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	HCA-0030	A. BUILDING: _____ B. WING _____	C 10/28/2015

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

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H 000	INITIAL COMMENTS 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 Health Regulation Licensure Administration - HRLA Home Care Agency - HCA Home Health Aide - HHA Intermediate Care Facilities Division - ICFD Plan of Care - POC	H 000		

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H 000	Continued From page 1 Registered Nurse - RN Skilled Nurse - SN	H 000	*H 070 3904.1 Director* In investigating the first allegation of physical abuse in our company's 21 year history, we have completed our work without a true conclusion about exactly what happened. We are grateful that no serious or permanent injuries were experienced by the patient. We utilized our typical approach to performance improvement –talk to people involved, collect information from many sources, ask a lot of questions, investigate, analyze and remain open to new findings and needs for change; and identify, document, implement and monitor our improvement strategies to ensure true improvement and lasting change. Timely escalation of a potentially important clinical finding did not occur in this instance. The PSC did not recognize that injury of unknown origin might represent physical abuse and that immediate response was indicated. <u>Actions to correct this deficient practice:</u> 1. Education and performance counseling of PSC regarding the specific deficiencies of this incident, to identify knowledge deficits and opportunities missed to assure safety of client, and expected actions in future. Reviewed incident reporting and elder abuse and neglect policies. 2. In-service with case study review of this incident with the entire Personal Care supervisory team, including all Patient Service Coordinators and RN Case Managers, with review of initial revisions to policy, and education on expected awareness and responses to any such	11/20/15
H 070	3904.1 DIRECTOR The governing body shall appoint a Director who shall be responsible for managing and directing the agency's operations, serving as liaison between the governing [*2880] body and staff, employing qualified personnel, and ensuring that staff members are adequately and appropriately trained. This Statute is not met as evidenced by: Based on interviews and record review, the the Home Care Agency's (HCA's) director failed to ensure that one (1) of 1 Employee #1 (Patient Service Coordinator) was adequately and appropriately trained on the agency's policy on reporting unusual incidents. (Employee #1) The finding includes: On October 26, 2015, at 3:43 p.m., interview with HHA #3 revealed that he/she called the Patient 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 bruises on the patient's left and right buttocks and a purplish/green bruise on the left thigh. On October 26, 2015, at 12:35 p.m., during an 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 abused.	H 070		

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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 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 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. On October 27, 2015, at 11:35 a.m., review of the DCMPD Public Incident Report CCN #15159852,	H 070	future findings of injury of unknown origin. Discussion and input obtained to final policy revisions. Instructed all that new procedures in the policy are to be implemented immediately. 10/13/15 3. Conducted in-depth interviews with HHA #2 and #3 to attempt to further ascertain what happened in this incident, and used the opportunity to reinforce observation and reporting responsibilities. 11/8/15 <u>Measures or systemic changes to prevent future recurrences:</u> 1. Presented case study and sought input to improvement strategies from PHR Quality Council, 11/2/2015 and Professional Advisory Committee 11/10/2015 and Branch Administrators 10/29/2015. All PHR staff were instructed to implement the new procedures in the Abuse and Neglect Policy immediately. 11/2/15 11/10/15 10/29/15 2. Finalize Elder Abuse and Neglect policy revisions, present to the President and Governing Body for approval. 12/15/15 3. In-service all PSC and RN Case Managers on the updated Elder Abuse and Neglect Policy (this is a 2nd in-service to reinforce key items in the final policy) 1/15/16	

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H 070	Continued From page 3 dated October 8, 2015, at 10:28 p.m., revealed that Patient #1 was mentally ill and was non-verbal and unable to communicate how her injuries had occurred. Further review revealed that Patient #1 was under the care of a HHA from a HCA. On October 28, 2015, at 11:45 a.m., review of the Incident Report policy revised on August 16, 2013, revealed that "The Branch Administrator will be notified immediately of serious client injury or occurrence that may be a potential liability issue." At the time of the investigation, the facility failed to provide evidence that all allegations of abuse (injuries of unknown origin) were reported and investigated timely to ensure patient safety. Note: On October 22, 2015, HHA #1 was terminated from the agency for failure to observe and report changes in Patient #1's condition to the agency. HHA #1 was referred to the BON for a review of their practice. The HCA stated that they were unable to substantiate the allegation of abuse.	H 070	4. Updated PC PSC orientation checklist to include training on updated policy for all newly hired PSC staff 5. Review and update as needed HHA Orientation content on Elder Abuse and Neglect, per finalized policy updates 6. Reinforce mandatory reporter requirements to all HHA staff through in-service <u>Quality monitoring measures we will institute:</u> 1. Add Elder Abuse and Neglect items to annual knowledge competency for all staff . 2. Quarterly review of standard quality indicators, including incidents and complaints	11/30/15 1/31/15 January-March 2016 11/1/16 1/1/16 and ongoing
H 305	3912.2(i) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (i) To be free from mental and physical abuse, neglect, and exploitation by agency employees or contract personnel;	H 305	*H 305 3912.2 (i) Patient Rights and Responsibilities* PHR staff has not detected any signs of serious or permanent injury in our patient. We will continue to carefully monitor her condition. We have identified opportunities for improvement in our policy and education of management and direct care staff to more securely assure patient safety and better ensure the patient's right to freedom from physical abuse.	

