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-0010	A. BUILDING: _____ B. WING _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABA HOME HEALTH CARE	821 KENNEDY STREET, NW WASHINGTON, DC 20011

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H 000	INITIAL COMMENTS An annual licensure survey was conducted on 05/15/2023, 05/16/2023, 05/17/2023, 05/18/2023, and 05/19/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 245 patients and employed 378 staff. The findings of the survey were based on the review of administrative records, 20 active patient records, five discharged patient records, 27 personnel records, and a review of the agency's response to complaints and incidents received. The survey findings were also based on the completion of two patient home visits. Listed below are abbreviations used throughout this report: ADL - Activities of Daily Living DI - Deciliter DON- Director of Nursing HCA - Home Care Agency HHA - Home Health Aide HIV - human immunodeficiency virus IADL- Instrumental Activities of Daily Living Mg- Milligram OT - Occupational Therapist PCA - Personal Care Aide POC - Plan of Care PPD - Purified Protein Derivative PT - Physical Therapist RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care	H 000	On Friday, June 30th, 2023 Provider Agency was sent via email, this Statement of Deficiencies related to the survey that was conducted by Health Regulations and Licensing Administration from May 15th, 2023 to May 19th.	
H 002	3900.2 GENERAL PROVISIONS Each home care agency serving one or more patients in the District of Columbia shall be	H 002		

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H 002	Continued From page 1 licensed, and shall comply with the requirements set forth in this Chapter [*2877] and with those set forth in Chapter 31 of Title 22 of the District of Columbia Municipal Regulations (DCMR), which contains provisions on inspections, licensing and enforcement actions pertaining to home care agencies and other facilities authorized under the Act. Each home care agency serving one or more patients in the District of Columbia under the auspices of the Medicare Program or the D.C. Medicaid Program shall also comply with all applicable requirements and conditions of participation of that program. This Statute is not met as evidenced by: Based on staff interview and record review, the Home Care Agency failed to inform the Department of a leadership change as per requirements. (Director of Nursing) Findings included: Pursuant to DCMR Chapter 31, §3102.7 The licensee of a health care facility shall inform the Director of any change in operation, program, or services ...." During the survey entrance conference on 05/15/2023 at 9:40AM, agency leadership communicated that there was a change in personnel for the role of Director of Nursing (DON). The DON was not present during the conference. Review of the new DON's personnel record on 05/15/2023 at 3:17 PM showed that she was hired 11/08/21 as a field nurse, promoted to DON	H 002	The formal Director of Nursing (DON)/Clinical Manager(CM) had family issues that required her to change her position to Assistant Director of Nursing (ADON). Provider Agency interviewed several candidates for the position and has hired a qualified candidate for this leadership position. The start date for the DON/CM was July 10, 2023. The name, resume, telephone number, and email address was forwarded to the Department of Health (DOH). Going forward, the Administrator, HR Manager, and Clinical Director will ensure that any vacancy in the agency is filled immediately and shall notify the DOH of a leadership vacancy immediately.	07/15/2023

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H 002	Continued From page 2 2/14/2023 and actively started the role of DON March 2023. The home care agency failed to provide evidence of notification to the Department of Health of the leadership change. At the time of the interview, the home care agency acknowledged the finding.	H 002		
H 099	3905.2(i) POLICIES AND PROCEDURES Written policies and procedures shall be developed for, at a minimum, the following: (h) Infection control; and... This Statute is not met as evidenced by: Based on record review and interview, home care agency (HCA) failed to implement its policy for unusual incident reporting for two of 20 patients sampled. Patients #5 and #16. Findings included: During the review of the complaints/incidents on 05/15/2023 at 1:47 PM, there was no documented evidence that the home care agency (HCA) implemented its Incident Report Policy as evidenced below: Review of Patient #16 ' s clinical record on 05/18/2023 at 11:05 AM showed that the registered nurse (RN #5) documented in a communication note dated 05/24/2022 that the	H 099		

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H 099	Continued From page 3 home health aide reported Patient #16 was increasingly weak, sustained a fall on 5/23/23 and was observed on the floor upon arrival on 5/24/23. Nurse's entry dated 05/25/2022 revealed the home health aide (HHA #6) notified the agency ' s Staffing Coordinator that Patient #16 was transported to the hospital on 5/25/23 secondary to a fall. There was no documented evidence that HHA#6 or RN#5 completed an incident report as specified in the agency's Incident Report Policy.# HHA #6 or RN #5 completing the agency ' s incident report form as outlined in the agency ' s Incident Report Policy. Review of Patient #5 ' s clinical record on 05/17/2023 at 11:39 am showed that the RN documented on 09/22/2022 that "the client ' s environment was worse than last month when she saw him." The nurse noted during her visit that the patient's "apartment had several structural damages in need of repair and might have rodent infestations." During an interview on 05/18/2023 at 9:55 AM, the agency's Incident Manager stated that the incidents are recorded in an electronic system with the District of Columbia (DC) Care Connect. She also stated that the staff are instructed to come to the office to complete an incident report form when deemed necessary. On 05/17/2023, at 4:01 PM, review of the agency's Incident Reporting policy showed that "An incident report will be completed whenever there is an incident involving a staff member or a client...Staff members will immediately report the	H 099	The RNs for patients #5 and# 16 were given the opportunity to review the records after being informed of this deficiency. All nurses will be trained in comprehensive patient assessment, documentation, and completion of incident reports. All PCAs/HHAs will also be trained during in-services and as necessary the documentation and completion of incident report forms. Moving forward, Agency Incident Manager will enter ALL incidents and the subsequent investigations in ABA's EHR Axxess as well as the District of Columbia (DC) Care Connect. This will serve as the Incident Form as referenced in Provider Agency's Policy and Procedures. The Director of Nursing shall review the agency's EHR Axxess and the DCCC quarterly to ensure the reports are being completed and reported as warranted.	8/30/2023

