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 _____	03/13/2015

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 March 10, 2015 through March 13, 2015, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to three hundred and ten (310) patients and employs four hundred (400) employees. The findings of the survey were based on observations, record reviews and interviews with patients, staff and caregivers. Please Note: Listed below are abbreviations used in this report. Director of Nursing - DON Home Care Agency - HCA Home Health Aide - HHA Human Resources Manager - HRM Plan of Care - POC Purified Protein Derivative - PPD Registered Nurse - RN Skilled Nurse - SN	H 000	Received 4/30/15 CW	
H 163	3907.7 PERSONNEL Each employee shall be screened for communicable disease annually, according to the 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 each employee was screened for communicable diseases annually, (according to the guidelines issued by the Federal Centers for Disease Control), and certified free of communicable diseases for three (3) of the fifteen	H 163		

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H 163	Continued From page 1 employees in the sample. (HHA #3, HHA #5, RN #11, and HHA #15) The findings include: 1. Review of the HCA personnel records on March 12, 2015, beginning at approximately 10:24 a.m., there was no documented evidence that HHA #3 was certified free of any communicable disease since February 28, 2014. At the time of the survey, interview with the HRM verified that HHA #3 had no documented evidence that she/he was certified free of any communicable disease. 2. Review of the HCA personnel records on March 12, 2015, at 11:15 a.m. revealed that HHA #5's health certificate failed to evidence a date or reading of the PPD. At the time of the survey, the HCA failed to ensure documented evidence that HHA #5 had been certified free of any communicable disease. 3. Review of the HCA personnel records on March 12, 2015, at approximately 12:15 p.m., there was no documented evidence that RN #11 was certified free of any communicable disease since March 7, 2014. At the time of the survey, interview with the HRM verified that RN#11 had no documented evidence that she/he was certified free of any communicable disease. 4. Review of the HCA personnel records on March 12, 2015, at approximately 12:15 p.m., revealed that HHA#15's date of hire was June 9, 2012. Further of the record failed to evidence that HHA #15 was free of communicable disease for 2014. During an interview with the HRM on March 12,	H 163	To promote compliance in local and federal statues related to Human Resources, the agency re-organized the department and a new HR manager was assigned effective March 1, 2015. As of April the HR manager and associate has completed a 100% audit of HR files and updated the HR compliance file. As a quality improvement initiative , the Director of Nursing/designate will complete a quality check to assure required documents are in file prior to hiring to include the PPDs. The HRM will provide the Director of Nursing/designate with a monthly monitoring report of Human resources file compliance On 4/17/15, the HR Manager provided the HCA staff members without a current document certifying that they are free from communicable a notice indicating they had one week to comply with the request to provide supporting documentation. Failure to comply with the request will result in the staff member not being scheduled. Effective 5/8/15 all staff members will have a current document certifying that the staff member is free from communicable disease. The HR Manager will generate a monthly "soon to expire" list monthly and provide the information to the Director of Nursing/designate and staffing assistant for the purpose of scheduling the PPD and/or annual CXR symptomology review.	4/24/2015 and ongoing 5/8/15 and ongoing

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H 163	Continued From page 2 2015, at 1:43 p.m., the HRM indicated that HHA#15's PPD results should have been in the record.	H 163		
H 293	3912.2(c)(1) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the following: (1) Services to be provided by the agency, including any limits on service availability; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to inform patients in writing of the services to be provided for five (5) of fifteen patients in the sample.(Patients #4, #5, #7, #9, and #12) The findings include: On March 12, 2015, at 11:30 a.m., review of the "Patient Rights and Responsiblities Policy" indicated that the agency was to inform the patients of treatment or services to be provided. On March 12, 2015, at 12:00 noon, review of the "Admission Consent" form in the clinical records of Patients' #4, #5, #7, #9, and #12 failed to identify services to be provided. During a face to face interview with the Administrator and DON on March 12, 2015, at	H 293	Beginning 3/31/15, the Director of Nursing/Designate initiated documentation competency reviews with the Skilled Staff. Including in the competency review was a re-orientation to the Patient's Rights and Responsibilities policy. The Skilled staff was re-oriented to the appropriate completion of the Consent form. The SN will receive additional information regarding Patient's Rights and responsibilities via a newsletter on 5/1/15 The documentation competency review will be completed by May 29, 2015. The Director of Nursing/designate will complete a random monthly medical records audit of 10% of the patient medical record to measure compliance	3/31/15 and ongoing 5/29/15 and on-going

