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	HCA-0009	A. BUILDING: _____ B. WING _____	03/17/2017

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PREMIUM SELECT HOME CARE, INC	5513 ILLINOIS AVENUE, NE WASHINGTON, DC 20011

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H 000	INITIAL COMMENTS An relicensure survey was conducted from March 13, 2017, through March 17, 2017, to determine compliance with Title 22B District of Columbia Municipal Regulation, Chapter 39 (Home Care Agencies Regulations). The home care agency provides home care services to three hundred-fifteen (315) patients and employs seven hundred-forty-six (746) staff. The findings of the survey were based on a review of administrative records, fourteen (14) active patient records, six (6) discharged patient records, twenty (20) employee records, ten (10) patient telephone interviews and interviews with patients/family and staff. The following are abbreviations used within the body of this report: CHF - Congested Heart Failure CVA - Cerebral Vascular Accident GERD - Gastroesphageal Reflux Disease HCA - Home Care Agency POC - Plan of Care SOC - Start of Care SN - Skilled Nurse HHA - Home Health Aide DON - Director of Nursing PCA- Personal Care Aide	H 000	Premium Select Home Care Inc., has reviewed the findings of the survey conducted by the Health Regulations & Licensing Administration on March 13, 2017 through March 17, 2017. The following Plan of Correction (POC) has been developed and is being submitted to address the deficiencies and concerns noted during the survey. The Correction Plan will be implemented, as specified, and will be ongoing.	
H 053	3903.2(c)(1) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following:	H 053	To address H 053: The HCA uses Deyta Analytics, a CMS approved Home Health Care Consumer Assessment of Healthcare Providers and Systems to conduct monthly surveys of patients. The results are reviewed by the Administrator and administrative staff and also presented to the Board of Directors and the Quality Assurance/Quality Improvement Committee (QA/IC) at all meetings. The QA/QI Committee, on July 14, 2016, decided to have a patient survey form developed that could be used to assess the patient satisfaction for unskilled clients. The form will be administered biannually to 10% of the unskilled patients chosen randomly (see attached, from the QA/QI Committee Meeting Minutes dated July 14, 2016). To ensure that we survey the required number of patients, we utilize the survey done by Deyta for skilled patients, as well as, the survey for unskilled patients developed by the QA/QI Committee.	7/14/16 ongoing

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H 053	Continued From page 1 (1) The evaluation shall include feedback from a representative sample consisting of either ten percent (10%) of total District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patients. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to include feedback from a representative sample consisting of either ten percent (10%) of the District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patients in its annual review and evaluation. The finding includes: Review of the agency's "Board of Directors Meeting" minutes dated January 17, 2017 on March 13, 2017, beginning at 2:41 p.m. failed to provide evidence that feedback from a representative patient sample regarding the provision of services had been included in the annual review and evaluation. Interview with the Director of Professional Services on March 13, 2017, beginning at 10:31 a.m. revealed that satisfaction surveys are disseminated to patients by an outside service agency. Further interview revealed that the information received through the aforementioned surveys will be reviewed during the board meetings and incorporated into the minutes in the future. At the time of this survey, there was no documented evidence that the agency had included feedback from a representative patient sample regarding the provision of services in the	H 053	The Customer Service Survey (see attached) was conducted on November 1, 2016. The sample included thirty (30) randomly chosen unskilled patients. Overall, the patients seemed to be satisfied with the agency and the aides. However, several patients had concerns that the Supervisory Nurse did not always discuss their satisfaction with the agency and their concerns regarding their PCAs and the POC during the monthly visit. Two (2) patients discussed concerns about the office staff's handling of incoming calls and transferring the call to the appropriate person. The Customer Survey results, for the unskilled patients and the Deyta Survey of skilled patients was reviewed at the Board of Directors meeting held on January 19, 2017 and at the QA/QI Committee Meeting held on March 7, 2017. The Administrator reviewed telephone etiquette and appropriate referrals with the office staff on April 10, 2017. The RNs will be in-serviced on procedures, practices and issues related to the monthly supervisory visits. In addition, to prevent any recurrences in the future, all new hires will be in-serviced during orientation on these procedures and practices. Printed results of all surveys will be made available to the Director of Professional Services and the Director of Nursing. These results will be kept on file in the administrative offices for review.	11/1/16 6/2/17 ongoing 6/6/17 6/10/17 ongoing 6/4/17 ongoing

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H 053	Continued From page 2 annual review and evaluation for the year 2016.	H 053	To address H 070:	
H 070	3904.1 DIRECTOR The governing body shall appoint a Director who shall be responsible for managing and directing the agency's operations, serving as liaison between the governing [*2880] body and staff, employing qualified personnel, and ensuring that staff members are adequately and appropriately trained. This Statute is not met as evidenced by: Based on record review and interview, the HCA's director failed to ensure that I) staff was adequately and appropriately trained on agency policy for one (1) of twenty patients in the sample (Patient #2); and II) failed to ensure that staff was adequately and appropriately trained to provide care for one (1) of two (2) patient's with Autism and self-injurious behavior. (Patient #10) The findings include: The HCA director failed to ensure that staff was adequately and appropriately trained on agency policy as evidenced below: Review of the agency's complaints and incidents on March 13, 2017, at 12:46 p.m. revealed a complaint dated January 3, 2017 involving Patient #2. According to the report, Patient #2 accompanied HHA #1 to " a family house" for New Year's dinner. Further review of the report and interview with the Director of Professional Services on March 15, 2017 beginning at 1:16 p.m. revealed that HHA #1 transported Patient #2 to the dinner in a vehicle that neither belonged to	H 070	To address HHA #1's failure to follow the HCA's policy regarding: 1) the transporting of a patient in a personal vehicle and 2)notifying the agency and getting permission to take the patient on personal outings. Premium Select Home Care, Inc., has always had a policy that forbids staff from transporting patients in their personal vehicles. In addition, the agency has a policy that states that staff and HHAs can only take patients to outings for medical purposes and other personal errands such as grocery shopping, picking up prescriptions, beauty and barber appointments, banking, etc. Staff members are informed of these policies during orientation and periodically during in-services. Employees are required to sign an Orientation Checklist to confirm that they have received this information during their orientation. These policies were reviewed with HHA #1, during her initial orientation; however, the Personnel Director failed to ensure that this particular HHA had signed the Orientation Checklist. Once the oversight was noted, the HHA signed the required orientation form noting that she had been informed of all policies.	3/17/17 ongoing 3/17/17