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H 099	Continued From page 4 incident to their supervisor and/or incident manager. An incident report shall be initiated, investigated and completed by the incident manager or designee. Such reports shall be initiated within 24 hours of the occurrence and completed within 5 business days..." During an interview with the Clinical Director and Compliance Officer on 05/18/2023 at 1:30 PM, they stated that all the incidents were documented in the DC Care Connect electronic system. At the time of the survey, the agency failed to implement their policy for Incident Reporting as written.	H 099		
H 300	3912.2(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (d) To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to ensure that services were provided in accordance with the plan of care (POC) as evidenced by missed home health aide (HHA) visits for two of 20 active patients in the sample (Patients #1 and #8) Findings included:	H 300		

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H 300	Continued From page 5 1. On 05/15/2023 at 01: 36 pm, review of Patient #1's plan of care (POC) showed a duration period of 02/01/2023 through 08/31/2023. The patient's diagnoses included abnormalities of gait and mobility, scoliosis, chronic respiratory failure, and hypoxia/ hypercapnia. The POC indicated skilled nursing services once a month, and home health aide (HHA) services eight hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Continued review of Patient #1's clinical record showed that personal care services were not provided on 02/11/2023, 02/12/2023, 03/04/20203, 03/05/2023, 03/26/2023, 04/09/2023, and 04/30/2023. A home visit to Client #1 on 05/18/2023, revealed that she lived alone and was on received continuous oxygen. She indicated that she was not getting her services seven days per week, especially on the weekends. The director of nursing (DON) and the Clinical Director and Compliance Officer were made aware. They stated they would ensure she was getting the weekend services. 2. On 05/16/2023 at 03:20 pm, review of Patient #8's POC showed a duration period of 11/1/2022 through 10/31/2023. The patient's diagnoses included Spinal Bifida, acquired absence of right leg, sacral pressure ulcer, anemia, osteomyelitis, and hypotension. The POC indicated skilled nursing services once a month, and personal care services eight hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Continued review of Patient #8's clinical record showed that personal care services were not provided from 01/03/2023 to 01/15/2023,	H300	The staffing coordinators for patients #1 and # 8 were given the opportunity to review the deficiency. To prevent this from occurring again, the staffing coordinators were given the opportunity to review the agency's missed visit policy. Moving forward, the staffing coordinator must promptly complete the missed visit form to include the reasons it was missed and notify the DON/CM of it. The DON/CM or designee shall make a follow up call to the patient or the emergency patient contact to inform them of the missed visit and to ensure that patient is safe. The DON/CM or designee shall review the reasons of the missed visit and promptly notify the patient's physician of the missed visits. The DON/CM, ADON, and the Quality Assurance Manager shall on monthly bases review at least 20% of the agency's patient census to ensure that clients are adequately staffed, missed visits are properly documented and that the	

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H 300	Continued From page 6 01/21/2023, and 01/22/2023. On 05/16/2023 at 04:21 pm, the clinical compliance director was made aware. At the time of the survey, the home care agency failed to ensure that personal care services were performed by home health aides in accordance with the plan of care for Patients #1 and #8.	H 300	physician is informed. Unreported, undocumented missed visits without proper explanations shall be noted and information shall be used to guide future agency operations with goals to prevent recurrence.	8/10/2023
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to include emergency protocols specific to patient's diagnoses in the plan of care (POC) for six of 20 active patients included in the sample (Patients #3, 4, 5, 15, 18, and #19). Findings included: 1. On 5/17/2023 at 10:19 am, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 10/6/2022 through 05/31/2023. The patient's diagnoses included hypertensive heart disease, hyperlipidemia, vitamin D deficiency, and glaucoma. A nursing assessment note dated 12/02/2022 revealed the following: "Client is homebound with history of dementia, she is very forgetful, not trusting, and love her independence." On 01/03/2023, a communication note from the staffing coordinator indicated that the patient had asked the aide	H 364	Provider Agency has identified specific personnel that will be in charge of ensuring that the emergency protocol for specific diagnoses are included in the patient's Plan of Care. The Plans of Care of patients identified in this deficiency have been updated with the specific emergency protocols for each specific diagnosis and sent to their respective physicians for review and signature. To prevent recurrence of this deficiency, the DON/CM or designee shall henceforth ensure that all patients' Plans of Care include emergency protocols specific to their diagnoses. He/she shall review clinical records and the plans of care monthly, then provide support and supervision to clinical staff as needed.	

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H 364	Continued From page 7 leave her house and to never come back; thereafter, the aide declined to continue to work with the patient. Consequently, Patient #9 did not receive services from 01/04/2023 to 02/20/2023 as the agency could not find a replacement. The POC lacked the diagnosis of dementia and its relative emergency protocols. 2. On 05/16/2023 at 10:36 am, review of Patient #4's clinical record showed a POC with a duration period from 08/01/2022 through 07/31/2023. The patient's diagnoses included end stage renal disease, renal dialysis, gastro-esophageal reflux disease, hypothyroidism, epilepsy, amyloidosis, blindness, one eye, and low vision on another eye. The patient was prescribed Levetiracetam 500 mg, one tablet oral two times a day for seizures. Continued review of the POC lacked evidence of emergency protocols related to the patient's seizure diagnosis. 3. On 05/17/2023 at 11:39 am, review of Patient #5's clinical record showed a POC with a duration period from 12/01/2022 through 11/30/2023. The patient's diagnoses included Poor Gait, Limb Pain, Dorsalgia, Asthma, Depression, hypertension, and Schizophrenia. The patient was prescribed Paliperidone 3mg, one tablet oral daily for Schizophrenia. Continued review of the POC lacked evidence of emergency protocols related to the patient's Schizophrenia diagnosis. 4. On 5/17/2023 at 01:20 pm, review of Patient #15's clinical record showed a POC with a duration period of 02/01/2023 through 01/31/2024. The patient's diagnoses included hypertension, gastro-esophageal reflux disease, arthritis, spinal stenosis, neuralgia, and congestive heart failure. The patient was prescribed Furosemide 20mg orally, one table	H 364	The updated Plan of Care shall be forwarded to the physician within 72 hours for review and approval. To further ensure that all patients' Plans of Care include specific emergency protocol, the DON/CM, Quality Assurance (QA) team, and a designated office registered nurse shall sample at least 25% of agency's patient censors on a quarterly bases to ensure that it contains specific emergency protocols for all diagnoses including falls. The internal quality assurance tool shall be updated to include emergency protocols for specific diagnoses such as seizures, dementia, and schizophrenia, other mental illness, and patient falls as determined in the deficiencies. Also, all Registered Nurses will be trained on developing and updating patients' plans of care, and ensuring that all patient diagnoses, procedures, and emergency protocols of specific diagnoses are included in them.	08/30/2023

