FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HCA-0030 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW. SUITE 300 PROFESSIONAL HEALTHCARE RESOURCES (WASHINGTON, DC 20007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 000 INITIAL COMMENTS H 000 On October 8, 2015, the Department of Health/Health Regulation Licensing Administration/Intermediate Care Facilities Division (DOH/HRLA/ICFD) received notification. via email from the District of Columbia Department on Aging alleging possible physical abuse to Patient #1. On October 3, 2015, the patient was found with skin discolorations to her buttocks and back, that appeared to be possible bruises. On October 6, 2015, the patient was observed with a new bruise on the right eye. Reportedly the patient is not capable of verbalizing how she sustained the bruises. Due to the nature of the complaint, on October 26, 2015, the DOH/HRLA/ICFD initiated an onsite investigation, to verify compliance with the basic standards of practice and Title 22B. Chapter 39 (Home Care Agencies Regulations). The findings of the investigation were based on record review and interviews. The following are abbreviations used within the body of this report: Activities of Daily Living - ADL Adult Protective Services - APS Board of Nursing - BON Centimeters - cm Department of Health - DOH District of Columbia Metropolitan Police Department - DCMPD District of Columbia Department on Aging -DCOA Emergency Room - ER

Plan of Care - POC

Home Care Agency - HCA Home Health Aide - HHA

HRLA

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE T) /-

Intermediate Care Facilities Division - ICFD

Health Regulation Licensure Administration -

TITLE

(X6) DATE

Interim Administrator/VP of Home Health and Personal Care/Private Duty

IRP011

12/15/2015

PRINTED: 12/01/2015 FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: HCA-0030 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW, SUITE 300 PROFESSIONAL HEALTHCARE RESOURCES (WASHINGTON, DC 20007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 000 Continued From page 1 H 000 H 070 3904.1 Director Registered Nurse - RN In investigating the first allegation of physical Skilled Nurse - SN abuse in our company's 21 year history, we have completed our work without a true H 070 3904.1 DIRECTOR H 070 conclusion about exactly what happened. We are grateful that no serious or The governing body shall appoint a Director who permanent injuries were experienced by the shall be responsible for managing and directing patient. We utilized our typical approach to the agency's operations, serving as liaison performance improvement -talk to people between the governing [*2880] body and staff, involved, collect information from many employing qualified personnel, and ensuring that sources, ask a lot of questions, investigate, staff members are adequately and appropriately analyze and remain open to new findings trained. and needs for change; and identify, document, implement and monitor our improvement strategies to ensure true This Statute is not met as evidenced by: improvement and lasting change. Timely Based on interviews and record review, the the escalation of a potentially important clinical Home Care Agency's (HCA's) director failed to finding did not occur in this instance. The ensure that one (1) of 1 Employee #1 (Patient PSC did not recognize that injury of unknown Service Coordinator) was adequately and origin might represent physical abuse and appropriately trained on the agency's policy on that immediate response was indicated. reporting unusual incidents. (Employee #1) Actions to correct this deficient practice: The finding includes: 1. Education and performance counseling On October 26, 2015, at 3:43 p.m., interview with of PSC regarding the specific deficiencies HHA #3 revealed that he/she called the Patient 11/20/15 of this incident, to identify knowledge Service Coordinator on October 3, 2015, between deficits and opportunities missed to 8:30 a.m. and 8:45 a.m., to report that while assure safety of client, and expected bathing Patient #1, he/she noticed purplish/brown actions in future. Reviewed incident bruises on the patient's left and right buttocks and reporting and elder abuse and neglect a purplish/green bruise on the left thigh. policies. On October 26, 2015, at 12:35 p.m., during an 2. In-service with case study review of this

abused.

interview with the Social Worker from APS, it was

revealed that their agency conducted a face to

face visit at Patient #1's home on October 22.