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H 293	Continued From page 3 approximately 2:30 p.m., the Administrator and DON acknowledged that the forms were incomplete and did not inform Patients #4, #5, #7, #9, and #12 of the services to be provided by the HCA.	H 293		
H 300	3912.2(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (d) To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to implement their policy to ensure treatment, care and services were consistent with the patient's POC for seven (7) of fifteen (15) patients in the sample. (Patient #2, #3, #4, #7, #8, #11, and #12). The findings include: 1. On March 10, 2015, at approximately 11:30 a.m., a review of Patient #2's clinical record revealed a POC with a certification period of December 15, 2014, through February 12, 2015, for skilled nursing visits one (1) to two (2) times a week for nine (9) weeks for "assessment / observation of all systems, instruct on disease process, medications..." Further review of the record failed to evidence SN services were provided after January 5, 2015.	H 300	Client (2) has two parts of the medical record; medicare and medicaid. The client was admitted to the hospital on 1/8/2015. Care was resumed on 2/3/15 . Since the resumption of care, the client had skilled nursing visits; 2/6/15, 2/9/15, 2/16/15, 2/18/15, 2/26/15, 2/27/15, 2/28/15, 3/4/15, 3/6/15, 3/9/15, 3/11/15. During the time of the survey, the staff member responsible for logging the visits was out on an extended medical leave, thus the notes may have not been filed. Effective 4/24/15 the administrator has restructured and re-assigned the task of logging in visit notes. As well, the administrator has allocated additional staff to logging in visits and filing the visits. *(see attached notes referencing #2)	4/24/15 and ongoing

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H 300	Continued From page 4 2. On March 10, 2015, at approximately 12:30 p.m., a review of Patient #3's clinical record revealed a POCs' with a certification period of September 23, 2014, through March 23, 2015, for skilled nursing visits one (1) to two (2) times a month for six (6) months for "assessment / observation of all systems, instruct on disease process, medications..." Further review of the record failed to evidence SN services were provided after January 13, 2015. 3. On March 10, 2015, at approximately 1:15 p.m., a review of Patient #4's clinical record revealed a resumption of care (following a period of hospitalization) order dated February 3, 2015, for home health aide service eight (8) hours a day, seven (7) days a week to assist the patient with bathing, light housekeeping, grooming, meal preparation, medical appointments and laundry. Further review of the record failed to evidence HHA services were provided February 7, 8, and 12, 2015. Additionally, the record failed to evidence HHA services were provided after February 13, 2015. 4. On March 11, 2015, at approximately 10:30 a.m., a review of Patient #7's clinical record revealed a verbal order dated February 2, 2015, for "social worker to perform assessment and assist with obtaining home health aide, assistance with attending senior center for socialization and contacting meals on wheels". There was no documented evidence that social worker services were provided at the time of the survey. 5. On March 11, 2015, at approximately 11:30 a.m., a review of Patient #8's clinical record revealed a POC dated January 14, 2015, to July 14, 2015 for skilled nursing visits one (1) to two	H 300	As it relates to Client #3, The SN provided a supervision visit on 2/14, 3/04. During the time of the survey, the staff member responsible for logging the visits was out on an extended medical leave, thus the notes may have not been filed. Effective 3/9/15, the administrator has restructured and re-assigned the task of logging in visit notes. As well, the administrator has allocated additional staff to logging in visits and filing the visits. The Administrator or designate will monitor the logging in/filing process on a weekly basis effective 5/1/15 Effective March 30, 2015, the Director of Nursing/designate will "huddle " with the staffing coordinator daily to determine staffing needs, and/or the inability to staff. The Staffing Coordinator was reminded via memorandum to complete a 'missed visit' form and document on the form and/or nursing note the reason why the PCA services was not initiated. The Director of Nursing/designate will assess 10% of the medical records monthly to determine if HHA are present or missed visit documentation is present. This client (4) continues to receive PCA services 8hours x 5 days (per the authorization and the signed POC), The order written by the RN was incorrect and corrected by the Director of Nursing on the Plan of Care. Client (4) has noted filed in the Medical record through 4/10/15. During the time of the survey, the staff member responsible for logging the visits was out on an extended medical leave, thus the notes may have not been filed. Effective 3/9/15 The Administrator has reassigned the task, along with structuring the process to include the assistance of additional staff members to log in and file in the medical record. The Skilled staff was reminded via memorandum on 4/24/15 to inform the DON/ designate of any verbal orders for additional services. The DON/designate will inform the required services and track compliance with the order.	3/9/15 and ongoing 5/1/15 and ongoing 3/30/15 and ongoing 3/9/15 and ongoing 4/24/15 and on-going.

