordered PT assessment has been discontinued at the physician's request.. • The Coordination of Care Communication Log is now mandatory form to be completed by professionals whenever they visit a

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3911.2(q)	**Each clinical record shall include the following information related to the patient:** **(q) communication between the agency and all health care professionals involved in the patient's care;** Based on interview and record review, the agency failed to provide evidence of communication between the agency and all health care professional involved in the patient's care for one of the seventeen patients in the sample. (Patient #2) The finding includes: Review of Patient #2's Home Health Certification and POC dated December 16, 2008 to February 13, 2009 on January 26, 2008 at approximately 12:00 PM revealed Patient #2 was to have a Physical Therapy (PT) assessment. Review of the Patient's PT progress notes dated December 18, 2008 and January 18, 2009 revealed that the patient refused the assessment. Interview with the DON on January 26, 2009 at approximately	Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings. By 30 March 2009 5.2 Plan of Correction (A-E) 5.A. Corrective Actions to be accomplished for clients affected by the deficiency. • The PT involved in the patients care completed the Coordination of Care Communication log that indicated that the Physician Ordered PT assessment has been discontinued at the physician's request.. • The Coordination of Care Communication Log is now mandatory form to be completed by professionals whenever they visit a

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		12:00 PM revealed that the PT had not communicated to the agency that Patient #2's Primary Medical Doctor (PMD) had discontinued the assessment. There was no evidence in the clinical record that the PT involved in the patient's care communicated with the agency that the ordered PT assessment had been discontinued.		patient to alert about progress and changes in patient care. 5.B. Identifying other clients who might be affected by the same deficiency • The Coordination of Care Communication Log will be received by the Clinical Manager on a weekly basis to ensure that all professionals communicate their findings after each visit and document their findings so that other professionals are aware and are updated about changes on a regular basis.. • The Coordination of Care Communication Log will be updated in the Patient Chart Record and will be tracked on a Patient Record Checklist and Clinical Master Checklist that allows to frequently review its regular implementation by the Clinical Manager ([redacted]). 5.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur. • Update of the Coordination of Care Communication Log will be maintained and compiled in the Patient Record regularly and monitored on a weekly basis by the Clinical Manager ([redacted]) and reported to respective manager/supervisor ([redacted] RN) on a weekly productivity report. • (Provide Monthly Report on all Clinical

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Chart Review with appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.

5.D Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

- Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the clinical manager ([redacted]) and to be reported by the Supervisor ([redacted], RN).)
- Monthly Tracking. The Clinical Manager will report Coordination of Care Communication Log Productivity Report on a monthly basis to the Quality Improvement Director ([redacted])
- Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board.

Measure of Success:

- 95% Compliance to these standards will be considered a successful compliance.
- Annual Compliance Report to Professional Advisory Board on this standard & regulations citations.

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3911.2(i)	**Each clinical record shall include the following information related to the patient:** **(i) Documentation of supervision of home care services:** Based on interview and record review, the agency failed to ensure documentation of supervision of home care services for one of the seventeen patients in the sample. (Patient #12) The finding includes: Review of Patient #12's Home Health Certification and Plan of Care (POC) dated December 16, 2008 to June 13, 2008 on January 28, 2009 at approximately 11:00 AM revealed no documentation of supervision of home care services. Interview with the DON on January 28, 2009 at approximately 2:00 PM revealed that the nurse had been to the patients residence but failed to document the supervision of home care	5. E. Quality Assurance Programs to be implemented • Tracking, monitoring and reporting. The above standards on Coordination of Care Communication Log will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings. By 30 March 2009 6.2 Plan of Correction. 6.A. Corrective Actions to be accomplished for clients affected by the deficiency. • The Clinical Manger [redacted] contacted the specific nurse and asked for the Supervisory Visit Notes to be documented and filed in the Patient Chart within a week from the day of notice. • The Clinical Manager [redacted] has administered an in-service training on the need to document each supervisory visit and file them on the patients chart within a period of the visit made

