Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0055	A. BUILDING: _____ B. WING _____	07/09/2015

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HEALTH MANAGEMENT, INC	1707 L STREET, NW SUITE 900 WASHINGTON, DC 20036

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H 000	INITIAL COMMENTS An annual survey was conducted from June 30, 2015 through July 9, 2015 to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22 DCMR Chapter 39). The Home Care Agency provides home care services to two hundred forty-six (246) patients and employs three hundred (300) staff. The findings of the survey were based on a review of fourteen (14) active patient records, two (2) discharged patient records, nineteen (19) employee records, four (4) home visits and interviews with patients/family and staff. The following are abbreviations used within the body of this report: ABBREVIATIONS ADL --- activities of daily living BPM --- beats per minute CPR --- Cardiopulmonary Resuscitation D/BP --- diastolic blood pressure DMII --- diabetes mellitus type II BID --- twice a day HCA --- Home Care Agency HHA --- home health aide HR --- heart rate HTN --- hypertension IADL --- instrumental activities of daily living IV --- intravenous kg --- kilogram mcg --- microgram mg --- milligram ml --- milliliter mmHg --- millimeters of mercury POC --- plan of care PT --- physical therapy RN --- registered nurse S/BP --- systolic blood pressure	H 000		

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H 000	Continued From page 1 SOC --- start of care SN --- skilled nurse XL --- extended length	H 000		
H 148	3907.2(d) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (d) Documentation of current CPR certification, if required; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to maintain accurate personnel records, which included documentation of current CPR certification, for one (1) of nineteen (19) employees in the sample. (Employee #8). The finding includes: On July 7, 2015, at approximately 2:40 p.m., review of Employee #8's personnel file failed to evidence a current CPR certification. During a face-to-face interview with the director of operations on July 7, 2015, at approximately 3:00 p.m., it was acknowledged that the CPR certification was not in Employee #8's personnel file. Further interview revealed that the agency would locate the CPR certification and emailed the certification to DOH/HRLA. It should be noted that DOH/HRLA did not receive an e-mail of the CPR certification.	H 148	# H 148 Employee #8 CPR is in place (see attached document) 07/2015 All active employees' records have been screened for compliance 09/30/15 Any employee found to have an current CPR certification was notified and instructed to comply by 09/30/2015. All employees personnel records are monitored for compliance by using excel spreadsheet. Employees will be notified 60 days prior to the date of expiry. This will be followed up with another reminder if it is not obtained within 30 days. Failure to comply will result the employee being removed from assignment. On going	
H 163	3907.7 PERSONNEL Each employee shall be screened for communicable disease annually, according to the	H 163	# H 163 Employee #8 Screen for communicable disease is in place. (see attached document) 07/2015	

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H 163	Continued From page 2 guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure that each employee was screened for communicable diseases annually for one (1) of the nineteen (19) employees in the sample. (Employee #8) The finding includes: On July 7, 2015, at approximately 2:40 p.m., review of Employee #8's personnel file failed to evidence a current health certificate. During a face to face interview with the director of operations on July 7, 2015, at approximately 3:00 p.m., it was acknowledged the health certification was not in Employee #8's personnel file. Further interview revealed that the agency would locate the current health certification and email the certification to DOH/HRLA. It should be noted that DOH/HRLA did not receive an e-mail of the current health certification.	H 163	Continued from page 2 # H 163 All active employees' records have been screened for free of communicable disease. Any employee found not to have an updated screening document was notified and instructed to comply by 09/30/2015. All employees personnel records are monitored for compliance by using excel spreadsheet. Employees will be notified 60 days prior to the date of expiry of document. This will be followed up with another reminder, if it is not obtained within 30 days. Failure to comply will result themployee being removed from assignment.	9/30/15 On going
H 265	3911.2(e) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (e) Physician's orders; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to ensure that the clinical record for one (1) of (1) patient's in the	H 265	# H 265 clarification order sent to the the physician's office for patient #8. Clinician was counselled. Clinicians are instructed to follow the POC during each visit to verify the accuracy of care especially for medication management.	07/2015