2015. The interview revealed that Patient #1

mumbled yes, when asked if he/she had been

incident with the entire Personal Care

supervisory team, including all Patient

to policy, and education on expected

awareness and responses to any such

Managers, with review of initial revisions

Service Coordinators and RN Case

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL HEALTHCARE RESOURCES ((X4) ID SUMMARY STATEMENT OF DEFICIENCIES SERVING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW, SUITE 300 WASHINGTON, DC 20007 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Sumany stratement or perpetisences Deposition of the precision of the precisions instructed all that the wasterial policy are to be implementated to final policy or unknown origin. Department precisions instructed all that the wasterial policy are to be implementated to the precisions instructed to the precisions instructed all that the wasterial policy are to be implementated to the precis	NAME OF	PROVIDÉR OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) H 070 Continued From page 2 On October 28, 2015, at 1:05 p.m., interview with the Patient Service Coordinator revealed that it was HHA #2 that called him/her on October 3, 2015, (time unknown) to report that Patient #1, had marks on his/her buttocks and back which appeared to be bruises. Further interview revealed that the HCA regarding the aforementioned incident until October 5, 2015, two (2) days later because he/she didn't think it was that serious at the time. On October 28, 2015, at 1:15 p.m., during an interview with the Vice President of the HCA, it was acknowledged that the Patient \$4** injuries of unknown origin. When asked, the Vice President of the Whole October 3, 2015, two (2) days later because he/she didn't think it was that serious at the time. On October 28, 2015, at 1:15 p.m., during an interview with the Vice President of the HCA, it was acknowledged that the Patient \$4** injuries of unknown origin. When asked, the Vice President confirmed that HHA #1 worked his/her regular tour of duly from October 5, 2015 through October 8, 2015. Further interview revealed that the agency should have removed all assigned HHA #2 and HHA #3 continued to provide home care services in Patient #1's home during the process of the investigation. The Vice President concluded by saying that the agency would re-train all employees on incident reporting. On October 28, 2015, at 1:45 p.m., review of the agency's timesheets during the aforementioned time periods confirmed that HHA #1, HHA #2 and HHA #3 continued to provide home care services in Patient #1's home.	PROFES	SIONAL HEALTHCAR	CE RESOURCES (
On October 28, 2015, at 1:05 p.m., interview with the Patient Service Coordinator revealed that it was HHA #2 that called him/her on October 3, 2015, (time unknown) to report that Patient #1, had marks on his/her buttocks and back which appeared to be bruises. Further interview revealed that he/she did not notify the Vice President of the HCA regarding the aforementioned incident until October 5, 2015, two (2) days later because he/she didn't think it was that serious at the time. On October 28, 2015, at 1:15 p.m., during an interview with the Vice President of the HCA, it was acknowledged that the Patient Service Coordinator should have notified him/her immediately on October 3, 2015, of Patient #1's injuries of unknown origin. When asked, the Vice President confirmed that HHA #1 worked his/her regular four of duty from October 5, 2015 through October 8, 2015. Further interview revealed that the agency should have removed all assigned HHA staff from Patient #1's home pending the outcome of the investigation. The Vice President additionally revealed that HHA #2 and HHA #3 continued to provide home care services in Patient #1's home during the process of the investigation. The Nice President concluded by saying that the agency should have removed all assigned HHA staff from Patient #1's home eare services in Patient #1's home during the process of the investigation. The Vice President concluded by saying that the agency son incident reporting. On October 28, 2015, at 1:45 p.m., review of the agency's timesheets during the aforementioned time periods confirmed that HHA #1, HHA #2 and HHA #3 continued to provide home care services in Patient #1's home.	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE	
continued to provide home care services in Patient #1's home during the process of the investigation. The Vice President concluded by saying that the agency would re-train all employees on incident reporting. 2. Finalize Elder Abuse and Neglect policy revisions, present to the President and Governing Body for approval. 3. In-service all PSC and RN Case Managers on the updated Elder Abuse and Neglect Policy (this is a 2 nd inservice to reinforce key items in the final policy) 12/15/15	H 070	Continued From page 2 On October 28, 2015, at 1:05 p.m., interview with the Patient Service Coordinator revealed that it was HHA #2 that called him/her on October 3, 2015, (time unknown) to report that Patient #1, had marks on his/her buttocks and back which appeared to be bruises. Further interview revealed that he/she did not notify the Vice President of the HCA regarding the aforementioned incident until October 5, 2015, two (2) days later because he/she didn't think it was that serious at the time. On October 28, 2015, at 1:15 p.m., during an interview with the Vice President of the HCA, it was acknowledged that the Patient Service Coordinator should have notified him/her immediately on October 3, 2015, of Patient #1's injuries of unknown origin. When asked, the Vice President confirmed that HHA #1 worked his/her regular tour of duty from October 5, 2015 through October 8, 2015. Further interview revealed that the agency should have removed all assigned HHA staff from Patient #1's home pending the		PREFIX TAG	future findings of injury of unknoorigin. Discussion and input obta to final policy revisions. Instructe that new procedures in the policy to be implemented immediately. 3. Conducted in-depth interviews we HHA #2 and #3 to attempt to furth ascertain what happened in this incident, and used the opportunity reinforce observation and report responsibilities. Measures or systemic changes to prefuture recurrences: 1. Presented case study and sought to improvement strategies from Quality Council, 11/2/2015 and Professional Advisory Committee 11/10/2015 and Branch Administ 10/29/2015. All PHR staff were instructed to implement the new procedures in the Abuse and Neg	ined ad all 10/13/15 vare 10/13/15 vith ther 11/8/15 vity to ing event 11/2/15 vity to 11/2/15 vity to 11/2/15 vity to 11/10/15 vity to 11/10/	
employees on incident reporting. 3. In-service all PSC and RN Case Managers on the updated Elder Abuse and Neglect Policy (this is a 2 nd in- service to reinforce key items in the final policy) 1/15/16 3. In-service all PSC and RN Case Managers on the updated Elder Abuse and Neglect Policy (this is a 2 nd in- service to reinforce key items in the final policy)		continued to provide Patient #1's home of investigation. The V	e home care services in luring the process of the Vice President concluded by		revisions, present to the Presider	12/13/13	
DCMPD Public Incident Report CCN #15159852		On October 28, 201 agency's timesheets time periods confirm HHA #3 continued to in Patient #1's home On October 27, 201	5, at 1:45 p.m., review of the s during the aforementioned ned that HHA#1, HHA#2 and o provide home care services e. 5, at 11:35 a.m., review of the		Managers on the updated Elder A and Neglect Policy (this is a 2 nd in service to reinforce key items in t	I-	