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	services. There was no documented evidence that the agency documented the supervision of the home care services.		to the patient's residence. 6.B. Identifying other clients who might be affected by the same deficiency • The Clinical Manager has reviewed all active charts and have found all supervisory visits are documented and filed in the charts appropriately. • The Clinical manager has a Clinical Chart Audit Form that includes Supervisory Visit dates and is completed each week at the Weekly Quality Improvement Chart Review meeting. 6.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur. • The Clinical Manager ([redacted]) updates the Clinical Chart Audit Form and Patient Tracking Form on a daily basis and report to the supervisory/ Director of Nursing ([redacted]). Update of the Clinical Supervisory Visit Notes will be maintained and compiled in the Patient Record regularly and monitored on a weekly basis by the Clinical Manager ([redacted]) and reported to respective manager/supervisor ([redacted] RN) on a weekly productivity report. • The Director of Nursing ([redacted]) will provide Monthly Report on all Clinical Chart Review with appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the

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Quarterly Professional Advisory Board Meeting for compliance with this regulation.

6.D Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

- Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the clinical manager ([redacted]) and to be reported by the Supervisor ([redacted] RN).)
- Monthly Tracking. The Clinical Manager will report Supervisory Visit Note Documentation on a Monthly Productivity Tracking Report on a monthly basis to the Quality Improvement Director ([redacted])
- Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board.

Measure of Success:

- 95% Compliance to these standards will be considered a successful compliance.
- Annual Compliance Report to Professional Advisory Board on this standard & regulations citations.

6. E. Quality Assurance Programs to be implemented

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3911.2(s)	**Each clinical record shall include the following information related to the patient:** **(s) Documentation of training and education given to the patient and the patient's caregivers.** Based on interview and record review, the agency failed to ensure documentation of training and education given to the patient and the patients' caregivers for two of the seventeen patients in the sample. (Patients #11, 12) The findings includes: 1. Review of Patient #11's Home Health Certification and Plan of Care (POC) dated December 4, 2008 to June 1, 2009 on January 28, 2009 at approximately 10:00 AM revealed Patient	• Productivity Report Tracking, monitoring and Evaluation. The above standards on Documentation of the Supervisory Visit Notes will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings and eventually reported to the Professional Advisory Board for compliance of DC regulations. By 30 March 2009 7.1 Plan of Correction 7.A. Corrective Actions to be accomplished for clients affected by the deficiency. • Contacting nurses to complete patient education notes. The Clinical Manger [redacted] contacted the specific nurses and asked for the Nurse Visit Notes with documentation of training

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#11 was to be instructed on her diet and hydration.

Review of the nursing clinical progress notes dated February 2007 to December 2008 on January 28, 2009 at approximately 2:00 PM did not reveal documentation of training and education given to the patient and the caregiver related to diet and hydration.

2. Review of Patient #12's Home Health Certification and Plan of Care (POC) dated December 16, 2008 to June 6, 2009 at approximately 11:00 AM on January 28, 2009 revealed Patient #11 was to be instructed on her diet and hydration.

Review of the nursing clinical progress notes dated December 16, 2008 to January 2009 on January 28, 2009 at approximately 2:00 PM did not reveal documentation of training and education given to the patient and the caregiver related to diet and hydration.

3. Review of Patient #9's Home Health Certification and Plan of Care dated December 24, 2008 to June 21, 2009 on January 27, 2009 at approximately 2:00 PM revealed no documentation of training and education was given to the patient and the caregiver related to diet and hydration.

Review of the nursing clinical progress notes dated December 2008 on January 27, 2009 at approximately 2:30 PM did not reveal documentation of training and education given to the patient and the caregiver related to diet and hydration. hydration.

and education on diet and hydration.

- In-service training on patient education. The Clinical Manager [redacted] has administered an in-service training on the need to document Patient education and training on diet and hydration to the respective nurses and to document the training given on the Nursing Visit Notes regularly.

7.B. Identifying other clients who might be affected by the same deficiency

- Review of all charts. The Clinical Manager has reviewed all active charts and has found all supervisory visits are documented and filed in the charts appropriately.
- Weekly Chart Audit Review. The Clinical manager has a Clinical Chart Audit Form that includes Supervisory Visit dates and is completed each week at the Weekly Quality Improvement Chart Review meeting.

7.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur.