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H 265	Continued From page 3 sample receiving vitamin B had a physician order for the administration of vitamin B. (Patient #8) The finding include: On July 7, 2015, review of Patient #8 's clinical record revealed a skilled nursing note dated January 14, 2015 in which the nurse documented, "vit [vitamin] B injection given to left deltoid muscle. Client tolerated the injection well." Further review of the record failed to evidence an order for vitamin B injection. On July 7, 2015, starting at approximately 2:00 p.m., interview with the clinical director revealed that he/she did not see an order in the record for the administration of injectable vitamin B.	H 265	Continued from page 3 Clinicians are instructed to do an addendum to the POC, when it is warranted. Clinical Director will meet with each clinician as needed for it's compliance.	On Going
H 355	3914.3(d) PATIENT PLAN OF CARE The plan of care shall include the following: (d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies; This Statute is not met as evidenced by: Based on interview and record review, the HCA failed to provide a description on the POC of the PT services to be provided for one (1) of one (1) patient's in the sample that was receiving PT services. (Patient #12)	H 355	# H 355 Plan of Care for patient #12 does indicate the frequency of nursing, PT and HHA. (Copy of the POC is attached) An addendum has been added to the POC. (Copy of the addendum is attached) Prior to sending the POC to the Doctor's office, the Clinical Director will review the POC to ensure the description of services are included in the POC.	07/2015 On Going

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H 355	Continued From page 4 The finding includes: On July 6, 2015, at approximately 1:35 p.m., review of Patient #12's POC with a certification period of June 26, 2015 through August 21, 2015, revealed an order for PT services. The POC however failed to indicate the frequency, amount and duration of physical therapy services. PT visit notes indicated that Patient #12 received PT services on the following dates: - June 27th and 30th; - July 2nd and 4th 2015. On July 6, 2015, at approximately 1:45 p.m., during an interview with the clinical director, it was acknowledged that Patient #12's POC failed to detail a description for the PT services. Further interview revealed that the agency recently incorporated a new computer system and the PT service description was omitted in error.	H 355		
H 362	3914.3(k) PATIENT PLAN OF CARE The plan of care shall include the following: (k) Safety measures required to protect the patient from injury; This Statute is not met as evidenced by: Based on interview and record review, the HCA failed to ensure the POC included the safety measures required to protect the patient from injury for one (1) of sixteen (16) patients in the sample. (Patient #4) The finding includes:	H 362	# H 362 The safety measures and emergency protocols have been included in the POC. This correction has been already made to the software. (A copy of the corrected version has been included.) Prior to sending any POC to the Doctor's office, the Clinical Director will review to ensure the safety measures and emergency protocols are included in the POC.	07/2015 On Going

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H 362	Continued From page 5 On July 6, 2015, at approximately 10:00 a.m., a review of Patient #4's clinical record revealed a POC with certification period of May 15, 2015 through July 13, 2015. The POC failed to evidence the safety measures required to protect the patient from injury. During an interview with the clinical director on July 6, 2015, starting at approximately 2:30 p.m., the clinical director indicated that they have implemented a new computer program and the safety measures were omitted in error.	H 362		
H 363	3914.3(l) PATIENT PLAN OF CARE The plan of care shall include the following: (l) Identification of employees in charge of managing emergency situations; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to identify personnel in charge of managing emergencies on the POC for one (1) of sixteen (16) patients in the sample. (Patient #4) The finding includes: On July 6, 2015, starting at approximately 10:00 a.m., review of Patient #4's POC with certification period of May 15, 2015 through July 13, 2015, failed to evidence personnel in charge of managing emergencies. During an interview with the clinical director on July 6, 2015, starting at approximately 2:30 p.m.,	H 363	# H 363 The safety measures and emergency protocols have been included in the POC. This correction has been already made to the software. (A copy of the corrected version has been included) Prior to sending any POC to the Doctor's Office, the Clinical Director will review to ensure the safety measures and emergency protocols are included in the POC.	07/2015 On Going

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H 363	Continued From page 6 the clinical director indicated that they have implemented a new computer program and the personnel in charge of managing emergencies was omitted in error.	H 363		
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to ensure that the POC included an emergency protocol for four (4) of sixteen (16) patients in the sample. (Patients #4, #12, #13, #14) The finding includes: 1. On July 6, 2015, starting at approximately 10:00 a.m., review of Patient #4's POC with certification period of May 15, 2015 through July 13, 2015, failed to evidence the HCA's emergency protocol. 2. On July 2, 2015, at approximately 1:35 p.m., review of Patient #12's POC with a certification period of June 26, 2015 through August 21, 2015, failed to evidence the HCA's emergency protocol. 3. On July 6, 2015, at approximately 12:45 p.m., review of Patient #13's POC with a certification period of May 1, 2015 through July 3, 2015, failed to evidence the HCA's emergency protocol. 4. On July 2, 2015, at approximately 10:15 a.m., review of Patient #14's POC with a certification	H 364	# H 364 The safety measures and emergency protocols have been included in the POC. This correction has been already made to the software. (A copy of the corrected version has been included). Prior to sending any POC to the Doctor's Office, the Clinical Director will review to ensure the safety measures and emergency protocols are included in the POC.	07/2015 On Going