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FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HCA-0030 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW. SUITE 300 PROFESSIONAL HEALTHCARE RESOURCES (WASHINGTON, DC 20007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 305 Continued From page 4 H 305 **Actions To Correct This Deficient Practice:** This Statute is not met as evidenced by: 1. Revise Elder Abuse and Neglect policy Based on record review and interview, it was to clarify need for immediate reporting determined that the home care agency failed to and investigation, immediate staffing develop policies and procedures to ensure changes. Draft revisions completed; patient's right to be free from physical abuse, for 12/15/15 one (1) of 1 patient in the investigation. (Patient approve and implement final revisions #1) 2. Educate/in-service of PHR policy The finding includes: requirements for all PSC and RN case January – managers through in-service, March On October 23, 2015, at 11:45 a.m., the surveyor emphasize duty for patient safety and 2016 requested the agency's policies and procedures protection from abuse and PHR policies that addressed the patient's right to be free from and procedures to do so physical abuse. The agency provided a policy entitled "Elder Abuse and Neglect" effective date Measures or Systemic Changes to Prevent January 1, 2008. Review of the policy failed to **Future Recurrence:** provide evidence of the procedures that staff were to implement to ensure the patient's rights 1. Provide new hire training and to be free from physical abuse was maintained. education on updated Elder Abuse and 1/1/16 and At approximately 1:00 p.m., during an interview Neglect policy requirements to all staff ongoing the Vice President of the HCA, confirmed that the policy failed to reflect procedures to be 2. Include content about Elder Abuse and implemented that would ensure the patient's right 11/1/16 Neglect in annual education and to be free from physical abuse. Further interview and competency training revealed that the agency would be making ongoing revisions to their policy on "Elder Abuse and **Quality Monitoring Measures:** Neglect". 1. Add Elder Abuse and Neglect items to On October 26, 2015, at 3:43 p.m., interview with 11/1/16 HHA #3 revealed that he/she called the Patient annual knowledge competency for all Service Coordinator on October 3, 2015, between 8:30 a.m. and 8:45 a.m., to report that while bathing Patient #1, he/she noticed purplish/brown 2. Quarterly review of standard quality 1/1/16 and bruises on the patient's left and right buttocks and indicators, including incidents and ongoing a purplish/green bruise on the left thigh. complaints On October 28, 2015, at 1:05 p.m., interview with

