

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2015
NAME OF PROVIDER OR SUPPLIER HUMAN TOUCH HOME HEALTH CARE AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1416 9TH STREET, NW WASHINGTON, DC 20001		
(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	<p>INITIAL COMMENTS</p> <p>On August 14, 2015, the Department of Health, Health Regulation and Licensing Administration received a complaint from the Office of the Mayor, on behalf of the complainant regarding the care and treatment her mother received from Human Touch Home Health Care Agency.</p> <p>Due to the nature of the complaint, on August 14, 2015, the Department of Health, Health Regulation and Licensing Administration initiated an investigation, to verify compliance with the basic standards of practice and Title 22, Chapter 39 (Home Care Agencies Regulations). The findings of the investigation were based on record review and interviews.</p> <p>Please Note: Listed below are abbreviations used in this report.</p> <p>Director of Nursing - DON Home Care Agency - HCA Home Health Aid - HHA Plan of Care - POC</p> <p>Allegation #1: On August 9, 2015, the HHA left Patient #1 sitting in bed with the bed rails down. The patient fell out of the bed and was injured.</p> <p>Findings - On August 14, 2015, at approximately 1:05 p.m., Human Touch Home Health Care agency DON and office manager were interviewed. The agency was aware of the August 9, 2015, incident and had done their internal investigation. The DON stated that the HHA left the patient sitting in bed while he/she went to dispose of the soiled diaper. The HHA heard a "thump" and on rushing back to the room saw the Patient on the floor. The HHA called 911 and the patient was taken to the hospital.</p>	H 000	<p>H453 3917.2(c) SKILLED NURSING SERVICES</p> <p>H393 39159 HOME HEALTH & PERSONAL CARE AIDE SERVICE.</p> <p>Corrective Actions will be monitored by the Quality Assurance Personnel (s) and intern the Quality Assurance Personnel(s) will be monitored by the DON and administrator to prevent further occurrence of the incident.</p>	Ongoing

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8899

ZCIG11

If continuation sheet 1 of 4

Gassner *Schorn*

RN DON

10/13/15

Health Regulation & Licensing Administration

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H 000	Continued From page 1 Conclusion - This allegation was substantiated. Deficiencies were identified and cited throughout this report.	H 000			
H 393	<p>3915.9 HOME HEALTH & PERSONAL CARE AIDE SERVICE</p> <p>Each home care agency shall define the duties of home health aides and personal care aides.</p> <p>This Statute is not met as evidenced by: Based on record review and interview it was determined that the home care agency (HCA) failed to define the duties of home health aide for one (1) of one (1) patient in the sample. (Patient #1)</p> <p>The finding includes:</p> <p>On August 14, 2015 at approximately 1:05 p.m., a telephone interview was conducted with the DON and office manager regarding Patient #1's incident. According to the interview, Patient #1 was left sitting in the bed unattended by the home health aide and fell to the floor. 911 was called and the patient was rushed to the hospital.</p> <p>On August 25, 2015, during review of section 21 of the POC titled "safety measures" it was identified that the statement "Client cannot be left unattended" was checked by the agency nurse as he/she prepared the POC.</p> <p>Further review of the PCA Care Plan (a document prepared by the RN defining the duties of the HHA) failed to reveal that the instruction "Client</p>	H 393	<p>H393 39159 HOME HEALTH & PERSONAL CARE AIDE SERVICE: Corrective Actions to be accomplished for all the Nurses and all Personal Care Aides Employed with Human Human Touch Home Health Care Agency.</p> <p>. All Nursing personnel employed with Human Touch will have an in-service on proper documentation, development of a Plan of Care, giving instructions to the Personal Care Aides and Educating patient and caregiver/s then, documenting in the visit notes.</p> <p>. All I Personal Care Aides will have a Home Fall Prevention in service upon hiring and annually as part of the Agency's requirement for employment.</p> <p>. All Personal Care Aides will receive a Check for Safety material as a guide for a Home Safety and Prevention containing a checklist and intervention on Fall Prevention by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Injury Prevention and Control.</p> <p>. A one on one in-service on Fall Prevention to the Personal Care Aides assigned to Patient #1 will be done to ensure that there will be no incident of Fall that will occur. Explained update of POC and what " Client cannot be left unattended" means. An additional safety measure is added "keep bedside rails up at all times".</p>	<p>9/4/15</p> <p>11/1/15</p> <p>and</p> <p>on-going</p> <p>11/1/ 15</p> <p>and</p> <p>on-going</p> <p>8/28/15</p>	

