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-0026	A. BUILDING: _____ B. WING _____	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMAN TOUCH HOME HEALTH CARE AGENC	1416 9TH STREET, NW WASHINGTON, DC 20001

APR 20 2015

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H 000	INITIAL COMMENTS An annual survey was conducted from March 24, 2015 through March 26, 2015, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provided home care services to three hundred and thirty-one (331) patients and employed five hundred and eighteen (518) employees. The findings of the survey were based on observations, record reviews and interviews with patients and staff. Please Note: Listed below are abbreviations used in this report. Director of Nursing - DON Home Care Agency - HCA Personal Care Aide - PCA Plan of Care - POC Registered Nurse - RN Start of Care - SOC	H 000	Human Touch Home Health has reviewed the Licensure Survey Report dated April 2, 2015 and all records and results of the home visits conducted during the **Licensure Survey for March 24-26, 2015**.	04/12/2015
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 a record review and interview, the HCA failed to include the description of services to be provided, including: frequency and expected duration on the POC's for one (1) of fifteen (15) patients in the sample. (Patient #3)	H 355	**H 355 3914.3(d) Patients Plan of Care** The plan of care will 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. **Finding: The HCA failed to include the description of services to be provided including: frequency and expected duration on the POC.** **1. Corrective Actions.** Policy No. 2-019 Physician Participation in the Plan of Care states: Physician (or other authorized licensed independent practitioner) orders will be individualized, based on patient's needs, and include: a. Treatments and/or procedures needed, including type, frequency, duration, and goals an in-service training was conducted on 4/10/15 related to completeness of orders to include frequency, duration and specific orders for all services. Verbal/supplemental orders have been written to clarify the specific orders for the HHA.	04/12/2015

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H 355	Continued From page 1 The findings include: 1. On March 24, 2015, at approximately 11:30 a.m., review of Patient #3's POC with a certification period of March 11, 2015 through May 9, 2015, failed to evidence the expected duration of the PCA services. During a telephone interview on March 27, 2015, at approximately 1:00 p.m., the administrator admitted that the POC did not have a duration of PCA services.	H 355	**2. Identifying similar deficiencies.** All active patient records have been reviewed for similar deficiencies and verbal/supplemental orders have been written to clarify the specific orders for the HHA if missing in the plan of care. **3. Quality Assurance Program.** The DON and/or clinical manager will review the plan of care for completeness of orders, making sure they include frequency, duration and specific orders, prior to signing the 485 **4. Monitoring Corrective Actions.** Weekly chart audits will be conducted on all active patient records to assure the completeness of orders in each record. Should a clinician not comply with the requirements the DON and Administrator will be notified immediately and the individual will be subject to disciplinary action. Patient #3 has a verbal order written for the PCA frequency and duration of services.	
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 POC's were approved and signed by a physician within thirty (30) days of the SOC, for two (2) of fifteen (15) patients in the sample. (Patients #7 and #8) The finding includes: 1. On March 25, 2015, at approximately 9:45 a.m., review of Patient #7's record revealed a POC with a SOC date of January 13, 2015. The	H 366	**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. **Finding: The HCA failed to ensure the patients POC's were approved and signed by a physician within thirty days of SOC.** **1. Corrective Actions.** All delinquent 485's have been signed by the doctor. A stricter Policy and Procedure (P&P) for "Physician's Verbal orders / Plan of Treatment Signature" has been enforced. Per the P&P, the DON/Clinical Manager is to be notified of any 485 not signed and returned within 14 days, a daily phone call will be placed to the physician until receipt. Any 485 not received back from the physician signed and dated within 21 calendar days, after 5 consecutive days of calling the office, will be referred to the DON for follow up and assurance of compliance. **2. Identifying similar deficiencies.** All patient records have been reviewed to identify similar problems and a more aggressive approach has been implemented to assure signature of the 485 in a timely manner. Any 485 not signed and returned within 14 days, a daily phone call will be placed to the physician until receipt. Any 485 not received back from the physician signed and dated within 21 calendar days, after 5 consecutive days of calling the office, will be referred to the DON for follow up and assurance of compliance	04/12/2015

