STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0080	A. BUILDING: _____ B. WING _____	10/12/2017

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PROFESSIONAL HEALTHCARE RESOURCES (	501 SCHOOL STREET, SW SUITE 200 WASHINGTON, DC 20024

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H 000	INITIAL COMMENTS An annual survey was conducted from October 3, 2017, through October 12, 2017, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency's Regulations). The home care agency provides home care services to four hundred and fifty-two (452) patients and employs two hundred and fifty-five (255) staff. The findings of the survey were based on a review of administrative records, twenty (20) complaint and incident reports, twenty-one (21) active patient records, four (4) discharged patient records, and twenty-three (23) employee records. The findings were also based on four (4) home visits, ten (10) patient telephone interviews and interviews with patients/family and staff. The following are abbreviations used within the body of this report: ALR -- Assisted Living Residence CEO -- Chief Executive Officer CPR -- Cardio-Pulmonary Resuscitation CVA -- cerebrovascular accident DNR -- Do Not Resuscitate DON -- Director of Nursing HCA -- Home Care Agency HHA -- Home Health Aide PCA -- Personal Care Aide POC -- Plan of Care SN -- Skilled Nurse SOC -- Start of Care RN -- Registered Nurse	H 000		
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and...	H 364	Reed - 1/12/18 D.J.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Colleen Reed RN, BSN — TITLE: General Manager, QCMA — (X6) DATE: 1/5/2018

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H 364	Continued From page 1 This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure emergency protocol for CPR was patient-specific for twenty-one (21) of 25 patient POCs reviewed (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21, 22, 23, 24 and 25). Findings included: 1. On October 3, 2017, through October 12, 2017, starting at 10:00 a.m. through 4:30 p.m., review of the clinical records for Patients #1, 2, 3, 4, 16 and 17 showed all POCs for personal care indicated, "staff instructed to call 911 in emergency situation and report to RN/Administrator." There was no documented evidence requiring staff to initiate CPR in the absence of a DNR. 2. On October 3, 2017, through October 12, 2017, starting at 10:00 a.m. through 4:30 p.m., review of clinical records for Patients #5, 6, 7, 8, 9, 10, 11, 18, 19, 20, 21, 22, 23, 24 and 25 showed all POCs for skilled care indicated, "if the patient is in cardiac or respiratory arrest, in the absence of a Do Not Resuscitate order (DNR), the staff will call 911 and initiate CPR." The POC was not specific by identifying how to respond to those patients with a DNR. On October 11, 2017, at 3:30 p.m., interview with the administrator and clinical manager revealed that the software used by the HCA to create POCs contained the language found on the aforementioned POCs. The clinical manager further stated that POCs will be made patient-specific by individualizing each POC to reflect CPR intervention in the emergency	H 364	**3914.3 (m) Plan of Care** **Corrective Action:** Both Personal Care and Skilled staff were educated on the processes for documenting advance directives/code status of patients on the Plan of Care including staff to initiate CPR (Cardio Pulmonary Resuscitation) for patients without DNR (Do not Resuscitate) status. Instructions include: If a patient is found in cardiac or respiratory arrest, the staff will call 911 and initiate CPR and remain with the patient continuing life support measures until the patient is transferred to an EMT (Emergency Medical Technician). If the patient is a DNR (DO Not Resuscitate), the staff will instruct patient/caregiver to post a copy of the Do Not Resuscitate order in a prominent place in the home so first responders do not overlook the order (for example: Patient Handbook, refrigerator, next to medications). If a Do Not Resuscitate (DNR) patient is found in cardiac or respiratory arrest, the staff is instructed to notify the POA/Caregiver immediately, call emergency service, notify their manager at the office and stay with the patient until help arrives. Staff were educated to review the Plan of Care and ensure that correct code status and actions are present. Skilled clinicians were educated on use of the new Goals and Interventions in the Electronic Medical Record.	10/5/17

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A3t4 3914.3(m) continued p.2

