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	HCA-0022	A. BUILDING: _____ B. WING _____	11/21/2022

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BERHAN HOME HEALTH CARE AGENCY	7826 EASTERN AVENUE, NW, SUITE L1-16 WASHINGTON, DC 20012

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H 000	INITIAL COMMENTS An annual survey was conducted on 11/16/2022, 11/17/2022, 11/18/2022, and 11/21/2022 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 181 patients and employed 318 staff. The findings of the survey were based on the review of administrative records, 15 active patient records, five discharged patient records, 25 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 three patient telephone interviews. Listed below are abbreviations used throughout this report: ADL - Activities of Daily Living DON- Director of Nursing HHA - Home Health Aide HCA - Home Care Agency IADL- Instrumental Activities of Daily Living OT - Occupational Therapist PCA - Personal Care Aide POC - Plan of Care PPD - Purified Protein Derivative PT - Physical Therapist RN - Registered Nurse	H 000	Please begin typing your responses here:	

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H 000	Continued From page 1 SN - Skilled Nurse SOC - Start of Care	H 000		
H 162	3907.6 PERSONNEL At the time of initial employment of each employee, the home care agency shall verify that the employee, within the six months immediately preceding the date of hire, has been screened for and is free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that each employee was free of communicable disease within the six months immediately preceding the employee's date of hire for six of 25 personnel files included in the sample. (Administrative Assistant/Staffing Coordinator #1, Administrative Assistant/Staffing Coordinator #2/ human resources (HR), Payroll Staffing Coordinator #3 occupational therapist (OT #2), Home Health Liaison and Billing Coordinator). Findings included: A review of the facility's personnel records was conducted 11/16/2022 at 11:50 AM and 11/17/2022 at 10:13 AM revealed the following: 1. The personnel file for the home care agency ' s Administrative Assistant/Staffing Coordinator #1 included a hire date of 08/05/2021. Further review of her personnel file showed that she had never been screened and verified free of communicable disease since her date of hire.	H 162	**Corrective Action Plan:** The provider acknowledges the deficient practice that it failed to verify that each employee was free of communicable disease within the six months immediately preceding the employee's date of hire for the above identified employees as indicated on the findings. The agency's administrator met with the HR team and discussed the identified deficiencies and the importance of verifying that each employee, within the six months immediately preceding the date of hire, has been screened for and is free of communicable disease. Going forward, plan will be implemented to ensure that all new hires will provide documents showing that they are free of communicable disease within the six months immediately preceding the employee's date of hire. **Systemic change:** The provider will review and update the policy on personnel to outline that all new hires are required to provide documents showing that they are free of communicable disease within the six months immediately preceding the employee's date of hire. Going forward, during the hiring process, the human resources department will ensure that new hires provide proof of health screening and documentation to show that each employee is free of communicable disease dated within the six months immediately preceding the date of hire	January 31, 2023 and ongoing

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H 162	Continued From page 2 2. The personnel file for the home care agency ' s Administrative Assistant/Staffing Coordinator/HR #2 included a hire date of 07/16/2018. Further review of her personnel file showed that she had never been screened and verified free of communicable disease since her date of hire. 3. The personnel file for the home care agency ' s Payroll/Staffing Coordinator #3 included a hire date of 03/02/2008. Further review of her personnel file showed that she had never been screened and verified free of communicable disease since her date of hire. 4. The personnel file for the occupational therapist (OT #2) included a hire date of 02/04/2022. Further review of the personnel file showed a QuantiFERON blood test dated 06/15/2022, four months after date of hire. 5. The personnel file for the agency ' s Home Health Liaison included a hire date of 03/08/2021. Further review of the personnel file lacked evidence of screening and verification of freedom of communicable disease since date of hire. 6. The personnel file for agency's Billing Coordinator included a hire date of 05/17/2021. Further review of the personnel file lacked evidence of screening and verification of freedom of communicable disease since date of hire During an interview on 11/17/2022 at 11:48 AM, the Payroll/Staffing Coordinator #3 stated that the office staff was not required to be screened. The Payroll/Staffing Coordinator was referred to Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations) that the agency is required to verify that each employee was screened and free of	H 162	**Quality assurance measure:** The agency's HR manager will review 100% of new employee records monthly to ensure that each newly hired employee provided proof of health screening and documentation to show that each employee is free of communicable disease dated within the six months immediately preceding the date of hire. **Date of Implementation:** By 01/31/2023	January 31, 2023 and ongoing