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H 366	Continued From page 2 POC was signed by the physician March 21, 2015. This was fifty-nine (59) days after the SOC. During an interview with the DON on March 25, 2014, starting at approximately 10:30 a.m., the DON stated that the POC was not signed because it was difficult getting in touch with the patient's doctor. 2. On March 25, 2015, at approximately 10:45 a.m., review of Patient #8's record revealed a POC with a SOC date of February 24, 2015. The POC failed to evidence approval by and signature of a physician. During an interview with the administrator on March 25, 2014, starting at approximately 10:55 a.m., the administrator stated that the HCA tried to contact the patient's physician multiple times to have the POC signed. Further interview revealed that the patient's physician was out of the office for the rest of the week.	H 366	**3. Quality Assurance Program.** The DON and/or clinical manager will conduct weekly meetings with the 485 specialist to determine further actions needed for 485's not signed within 21 days. **4. Monitoring Corrective Actions.** Bi-weekly chart audits will be conducted on 50% of active patient records by the QA Nurse for compliance with this policy. The chart audit tracking tool will be utilized to monitor the level of compliance. The results will be reported at monthly and quarterly meetings with the DON, QI officer and Senior Management Team. Patient #7 Plan of Care signed and in patient file Patient #8 Plan of Care is now signed and in patient file	
H 409	3915.11(d) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (d) Assisting the patient with self-administration of medication; This Statute is not met as evidenced by: Based on interview and record review, it was determined that the home care agency failed to ensure that the home health aide only assisted in	H 409	**H 409 3915.11(d) HOME HEALTH & PERSONAL CARE AIDE SERVICE** Home health aide duties may include the following: (d) assisting the patient with self-administration of medication **Finding: The HCA failed to ensure that the home health aide only assisted in self-administration of medications.** **1. Corrective Actions.** The PCA has been reprimanded/counseled on duties of aide and that taking medications out of the bottle and giving to patient to take is not allowed. The family and caregivers have been instructed that the PCA is not allowed to administer medications to the patient. A pill box must be filled by the family with appropriate medications if the PCA is to remind the patient to take medications. The Personal Care Aide Job Description states: "The personal care assistant will not function in any manner viewed as the practice of nursing according to the State's Nurse Practice Act. Specifically, the personal care assistant will not administer medications....." The Waiver-PCA Supervisory Visit Form has been modified to include questions specifically about how the patient takes their medications.	04/12/2015

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H 409	Continued From page 3 the self administration of medications, for one (1) of the five (5) patients observed during homes visits. (Patient #1) The finding includes: During a home visit with Patient #1 on March 26, 2015, at 11:53 a.m., a face to face interview was conducted with HHA #5 and Patient #1. Patient #1 revealed that HHA #5 takes the medications out the bottle and administers the medication to him/her. At approximately 11:55 a.m., HHA #5 stated that he should not have administered the medications to the patient but the "Lady of the house" asked him to administer Patient #1's medications. Interview with the administrator on March 26, 2015, at approximately 3:00 p.m., revealed that the HHA's are not allowed to administer medications. Further interview revealed that HHA #5 will be retrained.	H 409	**2. Identifying similar deficiencies.** All supervisory visits completed after April 10th will include questions specifically about how the patient takes their medications. "Does the patient use a medication/pill box? Yes or no; how does the patient take their medications? Patient takes independently, aide reminds patient to take, aide administers medication, other" **3. Quality Assurance Program.** The DON/Clinical Manager will review the Waiver-PCA Supervisory Visit Form, when the nurse turns it in, for completeness. Any incomplete documentation will not be accepted and returned to the nurse for immediate correction. Any answers of "the PCA Administers Medication" will result in disciplinary action for the PCA. **4. Monitoring Corrective Actions.** Bi-weekly chart audits will be conducted on 50% of active patient records by the QA Nurse for compliance with this policy. The chart audit tracking tool will be utilized to monitor the level of compliance. The results will be reported at monthly and quarterly meetings with the DON, QI officer and Senior Management Team. Patient #1 family and caregivers have been instructed that the PCA is not allowed to administer medications to the patient. A pill box must be filled by the family with appropriate medications if the PCA is to remind the patient to take medications. Employee #5 has been reprimanded/counseled on duties of aide and that taking medications out of the bottle and giving to patient to take is not allowed.	
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 have documented evidence of reviews and evaluations of the skilled services provided to patients at least every sixty-two (62) days and that a summary report of the evaluation was sent to the patient's physician for three (3) of fifteen	H 430	**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. **Finding: The HCA failed to have documented evidence of reviews and evaluations of the skilled services provided to patients at least every 62 days and that a summary of the report was sent to the physician.** **1. Corrective Actions.** Policy No. 2-037 60-Day Summary states: A 60-day summary will be completed for each patient at the end of the episode when the patient will be recertified. The summary will be forwarded to all physicians involved in the patient's care. An in-service training was conducted on 4/10/15 related to completing the 60 day summary.	04/12/2015