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H 364 394.3(m) continued p3

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H 364	Continued From page 2 protocol needs. At the time of the survey, the HCA failed to ensure that the emergency protocol contained within the POC patient-specific CPR and DNR instructions.	H 364	Immediately by the admitting clinician. Clinicians involved will be reeducated on the process. Personal Care: 100% Chart audit of all new Personal Care beneficiaries to be done post admission by the Clinical Managers to review for compliance. Chart audit of 100% re-authorization beneficiaries to be done monthly to review for compliance. Monitoring of the presence of personalized Emergency Protocols will be added to the Personal Care and Skilled chart audit tool. **391.4 Patient Plan of Care** **Corrective Action:** Both Plans of Care in question for patients #23 and #25 have been signed by the physician. The POC for patient #23 was signed on 09/22/17 and for #25 on 09/25/17. However, the signed Plans of Care were not scanned into the chart and were not available for surveyors to observe during survey. The person(s) responsible for this task were educated on the correct process for following up on orders and scanning into the Electronic Medical Records. **Measures and/or Systemic changes** To ensure that the Plan of Care is signed by the physician and in the chart An individual has been hired for the newly Created position of an Order *Entry Specialist* whose total responsibility includes	10/5/17
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 POCs were approved and signed by a physician for two (2) of 25 patients in the sample (Patients # 23 and 25). Findings included: 1. On October 11, 2017, at 12:30 p.m., review of Patient #23's clinical record revealed a POC with a SOC date of August 26, 2017, and a certification period of August 26, 2017, through October 24, 2017. The POC lacked documented evidence it had been approved or signed by a physician. 2. On October 11, 2017, at 2:30 p.m., review of Patient #25's clinical record revealed a POC with	H 366		

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H 364	Continued From page 2 protocol needs. At the time of the survey, the HCA failed to ensure that the emergency protocol contained within the POC patient-specific CPR and DNR instructions.	H 364	the Electronic Medical Record. Best Practice Goal #1: Monitor feet for presence of lesions every visit, instruct patient caregiver on proper diabetic foot care. Personal Care: A Best Practice action to assess and document health status of each beneficiary specific to active diagnosis with each monthly supervisory visit has been put into practice. **Ongoing Monitoring:** Skilled: Quarterly the Clinical Managers will audit 100% of the patients with a suprapubic catheter to ensure correct documentation of proper techniques. The audit will conclude when 100% of the documentation is in compliance. Monthly, 100% of diabetic patients will be audited by the Clinical Managers for foot checks at each visit. This 100% audit will continue until 90% of the charts reviewed are in compliance. Then the agency will continue with its quarterly PIP (Performance Improvement Project) audit of 10% of the patients with diabetes to ensure that diabetic foot checks are completed on every visit. For non-compliant charts the individual clinician will be held responsible and progressive action will be taken. Personal Care: 100% review of those Patients whose services have been put on hold as reported by the scheduler to to	
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 POCs were approved and signed by a physician for two (2) of 25 patients in the sample (Patients # 23 and 25). Findings included: 1. On October 11, 2017, at 12:30 p.m., review of Patient #23's clinical record revealed a POC with a SOC date of August 26, 2017, and a certification period of August 26, 2017, through October 24, 2017. The POC lacked documented evidence it had been approved or signed by a physician. 2. On October 11, 2017, at 2:30 p.m., review of Patient #25's clinical record revealed a POC with	H 366		

H366 394.4 Continued page 2

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H 366	Continued From page 3 a SOC date of September 3, 2017, and a certification period of September 3, 2017, through November 1, 2017. The POC lacked documented evidence it had been approved or signed by a physician. At the time of the survey, the HCA failed to ensure each POC was approved and signed by a physician.	H 366	ensure that orders were obtained for the hold in visits and the Plan of Care is adjusted as appropriate.	
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure the patient's needs were met in accordance with their POC for four (4) of 16 skilled patients in the sample (Patients #11, 16, 17 and 19). Findings included: 1. On October 6, 2017 at 11:00 a.m., review of Patient #11's POC revealed a SOC date of May 24, 2017, and a certification period from July 23, 2017, through September 20, 2017. The POC indicated Patient #11 had a diagnosis of "Type 2 Diabetes Mellitus and Heart Failure Unspecified." According to the POC, the SN was to conduct visits three (3) times a week for nine (9) weeks for wound care to the patient's left foot and "assess the patient's feet every visit."	H 453	**3917.2 (c) Skilled Nursing Services:** **Corrective Action:** Skilled: All clinicians have been re-educated on diabetic foot care and documentation of skilled services provided. Clinicians have been educated to documenting to the goals and interventions listed on the Plan of Care and when educating the Care-giver to document this education. Professional Health Resources has implemented best practice interventions of diabetic patients, which includes: to monitor feet for presence of lesions every visit, instruct footcare. This has been put into practice. Please see updated attached Plan of Care for Patient #11 per citation #453. Patient #19 has a Suprapubic Catheter which is changed by the Urologist monthly. The nurse is monitoring for signs and symptoms of infection and instructs the caregivers at the	10/12/17 12/7/17