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H 162	Continued From page 3 communicable diseases.	H 162	**Corrective Action:** The provider acknowledges the deficient practice that it failed to verify that each employee is screened for and is certified free of communicable disease communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, for the above identified employees as indicated on the finding. The agency's administrator met with the HR team and discussed the identified deficiencies and the importance of verifying that each employee is screened for and is certified free of communicable disease communicable disease annually. Going forward, plan will be implemented to ensure that all employees (office and field employees) will provide documents showing proof of annual screening for communication disease. The agency's HR department will verify that each employee is certified free of communicable disease. **Systemic change:** The provider will review and update the policy on personnel to outline that all active employees (office and field) are required to provide documents showing that they are screened for communicable disease annually and shall be certified free of communicable disease.	January 31, 2023 and ongoing
H 163	3907.7 PERSONNEL Each employee shall be screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that each employee was free of communicable diseases annually for five of 25 personnel files included in the sample. (Administrative Assistant/Staffing Coordinator #1, Administrative Assistant/Staffing Coordinator/human resources (HR #2), Payroll/Staffing Coordinator #3, Home Health Liaison, and Billing Coordinator). Findings included: Cross reference to 3909.6, H162	H 163		
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.	H 163	The human resources (HR) department will ensure that monthly system reporting is completed on all employees to identify employees whose physical examination documentation will be expiring in the futures. The HR department will contact each employee requiring renewal of the document that proves they are free of communicable disease at least 6 weeks prior to the document's expiration date.	

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H 366	Continued From page 4 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 medical team within 30 days of the start of care (SOC) for two of 15 active patients in the sample (Patients #7 and #11). Findings included: 1. On 11/17/2022 at 10:31 AM, review of Patient #7's clinical record showed a plan of care (POC) with a duration period of 09/17/2022 through 11/15/2022. The plan of care included physician's orders for physical therapy (PT) services one to two times per week for two weeks, one time a week for four weeks, and occupational therapy (OT) visits once a week for four weeks to evaluate the patient for therapy services and establish a plan of treatment. Further review of the patient's record showed that the POC was signed on 11/18/2022 by the patient's physician, during the time of the survey on day #3, and greater than 30 days of the start of care. 2. On 11/21/2022 at 08:45 AM, review of Patient #11's clinical record showed a plan of care (POC) with a duration period of 05/01/2022 through 04/30/2023. The POC included a physician's order for skilled nursing services one time a month and two times as needed to perform multi systems assessment, vital signs, patient instruction, and home health aide supervision. Also, the POC included an order for personal care services seven hours per day, seven days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL).	H 163 H 366	**Quality assurance measure:** The agency's HR manager will review 25% all active employee records monthly to ensure that each employee has been screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and is certified free of communicable disease. **Date of Implementation:** By 01/31/2023, **Patient affected by the deficient practice:** **Patient #7 and #11** The POCs for both patients were signed and approved after 30 days of the SOC as specified above. **Systemic change:** The provider will review and update the policy on the home care agency (HCA) responsibility in ensuring that each patient's plan of care (POC) is approved and signed by a physician and/or medical team within 30 days of the start of care (SOC) in accordance with the regulations. Going forward, this policy will be reviewed with each clerical employee both current and new hires. The clerical staff will be trained on how to send and follow-up on each patient's POC to ensure timely approval and signing by a physician and/or medical team within 30 days of the SOC. The clerical staff will report to the clinical manager at least 7 days of the deadline if getting the document signed and approved proves difficult. The agency will utilize the field employee to assist in hand-carrying the POCs to the physician's office if all efforts prove futile.	January 31, 2023 and ongoing

