

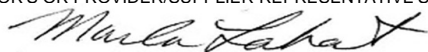
Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2023
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NAME OF PROVIDER OR SUPPLIER HOME CARE PARTNERS	STREET ADDRESS, CITY, STATE, ZIP CODE 1234 MASSACHUSETTS AVENUE NW, SUITE C-1002 WASHINGTON, DC 20005
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H 000	<p>INITIAL COMMENTS</p> <p>An annual licensure survey was conducted 06/21/2023, 06/22/2023, 06/23/2023 and 06/26/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 199 patients and employed 130 staff. The findings of the survey were based on the review of administrative records, ten active patient records, five discharged patient records, 15 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 nine patient phone interviews and three home visits.</p> <p>Listed below are abbreviations used throughout this report:</p> <p>HCA - Home Care Agency HHA - Home Health Aide POC - Plan of Care</p>	H 000		
H 260	<p>3911.1 CLINICAL RECORDS</p> <p>Each home care agency shall establish and maintain a complete, accurate, and permanent clinical record of the services provided to each patient in accordance with this section and accepted professional standards and practices.</p> <p>This ELEMENT is not met as evidenced by: Based on record review and interview it was determined that the Home Care Agency (HCA) failed to establish and maintain a complete, and accurate clinical records of the services provided to each patient in accordance with accepted professional standards and practices in six of ten</p>	H 260		

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



TITLE
Executive Director

(X6) DATE
7-19-2023

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H 260	<p>Continued From page 1</p> <p>clinical records reviewed (Clinical records #2, #3, #4, #6, and #8).</p> <p>Findings included:</p> <p>1. On 06/21/2023 at 2:20 PM, a review of clinical record #2 showed a document titled "HCP Assessment". This document is used by the clinician to perform a complete and accurate assessment of the patient and to generate a care plan for the home health aide to provide appropriate and accurate care for the patient. A continued review of this document showed that the patient has "blood pressure issues" and diabetes but under the diet section, the clinician checked the "Regular" diet and ignored the other options of "diabetic" and "low salt". A further review of clinical record #2 showed a document titled "Fall Risk Assessment". The admitting clinician identified that the patient has a history of falls but left the section titled "instructions and recommendations provided" blank.</p> <p>2. On 06/22/2023 at 9:30 AM, a review of clinical record #3 showed a document titled "HCP Assessment". This document is used by the clinician to perform a complete and accurate assessment of the patient and to generate a care plan for the home health aide to provide appropriate and accurate care for the patient. A continued review of this document showed that the patient has "blood pressure issues" but under the diet section, the clinician checked the "Regular" diet and ignored the other option of "low salt". Additionally, within the HCP assessment is a section titled "Emergency Response Needed (Specify Response Below)". The admitting clinician checked "No" emergency response needed but checked multiple responses to emergencies below.</p>	H 260	<p>1. Corrective Action: Clinical records will be completed in their entirety and include the correct diet that is appropriate to the client's health condition, such as hypertension or diabetes. Fall risk assessments will include recommendations to address fall risks if identified. Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings. Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p> <p>2. Corrective Action: Clinical records will be completed in their entirety and include the correct diet that is appropriate to the client's health condition, such as hypertension or diabetes. Response to emergencies will be correctly completed to reflect the plan for each client. Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings. Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p>	<p>8/1/23</p> <p>8/1/23</p>
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H 260	<p>Continued From page 2</p> <p>3. On 06/22/2023 at 11:15 AM, a review of clinical record #4 showed a document titled "HCP Assessment". This document is used by the clinician to perform a complete and accurate assessment of the patient and to generate a care plan for the home health aide to provide appropriate and accurate care for the patient. A continued review of this document showed a section titled "Emergency Response Needed (Specify Response Below)". The admitting clinician checked "Yes" emergency response needed but left the section below titled "Response to Emergencies" blank.</p> <p>4. On 06/22/2023 at 1:45 PM, a review of clinical record #6 showed a document titled "HCP Assessment" that was done by the admitting clinician on 05/30 2023. This document is used by the clinician to perform a complete and accurate assessment of the patient and to generate a care plan for the home health aide to provide appropriate and accurate care for the patient. A continued review of this document showed a section titled "Emergency Response Needed (Specify Response Below)". This section was left blank. The section titled "Response to emergencies" was left blank, the section titled "Client Goals" was left blank, the section titled "Prognosis to remain at home", was left blank.</p> <p>5. On 06/23/2023 at 10:00 AM, a review of clinical record #8 showed a document titled "HCP Assessment" that was signed by the admitting clinician on 03/03 2023. This document is used by the clinician to perform a complete and accurate assessment of the patient and to generate a care plan for the home health aide to provide appropriate and accurate care for the patient. A continued review of this document</p>	H 260	<p>3. Corrective Action: Clinical records will be completed in their entirety. Response to emergencies will be correctly completed to reflect the plan for each client. Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings. Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p> <p>4. Corrective Action: Clinical records will be completed in their entirety. Response to emergencies will be correctly completed to reflect the plan for each client. The section of the clinical assessment form on goals and prognosis to remain in the home will be completed for each client. Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings. Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p> <p>5. Corrective Action: Clinical records will be completed in their entirety and include the correct diet that is appropriate to the client's health condition. Client diets that do not seem to match the health conditions reported for the client will be corrected or require further explanation Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete...(Continued on next page)</p>	<p>8/1/23</p> <p>8/1/23</p> <p>8/1/23</p>

