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-0009	A. BUILDING: _____ B. WING _____	02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM SELECT HOME CARE, INC	5513 ILLINOIS AVENUE, NE WASHINGTON, DC 20011

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H 000	INITIAL COMMENTS An annual survey was conducted from February 20, 2014, through February 24, 2014, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agency Regulations). The findings of the survey were based on observations, record reviews and interviews with current patients and staff. Please Note: Listed below are abbreviations used in this report. Director of Professional Services - DOPS Home Care Agency - HCA Home Health Certification - HHC Physical Therapy - PT Physician's Order - PO Plan of Care - POC Registered Nurse - RN Resumption of Care - ROC Skilled Nursing - SN Three Times a Day - tid Twice A Day - bid Vice President - VP	H 000		
H 260	3911.1 CLINICAL RECORDS Each home care agency shall establish and maintain a complete, accurate, and permanent clinical record of the services provided to each patient in accordance with this section and accepted professional standards and practices. This ELEMENT is not met as evidenced by: Based on record review and interview, it was determined that the HCA agency failed to maintain accurate clinical records for one (1) of ten (10) patients in the sample. (Patient #5)	H 260		

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H 260	Continued From page 1 The finding includes: Review of Patient #5's clinical record on February 20, 2014, at 1:53 p.m. revealed a nursing note dated January 2, 2014. The nursing note indicated that the patient's Gabapentin medication was increased from 100 mg bid to 300 mg tid on December 17, 2013. Additionally, review of the nursing note revealed that the nurse referred the reader to the medication sheet to see the aforementioned medication change. Review of the clinical record on February 20, 2014, at 2:36 p.m. revealed that Patient #5's Gabapentin medication increase was not noted on any medication sheet. Interview with the RN on February 20, 2014, at 2:45 p.m. revealed that she/he thought that the medication sheet was at home and would contact the HCA later this afternoon. At 3:05 p.m., the HCA's VP provided the surveyor a copy of the medication sheet dated December 17, 2014. Review of the medication sheet revealed that the RN noted the increase of Patient #5's Gabapetin 100 mg bid to 300 mg tid. At the time of the survey, there was no documented evidence of a PO for Patient #5's Gabapentin 100 mg bid to be increased to 100 mg tid.	H 260	As it relates to Patient #5's Clinical Record, in the comment section of the January 2, 2014 nurses notes, the RN noted the change in medication. The surveyor noted that there was not a Physicians' order to support the change in medication. The RN stated that the order was submitted, however she would check her records. Upon review of the "pending" filing orders, the change for Gabanptin was noted and presented to the surveyor on February 21, 2014. At the time of the survey, the order was in agency and presented to the Surveyor. The RN involved was counseled regarding timely review of the medical record to assure timely services. Beginning on March 24, 2014, the Skilled nurses will be inserviced on updating the medication profile to include changes in medication regimen, as well as obtaining a written physician's order to reflect medication changes. The Inservices will be conducted by the VP of Home Care Operations March 24-April 24,2014	4/24/14
H 263	3911.2(c) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (c) Initial assessment and on-going evaluation;	H 263		

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H 263	Continued From page 2 This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to have an initial assessment in the clinical record for one (1) of ten (10) patients in the sample. (Patient #4) The finding includes: Review of Patient #4's clinical record on February 19, 2014, at approximately 4:00 p.m., revealed that the patient had a HHC and POC for January 18, 2014, through March 18, 2014. Further review of the patient's clinical record revealed that Patient #4 was ordered PT services and SN services. Although the POC revealed that SN services were ordered at the same time as the PT services, the patient's clinical record failed to evidence an initial nursing assessment. A face to face interview with the DOPS on February 19, 2014, at 2:40 p.m., revealed that Patient #4 did not have an initial nursing assessment because skilled nursing services were ordered after PT services. At the time of the survey, the HCA failed to ensure that Patient #4's clinical record included an initial nursing assessment.	H 263	The referral for Patient #4 indicated PT, OT services. The PT upon initiation of the OASIS noted that the patient required SN services. THe PT notified the DOPS, who assigned a SN to the case. Upon initiation of the care, the SN completed that Home Health agency's nursing notes, which includes a comprehensive assessment of patient's systems. During each SN visit, the RN completes an assessment/reassessment of the client. The VP for Home Care Services will conduct a re-orientation of nursing documentation standards and practices for all Skilled nurses effective March 24, 2014-April 24, 2014. As well, effective October 2013, documentation reminders and standards are provided via the clinical newsletter on a monthly basis. Currently the VP of Home Care Services reviews 50% of all assessment to determine comprehensiveness of the assessment. Based on the review, nurses who do not meet the standard assessment review will have 100% monitoring of assessments. The DOPS will individually work with the nurse until the documentation compliance is achieved.	4/24/14
H 279	3911.2(s) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (s) Documentation of training and education given to the patient and the patient's caregivers.	H 279		