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H 300	Continued From page 5 (2) times a month for six (6) months for "assessment / observation of all systems, instruct on disease process, medications..." Further review of the record failed to evidence that SN services were provided after January 26, 2015. Additionally, further review of the POC revealed an order for HHA services eight (8) hours a day on Monday, Wednesday and Friday, and four hours a day on Tuesday, Thursday, Saturday and Sunday for six (6) months. Further review of the record failed to evidence that HHA services were provided January 18, 21 through 26, 2015. Additionally, the record failed to evidence HHA services were provided after January 30, 2015.	H 300	As it related to Client (8), the client was admitted into the hospital on 2/2/15 and remains in the hospital. A transfer OASIS was completed on 2/2/15 and was in the medical record. The HHA note of 1/30/15 states "Patient went back into the hospital on Saturday morning 1/31/15. Effective March 30, 2015, the Director of Nursing/designate will "huddle " with the staffing coordinator daily to determine staffing needs, and/or the inability to staff. The Staffing Coordinator was reminded via memorandum to complete a 'missed visit' form and document on the form and/or nursing note the reason why the PCA service was not initiated The Director of Nursing/designate will assess 10% of the medical records monthly to determine of HHA notes or missed visit notes are present	3/30/15 and ongoing
	6. On March 12, 2015, at approximately 10:00 a.m., a review of Patient #11's clinical record revealed a POCs' with a certification period of December 29, 2014, through February 26, 2015, for skilled nursing visits three (3) to five (5) times a week for nine (9) weeks for "wound care to the scalp, assessment / observation of all systems, instruct on disease process, medications..." Further review of the record failed to evidence SN services were provided after January 31, 2015.		The Director of Nursing/designate will complete a medical records audit of 100% of Skilled charts to measure compliance with visits frequency, orders and outcomes of care by 5/29/15. The Director of Nursing/designate will meet with the Skilled staff to provide feedback, data related to the skilled medical records audit by 6/30/15. The Director of Nursing/designate will review 20% of the Skilled charts monthly to measure compliance.	5/29/15 6/30/15 and ongoing
	7. On March 12, 2015, at approximately 2:00 p.m., a review of Patient #12's clinical record revealed a POC with a certification period of December 29, 2014, through June 29, 2015, for home health aide service sixteen (16) hours a day, seven (7) days a week for six (6) months to assist the patient with bathing, light housekeeping, grooming, meal preparation, medical appointments and laundry. Further review of the record failed to evidence HHA services were provided from December 29, 2014, through January 6, 2015. Additionally, the record failed to evidence HHA services were provided after February 13, 2015.		As it related to Patient (12), the HHA notes of 12/29/14 - 1/6/15 were noted in the Medical Record. During the time of the survey, the staff member responsible for logging the visits was out on an extended medical leave, thus the notes may have not been filed. Effective 3/9/15, the administrator has restructured and re-assigned the task of logging in visit notes. As well, the administrator has allocated additional staff to logging in visits and filing the visits. The Administrator or designate will monitor the logging in/filing process on a weekly basis effective 5/1/15	3/9/15 and ongoing