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H 364	Continued From page 8 daily for congestive heart failure. Continued review of the POC lacked evidence of emergency protocols and weight management parameters related to the patient's congestive heart failure diagnosis. 5.On 5/18/2023 at 09:56 am, review of Patient #18's clinical record showed POCs with respective duration periods of 07/01/2022 through 12/31/2022 and 01/01/2023 through 12/31/2023. The patient's diagnoses included bipolar disorder, hemiplegia, asthma, diabetes mellitus, and hypertension. The POC showed that the patient was prescribed Quetiapine fumarate 400 mg, 2 tablets oral daily at bedtime for bipolar disorder. Continued review of the POC lacked evidence of emergency protocol related to the patient's mental health disorder. 6. On 5/18/2023 at 01:22 pm, review of Patient #19's clinical record showed POCs with respective duration periods of 07/01/2022 through 12/31/2022 and 01/01/2023 through 12/31/2023. The patient's diagnoses included bipolar disorder, hemiplegia, asthma, diabetes mellitus, and hypertension. The POC showed that the patient was prescribed Quetiapine fumarate 100 mg, 1 tablet oral daily at bedtime for bipolar disorder. Continued review of the POCs lacked evidence of emergency protocol related to the patient's mental health disorder. On 05/19/2023 at 03:40 pm, the Director of Nursing and Clinical Director and Compliance Officer were informed of the findings. At the time of survey, the home care agency failed to ensure that the patient's plan of care (POC) included an emergency protocol relative to	H 364		

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H 364	Continued From page 9 the patient's diagnoses for Patients #3, 4, 5, 15, 18, and #19.	H 364		
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 home care agency (HCA) failed to ensure that each patient's plan of care (POC) was approved and signed by a physician and/or designee within 30 days of the start of care (SOC) for five of 20 active patients in the sample (Patients #6, 11, 18, 19, and #20). Findings included: Review of the home care agency's clinical records beginning 05/15/2023 through 05/19/2023 showed that the agency failed to ensure that the plans of care (POC) for Patients #6, 11, 18, 19, and #20 were reviewed and signed by a physician and/or designee within 30 days of the start of cares (SOCs). On 05/19/2023 at 03:40 pm, the Director of Nursing and clinical compliance director were informed of the findings. They expressed	H 366	Patient # 6,11,18,19, & 20. Provider is aware that the plans of care were not signed by the their respective physicians within 30 days. This was mainly due to the physicians not responding to phone calls and numerous reminders via faxes to sign and send back to Agency as requested. Moving forward the agency will ensure that the plans of care are signed promptly within 30 days. The following process is in place. A designated RN and a designated Nursing Office Assistant has been tasked to specifically ensure that each plan of care is signed within 30 days. A plan of care follow up sheet for each patient and a daily follow up by the designated staff has proven to be successful. The physicians have been more responsive when persistent phone calls from staff is being made to remind them of the requirement of the plan of care to be signed within 30 days.	

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H 366	Continued From page 10 challenges in getting some of the physicians to sign the POCs despite multiple attempts. At the time of survey, the home care agency failed to ensure that the POCs for Patients #6, 11, 18, 19, and #20 were signed by the patient's physician and/or designee within 30 days of the start of care (SOC).	H 366 H 366	To further ensure compliance, Agency is also working with EHR Axxess representative to initiate using Axxess's Physician Portal by 8/31/2023 to send POCs to the physicians electronically and the physician can sign and send electronically to make it easier for the physicians and encourage timely response. Moving forward, on weekly bases, the Quality Assurance team which includes the DON/CM, Clinical Director, and a designated QA RN will review the plan of care tracking sheet. Each plan of care that is not signed within the first 14-21 days will be submitted again. The QA team shall on random bases select and review on a quarterly bases 20% of agency patient census to ensure that each plan of care selected was signed within the required 30 days. Any deficiency shall be immediately corrected and the information will be used to guide future agency operations.	8/31/2023

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H 399	Continued From page 11 disease, hyperlipidemia, vitamin D deficiency, and glaucoma. Further review of the record showed a post fall assessment from the nurse indicating that the home health aide (HHA) reported that Patient #3 had a fall on 12/21/2022. Continued review of the HHA documentation on 12/21/2022 failed to include that the patient had a fall, and that it was reported to the supervisor. 2. On 05/16/2023 at 10:36 am, review of Patient #4's clinical record showed a POC with a duration period from 08/01/2022 through 07/31/2023 that included orders for personal care services 15 hours per day, for three days and 17 hours per day, for four days to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADL). The patient's diagnoses included end stage renal disease, renal dialysis, gastro-esophageal reflux disease, hypothyroidism, epilepsy, amyloidosis, blindness, one eye, and low vision in the other eye. Further review of the record showed a communication note from the Staffing Coordinator dated 04/05/2023 indicating that the HHA had reported that Patient #4 was sent to the emergency room on 04/04/2023 in the evening due to vomiting. Continued review of the HHA documentation on 04/04/2023 failed to include Patient #4's change in condition. Interview with the Clinical Director and Compliance Director on 05/16/2023 at 12:44 pm, revealed that it was a challenge for them getting the HHAs to document and report patients' changes in condition. He added that they have a new timesheet design ready to be implemented in June 2023, that would reinforce the caregiver's documentation and reporting. 3. On 5/17/2023 at 02:52 pm, review of Patient #7's clinical record showed a POC with a duration period from 12/01/2022 through 11/30/2023 that	H 399	The agency staff has been retrained on reporting and documenting patient falls and a change in patient's condition. Moving forward, Agency shall conduct reinforcement training to all personal care aides and stress the importance of reporting patient falls or any change in patients' conditions. The reinforcement training will be repeated every quarter during in-service trainings. Any changes in the patient's condition requiring a change in the approved plan of care or physician orders will be communicated to the patient's physician for approval. All Registered Nurses will be trained on developing and updating patient's plan of care, and ensuring that all services are provided as ordered or approved by the physician. The DON/CM or designee and the Supervisory RN shall focus on ensuring that there is ongoing instructions on reporting falls and change in conditions during supervisory visits. Furthermore, the Agency is working with the software company (Axxess) to update the personal Care time sheets to reflect documentation for change in patient conditions, behavior, appearance or falls noted or reported by client or care giver.	