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H 364	Continued From page 7 period of of April 30, 2015 through June 26, 2015, failed to evidence the HCA's emergency protocol. During an interview with the clinical director on July 6, 2015, starting at approximately 2:30 p.m., the clinical director indicated that they have implemented a new computer program and the HCA's emergency protocol was omitted in error.	H 364		
H 366	3914.4 PATIENT PLAN OF CARE Each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care; provided, however, that a plan of care for personal care aide services only may be approved and signed by an advanced practice registered nurse. If a plan of care is initiated or revised by a telephone order, the telephone order shall be immediately reduced to writing, and it shall be signed by the physician within thirty (30) days. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure that patients POCs were approved and signed by a physician within thirty (30) days of the SOC, for three (3) of sixteen (16) patients in the sample. (Patients #11, #13, #14) The findings includes: 1. On June 30, 2015, at approximately 1:05 p.m., review of Patient #11's record revealed a POC with a certification period of January 26, 2015 to July 24, 2015. The POC was signed by the physician March 20, 2015. This was fifty-three (53) days after the SOC.	H 366	# H 366 Patient #11, a non compliant patient never kept his doctor's appointment for follow-up visits. He had missed multiple appointments with the doctor. (see notes) Physician liaison called and scheduled an appointment with Primary Care Physician. Current Plan of Care is signed within 30 days. (see attached document) Patient #13 , Plan of Care was signed within 30 days (see attached document) Patient #14, there was a glitch in printing the Plan of Care with the new software system and it has been rectified. Current Plan of care is signed	07/2015

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H 366	Continued From page 8 2. On July 6, 2015, at approximately 12:45 p.m., review of Patient #13's record revealed a POC with a SOC of May 1, 2015. The POC failed to evidence the physician's signature of approval. 3. On July 2, 2015, at approximately 10:15 a.m., review of Patient #14's record revealed a POC with a SOC of April 30, 2015. The POC failed to evidence the physician's signature of approval. On July 6, 2015 at 2:29 p.m., an interview with the clinical director, it was revealed that the agency recently converted to an electronic system and was in the process of having all POC's signed by the physicians.	H 366	Continued from Page 8 within 30 days. (see attached document)	
H 399	3915.10(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Personal care aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on interview and record review , it was determined that the agency failed to ensure PCA(s) observed and recorded on the patient's physical condition, behavior or appearance for seven (7) of sixteen (16) patients in the sample. (Patients #3, #5, #7, #10, #11, #15 and #16) The findings include:	H 399	# H 399 Will review and correct all the active patients' charts to ensure the PCA (s) have documented the patients physical condition, behavior, and appearance daily. Any abnormalities will be reported to the Clinical Director immediately. Will re-educate all PCAs to observe and record the patients physical condition/behavior and appearance daily during the in-service on September 27, 2015. Emphasis will be	10/2015

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H 399	Continued From page 9 During an interview with the clinical director on June 29, 2015, starting at approximately 2:30 p.m., the clinical director indicated that the PCA are to document on the PCA communication form when there is a change in the patients physical condition, behavior and/or appearance. A review of the following patient records revealed the following: 1. On June 29, 2015, starting at approximately 10:00 a.m., review of PCA communication sheets dated from January 18, 2015 through June 20, 2015, failed to evidence Patient #3's physical condition, behavior and/or appearance. 2. On July 7, 2015, starting at approximately 9:33 a.m., review of PCA communication sheets dated from May 7, 2015 through June 20, 2015, failed to evidence Patient #5's physical condition, behavior and/or appearance. 3. On July 7, 2015, starting at approximately 9:33 a.m., review of PCA communication sheets dated from May 17, 2015 through June 20, 2015, failed to evidence Patient #7's physical condition, behavior and/or appearance. 4. On July 7, 2015, starting at approximately 9:33 a.m., review of PCA communication sheets dated from May 17, 2015 through June 20, 2015, failed to evidence Patient #10's physical condition, behavior and/or appearance. 5. On June 30, 2015, starting at approximately 1:15 p.m., review of PCA communication sheets dated from January 26, 2015 through June 20, 2015, failed to evidence Patient #11's physical condition, behavior and/or appearance.	H 399	Continued from page 9 made to document the observations daily and report if further actions are to be taken Prior to processing timesheets, the staffing co-ordinators will review to ensure that all documents submitted by the HHAs are completed accurately.	On Going

