STATEMENT	equiation & Licensing r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COM	SURVEY IPLETED
		HCA-0080	B. WING	the second s	08/	24/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
PROFES	SIONAL HEALTHCARE	RESOURCES	DOL STREET,	SW SUITE 200 0024	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
H 000	INITIAL COMMENT	S	H 000		12	1
	08/21/2023, 08/22/2 08/24/2023 to deter DCMR, Chapter 39 Regulations). The H home care services staff. The findings or review of administra records, three disch personnel records, response to compla survey findings were of three home visits	survey was conducted on 2023, 08/23/2023, and mine compliance with Title 22 B (Home Care Agency lome Care Agency provided to 98 patients and employed 87 f the survey were based on the ative records, nine active patient harged patient records, 12 and a review of the agency's ints and incidents received. The e also based on the completion				
	ADL - Activities of DON- Director of N					
	HHA - Home Health		N No.			
	HCA - Home Care	Agency	2			1.6
1. 24		Activities of Daily Living	1.2			12.47
	North Street	nal Therapist				
	PCA - Personal Car POC - Plan of Care	AIUE	1.1			
	PT - Physical Thera	pist		2.2.2		
	RN - Registered Nu			A Particular State		1.4.3
	SN - Skilled Nurs					
	2 15 - JAL					

LABORATOR R REPRESENTATIVE'S SIGNATURE Clare hi ı STATE FORM

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Health R	egulation & Licensing	Administration	-			
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X	X3) DATE SI COMF	URVEY PLETED
		HCA-0080	B. WING		08/24	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PROFES	SIONAL HEALTHCARE	RESOURCES	DOL STREET, GTON, DC 20	SW SUITE 200 0024		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETE DATE
H 000	Continued From pag	ge 1	H 000			
	SOC - Start of Care					
H 054	3903.2(c)(2) GOVEF	RNING BODY	H 054	What corrective action(s) will be accomplished t address the identified deficient practice?	to	
	The governing body (c) Review and evalu- policies governing the determine the extern patient care that is a and efficient. This re- include the following (2) The evaluation s complaints made or	shall do the following: uate, on an annual basis, all ne operation of the agency to t to which services promote appropriate, adequate, effective eview and evaluation must p: hall include a review of all referred to the agency, of each complaint and the		Director of QA and Education will instruct the Branc Assurance Process Improvement team to ensure th during their monthly review of the data from the Cor Log that details of the complaints as far as what hay how was it investigated, how was it resolved and wit the appropriate people such as the PCP and the pa and/or family members were notified of how the cor was resolved. Director of QA and Education and Clinical Manager review the process with the staff and will ensure tha process of handling complaints is done on all the complaints. The Branch Quality Assurance Process Improveme will collate all these complaints documentation on a quarterly basis for submission to the VP of Clinical Operations, Regulatory and Compliance for review submitting the report to the Board of Directors.	nat mplaint ppened, hether atient mplaint r will at the ent team a prior to	10/31/23
	Based on record rev Governing Body faile complaints made or including the nature agency's response. Findings included: Review of the agend at 12:01 PM showed complaints recorded 09/2022 through 06/ evidence that the Go reviewed the seven Review of the agend	met as evidenced by: view and interview, the ed to evaluate and review referred to the agency, of each complaint and the cy's complaint log on 08/21/2023 the nature and response of for seven complaints from 2023, however, there was no overning Body evaluated or documented complaints. cy's Governing Body's minutes :30 AM showed that several	3	 BOD will review on a quarterly basis the Complaint submitted by the branch Quality Assurance Process Improvement team. The BOD will ensure that the pridentified on handling complaints are followed and t resolutions were completed including proper notifica documentation of the handling of complaints were prexecuted. BOD provides feedback to the branch Quality Assur Process Improvement on any further action to be ta prevent recurrence of the complaint. What measures will be put in place or what syst changes you will make to ensure the deficient p does not recur: The VP of Clinical Operations and Regulatory and Compliance and the Director of Quality Assurance F Improvement and Education will review with the Clin Manager all complaints filed on a monthly basis as at the end of the quarter prior to submitting Quality Assurance Process Improvement reports to the BOI ensure 100% of all complaints were handled, proce and resolved according to the procedure. 	s rocess that ation and properly arance aken to temic practice Process nical well as DD to	10/31/23 and on-going
		between 09/2022 through		How the corrective action will be monitored to e the deficient practice will not recur, i.e. quality assurance program will be implemented.		10/31/23