Health Regulation & Licensing Administration

the Patient Service Coordinator revealed that it was HHA #2 that called him/her on October 3. 2015, (time unknown) to report that Patient #1,

PRINTED: 12/01/2015 FORM APPROVED

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HCA-0030 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW, SUITE 300 PROFESSIONAL HEALTHCARE RESOURCES (WASHINGTON, DC 20007 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 305 H 305 Continued From page 5 had marks on his/her buttocks and back which appeared to be bruises. Further interview revealed that he/she did not notify the Vice President of the HCA regarding the aforementioned incident until October 5, 2015, two (2) days later because he/she didn't think it was that serious at the time. On October 28, 2015, at 1:15 p.m., during an interview with the Vice President of the HCA, it was acknowledged that the Patient Service Coordinator should have notified him/her immediately on October 3, 2015, of Patient #1's injuries of unknown origin. When asked, the Vice President confirmed that HHA #1 worked his/her regular tour of duty from October 5, 2015 through October 8, 2015. Further interview revealed that the agency should have removed all assigned HHA staff from Patient #1's home pending the outcome of the investigation. The Vice President additionally revealed that HHA #2 and HHA #3 H453 3917.2 (c) Skilled Nursing continued to provide home care services in Services Patient #1's home during the process of the investigation. The Vice President concluded by **Actions To Correct This Deficient Practice:** saying that the agency would re-train all employees on incident reporting. The October 9, 12, and 13 dates of service were not provided at the request of the On October 28, 2015, at 1:45 p.m., review of the patient's sister who wanted a regular agency's timesheets during the aforementioned replacement, only, rather than fill in staff. time periods confirmed that HHA #1, HHA #2 and PHR assured HHA services were provided HHA #3 continued to provide home care services on October 10 and 11 by her regular 10/10 and in Patient #1's home. weekend aide, and established a new 11/15 regular weekday HHA by October 14. We At the time of the investigation, the HCA failed to 10/14/15 confirmed that the patient's essential ensure policies and procedures were developed to protect Patient #1 from physical abuse. needs were attended to by her family, and that at no time was she not supervised. H 453 3917.2(c) SKILLED NURSING SERVICES H 453