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H 399	Continued From page 10 6. On July 2, 2015, starting at approximately 10:15 a.m., review of PCA communication sheets dated from February 18, 2015 through June 20, 2015, failed to evidence Patient #15's physical condition, behavior and/or appearance. 7. On July 7, 2015, starting at approximately 12:00 p.m., review of PCA communication sheets dated from February 12, 2015 through June 20, 2015, failed to evidence Patient #16's physical condition, behavior and/or appearance. There was no documented evidence that the HCA ensured PCAs recorded on the patients physical condition, behavior and/or appearance.	H 399		
H 430	3916.1 SKILLED SERVICES GENERALLY Each home care agency shall review and evaluate the skilled services provided to each patient at least every sixty-two (62) calendar days. A summary report of the evaluation shall be sent to the patient's physician. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to send a summary of their review and evaluation of skilled services provided to the physician at least every 62 days for seven (7) of sixteen (16) patients in the sample. (Patients #3, #6, #8, #9, #11, #15, #16) The finding include: 1. On June 30, 2015, at approximately 12:45 p.m., review of Patient #3's POC, with certification period of January 18, 2015 through July 16, 2015, revealed that the skilled nurse was to provide	H 430	# H 430 Clinicians have been instructed to complete 62 day summary of skilled services. This will be sent to the physician. (see attached memo) Spreadsheet will be developed and maintained to monitor this activity by the Clinical Director. Clinical Director will meet with each Clinician in order to meet it's compliance.	09/2015

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H 430	Continued From page 11 service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician. 2. On July 6, 2015, at approximately 11:00 a.m., review of Patient #6's POC, with certification period of February 2, 2015 through July 31, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician. 3. On July 7, 2015, at approximately 9:40 a.m., review of Patient #8's POC, with certification period of January 1, 2015 through July 29, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician.	H 430		

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H 430	Continued From page 12 4. On July 7, 2015, at approximately 11:25 a.m., review of Patient #9's POC, with certification period of February 6, 2015 through August 4, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician. 5. On July 7, 2015, at approximately 11:25 a.m., review of Patient #9's POC, with certification period of February 6, 2015 through August 4, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician. 6. On June 30, 2015, at approximately 1:15 p.m., review of Patient #11's POC, with certification period of April 1, 2015 through September 27, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and	H 430		

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	HCA-0055	A. BUILDING: _____ B. WING _____	07/09/2015

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H 430	Continued From page 13 evaluation of skilled services was conducted and submitted to the physician. 7. On July 2, 2015, at approximately 10:15 a.m., review of Patient #15's POC, with certification period of February 18, 2015 through August 17, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician. 8. On July 7, 2015, at approximately 1:00 p.m., review of Patient #16's POC, with certification period of February 12, 2015 through August 10, 2015, revealed that the skilled nurse was to provide service every 30 days. The skilled nurse was to provide observation and assessments the neurological system, cardio-pulmonary system, cardio-vascular system, gastro-intestinal system, genitourinary system, monitor vital signs, assess for signs of hypertensive crisis... There was no documented evidence that a review and evaluation of skilled services was conducted and submitted to the physician. On June 30, 2015, starting at approximately 2:30 p.m., the clinical director was interviewed to ascertain if the patients' primary physician were provided a summary of the skill services assessments and evaluations. The clinical director indicated that the evaluation and	H 430		