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H 305	Continued From page 4 This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency failed to develop policies and procedures to ensure patient's right to be free from physical abuse, for one (1) of 1 patient in the investigation. (Patient #1) The finding includes: On October 23, 2015, at 11:45 a.m., the surveyor requested the agency's policies and procedures that addressed the patient's right to be free from physical abuse. The agency provided a policy entitled "Elder Abuse and Neglect" effective date January 1, 2008. Review of the policy failed to provide evidence of the procedures that staff were to implement to ensure the patient's rights to be free from physical abuse was maintained. At approximately 1:00 p.m., during an interview the Vice President of the HCA, confirmed that the policy failed to reflect procedures to be implemented that would ensure the patient's right to be free from physical abuse. Further interview revealed that the agency would be making revisions to their policy on "Elder Abuse and Neglect". On October 26, 2015, at 3:43 p.m., interview with HHA #3 revealed that he/she called the Patient 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 bruises on the patient's left and right buttocks and a purplish/green bruise on the left thigh. 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,	H 305	**Actions To Correct This Deficient Practice:** 1. Revise Elder Abuse and Neglect policy to clarify need for immediate reporting and investigation, immediate staffing changes. Draft revisions completed; approve and implement final revisions — 12/15/15 2. Educate/in-service of PHR policy requirements for all PSC and RN case managers through in-service, emphasize duty for patient safety and protection from abuse and PHR policies and procedures to do so — January – March 2016 **Measures or Systemic Changes to Prevent Future Recurrence:** 1. Provide new hire training and education on updated Elder Abuse and Neglect policy requirements to all staff — 1/1/16 and ongoing 2. Include content about Elder Abuse and Neglect in annual education and competency training — 11/1/16 and ongoing Quality Monitoring Measures: 1. Add Elder Abuse and Neglect items to annual knowledge competency for all staff — 11/1/16 2. Quarterly review of standard quality indicators, including incidents and complaints — 1/1/16 and ongoing	

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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 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. At the time of the investigation, the HCA failed to ensure policies and procedures were developed to protect Patient #1 from physical abuse.	H 305	*H453 3917.2 (c) Skilled Nursing Services* **Actions To Correct This Deficient Practice:** The October 9, 12, and 13 dates of service were not provided at the request of the patient's sister who wanted a regular replacement, only, rather than fill in staff. PHR assured HHA services were provided on October 10 and 11 by her regular weekend aide, and established a new regular weekday HHA by October 14. We confirmed that the patient's essential needs were attended to by her family, and that at no time was she not supervised.	10/10 and 11/15 10/14/15
H 453	3917.2(c) SKILLED NURSING SERVICES	H 453		

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H 453	Continued From page 6 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 skilled nurse failed to ensure that the patient's needs were met in accordance with their POC, for one (1) of one (1) patient in the investigation. (Patient #1) The finding includes: On October 26, 2015, at 10:00 a.m., review of Patient #1's POC, with a documented certification period of April 3, 2015 to October 29, 2015, revealed a physician's order for HHA visits eight (8) hours a day seven (7) days a week to provide personal care, assistance with ADL, medication reminders, safety and emergency precautions management. On October 28, 2015, at 2:00 p.m., review of Patient #1's timesheets revealed no documented evidence that HHA services were provided on October 9, 2015, October 12 and October 13, 2015. On October 28, 2015, at 2:15 p.m., interviews with the Vice President and the Patient Service Coordinator confirmed that HHA services were not provided for Patient #1 on October 9, 2015, October 12 and October 13, 2015, according to the POC. At the time of the investigation, the agency failed to ensure Patient #1 received home care services	H 453	On October 27, when PHR became aware of the non-attendance of the assigned HHA, the PSC immediately worked to assign a fill-in aide. That HHA arrived at the patient's home at 10: 40 AM. HHA #2 was in the home on a regular basis and had a relationship with the patient, so ensured her basic morning care and breakfast. These were incidental support services; the aide was not assigned to care for both patients, no services were billed to the payer. This oversight support was provided by the aide on a volunteer basis and was not billed to the payer. PHR has policies and procedures in place for HHA sick calls and last minute coverage, including a staffing agency contract. **Measures or Systemic Changes to Prevent Future Recurrence:** 1. In-service to Personal Care RN's and PSC's to include reminders about emergency plans with patients and families in case of aide absence and need to communicate with MD when Plan of Care cannot be carried out **Quality Monitoring Measures:** Quarterly clinical record review of a 10% sampling of records-emergency plans complete on Plan of Care, notification to MD of missed shifts	10/27/15 12/9/15 3/1/16