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H 430	Continued From page 4 (15) patients in the sample. (Patient #6, #7, and #9) The findings include: 1. On March 24, 2015, starting at approximately 3:00 p.m., a review of Patient #6's record revealed a POC with a certification period of October 29, 2014 through April 27, 2015. The POC documented that the skilled nurse was to provide service every 30 days to conduct "skilled assessment and evaluation of systems...". Review of the patient's record failed to provide evidence that the agency evaluated the patient's skilled nursing services at least every 62 days and reported it to the patient's physician. During a face-to-face interview, on March 24, 2015, starting at approximately 3:30 p.m., the DON indicated that Patient #6 was receiving PCA services and not considered a "skilled patient". 2. On March 25, 2015, starting at approximately 11:45 a.m., a review of Patient #7's record revealed a POC with a certification period of January 13, 2015 through July 11, 2015. The POC documented that the skilled nurse was to provide skilled service every 30 days to conduct "skilled assessment and evaluation of systems...". Review of the patient's record failed to evidence that the agency evaluated the patient's skilled nursing services at least every 62 days and reported it to the patient's physician. During a face-to-face interview, on March 25, 2015, starting at approximately 12:15 p.m., the DON indicated that Patient #7 had been recieving PCA services with only quarterly nursing visits due to his/her insurance coverage.	H 430	**2. Identifying similar deficiencies.** All active patient records have been reviewed for similar deficiencies and supervisory nurses have been instructed to complete 60 day summaries upon the next monthly supervisory visit. The Plan of Care Specialist has been instructed to send every 60 day summary to the MD. **3. Quality Assurance Program.** The DON/Clinical Manager will review the 60 Day Summary form, when the nurse turns it in, for completeness. Any incomplete documentation will not be accepted and returned to the nurse for immediate correction. **4. Monitoring Corrective Actions.** Bi-weekly chart audits will be conducted on 50% of active patient records by the QA Nurse for compliance with this policy. The chart audit tracking tool will be utilized to monitor the level of compliance. The results will be reported at monthly and quarterly meetings with the DON, QI officer and Senior Management Team. Patient #6 now has a review and evaluation of services provided and the 60 day summary was sent to the physician. Patient #7 now has a review and evaluation of services provided and the 60 day summary was sent to the physician. Patient #9 now has a review and evaluation of services provided and the 60 day summary was sent to the physician.	