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H 430	Continued From page 14 assessments were not provided every 62 days. There was no evidence that physicians were notified of the skilled nursing assessments and evaluations.	H 430		
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse failed to ensure that the patient's needs were met in accordance with their POC for five (5) of sixteen (16) patients in the sample. (Patients' #3, #6, #9, #11 and #16) The findings include: 1. On July 6, 2015, starting at approximately 11:00 a.m., review of Patient # 3's record revealed a POC with the certification period of February 2, 2015 through July 31, 2015. The POC documented that Patient #3 had a history of DMII was prescribed Glucotrol XL 2.5 mgs bid by mouth. Further review of the POC revealed that the skilled nurse was to visit the patient once a month to conduct a complete systems assessment and observations to include reporting blood sugar results greater than 300 and less than 60 to the patient's primary physician. Also, the POC documented that the HHA was to visit the patient eight (8) hours a day , seven (7) days a week for 180 days to assist with ADL's and IADL's. Continued review of the record revealed	H 453	# H 453 1. a) Clinicians have been instructed to monitor and record the blood sugar values in clinical notes each time visiting the patient. If the blood surgar values are out of range from the POC, it is the duty of the clinician to notify the Primary Care Physician/ and/or the Clinical Director and document the outcomes in clinical notes. (see attached memo) Clinical Director will meet with each clinician to review the care provided once a month, to improve the quality of care.	07/2015 On going

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H 453	Continued From page 15 the following: a). Review of skilled nursing notes dated April 23, 2015 and May 29, 2015, failed to evidence a blood sugar result. b). Review of HHA time sheets failed to evidence HHA services were provided on the following dates: - January 23rd and 24th; - February 8th, 15th, and 22nd; - April 18th, 19th, 25th, and 26th; and - May 23rd and 24th. Continued review of the HHA time sheets, revealed the agency's HHAs provided more than the prescribed eight (8) hours of service on multiple days starting from January 20, 2015 through June 21, 2015. The hours varied from ten to sixteen. On July 2, 2015, starting at approximately 2:00 p.m., interview with the clinical director revealed that the agency's policy for diabetic patients is that the patients/family/HHA are responsible for performing the fingerstick's to obtain blood sugar results and the skilled nurse is responsible for reviewing the blood sugar results and documenting them on their monthly skilled nursing note. The DON also indicated that the order was eight (8) hours of HHA services and the patient did not want any additional hours. 2. On July 6, 2015, starting at approximately 11:00 a.m., review of Patient #6's record revealed a POC with the certification period of February 2, 2015 through July 31, 2015. The POC documented that Patient #6 had a history of DMII uncontrolled and was prescribed Levemir 25 units	H 453	Continued from page 15 # H 453 1. b) Patient # 3 refused services for all the mentioned dates. When a patient refuses the authorized hours of PCA services it will be documented and the physician will be notified. DHCF and Delmarva will be informed. Staffing Coordinators will report daily to the Clinical Director when patients refuse services.	09/2015 On going

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H 453	Continued From page 16 subcutaneously BID. Further review of the POC revealed that the skilled nurse was to visit the Patient #6 once a month to conduct a complete systems assessment and observations. The POC failed to reflect monitoring of blood sugars and parameters to report to the physician. Additionally, the POC ordered HHA services were to be was to provide eight (8) hour a day, seven (7) days a week for 180 days to assist with ADL's and IADL's. a). Review of skilled nursing notes dated March 6, 2015, May 23, 2015 and June 6, 2015 failed to evidence blood sugar results. b). There was no evidence the skilled nurse had ensured adequate HHA time coverage in accordance with the POC on the following dates: - February 15th, 17th, 21st and 22nd; - March 14th and 29th ; - April 12th, 13th , 25th - 30th; and - June 13th and 14th. On July 6, 2015, starting at approximately 2:00 p.m., interview with the clinical director revealed that the skilled nurse should have documented a blood sugar result on each of the aforementioned skilled nursing notes. On July 6, 2015, starting at approximately 2:30 p.m. interview with the physician liaison , the physician liaison stated ,"We did not bill for those dates so services were not provided." 4. On July 7, 2015, starting at approximately 11:25 a.m., review of Patient #9's record revealed	H 453	Continued from page 16 # H 453. 2.b) HCAs refused assignment to patient # 6 due to poor environmental conditions. APS was notified regarding the enironmental condition of the patient Currently patient has been transferred to nursing home for a higher level of care. Community Resources will be contacted and DHCF representative will be informed.	On going