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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H 453	Duties of the nurse the following: (c) Ensuring that paraccordance with the accordance with the This Statute is not Based on record renurse failed to ensure were met in accordance (1) of one (1) patient #1)	shall include, at a minimum, atient needs are met in a plan of care; met as evidenced by: view and interview, the skilled are that the patient's needs ance with their POC, for one of in the investigation. (Patient	H 453	On October 27, when PHR became as the non-attendance of the assigned he the PSC immediately worked to assig in aide. That HHA arrived at the patien home at 10: 40 AM. HHA #2 was in home on a regular basis and had a relationship with the patient, so ensure her basic morning care and breakfast. These were incidental support service aide was not assigned to care for bot patients, no services were billed to the payer. This oversight support was proby the aide on a volunteer basis and not billed to the payer.	HHA, 10/27/15 n a fill- ent's the ured :. es; the h ne ovided	
	Patient #1's POC, w period of April 3, 20 revealed a physicial (8) hours a day seve personal care, assis reminders, safety an management. On October 28, 201 Patient #1's timeshe evidence that HHA:	15, at 10:00 a.m., review of with a documented certification 15 to October 29, 2015, n's order for HHA visits eight en (7) days a week to provide stance with ADL, medication and emergency precautions 15, at 2:00 p.m., review of eets revealed no documented services were provided on ctober 12 and October 13,		PHR has policies and procedures in pl for HHA sick calls and last minute covincluding a staffing agency contract. Measures or Systemic Changes to Pr Future Recurrence: 1. In-service to Personal Care RN's a PSC's to include reminders about emergency plans with patients ar families in case of aide absence a need to communicate with MD w Plan of Care cannot be carried out	event and and and and and and and and and an	
	2015. On October 28, 201 with the Vice Presid Coordinator confirm not provided for Pat October 12 and Oct the POC. At the time of the in-	5, at 2:15 p.m., interviews lent and the Patient Service led that HHA services were lient #1 on October 9, 2015, lober 13, 2015, according to exestigation, the agency failed become care services.		Quality Monitoring Measures: Quarterly clinical record review of a 1 sampling of records-emergency plans complete on Plan of Care, notification MD of missed shifts	5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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H 456	in accordance with Note: It should be r 2015, at 10:30 a.m. the home revealed Interview with HHA providing HHA serv #2 at the time of the HHA #2 revealed th HHA services for be since 8:00 a.m. tha 3917.2(f) SKILLED Duties of the nurse the following: (f) Supervision of se health and persona support staff, as ap This Statute is not Based on record re care agency failed the services being delive for one (1) of one personal delive	the POC. noted that on October 27, , observations conducted at Patient #1 was without a HHA. #2 revealed that he/she was ices for Patient #1 and Patient e visit. Further interview with that he/she had been providing oth Patient #1 and Patient #2 t morning. NURSING SERVICES shall include, at a minimum, ervices delivered by home I care aides and household propriate; met as evidenced by: view and interview, the home to document the supervision of pered by the weekend HHAs, atient in the investigation.		H 456 3917.2 (f) Skilled Nursin Services—supervision of weeke aides not provided Actions To Correct This Deficient Provided 1. Review after hours staffing with Case Managers and determine a hours availability 2. Complete analysis of SN staffing and regulations to allow all aides shift, to receive direct supervision required 3. Determine any RN recruitment in to complete these after hours supervisions 4. Continue RN recruitment efforts targeting after hours field supervisions	RN fter 12/9/15 plan 1/28/16 s, any on as 2/15/16 12/15/15 and			

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H 456	Continued From pa	ge 8	H 456	Measures or Systemic Changes to Pr	event	
				Future Recurrence:		
		eek to provide personal care, L, medication reminders,				
		ncy precautions management.		Update Supervision Policy to more clearly specify all HHA staff receives		1/31/16
		15, at 12:30 p.m., review of		onsite supervisory visit		
		utine Visit notes dated May 11,		Revise supervisory monitoring re	norts	
		gust 18, September 18, 8 and October 19, 2015,		to guide this planning	ports	3/1/16
		N conducted assessments of				
		ervised care provided by the				
weekday HHAs. There was no documented evidence however, that the SN conducted an				Quality Monitoring Measures:		
				Quarterly clinical record review (w of a	
	provided by the wee	ent #1 and supervised care		10% sampling of records to moni		
	provided by the wet	ekelia HHAS.		compliance with supervision prot	tocols	3/1/16
	On October 28, 201	5 at 1:11 p.m., interview with		established as above		
	the SN confirmed th	nat he/she never supervised				
	the services being delivered by Patient #1's			Attempt to develop automated Supervisory compliance everight		
	weekend HHAs acc	cording to the POC.		Supervisory compliance oversight reporting tools and process	ι	5/31/16
	At the time of the in	vestigation, there was no		reporting tools and process		
		ce that the SN supervised the]	
		ered by the weekend HHA's.		H458 3917.2 (h) Skilled Nursing	7	
				Services		
H 458	3917.2(h) SKILLED	NURSING SERVICES	H 458			
	Duties of the sure	aballia duda atausisissus		Actions To Correct This Deficient Pra	ictice:	
	the following:	shall include, at a minimum,		MD not notified of changes in conditi	ion,	
	the following.			investigation of injury of unknown or		
	(h) Reporting change	es in the patient's condition to		missed dates of service		
	the patient's physici	an;				
				Counsel and educate specific RN Manager involved	Case	10/21/15
	This Statute is not	met as evidenced by:		2. In-service PC RN and PSC team or	n	
		and record review, the		requirements to notify MD of cha		12/9/15
	agency's nurse faile	d to report injuries of		in patient condition, missed date		
		ecifically bruises to the		injury of unknown origin		
	right/left buttocks ar	nd right eye) to the patient's				