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H 366	Continued From page 5 Further review of the patient's record showed that the POC was signed by the patient's physician on 07/15/2022, greater than 30 days. On 11/21/2022 at 03:39 PM, the Director of Nursing and Administrator were informed of the findings. At the time of survey, the home care agency failed to ensure that plans of care for Patients #7 and #11 were signed by physicians and/or medical team within 30 days of the start of care.	H 366	**Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care in accordance with the regulations. **Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing
H 399	3915.10(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Personal care aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the home health aide (HHA) recorded and reported the patient's physical condition, behavior, and/or appearance for one of the 15 active patients included in the sample (Patient #6). Findings included: On 11/18/2022 at 11:42 AM, review of Patient #6's clinical record showed a plan of care (POC) with a duration period from 01/01/2022 through 12/31/2022. The patient's diagnoses included Neuropathy, Hypertension, dehydration, failure to	H 399	**Patient affected by the deficient practice:** **Patient #6** For Patient #6, the clinical manager contacted the assigned home health aides (HHAs)) with the identified deficient practice and conducted a one-to-one counseling. Employees acknowledged the findings of not reporting or recording the patient's wound, and understand the need to record and report changes in patient's physical condition, behavior, and/or appearance. The HHAs will be responsible for reporting and documenting changes in patient's condition to also include changes in the skin condition. **Systemic change:** The provider will review and update the policy on the home health aide (HHA)'s responsibility in observing, recording, and reporting the patient's physical condition, behavior, or appearance in accordance with the regulations. Going forward, this policy will be reviewed with each employee both current and new hires.	January 31, 2023 and ongoing

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H 399	Continued From page 6 thrive, Hyperlipidemia, Major depressive disorder, abnormal weight loss, Dysphagia, and seizures. The POC contained a physician' s order for personal care services (PCA) 16 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Interview with the patient's power of attorney on 11/18/2022 at 01:09 PM revealed that the patient had a pressure ulcer wound and a nurse was coming from another homecare agency (HCA) three times a week for wound care. Interview with the wound care nurse from the other agency on 11/18/2022 at 03:01 PM confirmed that the patient had a stage III wound on his sacrum (on 10/05/2022) that was healing. She stated she performs wound care on Mondays, Wednesdays, and Fridays, and that the aides were educated to turn and reposition the patient. Further review of the record showed that the Home Health Aides (HHA) failed to record and report that the patient had a wound. The HHA timesheets, from October 10, 2022, through November 6, 2022, showed that the aides were documenting "No" to the question asking if the patient had a wound. Please note, the patient acquired the wound on 10/05/2022, according to the wound care nurse. On 11/21/2022 at 03:39 PM, the Director of Nursing and Administrator were informed of the findings.	H 399	In addition, to ensure a comprehensive care, The provider will conduct a mandatory meeting by 01/31/2023 with all HHAs to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the HHA recorded and reported the patient's physical condition, behavior, and/or appearance in accordance with the regulations. **Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing
H 433	3916.2(c) SKILLED SERVICES GENERALLY			

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H 433	Continued From page 7 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 providing care to one of 15 active patients in the sample. (Patient #6) Findings included: On 11/18/2022 at 11:42 AM, review of Patient #6's clinical record showed a plan of care (POC) with a duration period from 01/01/2022 through 12/31/2022. The POC included a physician's order for skilled nursing visits every 30 days and two visits as needed for one year, and personal care aide (PCA) services 16 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The POC listed another home health agency as "supportive assistance and providing eight hours of direct care from 12 AM to 8:00 AM." Interview with the client's power of attorney on 11/18/2022 at 01:09 PM revealed that the patient had a pressure ulcer wound, and a nurse was coming from another homecare agency (HCA) three times a week for wound care.	H 433	**Patient affected by the deficient practice:** **Patient #6** Patient #6 has been assigned a skilled nurse and going forward, the assigned nurse will ensure that care coordination with other agencies actively involved in the patient's care, through written communication and/or interdisciplinary conferences, in accordance with the patient's needs. **Systemic change:** The provider will review and update the policy on employee's responsibility in 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. Going forward, this policy will be reviewed with each employee both current and new hires. The staffing coordinator will ensure that each patient is adequately staffed with skilled nurses and the nurses will ensure that care coordination with other agencies actively involved in the patient's care, through written communication and/or interdisciplinary conferences, is completed in accordance with the patient's needs. In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the agency is 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.	January 31, 2023 and ongoing

