PRINTED: 04/29/2015
FORM APPROVED

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-0030	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HEALTHCARE RESOURCES (	1010 WISCONSIN AVENUE, NW, SUITE 300 WASHINGTON, DC 20007

RECEIVED MAY 12 2015

(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 000	INITIAL COMMENTS An annual survey was conducted from April 13, 2015 through April 15, 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 fifty (350) patients and employs three hundred and fifty (350) 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. Activities of daily living - ADL Home Care Agency - HCA Home Health Aide - HHA Instrumental activities of daily living - IADL Skilled Nurse - SN	H 000	H450 3917.1Skilled Nursing Services Skilled nursing services shall be provided by a 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. A. Corrective Actions for patient found to be affected by these deficiencies: 1. Patient #9's clinical record has been reviewed by the Clinical Manager and Administrator with clinical staff caring for patient. Current documentation of wound care reflects MD orders for care. a. Specific staff involved in deficiency were counseled and a mandatory review of Wound Care policies and documentation was completed by the staff involved with this specific deficiency on May 1, 2015.	5/1/2015
H 450	3917.1 SKILLED NURSING SERVICES Skilled nursing services shall be provided by a 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 #3, #5, #9 and #12) The findings include: 1. On April 11, 2015, at approximately 10:30 a.m., review of Patient #9's POC with a	H 450	b. An updated order for wound care was sent to the MD reflective of the care provided on March 28 and April 1. 2. A more detailed review of Patient #12 provided evidence of MD order on 3/12/15 "Location: anterior aspect RLE skin tears. Treatment: Cleanse with/NSS. Apply hydrogel sheet to skin tears, wrap with kling and tape.(see attached) This order reflects wound care performed. 3. Timesheets and documentation of personal care for Patient #3 on January 18 and 24, 2015 were located on April 17, 2015. (see attached) 4. Timesheets and documentation of personal care for Patient #5 were submitted by the aide on April 17, 2015. Care on these dates were confirmed by phone call with patient's daughter on April 17 by the Administrator. These dates of services were not billed to the Department of Healthcare Finance until the next bill cycle in May 2015 as well as paid to the aide until May 8, 2015.	3/28/15 & 4/1/15 4/17/15 4/17/15 5/15 & 5/8/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alma Kelley — TITLE: RN administrator — (X6) DATE: 5/11/15

STATE FORM 6899 9S4411 If continuation sheet 1 of 3

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H 450	Continued From page 1 certification period of March 28, 2015, through May 26, 2015, revealed an order for SN visits two (2) to three (3) times a week for one (1) week, one (1) to two (2) times a week for two (2) weeks and one (1) time a week for two (2) weeks to clean wound on right and left posterior tibia with normal saline, apply xeroform, cover with gauze and ABD pad, wrap with kerlix and secure with ace bandage two (2) to three (3) times a week. Review of nurse's note dated March 28, 2015 revealed that the SN cleansed the right and left posterior tibia wounds with normal saline and applied hydrogel to both sites. Further review of the SN note dated April 1, 2015, revealed that the SN applied hydrogel to the left posterior tibia wound. 2. On April 11, 2015, at approximately 12:30 p.m., review of Patient #12's POC with a certification period of March 10, 2015, through May 8, 2015, revealed an order for "wound care to be performed by SN one (1) time a week, patient/caregiver (pt/cg) one (1) to two (2) times a week." The order did not specify the type of dressing to be applied or the location of the wound. Review of SN notes dated March 12, 2015, March 19, 2015, March 26, 2015 and April 2, 2015, revealed that the SN cleansed multiple skin tears on the patient's right lower extremity (anterior aspect) with normal saline and applied hydrogel sheet. Face to face interview with the Administrator on March 11, 2015 at approximately 1:00 p.m., confirmed the findings of the surveyor.	H 450	**B. Identification of other patients having the potential to be affected by this deficiency:** 1. The deficient documentation (Patient #9) was presented and reviewed with the entire staff on April 29, 2015.	4/29/15
			2. Wound care policies were presented at mandatory Wound Care Symposium held on March 10 and 11, 2015 to all RN and LPN company wide. 9 hours of training including hands on competencies, writing orders for wound care, and documenting the care ordered.	3/10/15 & 3/11/15
			3. The Clinical Managers reviewed all clinical records of all current wound care patients to assure compliance with the plan of care was completed on April 30,2015. There were an additional 2 (out of 22) documentation issues that were addressed and corrected to reflect the plan of care.	4/30/15
			4. Patient #12 care was provided and documented according to the Plan of Care.	
			5. The current back-up system of electronic files of personal care timesheets is adequate to provide evidence of care. Timeliness of retrieval of records will be addressed to the IT department.	
			6. A report of timesheets not submitted (known as a Tentative Report) was used to determine missing timesheets for the last 3 months. Patients, family members and aides were contacted to determine if care was provided. MD's were notified of any "missed visits" and documentation placed in clinical records.	
			C. Systemic Changes to ensure deficient practice does not recur:	
			1. Wound care clinical records and care will be reviewed by Clinical Managers every two weeks. This will be incorporated into routine responsibilities.	Every 2 wks
			a. Annual joint field staff visits will include wound care patients.	Every year

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H 450	Continued From page 2 3. On April 13, 2015, at approximately 12:00 p.m., review of Patient #3's POC with a certification date of July 3, 2014, to December 29, 2014, revealed that Patient #3 was to receive home health aide (HHA) services eight (8) hours a day, seven days a week to provide personal care assistance with ADL and IADL. Further review of the record revealed that the HHA did not visit the Patient on January 18 and 24, 2015. 4. On April 13, 2015, at approximately 1:30 p.m., review of Patient #5's POC with a certification date of October 4, 2014, to April 1, 2015, revealed that Patient #5 was to receive home health aide (HHA) services sixteen (16) hours a day, seven days a week to provide personal care assistance with ADL and IADL. Further review of the record revealed that the HHA did not visit the Patient on March 1, 7, 8, 14 and 15, 2015. During a face to face interview with the Administrator on April 13, 2015 at approximately 2:30 p.m., the Administrator stated that time sheets were scanned into their computer system and she/he will access the computer system and print the missing time sheets requested. However, the Administrator was unable to provide the surveyor with HHA time sheets or documented evidence for the missed visits at the conclusion of the survey.	H 450	c. The branch will identify and support a staff member to be Wound Care Certified by January 2016. d. A focused clinical record peer review audit with a random sample of 10 patients will be performed monthly beginning June 2015 for a period of at least 6 months. 2. The care plan for patient #12 was reflected in care—there was no deficient practice. 3. Personal care clinical records will be audited every 6 months for compliance to Plan of Care and completeness of record to begin June 2015. 3. At the end of every pay period time frame a "Tentative Report" will be produced and reviewed by personal care staff. Any visits or care not reflective in the clinical record will be investigated and notification to MD documented. D. Monitoring of Corrective Action 1. The Administrator is responsible for all monitoring of corrective actions. 2. The Administrator will submit to the Vice President of Branch Operations a quarterly report on all corrective actions. At any time of deficient practices the Administrator will implement additional Corrective Plans of Action. 3. All corrective action plans and deficiency results will be reported to the Professional Advisory Committee and Quality Council.	1/2016 Monthly from 6/2015 to 12/2015 Every 6 mos. from 6/2015