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	HCA-0010	A. BUILDING: _____ B. WING _____	05/19/2023

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H 399	Continued From page 12 included orders for personal care services eight hours per day, five days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADLs). The patient's diagnoses included chronic venous insufficiency, chronic pain, headache, and asthma. Continued record review showed a nursing note dated 03/21/2023 indicating that the patient was sent to the emergency room on 03/17/2023 secondary to a fall reported by the home health aide. Continued review of the HHA documentation on 03/17/2023 failed to include that the patient had a fall, and that it was reported to the supervisor. 4. On 05/16/2023 at 01:07 pm, review of Patient #9's clinical record showed a POC with a duration period from 10/1/2022 through 09/30/2023 that included personal care services 12 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included monoplegia of left lower limb, paralytic gait, multiple sclerosis, lack of coordination, muscle weakness, hypertension, acute embolism, and deep vein thrombosis, lymphedema, and stage four sacral wound. The patient was ordered wound care services three times a week from another agency that "mistakenly discharged the patient as of 04/21/2023. Further review of the records showed a nursing assessment dated 05/10//2023 indicating the following: "Patient was seen today for a PRN (as necessary) visit because the family had called to report that patient had not received wound care from a skilled nurse in two weeks..." Continued review of the HHA documentations failed to include the lack of wound care treatments from the skilled nurse. The aide was interviewed during a home visit with Patient #9 on 05/18/2023 at 02:38 pm. She acknowledged the lack of documentation but	H 399	The DON/CM and QA team shall conduct a review of at least 20% of agency patients every 60 days to ensure that ongoing reinforcement instructions by the supervisory nurse is being provided. The DON/CM and QA team shall also review at least 20% of patients' records every quarter to identify unreported falls or change in patient's conditions to demonstrate that the new policy is being followed. This information shall be used to guide the agency with specific goals to prevent the occurrence of the deficiency.	8/31/2023

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H 399	Continued From page 13 stated that she reported to the office that the patient was not getting wound care treatments from the skilled nurse. She added that she could not reach anyone in the office, so she decided to notify the family and suggested they call the office. 5. On 5/17/2023 at 02:03 pm, review of Patient #10's clinical record showed a POC with a duration period from 12/01/2022 through 11/30/2023 that included orders for personal care services eight hours per day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included type II diabetes mellitus, osteoarthritis, chronic kidney disease, hyperlipidemia, gout, and benign prostatic hyperplasia. Continued record review showed a nursing note dated 03/21/2023 indicating that the patient was sent to the emergency room on 03/17/2023 secondary to a fall reported by the home health aide. Further review of the aide's documentation revealed the following on 12/26/2022, 12/27/2022, 12/28/2022, 12/29/2022, 12/30/2022, and 12/31/22: "When leaving the client house, he was not in good condition." Further review of the records failed to show evidence that the aide reported the change in condition to the nurse. 6. On 05/18/2023 at 11:05 am, review of Patient #16's clinical record showed a POC with a duration period from 03/01/2022 through 02/28/2023 that included orders for personal care services ten hours per day seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included delusional disorder, sciatica, osteoarthritis, scoliosis, stage III heel pressure ulcer, Parkinson's disease, dysphagia,	H 399		

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H 399	Continued From page 14 chronic pulmonary embolism, and brachial plexus disorder. Continued record review showed a communication note from the staffing coordinator dated 10/28/2022 indicating the following: "Client has just been transported to the emergency room (ER) as reported by the aide." Further review of the aide's documentation on 10/28/2022 failed to include the patient's change in condition and transfer to ER. On 05/19/2023 at 03:40 pm, the Director of Nursing and clinical compliance director were informed of the findings. At the time of the survey, the agency failed to ensure that the home health aide (HHA) recorded assigned tasks for Patients #3, 4, 7, 9, 10, and #16' s physical condition, behavior, and appearance.	H 399		
H 433	3916.2(c) SKILLED SERVICES GENERALLY Each home care agency shall develop written policies for documenting the coordination of the provision of different services. Written policies shall include, at a minimum, the following: (c) Coordinating services with other agencies actively involved in the patient's care, through written communication and/or interdisciplinary conferences, in accordance with the patient's needs; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to document coordination of services between two home care agencies (HCA) providing care to four of 20	H 433	The RNs for patients # 4, 8, 9, and 13 were given the opportunity to review the deficiencies. In- service training shall be provided to all nurses with emphasis to focus on the importance of coordinating care and the documentation of such coordination with all entities involved in patient care including physicians, Case Managers, Dialysis Centers, other agencies providing care to patients.	

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H 433	Continued From page 15 active patients in the sample (Patients #4, 8, 9, and #13). Findings included: 1. On 05/16/2023 at 10:36 am, review of Patient #4's clinical record showed a plan of care (POC) with a duration period from 08/01/2022 through 07/31/2023. The patient's diagnoses included end stage renal disease, renal dialysis, gastro-esophageal reflux disease, hypothyroidism, epilepsy, amyloidosis, blindness, one eye, and low vision on another eye. The POC included a physician's order for skilled nursing visits once a month, and personal care services 15 hours per day, for three days and 17 hours per day for four days to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the records showed that Client #4 underwent hemodialysis three days per week. However, there was no evidence of care coordination with the dialysis center. On 05/16/2023 at 12: 44 pm, the clinical compliance director was made aware. 2. On 05/16/2023 at 03:20 pm, review of Patient #8's clinical record showed a POC with a duration period from 11/01/2022 through 10/31/2023. The patient's diagnoses included Spinal Bifida, acquired absence of right leg, presence of pressure ulcer of the sacral region, anemia, osteomyelitis, and hypotension. The POC indicated skilled nursing services once a month, and home health aide services (HHA) eight hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the records showed that a nursing assessment dated 02/21/2023 indicating that Client #8 was seen "by a skilled nurse 3 times a week for	H 433	The Office RN shall review the clinical records for patients for any discrepancies and notify the nurses assigned of each patient. The RN assigned for the patient shall coordinate services with the care team and update the plan of care. The updated plan of care shall be sent to the patient's physician for review and signature. To prevent further recurrence, the QA team which includes the DON/ CM, Clinical Director, and QA Office RN shall be tasked to review monthly visit notes submitted by nurses to look for documented evidence of care coordination with patients who are receiving care from other entities such as dialysis, other providers, and physicians to ensure that patient is receiving properly coordinated care. The notes will be rejected and the nurse will be asked to include documented evidence of care coordination.	