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H 070	Continued From page 3 the patient nor was secured by the patient. Further interview with the Director of Professional Services revealed that the agency did not know that Patient #2 was going to a dinner with HHA #1 during her tour of duty and did not know that Patient #2 was being transported in a personal vehicle secured by HHA #1. According to the Director of Professional Services, the aide failed to follow agency rules by transporting the patient in a personal vehicle and not informing the agency of the outing. Interview with the human resources representative on March 16, 2017 at approximately 3:30 p.m. revealed that all new employees are required to go through orientation training. The agency has an established orientation guide that documents the agency rules. Review of the orientation guide and further interview with the human resources representative on March 16, 2017 at approximately 4:00 p.m. revealed that the guide documented to "never transport your client in your car." It should be noted that review of HHA #1's personnel record on March 16, 2017 failed to provide evidence that HHA #1 was provided with orientation training. At the time of the survey, the agency failed to ensure HHA #1 was adequately and appropriately trained on agency policy.	H 070	To ensure that the HCA does not encounter this problem in the future, a new procedure will be put in place. For quality control, the personnel file will be reviewed by both the assistant and the Director of Personnel. They will both have to sign off documenting that the personnel file is complete. In addition, HHA #1 was counselled and temporarily suspended regarding the violation of these policies. To prevent future recurrences of this violation, we gave in-services regarding agency policies to the HHAs and will continue to include, as part of our yearly in-service program, an in-service on agency policies. To address H 358: Our HCA failed to include parameters for blood glucose levels for patients with diabetes mellitus. From this time forward, all patients, skilled and unskilled patients with diabetes, who are testing their blood will have parameters for blood sugar levels included on their plan of care.	6/1/17 ongoing 3/7/17 3/11/17 6/13/17 ongoing 6/10/17 ongoing
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following: (g) Physical assessment, including all pertinent diagnoses;	H 358		

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H 358	Continued From page 4 This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure the POCs (1) included parameters for blood glucose levels as part of the physical assessment for five (5) of twenty (20) patients in the sample. (Patients #8, #9, #10, #14 and #16) The findings include: I. The HCA failed to ensure patients' POCs included parameters for blood glucose levels, as evidenced by: 1. On March 15, 2017, at 10:10 a.m., review of Patient #8's POC with a certification period of March 3, 2017 through May 1, 2017, revealed a SOC date of November 5, 2016. The patient was diagnosed with diabetes mellitus type II, diabetic neuropathy and an open wound on the right great toe. Further review revealed that the SN was to assess and evaluate the patient's endocrine system three (3) times a week for nine (9) weeks. However, there was no documented evidence that the POC included parameters for blood glucose levels. 2. On March 15, 2017, at 11:00 a.m., review of Patient #9's POC with a certification period of December 7, 2016 through June 7, 2017, revealed a SOC date of December 5, 2015. The patient was diagnosed with diabetes mellitus type II with ulcerated toes. Further review revealed that the SN was to assess and evaluate the patient's endocrine system one (1) to two (2) times a month for six (6) months. However, there was no documented evidence that the POC included parameters for blood glucose levels.	H 358	The SN will notify the patient's physician when the fasting blood glucose level is less than 60 mg/dl or greater than 200 mg/dl/. If any random blood glucose value is greater than 400 mg/dl, the patient's physician will be notified. The SNs will inquire about the recent blood glucose values and will document these values in their notes. For our skilled patients, our SNs will continue to instruct the patient in diabetic management, diabetic foot care, signs and symptoms of hypo-/hyperglycemia, and medication management. Also, the SN will instruct/monitor the patient's blood glucose levels and notify the physician if fasting blood glucose levels are greater than 200 mg/dl or less than 60 mg/dl or postprandial blood glucose levels are greater than 400 mg/dl. If our patients with diabetes have not been testing their blood glucose levels at home, the SN will inquire about their most recent Hemoglobin A1c (HbA1c) values and about any concerns that their physician may have concerning their diabetes and document the reported information.	6/10/17 ongoing 6/10/17 ongoing