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H 430	Continued From page 5 3. On March 25, 2015 , starting at approximately 1:40 p.m., a review of Patient #9's record revealed a POC, with a certification period of October 15, 2014 through April 13, 2015. The POC documented that the skilled nurse was to provide skilled service every 30 days to conduct "skilled assessment and evaluation of systems...". Review of the patient's record failed to evidence that the agency evaluated the patient's skilled nursing services at least every 62 days and reported it to the patient's physician. During a face-to-face interview, on March 25, 2015, starting at approximately 2:00 p.m., the DON indicated that Patient #9 was recieving PCA services, and not considered a "skilled patient".	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, it was determined that the skilled nurse failed to ensure that the patient's needs were met in accordance with their POC for one (1) of fifteen (15) patients in the sample. (Patient #3) The finding includes: On March 24, 2015, at approximately 11:30 a.m., review of Patient #3's POC with the certification period of March 11, 2015 through May 9, 2015 revealed that PCA services were to be provided	H 453	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 **Finding: The skilled nurse failed to ensure that the patients' needs were met in accordance with their POC.** **1. Corrective Actions.** Policy No. 2-005 Admission Criteria and Process states "the patient will be referred to other resources if the organization cannot meet his/her needs." An in-service training was conducted on 4/10/15 related to Admission Criteria and Process. A female aide has been assigned to the patient and is providing care. **2. Identifying similar deficiencies.** All active skilled patient records have been reviewed for similar deficiencies and no additional patients have been found. **3. Quality Assurance Program.** The DON/Clinical Manager will review skilled referrals, prior to accepting, for ability to staff all services ordered. If the agency is unable to provide all services ordered the agency will not accept the patient. The referral source will be notified for placement elsewhere.	04/12/2015

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H 453	Continued From page 6 1-3 times per week for 9 weeks. The record HCA failed to evidence PCA service were provided to Patient #3. During a telephone interview on March 27, 2015, at approximately 1:00 p.m., the administrator revealed that Patient #3 had not been provided with PCA services due to unavailability of a female aide.	H 453	**4. Monitoring Corrective Actions.** Bi-weekly chart audits will be conducted on 50% of active patient records by the QA Nurse for compliance with this policy. The chart audit tracking tool will be utilized to monitor the level of compliance. The results will be reported at monthly and quarterly meetings with the DON, QI officer and Senior Management Team. Patient #3 now has a female aide providing care. A verbal order for aide services to be held until female aide available dated 3/12/15 is in the patients chart along with an order to resume aide services dated 3/27/15.	
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 each patient's personal care aide (PCA) for one (1) of the fifteen (15) sampled patients. (Patient #7) The finding includes: On March 25, 2015, starting at approximately 11:45 a.m., review of Patient #7's record revealed a POC with a certification period of January 13, 2015 through July 11, 2015. The POC stated that PCA services were ordered for five (5) hours a day for one day and four (4) hours a day for four days, five (5) days a week for six (6) months, and supervisory visits by an RN every thirty (30) days. Further record review failed to evidence that the PCA services were supervised by the RN.	H 456	**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 **Finding: The HCA failed to document the supervision of services being delivered by each patient's PCA.** **Corrective Actions.** Policy No. 4-008 Responsibility/Supervision of Clinical Services states: "Supervisory visits will be conducted as often as necessary, as determined by the client's needs, the assessment of the registered nurse, but not to exceed ninety (90) days." The VA policy for supervision of PCA services provided by an agency is 90 days also. A verbal order has been written to decrease the frequency of the RN visits to every 90 days. **Identifying similar deficiencies.** All active patient records have been reviewed for similar deficiencies and verbal/supplemental orders have been written to clarify the specific orders for the RN visits every 90 days if incorrect in the plan of care. **Quality Assurance Program.** The DON and/or clinical manager will review the plan of care for completeness of orders, making sure the RN frequency for VA patients is every 90 days prior to signing the 485. **Monitoring Corrective Actions.** Weekly chart audits will be conducted on all active patient records to assure the completeness of orders in each record. Should a clinician not comply with the requirements the DON and Administrator will be notified immediately and the individual will be subject to disciplinary action. Patient #7 has a verbal order written to decrease RN frequency for supervision to every 90 days, to comply with Policy No. 4-008 and the VA policy.	04/12/2015

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H 456	Continued From page 7 During a face-to-face interview with the DON, on March 25, 2015, starting at approximately 12:15 p.m., the DON indicated that Patient #7 recieved PCA services with only quarterly nursing supervisory visits due to his/her insurance coverage.	H 456		