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H 279	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the HCA failed to ensure documentation of training and education given to the patient and the patient's caregivers for one (1) of ten (10) patients in the sample. (Patient #3) The findings include: Review of Patient #3's plan of care (POC) dated January 2, 2014 to March 2, 2014, on February 19, 2014, beginning at 12:09 p.m., revealed that the patient had diagnoses that included Diabetes II, excretion wound debridement and an ulcer was located on the patient's foot. Further review of the POC revealed that the skilled nurse was to instruct/teach the patient about their disease process, diabetic management, and diabetic foot care, and signs and symptoms of hypo/hyperglycemia. Review of Patient #3's clinical record on February 19, 2014, at approximately 12:15 p.m., revealed skilled visit nursing notes dated January 2, 2014, January 4, 2014, through January 6, 2014, February 3, 2014, February 5, 2014 and February 7, 2014. At the time of the record review there was no documented evidence of the aforementioned training and education was provided to the patient and/or their caregivers. During a face to face interview with the DOPS on February 21, 2014, at approximately 5:15 p.m., it was acknowledged that the agency's nurses did not have documentation to support whether or not Patient #3 or their caregivers were trained on his/her disease processes, diabetic foot care, and signs and symptoms of hypo/hyperglycemia on the aforementioned date.	H 279	It is noted that PT#3 is alert, oriented and has a long standing diagnosis of DMII. It is also noted that the patient is a long established patient of the Home health agency. Prior documentation of the SN indicated teaching, instruction, diabetic management, diabetic foot care and signs/symptoms of hypo/hyperglycemia. The Home health agency developed a DMII teaching guide in November 2013. It is expected that all SNs providing DM management and teaching comply with educating the patient on the goals, objectives and content of the teaching guide. Patients with long standing diagnosis will receive re-inforcement/re-instruction of the teaching and the SN will document the level of disease management instruction. Effective 3/24/14 - 4/24/14 , all SNs will be re-oriented to the the teaching goals, objectives and content of the guide. The Quality Improvement staff will assess the compliance with the teaching guide and relevant content on a monthly basis. Information from the review will be provided to the SN, DOPS and Administrator.	4/24/14

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H 452	Continued From page 4	H 452		
H 452	3917.2(b) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (b) Coordination of care and referrals; This Statute is not met as evidenced by: Based on record review, interview, and observation, the HCA's nurse failed to ensure coordination of care and to make referrals for one (1) of ten (10) patients in the sample. (Patient #8) The finding includes: Review of Patient #8's clinical record on February 20, 2014, beginning at 10:45 a.m. revealed that the patient's SOC was initiated on July 10, 2012. Further review of the patient's clinical record revealed that Patient #8 was hospitalized from December 30, 2013, through January 1, 2014, and the ROC was initiated on January 8, 2014. Continued review of the clinical record on February 20, 2014, at 11:11 a.m. revealed a discharge summary that included the patient's "admitting history". The admitting history revealed that the patient had "several episodes where she had called the police for suspected break-ins which were false." Additionally, the admitting history indicated that the patient's family had not been able to take the patient to seek mental health treatment. Interview with the DOPS on February 20, 2014, at 12:10 p.m. revealed that Patient #8's psycho-social needs had not been addressed, because the referring case manager did not	H 452	Client #8 was referred to the Home Health Agency with alzheimers with dementia, HTN, Depressive disorder on 1/29/11. The client's Alzheimer's condition had become progressively worse and she required 24 hour supervision. On admission, the client was on Aricept 10mg qHS for Alzheimers. She currently remains on the same medication and dosage. The client was admitted into the waiver program for 8 hours per day to relieve and support the caregivers. Prior to admission, the client had exhibited behaviord related to alzheimers which included disorientation/confusion, rambling and wandering, which are safety risks. Since the enrollment of the client in the waiver program and the implementation of the 24 hour supervision, Client #8 has not had any reported incidences of wandering out of the home or calling the police. The SN and caregivers assess the clients at least monthly and report to the client's primary care provider any significant changes in psychsocial behavior that would warrant a reevalution or change in medical intervention. Effective 3/24/14-4/24/14, the Vice President for Home Care Services will coordinate a learning session on monitoring Psychosical behaviors and reporting to Primary Care provider when necessary.	4/24/14