- Daily Patient Tracking Log. The Clinical Manager ([redacted]) updates the Clinical Chart Audit Form and Patient Tracking Form on a daily basis and report to the supervisory/ Director of Nursing ([redacted]).
- Weekly Productivity Report. Update of the Nursing Visit Notes on patient education will

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be maintained and compiled in the Patient Record regularly and monitored on a weekly basis by the Clinical Manager ([redacted]) and reported to respective manager/supervisor ([redacted], RN) on a weekly productivity report.

- Monthly Progress Notes. The Director of Nursing ([redacted]) will provide Monthly Report on all Clinical Chart Reviews with appropriate tracking of data on Patient Education and Training record and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.

7.D Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

- Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the clinical manager ([redacted]) and to be reported by the Supervisor ([redacted], RN).)
- Monthly Tracking. The Clinical Manager will report Nursing Visit Notes and the documentation of patient education and training on diet and hydration on a Monthly Productivity Tracking Report be reported to the Quality Improvement Director ([redacted])
- Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis

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				to be reported to Senior Management Team and the Administrator and finally to the Governing Board. Measure of Success: • 95% Compliance to these standards will be considered a successful compliance. • Annual Compliance Report to Professional Advisory Board on this standard & regulations citations. 7.E. Quality Assurance Programs to be implemented • Productivity Report Tracking, monitoring and Evaluation. The above standards on Documentation of the Patient Education and Training on Diet and Hydration will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings and eventually reported to the Professional Advisory Board for compliance of DC regulations.		

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	3914 Patient Plan of Care	
3914.2	**The plan of care shall be approved by the patient's physician.** Based on interview and record review, the agency failed to ensure that patients POC was approved by the patient's physician for one of the seventeen patients in the sample. (Patient #5) The findings include: Review of Patient #5's Home Health Certification and Plan of Care (POC) dated November 12, 2008 to January 10, 2009 on January 27, 2009 at approximately 11:00 AM revealed Patient #5's POC was not approved by the patient's physician. Interview with the Director of Nursing (DON) on January 27, 2009 at approximately 12:00 PM revealed that the POC's should be signed within 30 days. There was no evidence in the clinical record that Patient #5's POC was approved by the patient's physician.	By 30 March 2009 8.2 Plan of Correction: 8.A. Corrective Actions to be accomplished for clients affected by the deficiency. • The Clinical Manger [redacted] has contacted the specific attending physician to approve the Plan of Care with signature and dates to cover the period of care. • The Clinical Manager [redacted] has filed the authorized and approved Plan of Care in patient's chart. 8.B. Identifying other clients who might be affected by the same deficiency • The Clinical Manager has reviewed all active charts and have found all Plan of Care has been approved, signed and dated by the attending physician of each patient. • The Clinical manager has a Clinical Chart

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Audit Form that includes timely approval of the Plan of Care by the attending physician and is reviewed each week at the Weekly Quality Improvement Chart Review meeting.

8.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur.

- The Clinical Manager ([redacted]) updates the Clinical Chart Audit Form and Patient Tracking Form on a daily basis and report to the supervisory/ Director of Nursing ([redacted]). Update of the timely approval of the Plan of Care by the attending physician will be maintained and compiled in the Patient Record regularly and monitored on a weekly basis by the Clinical Manager ([redacted]) and reported to respective manager/supervisor ([redacted], RN) on a weekly productivity report.
- The Director of Nursing ([redacted]) will provide Monthly Report on all timely approval of the Plan of Care by the attending Physician with appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.

8.D. Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

					• Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the clinical manager ([redacted]) and to be reported by the Supervisor ([redacted] RN).) • Monthly Tracking. The Clinical Manager will report timely approval of the Plan of Care by the attending physician on a Monthly Productivity Tracking Report once a month to the Quality Improvement Director[redacted] • Quarterly report to Prof Adv Board. The QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board. Measure of Success: • 95% Compliance to these standards will be considered a successful compliance. • Annual Compliance Report to Professional Advisory Board on this standard & regulations citations. 8.E. Quality Assurance Programs to be implemented • Productivity Report Tracking, Monitoring and Evaluation. The above standards on Documentation of the Supervisory Visit Notes will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly		