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H 453	Continued From page 17 a POC with the certification period of February 2, 2015 through July 31, 2015. The POC ordered HHA services eight (8) a day , five (5) days a week for 180 days to assist with ADL's and IADL's. There was no evidence the skilled nurse had ensured adequate HHA time coverage in accordance with the POC on the following dates: - only six (6) hours of HHA service was provide from April 6th - 16th and April 22nd - June 19th; and - there was no documented evidence HHA services were provided from April 17th- April 21st. On July 7, 2015, starting at approximately 2:00 p.m., interview with the clinical director revealed that Delmarva and not the physician had decreased the patient's HHA hours from eight (8) to six (6) , five (5) days a week. On July 7, 2015, starting at approximately 2:30 p.m., interview with the physician liaison revealed HHA services were not provided from April 17th through the 21st because the agency did not bill for those days. 5. On July 7, 2015 starting at 11:25 a.m., review of Patient #11's POC, with a certification period of January 26, 2015 to July 24, 2015, revealed that HHA services were to be provided eight (8) hours per day on Tuesday, Thursday, Saturday, and Sunday, and four (4) hours per day on Monday, Wednesday and Friday. Further review of the record revealed that there was no documented evidence HHA services were provided on the following dates:	H 453	Continued from Page 17 # 453 4. Patient #9 PCA service hours were decreased by Delmarva. Please see physician order attached When there is a change in hours from the POC, a written order will be sent to the physician to reflect the change in hours. Clinical Director will meet with clinicians as needed for it's compliance # 453 5. Patient #11 Error was made by staffing coordinator in scheduling the hours to be provided which has been rectified. Staffing coordinator was verbally counselled. The Supervisor will monitor daily, the hours scheduled are as per the POC	On Going 7/2015 On Going

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H 453	Continued From page 18 - January 29th; - February 1st, 8th, 15th, and 17th ; - March 1st, 5th, 28th and 29th; and - May 10th. Continued review of the HHA time sheets, revealed that the agency's HHAs provided more than the prescribed four (4) hours of service on multiple days starting from May 11, 2015 through through June 19, 2015 [six hours of service was provided on those days]. On July 2, 2015 at 9:44 a.m., during an interview with the clinical director, it was acknowledged that Patient #11 did not receive HHA services on the aforementioned dates. 6. On July 7, 2015, at approximately 2:00 p.m., review of Patient #16's POC, with a documented certification period of February 12, 2015 to August 10, 2015, revealed that HHA services were to be provided eight (8) hours per day, seven (7) days per week for six (6) months; The skilled nurse was to provide supervision to the HHA monthly. Further review of the record revealed that HHA services were not provided eight (8) hours per day, seven (7) days per week as evidenced below. A. There was no evidence that HHA services were provided on the following dates: - February 13th - 15th, 17th, 21st - 22nd, and 28th; - March 1st, 6th - 8th, 14th - 15th, 21st - 22nd, and 28th - 29th; - April 18th - 19th, and 25th - 26th; - May 2nd - 3rd, 9th -10th, 16th - 17th, 24th, and 30th - 31st; - June 6th - June 7th.	H 453	Continued from Page 18 # H 453 6. Patient #16. The assigned PCA was working 7 days a week. When she started working every other weekend, there was an oversight by staffing department. This has been rectified. Currently patient #16 is staffed as per the Plan of Care Staffing coordinators are to submit daily report to the Supervisor of the activities performed.	07/2015 On going

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H 453	Continued From page 19 B. HHA weekly visit record revealed less than eight (8) hours of HHA service was provided on the following dates: - February 23rd (3 hours); - March 2nd (5.75 hours); - March 5th (5.25 hours); - April 9th (4 hours); - May 11th (3.26 hours); and - June 13th (6.75 hours). On July 7, 2015 at 3:04 p.m., during an interview with the director of operations, it was revealed that the agency was aware that Patient #16 did not get eight (8) hours of HHA services as ordered. Further interview revealed that the agency previously had difficulty staffing the patient with an HHA, however has recently placed a permanent HHA to ensure the patient receives services as ordered.	H 453		
H 458	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the skilled nurse failed to inform a physician of a change in a patient's condition for two (2) of sixteen (16) patients in the sample. (Patient #13)	H 458	# H 458 Clinician was counseled regard- this deficiency. Clinicians are instructed to report any changes in the patients' condition and should be documented. This will be communicated to the physician and/or the Clinical Director (see attached memo) Clinical Director will meet	07/2015 On Going