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		SURVEY IPLETED
		HCA-0080	B. WING	08/	24/2023
NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE T, SW SUITE 200	
PROFES	SIONAL HEALTHCAR	E RESOURCES	STON, DC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 054	however, the minut each complaint refe agency's evaluation During an exit inter the agency leaders of complaints were	es revealed that an of the complaints was presented; es failed to include the nature of erred to the agency and the n and review. view on 08/24/2023 at 1:31 PM, hip staff verified that the number compiled and included in the nutes, but the nature and	H 054	The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will review 100% all complaints received by the branch to ensure that the process is being followed. This review will be done for at least 3 quarters threshold set at 100% and if threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the complaint process is not being followed 100%. Findings both positive and corrective will be discussed at the Branch Quality Assurance Process Improvement monthly meetings so that recurrence of non-compliance will be identified and corrected.	
H 147	Each home care ag personnel records, information: (c) Resume of educ checklist, and prior attendance at orien workshops or semin This Statute is not Based on record re	pency shall maintain accurate which shall include the following cation, training certificates, skills employment, and evidence of tation and in-service training,	H 147	What corrective actions will be accomplished to address the identified deficient practice? The Director of HR and the Director of QA and Clinical Education will meet with recruiters to discuss/review the on- boarding process and the required orientation program. The Recruiters will be re-educated in the process and the importance of ensuring that new employees are given orientation prior to starting work in the company. The orientation checklist must be completed and are filed in the personnel files of the employees. The recruiters will be required to ensure and provide documentation that the new employees beginning October 1, 2023, will undergo orientation prior to start of work.	10/31/23
	personnel records t participation in orien nurses included in t Findings included: A review of person 2:11 PM, revealed The agency's regist personnel file include	o include employee's ntation for one of two registered the sample (RN #2). nnel records on 08/21/2023 at		 The HR Director will review all orientation checklist beginning October 1, 2023, to ensure new employees were given orientation prior to start of work. What measures will be put in place or what systemic changes you will make to ensure deficient practice does not recur? The recruiters will ensure that the orientation checklists for all new employees are completed 100% of the time and filed in their personnel files. The HR Director or designee (Infinit-O HR team) will conduct a monthly audit using the worker productivity report to ensure all new hired employees were given orientation and the orientation were properly recorded in their orientation checklists and filed in the employee personnel files. 	10/31/23 a on-going

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY MPLETED
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AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
ROFES	SIONAL HEALTHCAR	E RESOURCES	IOOL STREE [®] IGTON, DC	T, SW SUITE 200	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 147	Continued From pa	ge 3 dence that the employee	H 147	How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assuranc program will be implemented?	e
	participated in the h	nome care agency's orientation, ing patient services for 11		The Director of QA and Clinical Education in collaboration wi the Director of HR will meet quarterly to review the audit results presented by the Infinit-o HR team.	th 10/31/23 and on-going
	During an interview 08/21/2023 at 3:24 new employee hired date, the office man	with the office manager on PM, revealed that she was a d on 03/17/2023. Due to her hird nager stated she had no #2 had not participated in the on.	e	The review will be done for at least 3 quarters. The Threshol is set for 100% and if the threshold is not met, the Director o HR will counsel the recruiters and remind them of the goal of 100% compliance.	on-going
	failed to ensure that	urvey, the home care agency t RN #2 participated in I to hire and prior to her			
H 151	3907.2(g) PERSON	INEL	H 151	What corrective actions will be accomplished to address the identified deficient practice?	
	personnel records, information:	ency shall maintain accurate which shall include the following	g	The Director of QA and Education in collaboration with the Director of HR will conduct a meeting with the Recruiters and HR Generalist to discuss and re-educate on the process of onboarding new employees. The process of obtaining the references such as one reference from previous employers and one reference for personal and/or professional reference	10/31/23
	(g) Documentation	of reference checks;		will be reviewed. The recruiters will immediately implement the process on the	
	This Statute is not	met as evidenced by:		hires for the month of October 2023.	
	care agency (HCA) personnel records t	view and interview, the home failed to maintain accurate o include documentation of		The HR Director or designee will check all of the hires in October 2023 to ensure that the 2 references have been obtained for 100% of the October hires.	
	sampled (RN #2 an	r two of 12 personnel files d the agency ' s Clinical Quality Assurance).		What measures will be put in place or what systemic changes you will make to ensure deficient practice does not recur?	
	Findings included:			The recruiters will ensure that the On-boarding checklist is used for all of the hires, all completed and that the required documents are all obtained before the new hire starts work.	10/31/23
		nel records conducted on PM revealed the following:		The recruiters will ensure that all hires 100% will have the tw references required prior to start of work.	o