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H 260	<p>Continued From page 3</p> <p>showed that the client has blood pressure and heart issues and no diabetes issues. Further review of the clinical record showed a document titled "HCP Plan of Care" that is used by the home health aide as instructions/guidance for care provided to the patient. A continued review of this document showed that the diet to be provided to the patient is listed as "Diabetic".</p> <p>The agency failed to establish and maintain complete and accurate clinical records for each patient in accordance with accepted professional standards and practice.</p> <p>On 06/23/2023 at 3:00 PM, during an interview with the Assistant Director, the findings were confirmed.</p>	H 260	<p><i>(Continued from Page 3)</i></p> <p>...documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings.</p> <p>Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p>	
H 355	<p>3914.3(d) PATIENT PLAN OF CARE</p> <p>The plan of care shall include the following:</p> <p>(d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies;</p> <p>This Statute is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the home care agency failed to include the dietary requirements as a guidance to the Home Health Aides (HHA) during care for six of ten active clients in the sample (Clients #1, #2, #3, #7, #8 and #10).</p> <p>Findings included:</p>	H 355		

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H 355	<p>Continued From page 5</p> <p>a thorough assessment of the client's condition and needs and to prepare a plan of care to guide and assist the HHA in providing care that is adequate, effective, and efficient. A continued review of the HCP assessment showed that the client had blood pressure issues. Further review of the clinical record showed a document titled "Plan of Care" that included a description of the duties of the HHA services including meal preparation and service. Within the section titled "Meals," the clinician documented "Prepare and serve" instead of the meal choice appropriate for the client's blood pressure issues.</p> <p>4. On 06/22/2023 at 2:40 PM, a review of Client #7's record showed a document titled "HCP Assessment". This document is used to conduct a thorough assessment of the client's condition and needs and to prepare a plan of care to guide and assist the HHA in providing care that is adequate, effective, and efficient. A continued review of the HCP assessment showed that the client had Diabetes. Further review of the clinical record showed a document titled "Plan of Care" that included a description of the duties of the HHA services including meal preparation and service. Within the section titled "Meals," the clinician documented "Prepare and serve" instead of the meal choice appropriate for the client's diabetes.</p> <p>5. On 06/23/2023 at 10:00 AM, a review of Client #8's record showed a document titled "HCP Assessment". This document is used to conduct a thorough assessment of the client's condition and needs and to prepare a plan of care to guide and assist the HHA in providing care that is adequate, effective, and efficient. A continued review of the HCP assessment showed that the client had blood pressure and heart issues.</p>	H 355	<p><i>(Continued from Page 5)</i></p> <p>...Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings.</p> <p>Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p> <p>4. Corrective Action: If the Plan of Care includes meal preparation even on an "as needed" or "as requested" basis, the correct diet that is appropriate to the client's health condition, such as hypertension or diabetes will be indicated. Plan and Serve is the aide's responsibility related to the meal preparation task but does not convey the diet which needs to be specified. Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings.</p> <p>Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p> <p>5. Corrective Action: Clinical records will be completed in their entirety and include the correct diet that is appropriate to the client's health condition. Client diets that do not seem to match the health conditions reported for the client will be corrected or require further explanation.</p> <p>Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment...<i>(Continued on Next Page)</i></p>	<p>8/1/23</p> <p>8/1/23</p>
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H 355	<p>Continued From page 6</p> <p>Further review of the clinical record showed a document titled "Plan of Care" that included a description of the duties of the HHA services including meal preparation and service. Within the section titled "Meals," the clinician documented a "Diabetic Diet" instead of the meal choice appropriate for the client's blood pressure and heart issues.</p> <p>6. On 06/23/2023 at 11:45 AM, a review of Client #10's record showed a document titled "HCP Assessment". This document is used to conduct a thorough assessment of the client's condition and needs and to prepare a plan of care to guide and assist the HHA in providing care that is adequate, effective, and efficient. A continued review of the HCP assessment showed that the client had blood pressure and heart issues. Further review of the clinical record showed a document titled "Plan of Care" that included a description of the duties of the HHA including meal preparation and service. There was no documentation of a meal choice appropriate for the client's blood pressure and heart issues.</p> <p>The HCA failed to include dietary requirements appropriate for their clients' condition in the Plans of Care.</p> <p>On 06/23/2023 at 3:00 PM, during an interview with the Assistant Director, the findings were confirmed.</p>	H 355	<p><i>(Continued from Page 6)</i></p> <p>...,plan of care, and fall risk assessment. This will be reviewed during monthly case manager meetings. Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p> <p>6.Corrective Action: If the Plan of Care includes meal preparation even on an occasional or "as needed" or "as requested" basis, the correct diet that is appropriate to the client's health condition, such as hypertension or diabetes will be indicated. Measures to Prevent Recurrence: Case managers will receive written instructions and a checklist on accurate and complete documentation of the clinical assessment, plan of care and fall risk assessment. This will be reviewed during monthly case manager meetings. Monitoring: Executive Director, Deputy Director or designee will randomly review clinical records on a monthly basis. Findings will be conveyed to the appropriate case manager for correction of any errors, and will also aggregated and discussed at monthly case manager meetings and quarterly Interdisciplinary Quality Improvement committee meetings.</p>	8/1/23