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H 458	Continued From page 20 The findings include: 1. On July 7, 2015, starting at 9:40 a.m., a review of Patient #7's POC with certification period of May 17, 2015 through November 12, 2015, revealed that the patient had a history of HTN and was prescribed atenolol 25 mg [used to treat hypertension] every day by mouth. Further review of the POC revealed that the physician ordered the skilled nurse to visit the patient once a month to conduct a complete systems assessment and observations to include notifying her when patient's BP is above 160/90... Further review of the record revealed a nursing note dated May 7, 2015 in which the skilled nurse documented the patient's BP was 133/103. Further review of the record failed to evidence that the skilled nurse made the physician aware of the patient's elevated diastolic blood pressure of 103 [which was above the ordered parameter of 90]. On July 7, 2015, starting at approximately 2:00 p.m., interview with the clinical director revealed that the skilled nurse should have documented some follow-up with the patient's physician's in reference to elevated diastolic blood pressure of 103. 2. On July 6, 2015, starting at 12:10 p.m., review of Patient #13's POC revealed that the skilled nurse was to provide a skilled assessment one (1) time per week, and as needed, for seven (7) weeks. Further review of the POC revealed prescribed parameters for Patient #13's vitals as follows:	H 458	Continued from Page 20 with each clinician to review the care provided once a month.	

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H 458	Continued From page 21 S/BP range: 80 - 160 mmHg; D/BP range: 60 - 90 mmHg; HR/pulse: 60 - 100 bpm. On July 6, 2015, starting at 12:15 p.m., review of Patient #13's record revealed weekly skilled nurse visit reports for the certification period of May 1, 2015 through June 25, 2015. On the following dates, Patient #13's blood pressure was below the prescribed range: - May 4, 2015 (84/54) - June 1, 2015 (73/58) - June 2, 2015 (79/59) - June 16, 2015 (93/56) On the following date, Patient #13's pulse was below the prescribed range: - May 26, 2015 (51 bpm) At the time of review, the record failed to evidence that the skilled nurse notified the physician of the patient's low blood pressure and pulse rate. On July 6, 2015, starting at approximately 2:35 p.m., during a face-to-face interview, the clinical director stated that the nurse should contact the physician when the patient's vitals are not within range and document in the patient's chart.	H 458		
H 492	3920.2(b) INTRAVENOUS THERAPY SERVICES The intravenous therapy service plan shall include, at a minimum, the following: (b) Type, dosage, frequency, duration, and mode	H 492	# H 492 Clinician was counceled regarding this defeciency. Clarification order sent to the physician for patient #13	07/2015

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H 492	Continued From page 22 of administration of medication; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to include the duration in which the IV medication was to be administered on the IV service plan for one (1) of two (2) patients in the sample that were receiving IV therapy services. (Patient #13) The finding includes: On July 6, 2015, starting at 12:10 p.m., review of Patient #13's POC revealed that skilled nurse services were to be provided for IV therapy to administer 468 mg of Dobutamine in 5% dextrose 4 mg/ml IV solution everyday. The POC failed to indicate the duration of each infusion. Further review of the record revealed a physician order, dated November 26, 2014, for Dobutamine 2.5 mcg/kg/ml to be infused continuous over 24 hours per day, 7 days per week. On July 6, 2015, at approximately 2:35 p.m., during a face-to-face interview, the clinical director acknowledged that the duration was missing from the POC. Further interview revealed that the skilled nurse would get the medication name, dosage, frequency, flow rate, and mode of administration from the preprinted label affixed to the IV medication bag that comes from the pharmacy.	H 492	Continued from page 22 Prior to sending the Plan of Care to the Primary Care Physician, the Clinical Director will review the Plan of Care. All Plan of Care documents will be reviewed with each clinician on a monthly basis or whenever warranted.	On going

ATTACHMENTS

October 2, 2015

Sharon H Mebane,
Program Manager
DC Department of Health
Health Regulations and Licensing Administration
899 North Capitol Street, NE 2nd Floor
Washington, DC 20002

Dear Ms Mebane,

I am herewith submitting by e-mail the Revised Plan of Correction to the recent Licensure Survey Report. The original is being mailed to you today.

Thanking you

Sincerely,

Ruth Joseph
Director of Operations

Health Management, Inc. 1707 L Street, N.W., Suite 900, Washington, D.C. 20036
TEL. (202) 887-8110 ◆ FAX (202) 659-8983 ◆ EMAIL info@HMI-USA.com ◆ www.HMI-USA.com