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H 433	Continued From page 16 wound care." However, there was no evidence of care coordination with the agency that was providing the wound care nor was there any other information related to the patient's wound. 3. On 05/16/2023 at 01:07 pm, review of Patient #9's clinical record showed a POC with a duration period from 10/01/2022 through 09/30/2023. The patient's diagnoses included monoplegia of left lower limb, paralytic gait, multiple sclerosis, lack of coordination, muscle weakness, hypertension, acute embolism, and thrombosis of unspecified deep veins of lower extremity, lymphedema, and stage four sacral wound. The POC indicated skilled nursing services once a month, and HHA services 12 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the records showed a nursing assessment dated 05/10//2023 indicating the following: "Patient was seen today for a PRN (as necessary) visit because the family had called to report that patient had not received wound care from skilled nurse in two weeks. RN called [Name of home care agency] and spoke to Clinical Manager, who reported that patient was discharged from [Name of home care agency] and was admitted by another [Name of another home care agency] services. Interview with the agency providing wound care's administrator on 05/16/2023 at 03: 58 pm, revealed that the patient was discharged from their services since 10/21/2022 and readmitted by another home care agency for skilled services. On 5/16/2023 at 03:33PM, the director of nursing (DON) and the Clinical Director and Compliance Officer were interviewed about the patient's wound status. The DON made calls to the last home care agency that provided wound care and found out at 04: 28 pm, that the latter admitted Patient #9 on	H 433	Action will be taken against any RN who is found to not be compliant in coordination of care. Furthermore, the QA team shall monitor as sample size of at least 20% of agency's patient censors on a quarterly bases to ensure that the sampled size contains proper documentation of care coordination with specific agencies such as dialysis if patient is receiving hemodialysis, other providers who are providing any care to patients such as wound care, falls, physical therapy or other, and patient physicians. Any deficiency found shall be used as a guide to Agency future operations with the goal of preventing same occurrence.	8/31/2023

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H 433	Continued From page 17 10/26/2022 and had been providing wound care until 04/21/2023.They indicated having "mistakenly discharged" Patient #9 for wound care services. They agreed to resume services the next day on 05/17/2023. A home visit to Patient #9 on 05/18/2023 at 02:38pm, revealed that the patient was readmitted for wound care services on 05/17/2023. The patient's sister stated that she was providing wound care all that time and was doing all she could despite not having received any wound care teaching. She was visiting her sister from out-of-state and did not know the agency that was supposed to provide the wound care services. Of note, the DON made a joint visit with the admitting wound care nurse on 05/17/2023. The review of the client's record lacked evidence of care coordination with the agency providing wound care to Patient #9. 4. On 05/16/2023 at 11:57 am, review of Patient #13's clinical record showed a POC with a duration period from 03/01/2023 through 07/31/2023. The patient's diagnoses included hypertension, end stage renal disease, human immunodeficiency virus (HIV), myocardial infarction, sarcoidosis, hyperlipidemia, and obesity. The POC indicated skilled nursing services once a month, and home health aide services seven hours a day six days per week, to assist with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Further review of the records showed that the patient was going to dialysis on Monday, Wednesday, and Friday." However, there was no evidence of care coordination with the dialysis center. On 05/19/2023 at 03:40 pm, the Director of	H 433		

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H 433	Continued From page 18 Nursing and clinical compliance director were informed of the findings. At the time of the survey, the agency failed to coordinate services with another entity actively involved in providing care for Patients #4, 8, 9, and #13.	H 433		
H 452	3917.2(b) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (b) Coordination of care and referrals; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the skilled nurse (SN) coordinated care with the physician's office for five of 20 active patients in the sample (Patients #1, 4, 6, 7, and #16). Findings included: 1. On 05/15/2023 at 01: 36 pm, review of Patient #1's plan of care (POC) showed a duration period of 02/01/2023 through 08/31/2023. The patient's diagnoses included abnormalities of gait and mobility, scoliosis, chronic respiratory failure, and hypoxia/ hypercapnia. The POC indicated skilled nursing services once a month, and home health aide services eight hours a day seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Continued record review showed a nursing note dated 03/23/2023 indicating the following: "She was hospitalized at MedStar Georgetown University Hospital on March 15, 2023, with a	H 452	The RNs for Patients # 1, 4, 6, 7, and 16 were given the opportunity to review the deficiencies. In- service training shall be provided to all nurses with emphasis to focus on the importance of coordinating care and the documentation of such coordination with physicians after patient hospitalization, Resumption of Care (ROC), post emergency room visit, post fall assessments, Case Managers, and other agencies providing care to patients. The Office RN shall review the clinical records for patients for any discrepancies and notify the nurses assigned of each patient. The RN assigned for the patient shall coordinate services with the care team and update the plan of care. evidence of such care coordination. Action will be taken against any RN who is found to not be compliant in coordination of care.	