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H 433	Continued From page 8 Interview with the wound care nurse from the other agency on 11/18/2022 at 03:01 PM confirmed that the patient had a stage III wound on his sacrum that was healing. She stated she had been providing wound care on Mondays, Wednesdays, and Fridays to the client, and that the aides were educated to turn and reposition the client. The client's records lacked documented evidence that the agency was aware of the client's wound. Furthermore, there was no evidence that the agency was in communication with the entity providing wound care from 10/05/2022 through the time of the survey. On 11/21/2022 at 03:39 PM, the Director of Nursing and Administrator were informed of the findings. At the time of the survey, the agency failed to coordinate services with another entity actively involed in providing care for Patient #6.	H 433	**Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing
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 primary physician for one of 15 active patients sampled (Patient #3).	H 452	**Patient affected by the deficient practice:** **Patient #3** The responsible nurse was contacted by the Clinical Manager and conducted a one-to-one counseling and employee acknowledged the findings.	January 31, 2023 and ongoing

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H 452	Continued From page 9 Findings included: On 11/18/2022 at 10:30 AM, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 04/01/2022 through 03/31/2023. The POC included orders for skilled nursing visits every 30 days and two visits as needed for one year, personal care services for eight hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The patient's diagnoses included Osteoarthritis, Hyperlipidemia, shortness of breath, Gastro-esophageal reflux disease, Hypertension, and Type II Diabetes Mellitus. Continued record review showed a hospital discharge summary dated 04/12/2022 indicating Patient #3 was in the emergency room (ER) for right hip pain. Furthermore, the records showed that the skilled nurse (SN) visited the patient on 05/06/2022 with no evidence in her notes that she was aware of the patient's ER visit on 04/12/2022. Also, the 60-day summary note dated 04/30/2022 indicated the following: "no ER or hospitalization since last report (02/28/2022)." There was no documented evidence in the clinical record that the skilled nurse coordinated care with the physician following the client's ER visit and overall condition. On 11/21/2022 at 03:39 PM, the Director of Nursing and Administrator were informed of the findings. At the time of the survey, the agency failed to ensure that the skilled nurse coordinated care with the primary physician for Patient #3.	H 452	**Systemic change:** The provider will review and update the policy on skilled nursing services to ensure that care coordination and referrals are completed in accordance with the regulations. Going forward, this policy will be reviewed with each employee both current and new hires. In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the skilled nurses are completing care coordination and referrals for assigned patients in accordance with the regulations. **Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing

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H 453	Continued From page 10			
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 (SN) services were provided in accordance with the patient's plan of care (POC) for two of 15 active patients sampled (Patients #4 and #6). Findings included: 1.On 11/16/2022 at 03:07 PM, review of Patient #4's clinical record showed a plan of care (POC) with a duration period of 08/15/2022 through 10/13/2022, for skilled nursing (SN) visits one to three times a week for eight weeks to conduct skilled assessments of body systems, evaluate co-morbid conditions, and intervene to minimize complications. Also, the nurse was ordered to perform wound care to right buttock and sacrum with duoderm hydrocolloid dressing two to three times a week and as needed, and to measure the wound every week. The patient's diagnoses included Stage 3 Pressure ulcer of other site, Stage 2 Pressure ulcer of right buttock, Epilepsy, Hemiplegia, and hypertension. Continued review of the clinical record showed that the skilled nurse (SN) visited the patient on 08/22/2022, 08/24/2022, 08/29/2022, 08/31/2022, and 09/02/2022 with no evidence of a measurement	H 453	**Patient affected by the deficient practice:** **Patient #4 and #6** For Patient #4, the clinical manager contacted the employee(s) with the identified deficient practice and conducted a one-to-one counseling. Employees acknowledged the findings and the need to provide measurement of the patient's wound as ordered. Patient #6 has been assigned a skilled nurse and going forward, the assigned nurse will ensure that patient needs are met in accordance with the plan of care. **Systemic change:** The provider will review and update the policy on skilled nursing services to ensure that patient's needs are met in accordance with the plan of care. Going forward, this policy will be reviewed with each employee both current and new hires. The staffing coordinator will ensure that each patient is adequately staffed with skilled nurses and the nurses will be required to ensure that patient needs are met in accordance with the plan of care. Skilled Nurses with the agency are required to follow the agency's policy in order to maintain employment with the agency. In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that patient needs are met in accordance with the plan of care.	January 31, 2023 and ongoing