Health Regulation & Licensing Administration STATE FORM

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HCA-0030 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW, SUITE 300 PROFESSIONAL HEALTHCARE RESOURCES (WASHINGTON, DC 20007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 458 Continued From page 9 H 458 **Measures or Systemic Changes to Prevent Future Recurrence:** physician, for one (1) of 1 patient in the investigation. (Patient #1) 1. Develop process to communicate 12/16/15 written information to MD by fax if no The findings include: response to telephone calls 1. On October 9, 2015, at 5:18 p.m., the state agency received an email entitled "Quality 2. Instruct RN's that documentation of Concerns Status Summary Report" from the Vice communication with MD must be 12/9/15 President of the HCA regarding Patient #1's more specific to include who they injuries of unknown origin. The report revealed spoke to, specific time and content of that on October 3, 2015, HHA #2 contacted the messages agency on call supervisor (Patient Service Coordinator) with concerns about marks found on **Quality Monitoring Measures:** Patient #1's buttock and back, which he/she felt might be bruises. The email further revealed that Quarterly clinical record review of a 10% on October 5, 2015, the Patient Service sampling of records to monitor for Coordinator notified the Vice President of the 3/1/16 documentation of communication with HCA about Patient #1's bruises to the buttock and MD back, two (2) days after being initially informed. Continued review of the email revealed that on Tuesday, October 6, 2015, the agency's RN conducted an unscheduled supervisory visit to Patient #1's home. The SN notes reflected that either faded bruises or a stage 1 pressure ulcer was noted. The SN instructed HHA#3 on pressure management and incontinence care. The SN also noted that the marks on Patient #1's buttock and back were vague and that he/she was unable to ascertain how they appeared. On October 23, 2015, at approximately 12:30 p.m., review of the SN Routine Visit note dated October 6, 2015, revealed that the SN noted the patient was observed to have three bruises, as follows: a. Upper lateral left thigh circular bruise measuring 4 cm. by 6 cm. (length and width respectively).

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B: WING __ HCA-0030 10/28/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(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 458	Continued From page 10 b. Middle left buttocks circular bruise measuring 6 cm by 7 cm. c. Right buttocks bruise measuring 5 cm by 8 cm. Further review of the note revealed that the patient denied pain to the aforementioned areas and denied being beaten by shaking his/her head. Interview conducted with agency's RN on October 28, 2015, at 1:11 p.m., confirmed that Patient #1 had sustained the 3 aforementioned bruises on his/her buttocks and thigh based on his/her head to toe assessment conducted on October 6, 2015. The RN stated that the injuries looked like a bed sore (pressure ulcer). When asked if Patient #1's physician had been made aware of the bruises, the RN responded by saying "yes". The RN then indicated that he/she called the physician on October 6, 2015, and left a message on the answering machine but could not recall the time. Continued interview with the RN revealed that he/she did not advise the family to take Patient #1 to the ER and/or to the doctor to be assessed for his/her injuries.	H 458	DEPICIENCY)	
	2. On October 9, 2015, at 5:18 p.m., the state agency received an email entitled "Quality Concerns Status Summary Report" from the Vice President of HCA regarding Patient #1's injuries of unknown origin. The report revealed that on October 8, 2015, HHA #2 notified the Patient Services Coordinator of bruising over Patient #1's right eye. The Patient Services Coordinator sent the agency's RN back to Patient #1's home on October 8, 2015, to assess the injured eye. The RN observed periorbital bruising, swelling and a subconjunctival hemorrhage in the right eye. On October 23, 2015, at approximately 12:45 p.m., review of the SN Routine Visit note			