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H 453	Continued From page 7 in accordance with the POC. Note: It should be noted that on October 27, 2015, at 10:30 a.m., observations conducted at the home revealed Patient #1 was without a HHA. Interview with HHA #2 revealed that he/she was providing HHA services for Patient #1 and Patient #2 at the time of the visit. Further interview with HHA #2 revealed that he/she had been providing HHA services for both Patient #1 and Patient #2 since 8:00 a.m. that morning.	H 453		
H 456	3917.2(f) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (f) Supervision of services delivered by home health and personal care aides and household support staff, as appropriate; This Statute is not met as evidenced by: Based on record review and interview, the home care agency failed to document the supervision of services being delivered by the weekend HHAs, for one (1) of one patient in the investigation. (Patient #1) The finding includes: On October 23, 2015, at 11:00 a.m., a review of Patient #1's POC with a certification period of April 3, 2015 to October 29, 2015, revealed a physician's order for the SN to provide one visit every fifty-five (55) to sixty (60) days with three (3) PRN visits to manage and evaluate patient care and to supervise the HHA. In addition, Patient #1 was to receive HHA visits eight (8) hours a day	H 456	*H 456 3917.2 (f) Skilled Nursing Services—supervision of weekend aides not provided* **Actions To Correct This Deficient Practice:** 1. Review after hours staffing with RN Case Managers and determine after hours availability 2. Complete analysis of SN staffing plan and regulations to allow all aides, any shift, to receive direct supervision as required 3. Determine any RN recruitment needs to complete these after hours supervisions 4. Continue RN recruitment efforts targeting after hours field supervision	12/9/15 1/28/16 2/15/16 12/15/15 and ongoing

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H 456	Continued From page 8 seven (7) days a week to provide personal care, assistance with ADL, medication reminders, safety and emergency precautions management. On October 23, 2015, at 12:30 p.m., review of Patient #1's SN Routine Visit notes dated May 11, June 18, July 7, August 18, September 18, October 6, October 8 and October 19, 2015, revealed that the SN conducted assessments of the patient and supervised care provided by the weekday HHAs. There was no documented evidence however, that the SN conducted an assessment of Patient #1 and supervised care provided by the weekend HHAs. On October 28, 2015 at 1:11 p.m., interview with the SN confirmed that he/she never supervised the services being delivered by Patient #1's weekend HHAs according to the POC. At the time of the investigation, there was no documented evidence that the SN supervised the services being delivered by the weekend HHA's.	H 456	**Measures or Systemic Changes to Prevent Future Recurrence:** 1. Update Supervision Policy to more clearly specify all HHA staff receive an onsite supervisory visit 2. Revise supervisory monitoring reports to guide this planning **Quality Monitoring Measures:** 1. Quarterly clinical record review of a 10% sampling of records to monitoring compliance with supervision protocols established as above 2. Attempt to develop automated Supervisory compliance oversight reporting tools and process *H458 3917.2 (h) Skilled Nursing Services*	1/31/16 3/1/16 3/1/16 5/31/16
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 interview and record review, the agency's nurse failed to report injuries of unknown origin, (specifically bruises to the right/left buttocks and right eye) to the patient's	H 458	**Actions To Correct This Deficient Practice:** MD not notified of changes in condition, investigation of injury of unknown origin, missed dates of service 1. Counsel and educate specific RN Case Manager involved 2. In-service PC RN and PSC team on requirements to notify MD of changes in patient condition, missed dates, injury of unknown origin	10/21/15 12/9/15

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H 458	Continued From page 9 physician, for one (1) of 1 patient in the investigation. (Patient #1) The findings include: 1. 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 the HCA regarding Patient #1's injuries of unknown origin. The report revealed that on October 3, 2015, HHA #2 contacted the agency on call supervisor (Patient Service Coordinator) with concerns about marks found on Patient #1's buttock and back, which he/she felt might be bruises. The email further revealed that on October 5, 2015, the Patient Service Coordinator notified the Vice President of the HCA about Patient #1's bruises to the buttock and 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).	H 458	**Measures or Systemic Changes to Prevent Future Recurrence:** 1. Develop process to communicate written information to MD by fax if no response to telephone calls 2. Instruct RN's that documentation of communication with MD must be more specific to include who they spoke to, specific time and content of messages **Quality Monitoring Measures:** Quarterly clinical record review of a 10% sampling of records to monitor for documentation of communication with MD	12/16/15 12/9/15 3/1/16

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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. 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	H 458		

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 _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 cm 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 further, the 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 called after business hours, you would be instructed by the answering service to call 911 if it	H 458		

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 _____	C 10/28/2015

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H 458	Continued From page 12 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.	H 458		