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H 358	Continued From page 5 3. On March 13, 2017, at 12:05 p.m., review of Patient #10's POC with a certification period of February 3, 2017 through April 3, 2017, revealed a SOC date of December 5, 2016. The patient was diagnosed with a complete traumatic amputation of the left foot and diabetes mellitus type II. Further review of the POC revealed an order for the SN to assess and evaluate the patient's endocrine system four (4) to five (5) times a week for 9 weeks. However, there was no documented evidence that the POC included parameters for blood glucose levels. 4. On March 13, 2017, at 12:05 p.m., review of Patient #14's POC with a certification period of October 7, 2016 through April 7, 2017, revealed a SOC date of April 3, 2014. The patient was diagnosed with diabetes mellitus type II. According to the POC, the SN was to monitor the patient's blood glucose levels 1 to 2 times a month for 6 months. However, there was no documented evidence that the POC included parameters for blood glucose levels. 5. On March 16, 2017, at 12:25 p.m., review of Patient #16's POC with a certification period of December 10, 2016 through June 10, 2017, revealed a SOC date of June 1, 2012. The patient was diagnosed with diabetes mellitus type II. Further review revealed that the SN was to evaluate the patient's endocrine system 1 to 2 times a month for 6 months. However, there was no documented evidence that the POC included parameters for blood glucose levels. On March 16, 2017, at 4:05 p.m., interview with the Director of Professional Services and the DON indicated that the HCA would train the SN's to include parameters for blood glucose levels on the POC as part of the physical assessment for	H 358	To ensure that these measures will be implemented, the Medical Director will conduct two (2) mandatory in-services for all SNs to: 1) Review and explain these measures and responsibilities. 2) Teach the clinical use of HbA1c (see attachment). 3) Answer any questions related to these new measures. To ensure that this deficiency does not reoccur, all new SNs will be trained on the management and blood sugar monitoring of diabetic patients during their new hire in-service. In addition, the Plan of Care Review Nurses will be trained to ensure that Diabetic Plans of Care for patients doing blood glucose monitoring includes blood glucose parameters. Finally, our QA/QI Manager will survey the HCA's compliance and report these findings at each QA/QI Committee Meeting. The QA/QI nurse will review 25% of diabetic charts to determine if the SNs are following the diabetic blood sugar management processes. The nurse will ascertain whether the patient is doing Blood Glucose Testing and if their testing techniques are appropriate. The nurse will ensure that the test results or ranges of the results are recorded and whether the nurse notifies the physician when results are below or above the parameters.	6/6/17 6/10/17 ongoing 6/10/17 ongoing

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H 358	Continued From page 6 the aforementioned patients. At the time of the survey the HCA failed to include parameters for blood glucose levels on the POCs.	H 358	To address H 366: To ensure timely approval of POCs by the patient's physician, the following steps will be implemented.	6/2/17 ongoing
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 each POC was approved and signed by a physician within thirty (30) days of the SOC, for one (1) of twenty (20) patients in the sample (Patient #2). The finding includes: Review of Patient #2's POC with a certification period of September 30, 2016 through March 30, 2017, on March 15, 2017, at 11:17 a.m., revealed a SOC date of September 30, 2016. Further review of the POC revealed it documented an order for SN services, one to two times per month for six months and HHA services, 12 hours a day for twenty four weeks. Continued review of the POC revealed it was signed and dated by the physician on November 16, 2016 (47 days after	H 366	1) The POC and any additional orders are mailed and faxed to the physician's office. The POC and orders are logged into an excel spreadsheet for tracking and monitoring. A copy is kept in the chart and in an order file box. 2) A follow-up call is made to the physician's office to verify that the orders were received. 3) If the orders are not received within a week of the due date, the orders will be re-faxed again and followed up with a phone call. If the orders are not received back that day, they are given to our community liaison staff member to be hand-carried to the physician's office. 4) If necessary, we will recruit the assistance of the patient/caregiver to get the orders signed.	

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H 366	Continued From page 7 the SOC). Discussion was held with the Director of Professional Services and DON during the exit conference on March 16, 2017, beginning at 4:29 p.m. They were informed that the provided POC for Patient #2 was not signed within the required timeframe. According to the DON, routinely POCs are sent to the physician and signed appropriately. At the time of the survey, however, the agency failed to ensure Patient #2's POC was signed by the physician within the indicated timeframe. At the time of the survey, the agency failed to ensure each POC was approved and signed by a physician within thirty days of the SOC.	H 366		
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 interview and record review, the HCA failed to ensure (1) the SN made certain home health aide services were rendered in the frequency prescribed on the plan of care (II) patients' blood glucose levels were monitored in accordance with their POC and (III) SN services were rendered as indicated in the POC, for five (6) of twenty patients in the sample. (Patients #2, #7, #8, #10, #14 and #16) The findings include:	H 453	To address H 453: To ensure that the patients needs are met in accordance with the plan of care the agency will in-service the RNs on development of the plan of care. The in-service will include how to determine the appropriate frequency of services and how to maintain and update the frequencies. The in-service will instruct the nurses to notify the physician of changes and to obtain change orders. RNs will be in-serviced to include on their orders specific instructions, such as blood glucose parameters and orders for PT/INR, and the specific levels that need to be reported to the physician.	6/6/17 6/10/17 ongoing