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			Quality Assurance Review meetings and eventually reported to the Professional Advisory Board for compliance of DC regulations.
	3917 Skilled Nursing Services		
3917.2(e)	**Duties of the nurse shall include, at a minimum, the following:** **(e) Ensuring that patient needs are met in accordance with the plan of care;** Based in interview and record review, the agency failed to ensure that patients needs were met in accordance with the POC for two of the seventeen patients in the sample. (Patients #5 and #8).		By 30 March 2009 9.1 Plan of Correction:

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The findings include:

1. Review of Patient #5's Home Health Certification and Plan of Care (POC) dated November 12, 2008 to January 10, 2009 on January 27, 2009 at approximately 11:00 AM revealed Patient #5's wound should be measured weekly.

Review of the nursing clinical progress notes dated November 2008 to January 26, 2009 on January 27, 2009 revealed no documented evidence of weekly wound measurements.

Interview with the Director of Nursing (DON) on January 27, 2009 at approximately 12:30 PM acknowledged no documentation.

2. Review of Patient #8's Home Health Certification and Plan of Care (POC) dated December 12, 2009 to February 9, 2009 on January 27, 2009 at approximately 11:30 AM revealed Patient #8's wound should be measured weekly.

Review of the nursing clinical progress notes dated December 2008 to January 26, 2009 on January 27, 2009 did not revealed documentation of weekly wound measurements.

Interview with the Director of Nursing (DON) on January 27, 2009 at approximately acknowledged no documentation.

There was no evidence in the clinical record documenting the weekly would measurements.

9.A. Corrective Actions to be accomplished for clients affected by the deficiency.

- The Clinical Manger ([redacted]) has contacted the specific nurses and instructed them to document wound measurement information according to the plan of care.
- The Clinical Manager ([redacted]) has provided in-service training on how to measure and document would status according to the Plan of Care once a week.

9. B. Identifying other clients who might be affected by the same deficiency

- The Clinical Manager has reviewed all active charts with wound care and has re-assigned those patients to clinicians who are dependable and competent in wound measurement and documentation to ensure compliance with this standard.

- The Clinical manager has set up a Clinical Chart Audit Form that includes weekly wound measurement and is reviewed each week at the Weekly Quality Improvement Chart Review meeting.

9.C. Measures put in place and systematic changes made to ensure that the deficiencies will not recur.

- The Clinical Manager ([redacted]) updates the Clinical Chart Audit Form and Patient Tracking

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Form on a daily basis and report to the supervisory/ Director of Nursing ([redacted]. Update of the timely wound measurement will be maintained and compiled in the Patient Record regularly and monitored on a weekly basis by the Clinical Manager ([redacted]) and reported to respective manager/supervisor ([redacted], RN) on a weekly productivity report.

- The Director of Nursing ([redacted]) will provide Monthly Report on all timely wound measurement and documentation by the attending nurse with appropriate tracking of data and reported to the Quality Improvement Director ([redacted]) on a monthly basis to be presented at the Quarterly Professional Advisory Board Meeting for compliance with this regulation.

9.D. Monitoring the corrective actions to ensure similar deficiencies will not recur.
Evaluation and Monitoring Methods:

- Weekly Productivity Report. The Organization has mandated Weekly Productivity Report on these standards by the clinical manager ([redacted]) and to be reported by the Supervisor ([redacted], RN).)
- Monthly Tracking. The Clinical Manager will report timely wound measurement and documentation on a Monthly Productivity Tracking Report once a month to the Quality Improvement Director ([redacted])
- Quarterly report to Prof Adv Board. The

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				QI Director will then compile a report to the Professional Advisory Board on a quarterly basis to be reported to Senior Management Team and the Administrator and finally to the Governing Board. Measure of Success: • 95% Compliance to these standards will be considered a successful compliance. • Annual Compliance Report to Professional Advisory Board on this standard & regulations citations. 9.E. Quality Assurance Programs to be implemented • Productivity Report Tracking, Monitoring and Evaluation. The above standards on Wound measurement and documentation according to Plan of Care will be tracked and reported on the Weekly Quality Improvement Meetings via Productivity Reports and then discussed at the Monthly Quality Assurance Review meetings and eventually reported to the Professional Advisory Board for compliance of DC regulations.		

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