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	HCA-0022	A. BUILDING: _____ B. WING _____	11/21/2022

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H 453	Continued From page 11 of the patient's wound as ordered. 2. On 11/18/2022 at 11:42 AM, review of Patient #6's clinical record showed a plan of care (POC) with a duration period from 01/01/2022 through 12/31/2022. The POC included a physician's order for skilled nursing visits every 30 days and two visits as needed for one year, and personal care services 16 hours a day, seven days per week to assist with activities of daily livings (ADLs) and instrumental activities of daily livings (IADLs). Also, the nurse was required to perform skilled observations of all systems, measure vital signs, review medications, monitor for side effects and compliance, instruct on safety measures, disease management, and make monthly supervision of home health aides. Further review of the clinical record lacked evidence that skilled nursing services were provided as ordered between the period of July 2021 and November 2022. On 11/18/2022 at 12:08 PM, interview with the Director of Nursing revealed that the client did not have an assigned skilled nurse. She indicated challenges in accomodating the client with a skilled nurse and reported that the last time a skilled nurse from this agency saw the client was 06/03/2021, and the agency was actively working on finding a nurse for the client. At the time of the survey, the home care agency failed to ensure that skilled nursing services were provided in accordance with Patients #4 and #6's plans of care.	H 453	**Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing
H 456	3917.2(f) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum,	H 456		

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H 456	Continued From page 12 the following: (f) Supervision of services delivered by home health and personal care aides and household support staff, as appropriate; This Statute is not met as evidenced by: Based on record review and interview, the home care agency's nurses (HCA) failed to document the supervision of services being delivered by each patient's home health aide (HHA) for one of 15 active patients in the sample (Patient #6). Findings included: On 11/18/2022 at 11:42 AM, review of Patient #6's clinical record showed a plan of care (POC) with a duration period from 01/01/2022 through 12/31/2022. The POC included a physician's order for skilled nursing visits every 30 days and two visits as needed for one year, and personal care services 16 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). Also, the nurse was required to perform skilled observations of all systems, measure vital signs, review medications, monitor for side effects and compliance, instruct on safety measures, disease management, and perform monthly supervision of home health aides. Further review of Patient #6's clinical record lacked evidence of supervision of services delivered by the aides from July 2021 to November 2022. On 11/18/2022 at 12:08 PM, interview with the Director of Nursing revealed that the client did not a have an assigned skilled nurse. She indicated challenges in accomodating the client with a skilled nurse and reported that the last time a	H 456	**Patient affected by the deficient practice:** **Patient #6** Patient #6 has been assigned a skilled nurse and going forward, the assigned nurse will ensure that the supervision of services delivered by home health, personal care aides, and household support staff are complete. The agency will ensure that the skilled nurse will maintain compliance by ensuring that supervision of services is provided in accordance with the regulations and POC. Please see "Attachment #1" for the supervisory visit notes completed by the assigned skilled nurse. **Systemic change:** The provider will review and update the policy on skilled nurses completing and documenting supervision of services delivered by home health and personal care aides and household support staff in accordance with the regulations. Going forward, this policy will be reviewed with each employee both current and new hires. The staffing coordinator will ensure that each patient is adequately staffed with skilled nurses and the nurses will be required to complete and document supervision of services delivered by home health and personal care aides and household support staff. Registered Nurses are required to follow the agency's policy in order to maintain employment with the agency. In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the clinical nurses complete and document supervision of services delivered by home health and personal care aides and household support staff.	January 31, 2023 and ongoing