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H 452	Continued From page 19 chief complaint of shortness of breath and swollen feet on both sides. She was discharged with a new diagnosis and significant medication changes on 03/21/2023." Further review lacked evidence in the clinical record that the SN coordinated care with the physician following the client's hospitalization and overall condition. 2. On 05/19/2023 at 10:36 am, review of Patient #4's clinical record showed a plan of care (POC) with a duration period from 08/01/2022 through 07/31/2023. The patient's diagnoses included end stage renal disease, dependence on renal dialysis, gastro-esophageal reflux disease, hypothyroidism, epilepsy, amyloidosis, blindness, one eye, and low vision on another eye. The POC included a physician's order for skilled nursing visits once a month, and personal care aide (PCA) services 15 hours per day for three days and 17 hours per day for four days to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). Continued record review showed a nursing note dated 02/09/2023 indicating the following: "An RN post emergency room (ER) visit conducted today due to his recent ER visit for pain and blockage of his left AV [Arteriovenous] Fistula site." Further review lacked evidence in the clinical record that the SN coordinated care with the providers following the ER visit and the patient's overall condition. 3. On 05/16/2023 at 12:30 pm, review of Patient #6's clinical record showed a plan of care (POC) with a duration period from 10/18/2022 through 03/31/2023. The patient's diagnoses included hypertension, Type II diabetes mellitus, obesity, asthma, low back pain, gastro-esophageal reflux disease, hyperlipidemia, post-traumatic stress disorder, and depression. The POC included a	H 452	The updated plan of care shall be sent to the patient's physician for review and signature. Going forward to prevent further recurrence, the QA team which includes the DON/CM, Clinical Manager, and QA Office RN shall be tasked to review monthly visit notes, post hospitalization notes, and post emergency room visit notes submitted by nurses, to look for documented evidence of care coordination with physicians to ensure that patient is receiving properly coordinated care. The notes will be rejected and the nurse will be asked to include documented evidence of such care coordination. Action will be taken against any RN who is found to not be compliant in coordination of care.	

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H 452	Continued From page 20 physician's order for skilled nursing visits once a month, and personal care aide (PCA) services 12 hours per day six days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). Continued record review showed a nursing note dated 01/06/2023 indicating the following: "An RN post resumption of care assessment conducted today due to her recent checkup at the hospital. She was experiencing elevated blood pressure and chronic pain on her left upper shoulder and bilateral lower extremity. She was treated at the hospital, now taking Oxycodone and heart medication as prescribed." Further review lacked evidence in the clinical record that the SN coordinated care with the providers following the client's hospitalization and overall condition. 4. On 5/17/2023 at 02:52 pm, review of Patient #7's clinical record showed a POC with a duration period from 12/01/2022 through 11/30/2023. The patient's diagnoses included chronic venous insufficiency, chronic pain, acute post-traumatic headache, and moderate persistent asthma. The POC included a physician's order for skilled nursing visits once a month, and PCA services eight hours per day, five days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Continued record review showed a nursing note dated 03/21/2023 indicating that the patient was sent to the emergency room on 03/17/2023 secondary to a fall reported by the home health aide. The nurse noted the following: "Patient was noted with superficial injury on the forehead measuring about 7 cm X 1.5 cm. This writer cleansed the wound with soap and water, patted dry and left open to air." There was no documented evidence in the clinical record that the SN coordinated care with the physician's	H 452	Furthermore, the QA team shall monitor a sample size of at least 20% of agency's patient censors on a quarterly bases to ensure that the sampled size contains proper documentation of care coordination with physicians after patient hospitalization ROC, emergency room visit, or other entity. Any deficiency found shall be used as a guide to Agency future operations with the goal of preventing same occurrence.	8/31/2023

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H 452	Continued From page 21 office following the client's hospitalization and overall condition. 5. On 05/18/2023 at 11:05 am, review of Patient #16's clinical record showed a POC with a duration period from 03/01/2022 through 02/28/2023. The patient's diagnoses included delusional disorder, sciatica, osteoarthritis, scoliosis, stage III heel pressure ulcer, Parkinson's disease, dysphagia, chronic pulmonary embolism, and brachial plexus disorder. The POC included a physician's order for skilled nursing visits once a month, and personal care aide (PCA) services ten hours per day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Continued record review showed a nursing note dated 11/02/2022 indicating the following: "Patient is discharged from the ER where she was taken after an overdose of Tylenol #3. She was treated and discharged home. Today during the home visit the patient is in her living room and assessed for any discomfort. Reviewed medications and reinforced instructions on importance of compliance and to take her medications as prescribed. She is instructed to avoid taking any extra dose of any of her medications without doctor's advice. She verbalized understanding the importance of compliance with her due medication." Further review lacked evidence in the clinical record that the skilled nurse (SN) coordinated care with the physician's office following the client's hospitalization and overall condition. On 05/19/2023 at 03:40 pm, the Director of Nursing and Clinical Director and Compliance Officer were informed of the findings. At the time of the survey, the home care agency	H 452		

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(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 452	Continued From page 22 failed to ensure that the skilled nurse coordinated care with the physician's office.	H 452		
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 home care agency (HCA) failed to ensure skilled nursing services were provided in accordance with the patient's plan of care (POC) for four of 20 active patients in the sample (Patients #2, 15, 18, and #20). Findings included: 1. On 5/15/2023 at 02:50 pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 6/1/2022 through 05/31/2023 that included orders for the registered nurse (RN) to visit the patient once a month for personal care aide (PCA) supervision, management of any medical health related issues, assessment and evaluation of body systems; and personal care aide (PCA) services ten hours a day, five days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included chronic kidney disease, chronic obstructive pulmonary disease, osteoarthritis, dependence on supplemental oxygen, acute embolism and thrombosis of	H 453	The RNs for Patients # 2 and 15 were given the opportunity to review these deficiencies. Nurses have been re-educated on Agency's policies and procedures for conducting monthly supervisory visits in accordance with the patient's plan of care and to ensure that they perform a head to toe assessment and focus on applicable areas depending on the interventions/ goals listed on the plan of care to include but not limited to: Quality Indicators for Monthly Visits: Standard Vital Signs: Pulse, BP, Resp., Temp, Pain Scale (Very important if patient is on any pain medication), Weight (actual or stated). Diseases such as CHF and it's management to include; assessing for patient weight on each visit and educate client to notify MD if weight increases 2lbs within a day or 5-7lbs within one week. Educating patient to take weight on same time everyday wearing similar clothing type.	