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H 300	Continued From page 6 During a face to face interview with the DON and Administrator on March 12, 2015, at approximately 2:30 p.m., the Administrator acknowledged the findings of the surveyor	H 300		
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, the HCA failed to ensure that each patient's POC included emergency protocols for twelve (12) of fifteen (15) patients in the sample. (Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12). The finding includes: Review of abovementioned POCs' starting on March 10, 2015, at approximately 11:30 a.m., through March 12, 2015, at 4:10 p.m., failed to include the agency's emergency protocol. During a face to face interview with the DON and Administrator on March 12, 2015, at approximately 3:10 p.m., it was acknowledged that the POCs' reviewed did not include the emergency protocol. Additionally, the administrator indicated that the agency would revise the POCs to include its emergency protocol.	H 364	The agency includes in the POC, instructions to the patient/caregiver and HHA/PCA on potential situations that my require implementation of the emergency plan. All staff is instructed to initiate the Emergency plan, call 911 or initiate CPR when necessary. During the admission, the skilled admitting staff provides the patient and orientation to the established emergency care plan in the Patient Orientation for Home Health Care Admission booklet (see attached) In addition, The Plan of Care were reformatted and will include the Emergency protocols individualized for the patient effective 4/24/15.	4/24/15 and ongoing
H 450	3917.1 SKILLED NURSING SERVICES Skilled nursing services shall be provided by a	H 450		

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H 450	Continued From page 7 registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, and in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the HCA failed to ensure services were provided in accordance with the POC for four (4) of fifteen (15) patients in the sample receiving care. (Patients #2, #3, #8 and #11) The findings include: 1. On March 10, 2015, at approximately 11:30 a.m., review of Patient #2's POC with a certification period of December 15, 2014, through February 12, 2015, for skilled nursing visits one (1) to two (2) times a week for nine (9) weeks for "assessment / observation of all systems, instruct on disease process, medications..." Review of Patient #2 record failed to evidence SN was provided in February 2015. 2. On March 10, 2015, at approximately 12:30 p.m., review of Patient #3's POC with a certification period of September 23, 2014, through March 23, 2015, ordered skilled nursing visits one (1) to two (2) times a month for six (6) months for "assessment / observation of all systems, instruct on disease process, medications." Review of the failed to evidence SN service was provided after January 13, 2015. 3. On March 11, 2015, at approximately 11:30 a.m., review of Patient #8's POC dated January 14, 2015, through July 14, 2015, for skilled nursing visits one (1) to two (2) times a month for six (6) months for "assessment / observation of all systems, instruct on disease process,	H 450	As it relates to Patient (#2), the Skilled nursing notes are in the medical record from 12/15/14 - February 12, 2015 . During the time of the survey, the staff member responsible for logging the visits was out on an extended medical leave, thus the notes may have not been filed. Effective 3/9/15, the administrator has restructured and re-assigned the task of logging in visit notes. As well, the administrator has allocated additional staff to logging in visits and filing the visits. The Administrator or designate will monitor the logging in/filing process on a weekly basis effective 5/1/15 As it related to Client #3, The SN provided a supervision visit on 2/14, 3/04. During the time of the survey, the staff member responsible for logging the visits was out on an extended medical leave, thus the notes may have not been filed. Effective 3/9/15, the administrator has restructured and re-assigned the task of logging in visit notes. As well, the administrator has allocated additional staff to logging in visits and filing the visits. The Administrator or designate will monitor the logging in/filing process on a weekly basis effective 5/1/15	3/9/15 and ongoing 5/1/15 and ongoing 3/9/15 and ongoing 5/1/15 and ongoing