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H 456	Continued From page 13 skilled nurse from this agency saw the client was 06/03/2021, and the agency was actively working on finding a nurse for the client. At the time of the survey, the home care agency (HCA) failed to ensure skilled nurse supervision of home health aide services for Patient #6.	H 456	**Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing
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: Based on record review and interview, it was determined that the home care agency (HCA) failed to ensure that the skilled nurse documented progress notes at least once every 30 calendar days and a summary note at least every 62 calendar days for one of 15 active patients sampled (Patient #6). Findings included: On 11/18/2022 at 11:42 AM, review of Patient #6's clinical record showed a plan of care (POC) with a duration period from 01/01/2022 through 12/31/2022. The POC included a physician's order for skilled nursing visits every 30 days and two visits as needed for one year, and personal care aide (PCA) services 16 hours a day, seven days per week to assist with activities of daily livings (ADLs) and instrumental activities of daily livings (IADLs). Also, the nurse was required to	H 457	**Patient affected by the deficient practice:** **Patient #6** Patient #6 has been assigned a skilled nurse and going forward, the assigned nurse will ensure the completion and documentation of the progress notes and summary notes as specified by the regulations. The agency will ensure that the skilled nurse will maintain compliance by ensuring that skilled nursing services are provided in accordance with the regulations and POC. Please see "Attachment #2 & #3" for the visit assessment notes completed by the assigned skilled nurse. **Systemic change:** The provider will review and update the policy on skilled nurses completing and documenting progress notes and summary notes in accordance with regulations. Going forward, this policy will be reviewed with each employee both current and new hires. The staffing coordinator will ensure that each patient is adequately staffed with skilled nurses and the nurses will be required to complete and document progress notes at least once every thirty (30) calendar days and summary notes at least once every sixty-two (62) calendar days. Registered Nurses are required to follow the agency's policy in order to maintain employment with the agency.	January 31, 2023 and ongoing

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H 457	Continued From page 14 perform skilled observations of all systems, measure vital signs, review medications, monitor for side effects and compliance, instruct on safety measures, disease management, and make monthly supervision of PCAs. Continued review of the clinical record lacked evidence of monthly progress notes from July 2021 to November 2022. Furthermore, the clinical record lacked evidence of 62-day summary notes between the period of July 2021 and November 2022. On 11/18/2022 at 12:08 PM, interview with the director of nursing DON) revealed that the client did not a have an assigned skilled nurse. She indicated challenges in accomodating the client with a skilled nurse and reported that the last time a skilled nurse from this agency saw the client was 06/03/2021, and the agency was actively working on finding a nurse for the client. At the time of survey, it was determined that the agency failed to ensure that a skilled nurse documented progress notes and summary notes in accordance with the regulatory requirements for Patient #6.	H 457	In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the clinicians document progress notes at least once every thirty (30) calendar days and summary notes at least once every sixty-two (62) calendar days. **Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing
H 550	3922.1 OCCUPATIONAL THERAPY SERVICES If a home care agency provides occupational therapy services, it shall provide those services in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure occupational therapy (OT) services were provided in accordance with the patient's plan of care (POC) for three of 15 active patients sampled (Patients	H 550	**Patient affected by the deficient practice:** **Patient #7, #8, and #14** For Patient #7, the provider acknowledges that the employee failed to complete OT services and the clinical record lacked evidence that the OT evaluated the patient as specified on the POC. For Patient #8 & #14, the provider acknowledges that the employee failed to complete OT services during the week of November 6, 2022 in accordance with the POC.	January 31, 2023 and ongoing

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H 550	Continued From page 15 #7, 8, and #14). Findings included: 1. On 11/17/2022 at 10:31 AM, review of Patient #7's clinical record showed a plan of care (POC) with a duration period of 09/17/2022 through 11/15/2022. The plan of care included physician's orders for occupational therapy (OT) visits once a week for four weeks to evaluate the patient for OT services and establish a plan of treatment. The patient's diagnoses included Multinodular Goiter, Sleep Apnea, Respiratory Failure, Obesity, dizziness and giddiness, weakness, failure to thrive, Type II Diabetes Mellitus, and Hypoglycemia. Continued review of the clinical record lacked evidence that the OT evaluated the patient or indicated the reason for the delay. Interview with the Director of Nursing (DON) at 11:12 AM revealed that the client refused OT services based on a communication note written by the staffing coordinator on 09/19/2022, which was not reported to the clinical team. The DON stated that she would notify the doctor immediately. Interview with Patient #7 on 11/18/2022 at 11:22 AM revealed that she denied refusing OT services. She added that "someone had called to schedule the appointment for OT but never came." 2. On 11/17/2022 at 11:15 AM, review of Patient #8's clinical record showed a POC with a duration period of 10/07/2022 through 12/05/2022. The POC included a physician's orders for OT visits one time a week for four weeks to evaluate the patient for OT services and establish a plan of treatment. The patient's diagnoses included	H 550	The clinical manager contacted the employees with the identified deficient practice and conducted a one-to-one counseling. Employees acknowledged the findings and the need to provide OT services in accordance with the POC. **Systemic change:** The provider will review and update the policy on occupational therapy services in accordance with the plan of care. Going forward, this policy will be reviewed with each employee both current and new ones. The Intake Coordinator will verify the information of patient's refusal of services and the clinician will be required to notify the physician concerning each refusal as well as complete necessary documentation in the chart of the applicable patient. The Intake Coordinator will further report all refusal to the clinical manager. In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the clinicians are providing services in accordance with the POC. **Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing