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	HCA-0010	A. BUILDING: _____ B. WING _____	05/19/2023

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H 453	Continued From page 23 unspecified femoral vein, Type II diabetes mellitus, atrial fibrillation, and congestive heart failure. Also, the POC included an order indicating the following: "SN to instruct on daily/weekly weights and recordings, daily weight self-monitoring program, and to report weight change of 2 to 3lbs. per day or 5 to 7lbs. per week. SN to assess client's weight log every visit." Continued review of the clinical record lacked evidence that the SN visited Patient #2 monthly from June 2022 to October 2022, and February 2023 with no evidence of an assessment of the patient's weight to determine whether the results warranted intervention or physician notification. 2.On 5/17/2023 at 01:20 pm, review of Patient #15's clinical record showed plans of care (POCs) with respective duration periods of 07/20/2022 through 01/31/2023 and 02/01/2023 through 01/31/2024 that included orders for the registered nurse (RN) to visit the patient once a month for personal care aide (PCA) supervision, management of any medical health related issues, assessment and evaluation of body systems; and PCA services eight hours a day five days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included hypertension, gastro-esophageal reflux disease, arthritis, spinal stenosis, neuralgia and congestive heart failure. Also, the POC included an order indicating the following: "SN to instruct on daily/weekly weights and recordings, daily weight self-monitoring program, and to report weight change of 2 to 3lbs per day or 5 to 7lbs per week. SN to assess client's weight log every visit." Continued review of the clinical record lacked evidence that the skilled nurse (SN) visited Patient #15 monthly from August 2022 to	H 453	To prevent further recurrence, an Office RN shall be tasked on reviewing nurses monthly visit notes, to look for documented evidence of documented patient weight, teaching of patient to report any weight gain to nurse and to the physician. Moving forward, the QA team which includes the DON/CM, Clinical Director, and QA Office RN shall be tasked to review a sample size of at least 20% of agency patient censors on a quarterly bases to ensure that the sampled size contains proper documentation of patient weight and education to patient to report any weight gain of in a week more than 2 pounds (lbs.) a day or 5- 7 pounds a week.to the physician. Any deficiency found shall be used as a guide to Agency future operations with the goal of preventing same occurrence.	08/31/2023

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H 453	Continued From page 24 November 2022, January 2023, and February 2023 with no evidence of an assessment of the patient's weight to determine whether the results warranted intervention or physician notification. 3. On 5/18/2023 at 09:56 am, review of Patient #18's clinical record showed POCs with respective duration periods of 07/01/2022 through 12/31/2022 and 01/01/2023 through 12/31/2023 that included orders for the registered nurse (RN) to visit the patient once a month for PCA supervision, management of any medical health related issues, assessment and evaluation of body systems; and PCA services eight hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included bipolar disorder, hemiplegia, mild intermittent asthma, diabetes Mellitus, and hypertension. Also, the POC included an order for the nurse to assess glucose levels each visit and notify the physician of fasting blood sugar greater than 110 or less than 70, random blood sugar greater than 300 or less than 70 mg/dl. Continued review of the clinical record showed the SN visited the patient on 10/14/2022 and 01/16/2023 with no evidence of an assessment of the patient's blood glucose level to determine whether the results warranted intervention or physician notification. 4. On 05/19/2023 at 01:43 pm, review of Patient #20's clinical record showed POCs with respective duration periods of 5/23/2022 through 3/31/2023 and 04/01/2023 through 02/29/2024 that included orders for the registered nurse (RN) to visit the patient once a month for PCA supervision, management of any medical health related issues, assessment, and evaluation of body systems; and PCA services eight hours a	H 453	Patient # 18 The RN for Patients # 18 was given the opportunity to review this deficiency. Nurses have been re-educated on Agency's policies and procedures for conducting monthly supervisory visits in accordance with the patient's plan of care and to ensure that they perform a head to toe assessment and focus on applicable areas depending on the interventions/ goals listed on the plan of care to include diabetes. To prevent further recurrence, an Office RN shall be tasked on reviewing nurses monthly visit notes, to look for documented evidence of monitoring of patient blood glucose level and education diabetes management. Moving forward, the QA team which includes the DON/CM, Clinical Manager, and QA Office RN shall be tasked to review a sample size of at least 20% of agency's patient censors on a quarterly bases to ensure that the sampled size contains proper documentation of blood glucose monitoring for diabetic patients and education on disease in accordance with Agency's policy and procedures. Any deficiency found shall be used as a guide to Agency specific goals of preventing same occurrence.	

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H 453	Continued From page 25 day, four days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included muscular dystrophy, hyperlipidemia, hypertension, gastro-esophageal reflux disease, dependence on supplemental oxygen, chronic obstructive pulmonary disease, obstructive sleep apnea, type II diabetes mellitus, and abnormalities of gait and mobility. Further review of the clinical record lacked evidence that the SN visited the patient according to the POC during the months of February 2023, March 2023, and April 2023. There was no documented evidence that the physician was informed of the missed visits. Interview with the Clinical Director and Compliance Officer on 05/19/2023 at 03:33pm revealed that the assigned nurse had resigned abruptly, and a new nurse had been reassigned to Patient #20. The latter saw the patient on 05/11/2023. At the time of the survey, the home care agency failed to ensure that skilled nursing services were provided in accordance with Patients #2, 15, 18, and 20's plans of care.	H 453	Patient # 20 The RN for Patients # 20 was given the opportunity to review this deficiency. To prevent this from occurring again, all nurses were re-educated on agency's policy and procedures for conducting monthly supervisory visits to ensure that they provide patient education that is in accordance with the client's plan of care. Furthermore, the Nursing Admin Assistant will conduct a monthly review of Provider's active census by the 20th of each month to ensure that monthly visits have been completed, contacting the specific RNs to determine the reason visit has not been completed or to determine if the visit needs to be reassigned, or if the patient needs to be contacted by a supervisor to ensure visit is completed. If the visit is missed, then proper notification will be made to the MD and documented.	
H 457	3917.2(g) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (g) Recording progress notes at least once every thirty (30) calendar days and summary notes at least once every sixty-two (62) calendar days; This Statute is not met as evidenced by:	H 457		