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H 453	Continued From page 8 I. The HCA failed to ensure HHA services were rendered in the frequency prescribed. Review of Patient #2's POC, with a certification period of September 30, 2016 through March 30, 2017 on March 15, 2017, beginning at 11:01 a.m. revealed the patient was to receive HHA services at a frequency of 12 hours a day, seven (7) days a week, for twenty-four weeks. Review of HHA time sheets for Patient #2 on March 15, 2017, beginning at 12:04 p.m. revealed that patient failed to receive HHA services for 12 hours as ordered on the dates indicated below: October 2016 10/1/16 - 8 hours of HHA services received 10/2/16 - 9 hours of HHA services received 10/3/16 - 8 hours of HHA services received 10/4/16 - 8 hours of HHA services received 10/5/16 - 5 hours of HHA services received 10/6/16 - 8 hours of HHA services received 10/7/16 - 8 hours of HHA services received November 2016 11/7/16 - 8 1/2 hours of HHA services received 11/14/16 - 7 hours of HHA services received December 2016 12/22/16 - 11.25 hours of HHA services received Further review of Patient #2's POC on March 15, 2017 revealed that nursing services were ordered at a frequency of one (1) to two (2) times a month for six months. Continued review of Patient #2's records on March 15, 2017, revealed that there was no evidence that the skilled nurse conducted a visit during the month of October 2016. It should be noted that the record documented a missed visit on October 10, 2016, but failed to	H 453	H 483 This correction will address Patient #2 where the HHA did not maintain the ordered frequency in accordance to the POC. Upon review of the chart and further discussion with the Director of Nursing and the staffing coordinator, it was revealed that their was an error or oversight on the initial referral. The referral said the patient was to get PCA services eight hours times seven days a week. However, the Delmarva assessment and the Prior Authorization specified 12 hours per day x 7 days per week. The intake nurse told the staffing coordinator and the Admission nurse that the patient was to receive 8 hours times seven days. After the oversight was corrected a PCA was scheduled to provide the additional four hours. The Intake nurse and the nurse reviewer have been counselled and in-serviced on the need to review all paper work closely to ensure that the patients get the services recommended on the prior authorization. The services are consistent with orders on the face-to-face and with the discharge instructions. They have been instructed to utilize the review process developed (see attachment.) In addition, they were notified to inform the physician via a order when services are not provided in accordance with the plan originally specified by the physician. If for some reason the HCA providers are not able to provide the required number of hours or visits. they are required to document a miss visits specifying the reason why and documenting notification of the patient/caregiver and the physician.	6/2/17 ongoing 6/2/17 ongoing 6/2/17 ongoing

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H 453	Continued From page 9 give any further detail regarding the missed visit. Additional review of Patient #2's record revealed that the nurse failed to successfully complete a visit during the month of December 2016. On December 23, 2016, a nurse documented the inability to gain access to the patient's home in a missed visit note. There was no evidence that another attempt was made to conduct a visit during the month. Interview with the Director of Professional Services on March 16, 2017 at 4:21 p.m. revealed that the case was very difficult to staff. At the time of the survey, the HCA failed to provide evidence to justify why Patient #2 failed to receive services as prescribed. At the time of this survey, the agency's skilled nurse failed ensure that Patient #2 received both HHA services and nursing services as ordered and in accordance with the patient's POC. II. The agency failed to ensure that the SN monitored patients' blood glucose levels according to the POC, as evidenced by: a. On March 15, 2017, at 10:00 a.m., review of Patient #7's POC with a certification period of January 25, 2017, through March 25, 2017, revealed a SOC date of February 5, 2015. The patient was diagnosed with diabetes mellitus type II and diabetic ulcers on the right lateral and right plantar foot. According to the POC, the SN was to monitor the patient's blood glucose levels three (3) to five (5) times a month for nine (9) weeks. On March 15, 2017, beginning at 10:15 a.m., review of Patient #7's Nursing Visit Notes dated March 7, 2017, March 1, 2017, February 10,	H 453	SN missed visits. In the case of Patient #2, the RN did do a visit for October. It was completed on October 15, 2016, as a Resumption of Care documented on the Oasis form. On December 23, 2016, the RN was unable to gain access to the client. The RN should have made a follow-up attempt to visit the patient. The RNs will be in-serviced and encourage to make their supervisory visits earlier in the month so they will have time to make up a missed visit. The RNs will also be instructed to make an appointment with the client and verify the appointment the night before. To ensure that we will be able to make all supervisory visits in the future, we are hiring a full-time RN who will be available to assist with visits when a nurse's schedule prevents him/her from fulfilling their obligation to make a visit. The RN will be required to notify the office and arrange for a replacement. To address Blood Glucose Monitoring: Our HCA failed to include parameters for blood glucose levels for patients with diabetes mellitus. From this time forward, all patients, skilled and unskilled patients with diabetes, who are testing their blood sugars at home will have parameters for their blood glucose levels included in their POCs. The SN will notify the patient's physician when the fasting blood glucose level is less than 60 mg/dl or greater than 200 mg/dl/.	6/6/17 6/10/17 ongoing 6/6/17 6/10/17 ongoing 6/6/17 6/10/17 ongoing

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H 453	Continued From page 10 2017, February 11, 2017, February 12-14, 2017, and January 27, 2017, revealed no documented evidence that the SN monitored the patient's blood glucose levels according to the POC. b. On March 13, 2017, at 12:05 p.m., review of Patient #10's POC with a certification period of February 3, 2017 through April 3, 2017, revealed a SOC date of December 5, 2016. The patient was diagnosed with a complete traumatic amputation of the left foot, diabetes mellitus type II, essential hypertension and vitamin B12 deficiency anemia. Further review of the POC revealed an order for the SN to assess and evaluate the patient's endocrine system. On March 16, 2017, beginning at 3:20 p.m., review of Patient #10's Nursing Visit Notes dated February 3, 2017, February 13, 2017, February 15, 2017, February 20, 2017, revealed no documented evidence that the SN monitored the patient's blood glucose levels. c. On March 13, 2017, at 12:05 p.m., review of Patient #14's POC with a certification period of October 7, 2016 through April 7, 2017, revealed a SOC date of April 3, 2014. The patient was diagnosed with diabetes mellitus type II, COPD, depressive disorder. According to the POC, the SN was to monitor the patient's blood glucose levels one (1) to two (2) times a month for six (6) months. On March 16, 2017, at 1:45 p.m., review of Patient #14's Nursing Visit Note dated November 20, 2016, revealed no documented evidence that the SN monitored the patient's blood glucose level according to the POC.	H 453	If any random blood glucose value is greater than 400 mg/dl, the patient's health care provider will be notified. The SNs will inquire about the recent blood glucose values and document these values in their notes. For our skilled patients, our SNs will continue to instruct the patient in diabetic management, diabetic foot care, signs and symptoms of hypo-/hyperglycemia, and medication management. Also, the SN will instruct/monitor the patient's blood glucose levels and notify the physician if fasting blood glucose levels are greater than 200 mg/dl or less than 60 mg/dl or postprandial blood glucose levels greater than 400 mg/dl. If our patients with diabetes have not been testing their blood glucose levels at home, the SN will inquire about their most recent Hemoglobin A1c (HbA1c) values and about any concerns that their physician may have concerning their diabetes. To ensure that these measures will be implemented, the Medical Director will conduct two (2) mandatory in-services for all SNs to: 1) Review and explain these measures and responsibilities. 2) Teach the clinical use of HbA1c (see attachment). 3) Answer any questions related to these new measures. To ensure that this deficiency doe not recur, all new nurses will be trained on the management and blood sugar monitoring	6/6/17 6/10/17 ongoing 6/6/17 6/10/17 ongoing