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H 550	Continued From page 16 Cerebral Infarction, Dysphagia, Chronic Obstructive Pulmonary disease, Asthma, Tracheostomy status, Hypothyroidism, Hypertension, and Major Depressive Disorder. Continued review of the clinical record lacked evidence that OT services were provided as ordered during the week of November 6, 2022. 3. On 11/17/2022 at 01:33 PM, review of Patient #14's clinical record showed a POC with a duration period of 10/06/2022 through 12/04/2022. The POC included a physician's order for OT visits one time a week for four weeks to evaluate the patient for OT services and establish a plan of treatment. The patient's diagnoses included end stage renal disease, Hypertension, Arthritis, Hypothyroidism, Hyperlipidemia, Malignant Neoplasm of Tonsil, and muscle weakness. Continued review of the clinical record lacked evidence that OT services were provided as ordered during the week of November 6, 2022. On 11/21/2022 at 03:39 PM, the Director of Nursing and Administrator were informed of the findings. At the time of the survey, the home care agency failed to provide documented evidence that the occupational therapist provided services in accordance with the plans of care for Patients #7, 8, and #14.	H 550		
H 560	3923.1 PHYSICAL THERAPY SERVICES If physical therapy services are provided, they shall be provided in accordance with the patient's plan of care.	H 560	**Patient affected by the deficient practice:** **Patient #8**	January 31, 2023 and ongoing

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H 560	Continued From page 17 This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure physical therapy (PT) services were provided in accordance with the patient's plan of care (POC) for one of 15 active patients sampled (Patient #8). Findings included: On 11/17/2022 at 11:15 AM, review of Patient #8's clinical record showed a plan of care (POC) with a duration period of 10/07/2022 through 12/05/2022. The POC included physician's orders for physical therapy (PT) visits one time per week for eight weeks for assessment, home safety evaluation, instruction on therapeutic exercises, and establishment of home exercise program. The patient's diagnoses included Cerebral Infarction, Dysphagia, Chronic Obstructive Pulmonary disease, Asthma, Tracheostomy status, Hypothyroidism, Hypertension, and Major Depressive Disorder. Further review of the records lacked evidence that PT services were provided during the week of October 16, 2022. On 11/21/2022 at 03:39 PM, the DON and Administrator were informed of the findings. At the time of the survey, the home care agency failed to ensure that physical therapy services were provided in accordance with the plan of care for Patient #8.	H 560	The provider acknowledges that the employee failed to complete PT services during the week of October 16, 2022 in accordance with the POC. The clinical manager contacted the employee with the identified deficient practice and conducted a one-to-one counseling. Employee acknowledged the findings and the need to provide PT services in accordance with the POC. **Systemic change:** The provider will review and update the policy on physical therapy services in accordance with the plan of care. Going forward, this policy will be reviewed with each employee both current and new ones. In addition, to ensure a comprehensive care, the provider will conduct a mandatory meeting by 01/31/2023 with all clinicians to address the findings. **Quality assurance measure:** The clinical manager will review 25% clinical records monthly to ensure that the clinicians are providing services in accordance with the POC. The clinical manager will ensure that appropriate documentation and provider notification are completed for all missed visit. **Date of Inservice:** By 01/31/2023, all clinical staff will complete an in-service training organized by the clinical manager in regards to the above identified findings.	January 31, 2023 and ongoing