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H 457	Continued From page 26 Based on record review and interview, it was determined that the home care agency (HCA) failed to ensure that the skilled nurse documented a progress note at least once every 30 calendar days and a summary note at least every 62 calendar days for three of 20 active patients sampled (Patients #7, 12, and #20). Findings included: 1. On 5/17/2023 at 02:52 pm, review of Patient #7's clinical record showed a plan of care (POC) with a duration period from 12/01/2022 through 11/30/2023. The POC included a physician's order for skilled nursing visits once a month for personal care aide (PCA) supervision, management of any medical health related issues, assessment, and evaluation of body systems. Further review of the clinical record lacked evidence of a progress note during the month of April 2023. 2. On 05/19/2023 at 02:29 pm, review of Patient #12's clinical record showed POCs with respective duration periods of 05/01/2022 through 04/30/2023 and 05/01/2023 through 04/30/2024 that included orders for the registered nurse (RN) to visit the patient once a month for PCA supervision, management of any medical health related issues, assessment, and evaluation of body systems. Further review of the clinical record lacked evidence of 62-day summary notes in February 2023 and April 2023. 3. On 05/19/2023 at 01:43 pm, review of Patient #20's clinical record showed POCs with respective duration periods of 5/23/2022 through 3/31/2023 and 04/01/2023 through 02/29/2024 that included orders for the RN to visit the patient once a month for PCA supervision, management	H 457	The DON/CM and QA team shall also review at least 20% of patients' records every quarter to identify if RN monthly visits are not being conducted as ordered on the Plan of Care. This information shall be used to guide the agency with specific goals to prevent the occurrence of the deficiency.	8/31/2023

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H 457	Continued From page 27 of any medical health related issues, assessment, and evaluation of body systems. Further review of the clinical record lacked evidence of progress notes during the months of February 2023, March 2023, and April 2023. Furthermore, the records lacked evidence of 62-day summaries in January 2023 and March 2023. Interview with Clinical Director and Compliance Officer on 05/19/2023 at 03:33pm revealed that the assigned nurse had resigned abruptly, and a new nurse had been reassigned to Patient #20. The latter saw the patient on 05/11/2023. At the time of survey, it was determined that the agency failed to ensure that the skilled nurse documented progress notes and summary notes in accordance with the regulatory requirements for Patients #7, 12, and #20.	H 457	The 62-day summary for patients # 7, 12, and 20 have been completed and sent to their respective physicians for review and signature. A reinforcement training of on time completion of the 62-day summary was immediately provided to the RNs of patients # 7, 12, and 20. Moving forward, the Agency shall conduct training to all field RNs on regular bases and as needed on time completion and submission of 30 days visits and 62-day summary notes. On at least once a year, the DON/CM shall provide focus training on the importance of providing proper skilled nursing to the patients and ensuring that the 62-day summary of the evaluation of services provided to the patient is completed and sent to the physician. To ensure compliance, a designated office RN shall be responsible for following up with each field RN to remind them to complete the summary. A monthly report of the 62- day summary shall be generated and reviewed by the DON/CM to ensure compliance. Action will be taken against any RN who is found to not be compliant in completing the 62-day summary.	8/31/2023

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H 459	Continued From page 28 1. On 5/15/2023 at 02:50 pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 6/1/2022 through 05/31/2023 that included orders for the registered nurse (RN) to visit the patient once a month for personal care aide (PCA) supervision, management of any medical health related issues, assessment and evaluation of body systems; and personal care aide (PCA) services ten hours a day, five days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included chronic kidney disease, chronic obstructive pulmonary disease, osteoarthritis, dependence on supplemental oxygen, acute embolism and thrombosis of unspecified femoral vein, Type II diabetes mellitus, atrial fibrillation, and congestive heart failure. The patient was prescribed Humalog 100 units/ml injectable solution sliding scale subcutaneous and Lantus 100 units/ml subcutaneous solution 18 units at bedtime for diabetes. Also, the POC included an order indicating the following: "SN to instruct on insulin preparation, administration, site rotation and disposal of supplies. SN to assess/instruct on diabetic management to include nail, skin, foot care, medication administration, and proper diet." Further review of the records lacked documented evidence of patient education or evaluation of instruction. 2. On 05/19/2023 at 10:36 am, review of Patient #4's clinical record showed a POC with a duration period from 08/01/2022 through 07/31/2023. The patient's diagnoses included end stage renal disease, dependence on renal dialysis, gastro-esophageal reflux disease, hypothyroidism, epilepsy, amyloidosis, blindness,	H 459	The RNs for Patients # 2 and #4 were given the opportunity to review this deficiency. To prevent this from occurring again, the Field RNs were re-educated on agency's policy and procedures for conducting monthly supervisory visits to ensure that they provide patient education that is in accordance with the client's plan of care to include disease process, medication management, safety, etc. and also document client's response to teaching. Furthermore, the QA team which include the DON/CM, Clinical Manager, and a QA Office RN, during the review of all monthly RN supervisory notes, PRN visits, Post fall assessments, Post ER and Post Hospitalization ROCs will ensure that RN documentation includes patient education on disease management and evaluation of understanding of teaching and the client's response in accordance with the plan of care. The DON/CM and QA team shall also review at least 20% of patients' records every quarter to identify if patient education is not being provided in accordance with Agency's policy and procedures. This information shall be used to guide the agency with specific goals to prevent the occurrence of the deficiency.	8/31/2023

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H 459	Continued From page 29 one eye, and low vision in another eye. The POC included a physician's order for skilled nursing visits once a month, and personal care aide (PCA) services 15 hours per day, for three days and 17 hours per day, for four days to assist with activities of daily living (ADL) and instrumental activities of daily livings (IADL). The patient was prescribed Levetiracetam 500 mg one tablet oral two times a day for seizures. Also, the skilled nurse was to assess and instruct on seizure disorder, signs and symptoms, and appropriate actions during seizure activity. Further review of the records lacked documented evidence of patient education or evaluation of instruction. On 05/19/2023 at 03:40 pm, the Director of Nursing and Clinical Director and Compliance Officer were informed of the findings. At the time of the survey, the agency failed to provide documented evidence that the registered nurses (RNs) provided patient instruction and evaluation of instruction for Patients #2 and #4.	H 459		