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H 453	Continued From page 11 d. On March 16, 2017, at 12:25 p.m., review of Patient #16's POC with a certification period of December 10, 2016 through June 10, 2017, revealed a SOC date of June 1, 2012. The patient was diagnosed with CVA, diabetes mellitus type II and hypertension, and general muscle weakness. Further review of the POC revealed an order for the SN to assess and evaluate the patient's endocrine system 1 to 2 times a month for 6 months. On March 16, 2017, at 12:30 p.m., review of Patient #16's Nursing Visit Note dated December 16, 2016, revealed no documented evidence that the SN monitored the patient's blood glucose level during the physical assessment. On March 16, 2016, starting at 4:50 p.m., interviews with Director of Professional Services and the DON revealed that the SNs will be trained on how to perform and document blood glucose checks as part of their skilled assessment process. At the time of this survey the HCA's SNs failed to monitor the patient's blood glucose levels as part of their skilled assessment process. III. The HCA failed to ensure SN services were rendered as indicated in the POC. Review of Patient #8's POC with a certification period of November 5, 2016 through January 3, 2017 on March 15, 2017 beginning at 3:26 p.m. revealed SN services were to be rendered three times a week for nine weeks to provide wound care and other associated services. Continued review of Patient #8's record on March 16, 2017 beginning at 4:16 p.m. revealed the patient failed to receive SN services as prescribed during the	H 453	of diabetic patients during their new hire in-service. In addition, the POC review nurses will be trained to ensure that diabetic Plans of Care for patients doing Blood glucose monitoring includes Blood glucose parameters Finally, our QA/QI Manager will survey the HCA's compliance and report these findings at each QA/QI Committee Meeting. The QA/QI Nurse will review 25% of diabetic charts to determine if the SNs are following the diabetic blood sugar management processes. The nurse will ascertain whether the patient is doing blood glucose testing and if their testing techniques are appropriate. The nurse will ensure the test results or ranges of the results are recorded and whether the nurse notifies the physician when results are below or above the parameters.	6/6/17 6/10/17 ongoing 6/10/17 ongoing

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H 453	Continued From page 12 following weeks: Week of November 13, 2016 - only one SN visit conducted, November 18, 2016. Week of December 18, 2016 - two SN visits conducted, December 19, 2016 and December 23, 2016. Interview was conducted with the Director of Professional Services on March 16, 2017 at 4:28 p.m. to ascertain information regarding why SN services were not rendered as prescribed. At the time of the survey, however, evidence was not provided to justify why visits were not rendered as prescribed.	H 453		
H 454	3917.2(d) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (d) Implementing preventive and rehabilitative nursing procedures; This Statute is not met as evidenced by: Based on interview and record review, the HCA's skilled nursing staff failed to provide evidence that preventive nursing procedures were afforded to patients related to their health conditions, for five (5) of fifteen (20) patients in the sample. (Patient #7, #9, #15, #16 and Patient #17). The finding includes: 1. On March 15, 2017, at 10:00 a.m., review of Patient #7's POC with a certification period of	H 454	To address H 454: Regarding documented weight issues: The RNs documents self-reported weights of the patients on the SOC, ROC and Recertifications. The patient's weight will be monitored, reported to the physician and documented when there is cause for concern and the patient appears to present with significant changes. For example: (1) if the patient reports a decrease in appetite and/or reports not eating an adequate amount of food or if the patient appears to have lost a significant amount of weight. (2) Any patient with signs or symptoms of de-compensated CHF (e.g., increased peripheral/pitting edema, exacerbation of SOB or dyspnea on exertion) will have his/her weight monitored, reported to the physician and documented on the nurse's note.	6/6/17 6/10/17 ongoing