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H 450	Continued From page 8 medications..." Review of the record failed to evidence SN services were provided after January 26, 2015. 4. On March 12, 2015, at approximately 10:00 a.m., a review of Patient #11's clinical record revealed a POCs' with a certification period of December 29, 2014, through February 26, 2015, for skilled nursing visits three (3) to five (5) times a week for nine (9) weeks for "wound care to the scalp, assessment / observation of all systems, instruct on disease process, medications..." Further review of clinical record #11 revealed no nursing visit notes after January 31, 2015, for the certification period of December 29, 2014, to February 26, 2015. A face to face interview with the DON and Administrator on March 12, 2015, at approximately 3:00 p.m., confirmed the findings of the surveyors. The Administrator stated that the agency is behind in filing both orders and time sheets.	H 450	As it related to Client (8), the client was admitted into the hospital on 2/2/15 and remains in the hospital. A A transfer OASIS was completed on 2/2/15 and was in the chart. The HHA note of 1/30/15, indicates that patient was back in the hospital. The Director of Nursing/designate will re-orient the Skilled staff members to complete a missed visit form and/or document the whereabouts of the patient by 5/1/15. The Director of Nursing/designate will monitor 10% of the charts to assure compliance with visits on a monthly basis beginning 5/29/15 The Director of Nursing/designate will complete a medical records audit of 100% of the skilled charts to measure compliance with visit frequency, orders and outcomes of care by 5/29/15. The Director of Nursing or designate will meet with the skilled staff to provide feedback, data related to the skilled medical records audit by 6/30/15. The Director of Nursing/designate will review 20% of the Skilled charts monthly to measure compliance	5/1/15 and ongoing 5/29/15 and ongoing
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 fifteen (15) patients in the sample. (Patient #4)	H 452		

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H 452	Continued From page 9 The finding includes: Review of Patient #4's clinical record on March 10, 2015. beginning at 1:15 p.m., revealed that the patient's SOC was initiated on June 20, 2014. Further review of the patient's clinical record revealed a communication note stating that Patient had suffered a fall and was hospitalized. There was also a resumption of care order in the record, dated February 3, 2015, written by the RN but was not signed by the physician. Continued review of the clinical record (#4) on March 10, 2015, beginning at 1:15 p.m., failed to reveal any documented evidence that the RN coordinated care with the physician and/or physical therapist regarding the Patient's fall. During a face to face interview with the DON and Administrator on March 12, 2015, at approximately 3:30 p.m., the DON and Administrator confirmed the finding of the surveyor.	H 452	Beginning 3/31/15, the Director of Nursing/Designate initiated documentation competency reviews with the Skilled Staff. Timely notification of the MD of any change in patient's condition and or injury was discussed. The Skilled staff continues to be re-oriented to documenting the change of condition and timely notification of the MD on the nurses notes. The documentation competency review will be completed by May 29, 2015. The Director of Nursing will monitor 10% of the medical records on a monthly basis to determine if appropriate documentation and notification occurred related to a change in the patient's condition	5/29/15 and ongoing
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, the HCA's nurse failed to report changes in the patient's condition to the Patient's physician for one (1) patient in the sample. (Patient #4)	H 458		

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 _____	03/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 458	Continued From page 10 The finding includes: Review of Patient #4's clinical record on March 10, 2015. beginning at 1:15 p.m., revealed that the patient's SOC was initiated on June 20, 2014. Further review of the patient's clinical record revealed a communication note stating that Patient had suffered a fall and was hospitalized. There was also a resumption of care order in the record, dated February 3, 2015, written by the RN but was not signed by the physician. Continued review of the record on March 10, 2015, beginning at 1:20 p.m., failed to reveal any documented evidence that the RN reported changes in the patient's condition to the physician. During a face to face interview with the DON and Administrator on March 12, 2015, at approximately 3:30 p.m., the DON and Administrator confirmed the finding of the surveyor.	H 458	Beginning 3/31/15, the Director of Nursing/Designate initiated documentation competency reviews with the Skilled Staff. Timely notification of the MD of any change in patient's condition and or injury was discussed. The Skilled staff was re-oriented to documenting the change of condition and timely notification of the MD on the nurses notes. The documentation competency review will be completed by May 29, 2015. The Director of Nursing will monitor 10% of the medical records on a monthly basis to determine if appropriate documentation and notification occurred related to a change in the patient's condition.	3/31/15 and ongoing 5/29/15 and ongoing