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H 393	Continued From page 2 cannot be left unattended" was given to the HHA. Additionally, there was no documented evidence in the nurse ' s notes that the HHA was instructed that the Patient cannot be left unattended. Telephone interview with the DON on August 25, 2015, at approximately 12:00 p.m., confirmed the finding that the HHA was never instructed that he/she could not leave the Patient unattended. On August 27, 2015, at approximately 1:00 p.m., a visit was conducted to Human Touch Home Health Care Agency. During this visit, interviews were conducted with the DON and office manager, and Patient #1's clinical record was reviewed. Based on the interviews and record review, it was confirmed that the patient cannot be left unattended as documented in the POC. Additionally, it was also confirmed by interview and record review that the Registered Nurse failed to instruct the HHA that the Patient could not be left unattended.	H 393			
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, it was determined that the skilled nurse failed to ensure that the patient's needs were met in accordance with their POC for one (1) of one (1) patient in the sample. (Patient #1) The finding includes:	H 453	H453 3917.2(c) SKILL NURSING SERVICES: Ensuring that patient needs are met in accordance with the plan of care. Corrective Action will be accomplished for all Nursing personnel.. . All Nursing personnel will have an In-service on Fall Prevention using a Material from Home Health Quality Improvement National Campaign "Best Practice Intervention Package-Fall Prevention". >Assess patients to identify at-risk patients using all fall risk assessment and clinical observation. >Collaborate with the therapist if needed. >Select patient-specific interventions for fall prevention.	9/4/15	

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H 453	Continued From page 3 On August 25, 2015, during review of section 21 of the POC titled "safety measures" it was identified that the statement "Client cannot be left unattended" was checked by the agency nurse as he/she prepared the POC. Further review of the PCA Care Plan (a document prepared by the RN defining the duties of the HHA) failed to reveal that the instruction "Client cannot be left unattended" was given to the HHA. Additionally, there was no documented evidence in the nurse's notes that the HHA was instructed that the Patient cannot be left unattended. Telephone interview with the DON on August 25, 2015, at approximately 12:00 p.m., confirmed the finding that the HHA was never instructed that he/she could not leave the Patient unattended. On August 27, 2015, at approximately 1:00 p.m., a visit was conducted to Human Touch Home Health Care Agency. During this visit, interviews were conducted with the DON and office manager, and Patient #1's clinical record was reviewed. Based on the interviews and record review, it was confirmed that the patient cannot be left unattended as documented in the POC. Additionally, it was also confirmed by interview and record review that the Registered Nurse failed to instruct the HHA that the Patient could not be left unattended.	H 453	<p>>Pursue appropriate referrals from physician</p> <p>>Communicate to interdisciplinary Team patient's Falls risk status and plan of interventions.</p> <p>>Include fall risk and prevention interventions in case conferences.</p> <p>>Participate in agency's fall prevention education.</p> <p>. Documentation of Personal Care Aide instruction 11/1/15 consist of:</p> <p>>Describing what Fall Prevention instruction was given to the Personal Care Aide in Accordance to the Plan of Care.</p> <p>>Describing what Fall Prevention instruction/education given to the patient/caregiver and other family member, document the name of the hand out.</p> <p>>Describe the response of instructions and teaching given.</p> <p>. A weekly Focus Chart Audit will be done to 10% of the Fall Risk patients to assure that appropriate POC was done and proper documentation instruction and teaching on Falls Prevention was given by the Nurse. Should any Nurse will not be able to comply will be subjected to re-education and counseling.</p>		