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H 454	Continued From page 13 January 25, 2017, through March 25, 2017, revealed a SOC date of February 5, 2015. The patient was diagnosed with diabetes mellitus type II, diabetic ulcers on the right lateral and right plantar foot, hypertension, chronic kidney disease and thyroid disorder. Further review revealed that the SN was to assess and evaluate the patient's disease processes three (3) to five (5) times a month for nine (9) weeks. On March 15, 2017, beginning at 10:15 a.m., review of Patient #7's Nursing Visit Notes dated March 7, 2017, March 1, 2017, February 3, 2017, February 11, 2017, February 12, 2017, February 13, 2017, February 14, 2017 and January 27, 2017, revealed no documented evidence that the SN actually weighed Patient #7 or recorded the patient's reported weight during the physical assessment. 2. On March 15, 2017, at 11:00 a.m., review of Patient #9's POC with a certification period of December 7, 2016 through June 7, 2017, revealed a SOC date of December 5, 2015. The patient was diagnosed with diabetes mellitus type II with ulcerated toes, hyperlipidemia and hypertension. Further review revealed that the SN was to assess and evaluate the patient's disease processes one (1) to two (2) times a month for six (6) months. On March 15, 2017, at 10:30 a.m., review of Patient #9's Nursing Visit Note dated February 11, 2017, revealed that the patient had a knowledge deficit related to non-compliance with his/her diet regimen. However, there was no documented evidence that the SN actually weighed Patient #9 or recorded the patient's reported weight during the physical assessment. On March 15, 2017, at 11:35 a.m., review of a	H 454	The SN will weigh the patient unless the patient is unable to stand or bear weight without causing harm to the patient. In the upcoming in-service, the SNs will be instructed to ask the patient for their last weight. If the patient is unaware of their current weight, the SN will ask the patient if on their last doctor's visit did their physician express any concerns regarding their weight. Also, the SNs will be instructed to provide thorough and complete documentation. The nurses will have to report and investigate all significant changes in the patient's condition, and to notify the patient's physician when indicated. In addition, to prevent any issues in the future, all SNs that are hired will be in-serviced, during orientation, on these procedures. For quality control, the QA/QI nurses will review 10% of the HCA's charts monthly to determine if the SNs are following the agency's policies and procedures. Finally, our QA/QI Manager will survey the HCA's compliance and report these findings, at each QA/QI Committee Meeting.	6/6/17 6/10/17 ongoing 6/6/17ong 6/6/17 ongoing

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H 454	Continued From page 14 Nursing Visit Note dated January 23, 2017, also revealed no documented evidence that the SN actually weighed Patient #9 or recorded the patient's reported weight during the physical assessment. 3. On March 16, 2017, at 12:15 p.m., review of Patient #15's POC with a certification period of October 22, 2016 through April 22, 2017, revealed a SOC date of October 21, 2015. The patient was diagnosed with GERD, diverticulosis, hypertension, partial blindness, cataracts, asthma, osteoarthritis and general muscle weakness. Further review revealed that the SN was to assess and evaluate the patient's disease processes 1 to 2 times a month for 6 months. On March 16, 2017, beginning at 12:20 p.m., review of Patient #15's Nursing Visit Notes dated February 14, 2017, January 29, 2017, December 22, 2016, November 12, 2016 and October 8, 2016, revealed no documented evidence that the SN actually weighed Patient #15 or recorded the patient's reported weight during the physical assessment. 4. On March 16, 2017, at 12:25 p.m., review of Patient #16's POC with a certification period of December 10, 2016 through June 10, 2017, revealed a SOC date of June 1, 2012. The patient was diagnosed with CVA, diabetes mellitus type II, hypertension and general muscle weakness. Further review revealed that the SN was to evaluate the patient's assess and evaluate the patient's disease processes 1 to 2 times a month for 6 months. On March 16, 2017, beginning at 12:30 p.m., review of Patient #16's Nursing Visit Notes dated February 28, 2017, January 28, 2017, January	H 454		

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H 454	Continued From page 15 12, 2017 and December 16, 2016, revealed no documented evidence that the SN actually weighed Patient #16 or recorded the patient's reported weight during the physical assessment. 5. On March 16, 2017, at 12:50 p.m., review of Patient #17's POC with a certification period of December 9, 2016 through June 9, 2017, revealed a SOC date of September 26, 2013. The patient was diagnosed with CHF, hypertension, senile dementia and general muscle weakness. Further review revealed that the SN was to assess and evaluate the patient's disease processes 1 to 2 times a month for 6 months. On March 16, 2017, beginning at 1:10 p.m., review of Patient #17's Nursing Visit Notes dated February 14, 2017, January 28, 2017, January 12, 2017 and December 16, 2016 revealed no documented evidence that the SN actually weighed Patient #16 or recorded the patient's reported weight during the physical assessment. On March 16, 2017, at 3:50 p.m., interview with the Director of Professional Services and the DON it was acknowledged at the time of the survey there was no documented evidence that the nurse actually weighed or recorded Patient #7, #9, #15, #16 and Patient #17's reported weights during their physical assessments. Further interview revealed that the POCs would be updated to include instructions for the nursing staff to weigh Patient #7, #9, #15, #16 and Patient #17 or record the patients reported weights from their physicians. An addition, the nursing staff would be re-trained on how to weigh and document the patients actual or reported weights on the Nursing Visit Notes.	H 454		