STATEMENT OF DEFICIACIONS DATE PROVIDER SUPPLIER DEFICIENCY	Health F	regulation & Licensin	ig Administration				
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL HEALTHCARE RESOURCES (1010 WISCONSIN AVENUE, NW, SUITE 300 WASHINGTON, DC 20007 PRETEX (FACH DEFICIENCY MIST BE PRECEDED BY PILL, TAG CROSH-CETTON SHOULD BE CROSH-TYAG CONTROLL BE CROSH-TYAG CROSH-CETTON SHOULD BE CROSH-TYAG CROSH-CETTON SHOULD BE CROSH-TYAG CROSH-CETTON SHOULD BE CROSH-CROSH-CETTON SHOULD BE CROSH-CETTON							
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WASHINGTON, DC 2007 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) RESOLUTION OR USE DIENTIFYING INFORMATION) H 458 Continued From page 11 summary dated October 8, 2015, revealed that the SN noted that the patient's right eye lid was bruised toward the bridge of the nose measuring 1 or in length by 1,5 cm in width. Further review of the routine visit summary revealed that the SN in length by 1,5 cm in width. Further review of the routine visit summary revealed that the SN left a message with Patient #1's physician that detailed his/her findings and suspected abuse. Interview conducted with agency's RN on October 28, 2015, at 1:11 p.m., revealed Patient #1's right eye was observed to be inflamed (dark purplish color). When asked if Patient #1's physician had been made aware of the injury to the right eye, the SN responded by saying "yes". The RN again indicated that he/she called the physician on October 8, 2015, and left a message on the answering machine but could not recall the time. Continued interview with the RN revealed that he/she did not advise the family to take Patient #1 to the ER and/or to the doctor to be assessed further. An earlier face to face interview was conducted with Patient #1's physician on October 28, 2015, at 10:11 a.m., at his/her office. According to the doctor, Patient #1's last visit to the doctor's occurred on July 15, 2015. When queried if he/she had been made aware of Patient #1's bruises to the buttocks and injury to the right eye that occurred on October 6, 2015 and October 8, 2015, the doctor responded by saying "no". The doctor was asked if he/she had spoken with the agency's RN or received a message regarding the patient's injuries. Again, the doctor replied by saying "no". When queried if he doctor indicated that you could not leave a message on the office phone when calls are placed after business hours. The doctor stated that if you	PPOFFS	SIONAL HEALTHCAL	1010 WIS		· ·		
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instructed by the answering service to call 911 if it	H 458	summary dated Octhe SN noted that it bruised toward the 1 cm in length by 1 of the routine visit s left a message with detailed his/her find. Interview conducted 28, 2015, at 1:11 p.i. eye was observed toolor). When asked been made aware of the SN responded to indicated that he/sh October 8, 2015, ar answering machine. Continued interview he/she did not advist to the ER and/or to further. An earlier face to fawith Patient #1's phyat 10:11 a.m., at his doctor, Patient #1's occurred on July 15 he/she had been mabruises to the buttoo that occurred on O	tober 8, 2015, revealed that he patient's right eye lid was bridge of the nose measuring 5 cm in width. Further review summary revealed that the SN in Patient #1's physician that dings and suspected abuse. If with agency's RN on October in the measuring and suspected abuse. If with agency's RN on October in the measure of the injury to the right eye, by saying "yes". The RN again the called the physician on the left a message on the expected by the measure of the last could not recall the time. If with the RN revealed that the doctor to be assessed the family to take Patient #1 the doctor to be assessed ace interview was conducted hysician on October 28, 2015, when office. According to the last visit to the doctor's 5, 2015. When queried if ade aware of Patient #1's cks and injury to the right eye ctober 6, 2015 and October 8, sponded by saying "no". The fine/she had spoken with the eived a message regarding and the doctor replied by queried further, the doctor ould not leave a message on the calls are placed after the doctor stated that if you is hours, you would be		DEPIGIENCY		

Health Regulation & Licensing Administration STATE FORM

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HCA-0030 10/28/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WISCONSIN AVENUE, NW, SUITE 300 PROFESSIONAL HEALTHCARE RESOURCES (WASHINGTON, DC 20007 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) H 458 Continued From page 12 H 458 was an emergency and for non-emergencies, to call during regular business hours. At the time of the investigation, there was no documented evidence that the physician had been made aware in a timely manner of the aforementioned changes in Patient #1's condition.