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H 453	Continued From page 4 Review of the skilled nursing visit notes for July 24, 2017, and July 28, 2017, failed to evidence that the SN assessed the patient's feet during these visits. On October 6, 2017, at 11:30 a.m., interview with the clinical manager confirmed the surveyor findings. Additionally, the clinical manager stated that an in-service will be conducted with the nurses to reinforce the need to conduct assessment of the patient's feet at every visit. 2. On October 3, 2017 at 1:30 p.m., review of Patient #16's clinical record revealed the patient had diagnoses that included kidney and ureter disorder, CVA with right side hemiparesis, osteoarthritis of the knee, hypertension, and gait disorder. Continued review of the clinical record revealed a POC with a SOC date of June 6, 2017, and a certification period of June 6, 2017, through May 15, 2018. The POC required the SN to provide services once a month, and the PCA to provide services eight (8) hours a day, seven (7) days a week. Additionally, the SN was to "evaluate disease process management and supervise the PCA." Further review of the clinical record revealed monthly nursing notes from June 7, 2017, to September 19, 2017, that lacked documented evidence the SN evaluated the patient's disease process management for the urinary system. Also, the clinical record lacked documented evidence that the PCA(s) provided services from June 6, 2017 to June 12, 2017. On that same day at 2:30 p.m., interview with the CEO showed that because of the patient's diagnosis of kidney and ureter disorder, the SN was to assess and evaluate the patient's urinary system during every visit.	H 453	Assisted Living Facility to monitor for signs and symptoms of infection as patient is not teachable. The nurse documents the teaching given and response of the caregivers. The clinician involved with patient # 19 received one-on-one coaching on proper documentation of skilled teaching and assessment. Please see corrected Plan of Care and notes for Patient #19 Personal Care: RN's attended a mandatory in-service that reviewed patient assessment and monitoring based upon patient diagnosis. An In-service was also held on the process for obtaining of doctors' orders for changes to services such as holding visits. **Measures and/or Systemic changes** Skilled: Professional Healthcare Services instituted new Goals and Interventions for the Electronic Medical Record. Best Practice Goal #1: Monitor feet for presence of lesions every visit, instruct patient caregiver on proper diabetic foot care. Personal Care: A Best Practice action to assess and document health status of each beneficiary specific to active diagnosis with each monthly supervisory visit has been put into practice.	12/7/17

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H 453	Continued From page 5 On October 11, 2017 at 3:15 p.m., interview with the Administrator revealed that HHA services were not provided from June 6, 2017 to June 12, 2017 because authorization paperwork was not signed. 3. On October 3, 2017 at 3:00 p.m., review of Patient #17's clinical record showed the patient had a history of hypertension, heart failure, chest pain, and falls. Continued review of the clinical record revealed a POC with a SOC date of July 28, 2017, and a certification period of July 28, 2017 through July 4, 2018. The POC required the SN to supervise the PCA monthly, and the PCA to provide services five (5) hours a day, seven (7) days a week. Continued review of the clinical record revealed HHA timesheets from July 31, 2017, to September 22, 2017, which documented HHA services were provided five (5) days a week versus seven (7) days a week, as required. On October 4, 2017 at 11:30 a.m., interview with the PCA clinical manager revealed that HHA services were provided five (5) days a week from July 31, 2017 to September 22, 2017 because the patient requested that weekend services be placed on hold. On that same day at 12:00 p.m. during a review of the "Patient Summaries" note dated July 27, 2017, the patient indicated that s/he did not want weekend aide services. 4. On October 6, 2017 at 10:00 a.m., review of Patient #19's clinical record revealed the patient had a suprapubic catheter. Continued review of the clinical record revealed a POC with a SOC date of June 26, 2017, and a certification period of June 29, 2017 through August 27, 2017. Additionally, the SN was to ensure the patient	H 453	**Ongoing Monitoring:** Skilled: Quarterly the Clinical Managers will audit 100% of the patients with a suprapubic catheter to ensure correct documentation of proper techniques. The audit will conclude when 100% of the documentation is in compliance. Monthly, 100% of diabetic patients will be audited by the Clinical Managers for foot checks at each visit. This 100% audit will continue until 90% of the charts reviewed are in compliance. Then the agency will continue with its quarterly PIP (Performance Improvement Project) audit of 10% of the patients with diabetes to ensure that diabetic foot checks are completed on every visit. For non-compliant charts the individual clinician will be held responsible and progressive action will be taken. Personal Care: 100% review of those Patients whose services have been put on hold as reported by the scheduler to to ensure that orders were obtained for the hold in visits and the Plan of Care is adjusted as appropriate.	

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H 453	Continued From page 6 demonstrated proper urinary catheter technique. Further review of the clinical record showed nursing notes from July 2, 2017 through August 24, 2017 that lacked documented evidence the patient demonstrated proper urinary catheter technique. On October 6, 2017 at 11:50 a.m., interview with a clinical manager revealed that the patient lived in an ALR, and the nurses in the ALR were responsible for providing education on urinary catheter care. At the time of the survey, the HCA failed to meet the skilled nursing needs of Patients #11, 16, 17, and 19 as stipulated in the POC.	H 453		