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H 456	Continued From page 16	H 456	To address H 456: Deficiency regarding supervision of the Home Health Aide.	
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 HCA failed to document the supervision of services being delivered by each patient's PCA for one (1) of the fifteen (15) sampled patients. (Patient #14) The finding includes: On March 13, 2017, at 12:05 p.m., review of Patient #14's POC with a certification period of October 7, 2016 through April 7, 2017, revealed a SOC date of April 3, 2014. Further review of the POC revealed a documented order for Patient #14 to have PCA services for fourteen (14) hours a day for twenty-four (24) weeks. Additionally, the SN was to supervise the PCA monthly. On March 16, 2017, beginning at 1:50 p.m., review of Patient #14's Nursing Visit Notes dated February, 28, 2017, January 31, 2017 and December 31, 2016, revealed no documented evidence that the SN supervised the PCA monthly as ordered by the POC. On March 16, 2017, at 2:45 p.m., interview with the DON revealed that the agency was aware that the SN had not provided supervisory visits to the PCA monthly. Further interview revealed that the agency would re-train the SN to comply with the	H 456	The requirements for RN supervision of the HHA are once every 60 days for unskilled patients and every 14 days for skilled patients. To ensure that our agency is in compliance with these standards, we will implement the following: 1. We will have an in-service with the RNs to reiterate the need for them to supervise each of their patient's HHA/PCA as per the regulations. The RN frequency for unskilled patients is currently written as 1-2 times per month for assessment, evaluation, and intervention related to the patients disease process. The HHA/PCA supervision is ordered to occur monthly. An additional order needs to be written if the RN needs to supervise more than two aides per month. However, many of these patients, particularly if the receive more than 8 hours 7 days a week,will have more than 2 aides. For example, a patient with 16 hours times 7 days a week might have 3-4 aides. Similarly, a patient with 24 hours times 7 days a week might have 5-6 Aides. The nurses will now be instructed to monitor each aide at least every 60 days. They will be instructed to try and make their visit overlap the shift of two of the aides and to supervise the weekend aides. Based on the number of hours the patient receives, the RN could be ordered 1-4 times per month with PRN visits for additional HHA/PCA supervision. 2. The SNs will be in-serviced to make their visits earlier in the month to allow time	6/6/17 ongoing 6/6/17 6/10/17 ongoing 6/6/17 6/10/17 ongoing

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H 456	Continued From page 17 POC. In addition, the agency would assign another SN to supervise Patient #14's PCA monthly. At the time of the survey, the agency failed to ensure the SN supervised the PCA monthly as ordered by the POC.	H 456	to revisit if they had a missed visit earlier. 3. We are hiring a full-time RN to be available to assist with supervisions when the patient's nurse schedule does not allow him/her to make the visit as required. 4.Each RN will have a Supervisory Visit Schedule.	6/12/17 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 SN failed to inform the physician of a change in a patient's condition, for one (1) of twenty patients in the sample. (Patient #2) The finding include: Review of Patient #2's records on March 15, 2017, at 12:34 p.m. revealed a nursing visit note dated November 16, 2016. The note documented that the patient stated that he/she felt a "slight burning when urinating." The note further indicated that the patient's primary medical doctor would be contacted by both the patient's daughter and the skilled nurse. There, however, was no documentation that verified the primary medical doctor had been contacted regarding the patient's change in condition. It should be noted that continued review of the patient's record failed to provide evidence that a	H 458	All new hires will be oriented on these supervisory processes during orientation. The QA/QI Nurses will monitor 10% of the patient records monthly to ensure that the nurses are doing the HHA/PCA supervisions in accordance with the regulations. Finally, our QA/QI Manager will survey the HCA's compliance and report these findings at each QA/QI Committee meeting held quarterly. To address H 458 Reporting changes in patient's condition: The SN providing services to Patient #2 will be individually counselled regarding her failure to either notify the physician of the change in the client's condition or her failure to document the notification to the physician. The SN will be in-serviced regarding evaluation and assessment of patients, notification of the patient's physician about significant changing in the patient's condition, documentation of actions taken and follow up with the patient to evaluate the interventions and outcomes.	6/6/17 ongoing 6/10/17 ongoing 6/6/17 6/6/17 6/10/17 ongoing

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H 458	Continued From page 18 skilled nurse visited with patient after November 16, 2016 through December 31, 2016. Interview with the Director of Professional Services on March 16, 2017, beginning at 4:21 p.m. revealed that the standard practice would be for the nurse to follow up with the patient's physician. At the time of the survey, the agency failed to provide evidence that the patient's physician had been informed of the change in the patient's condition.	H 458	To prevent a recurrence of nurses not reporting changes in the patient's condition, all new hires will be in-serviced on these standard practices. The QA/QI Nurse will monitor 10% of all current patients charts monthly, reviewing notes and assessments to determine if nurses are reporting and documenting patient condition changes and implementing appropriate interventions to address the patient's needs. Finally, our QA/QI Manager will survey the HCA's compliance and report the findings at the QA/QI committee meetings.	6/6/17 ongoin 6/10/17 ongoing
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on interview and record review, the agency failed to ensure its skilled nursing staff (I) provided evidence that specific instructions were afforded to patients related to their health care conditions and (II) documented the evaluation of provided training in a manner that reflected the patient's comprehension of the given instruction, for three (3) of twenty (20) patients in the sample (Patients #1, #8 and #10). The findings include: I. The agency failed to ensure its nurses documented the specific instructions that were afforded to the patient related to his/her health care conditions.	H 459	To address H 459: Patient instruction and evaluation of the patient instruction. Based on the survey findings and record review of five (5) of twenty (20) patient records, the SNs failed to adequately evaluate the patient's level of understanding of the teaching and instructions. The SNs evaluation response was too general. Basically, stating that the patient/caregiver understood the instructions. The SNs need to be more specific regarding the patient's/caregiver's level of understanding. How was understanding expressed? Was it recalled or demonstrated? Was the understanding specific to an identified problem that was being taught?	

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H 459	Continued From page 19 a. On March 13, 2017, at 12:05 p.m., review of Patient #10's POC with a certification period of February 3, 2017 through April 3, 2017, revealed a SOC date of December 5, 2016. The patient was diagnosed with a complete traumatic amputation of the left foot, diabetes mellitus type II, essential hypertension and vitamin B12 deficiency anemia. Further review of the POC revealed a documented order for the SN to instruct the patient in nutrition/hydration, elimination/metabolic status, disease process, infection control and medication regiment. On March 16, 2017, beginning at 3:20 p.m., review of Patient #10's Nursing Visit Notes dated March 1, 2017, March 3, 2017, February , 9, 2017, February 11, 2017, February 13, 2017, February 15, 2017, February 17, 2017, February 20, 2017, February 22, 2017, February 24, 2017 and February 27, 2017, revealed no documented evidence that the SN provided the patient with educational instructions related to his/her specific health care conditions as ordered by the POC. On March 16, 2017, at 4:15 p.m., interview with Director of Professional Services revealed that the nurses will be retrained to ensure the consistency of documentation related to Patient #10's specific health care conditions as ordered by the POC. At the time of the survey, the agency failed to ensure nurses documented specific instructions afforded to the patient related to their health care conditions. b. Review of Patient #8's POC with a certification period of March 3, 2017 through May 1, 2017, on March 15, 2017 beginning at 3:30 p.m. revealed	H 459	The SNs will be in-serviced on the teaching/instructional processes and documentation to include problem identification, intervention, and evaluation of the outcomes. If a SN identifies one or more problems that he/she addresses during a visit, the SN will be instructed to list each problem separately, and also describe the intervention in detail. The SNs will evaluate the patient's response to the intervention or the outcome of the intervention for each identified problem and intervention. The evaluation must be quantitative and the method of understanding needs to be documented. For instance, is the method of understanding expressed, recalled, or demonstrated? Does the patient understand the purpose, correct dosage, side effects and precautions? Does the patient completely understand and can recall 100% or only 40-50% or less. The purpose of the in-services will be to teach the SNs how to be more specific about their interventions and the evaluations of the intervention outcomes. The SNs will be in-serviced on documentation procedures with emphasis on teaching and documentation of the patient's responses and outcomes. Sample documentation notes will be distributed to the professional staff and the new professional hires. The QA/QI Manager or designee will monitor the skilled professional notes, for one (1) month, after the in-service, to check for compliance and for proper documentation.	6/6/17 6/10/17 ongoing 6/6/17 6/10/17 ongoing

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 _____	03/17/2017

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H 459	Continued From page 20 SN services were to be rendered three times a week for nine weeks to provide wound care and other associated services. The POC documented that the nurse was to provide instruction in various areas including in nutrition, the disease process, infection and standard precautions, medications and implementation of the emergency plan. Review of nursing visit notes beginning on March 15, 2017 at 12:34 p.m. revealed the nurse provided services to the patient on November 25, 2016, December 2, 2016, December 7, 2016, December 14, 2016, December 28, 2016, 17, January 6, 2017, January 13, 2017, January 21, 2017, January 27, 2017, and February 25, 2017. Continued review of the notes failed to provide evidence that the nurse provided any instruction to the patient and/or caregiver. Interview was conducted with the Director of Professional Services and the DON on March 16, 2017, beginning at 4:05 p.m. to ascertain information regarding why training was not conducted during the aforementioned visits. At the time of the survey, however, the agency failed to provide a rationale that justified why training failed to be provided and documented. II. The agency failed to ensure its nurses documented the patient's specific comprehension with the health teaching instructions related to his/her health care condition. a. On March 16, 2017, beginning at 3:25 p.m., review of Patient #10's Nursing Visit Notes dated March 6, 2017, March 10, 2017, and February 6, 2017, revealed that the patient was given instructions during the visit on the signs and	H 459	Finally, our QA/QI Manager will survey the HCA's compliance and report these findings at each QA/QI Committee Meeting.	6/10/17 ongoing

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H 459	Continued From page 21 symptoms of wound infection. However, the SN failed to document the specific components of the training that Patient #10 understood. On March 16, 2017, at 4:25 p.m., interview with the Director of Professional Services revealed that the nurses will be retrained to ensure the consistency of documentation related to Patient #10's understanding with all components of training. At the time of the survey, the agency failed to ensure nurses documented the patient's specific comprehension with the signs and symptoms of wound infection training. b. Review of Patient #8's record on March 16, 2017 at 12:18 p.m. revealed a nursing visit notes dated November 11, 2016. According to the note, the nurse trained the patient on when to notify the doctor and signs and symptoms of infection during the visit. There was no indication however, of the patient's level of understanding with the training received. Interview was conducted with the Director of Professional Services and the DON on March 16, 2017, beginning at 4:05 p.m. to ascertain information regarding why the documentation of training failed to include specific information related to the patient's understanding. At the time of the survey, however, the agency failed to provide a rationale that justified why the documentation failed to include the patient's specific degree of understanding. c. Review of Patient #1's record on March 13, 2017 beginning at 3:13 p.m. revealed nursing visit notes dated December 9, 2016, December 10, 2016, and December 28, 2016. According to the	H 459		

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H 459	Continued From page 22 notes, the nurse trained the patient on the use of his/her walker, monitoring blood glucose, and medication administration on December 9, 2016. On December 10, 2016, the nurse provided the patient education on proper disposal of diabetic supplies and the use of walker. On December 28, 2016, the nurse provided the patient instruction on nutrition and taking medication as prescribed. There was no indication however, of the patient's level of understanding with any of the training received. Interview was conducted with the Director of Professional Services and the DON on March 16, 2017, beginning at 4:05 p.m. to ascertain information regarding why the documentation of training failed to include specific information related to the patient's understanding. At the time of the survey, however, the agency failed to provide a rationale that justified why the documentation failed to include the patient's specific degree of understanding.	H 459		