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3) DATE CO	MPLETED
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	ROVIDER OR SUPPLIER SIONAL HEALTHCARE	ERESOURCES 501 SCI	ADDRESS, CITY, S HOOL STREE NGTON, DC	T, SW SUITE 200	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 151	hire of 09/26/ 2022 f documented eviden #2. 2. The personnel fil Educator/ Director /0 hire date of 11/28/20 personnel file showe reference checks.	ge 4 le for RN #2 revealed a date of however, there was no ce of reference checks for RN le for the agency's Clinical Quality Assurance included a 022. Further review of the ed no documented evidence of confirmed by the agency 's		How is the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented? The Director of HR or designee will review 100% quarterly for 3 quarters all newly hired personnel files which includes the on-boarding checklists to ensure that the files are complete and that there are two references on all of the files. The threshold is 100%. If 100% threshold is not achieved in the first quarter, the HR director will counsel the recruiters to ensure compliance.	•
H 152		NEL ency shall maintain accurate which shall include the followin	H 152	What corrective Actions will be accomplished to address the identified deficient practice? The Director of HR and HR Generalist assigned to the branch will work with the Branch Clinical Manager to ensure that the Performance Reviews are done annually for all of the staff starting this performance period.	10/31/23
	This Statute is not Based on personnel	eted annual evaluations; met as evidenced by: I record review and staff		The Director of QA and Education and the Director of HR wi send out the performance review calendar in mid-October 2023 for the Clinical Managers to start the performance revier for 2022-2023 for all of the staff in the DC Branch. The HR Director or designee will check off from the checklist all of the performance reviews already completed by the CM.	10/15/23
	reviews were compl personnel record, fo included in the samp	cy failed to ensure annual eted and located in the or two of four physical therapist ple (PTs #2 and #3, and one of es included in the sample RN		The HR Director or designee will ensure that all of the performance reviews for the entire staff is completed before 10/31/23. The completed performance reviews will be filed in personnel files by the HR data Entry Team in Infinit-O. What measures will be put in place or what systemic changes you will make to ensure deficient practice does not recur?	10/31/23
		ity's personnel records was /2023 at 2:38 PM revealed the		Annually, by October 1 of each year going forward, the HR Director will issue a memorandum designating the Performance Review period with specific deadlines for the different steps of the review process. The final deadline for completion of all performance reviews for all staff will be completed no later than 12/31 of each year	10/31/23 an on-going

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,) DATE SURVEY COMPLETED	
			A. BUILDING	:		
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NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
PROFESS	ONAL HEALTHCAR	- RESOURCES	OOL STREE STON, DC	T, SW SUITE 200 20024		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5 COMPL DAT	LETE
H 152	included a date of h	ge 5 e for physical therapist (PT # 2) ire of 04/23/2008. Further anel file lacked evidence of an	H 152	The HR Director will review no later that October 31, 2 and going forward the checklist for all branch personne ensure that all of the performance reviews have been completed for this performance review period based of deadlines in the performance Review Calendar. The HR Data Entry team will conduct a quarterly audit	el to n the of 10/31/2	23 and
	annual review since2. The personnel fileincluded a date of h			100% of all branch personnel files to ensure that all performance reviews were completed and properly file personnel files. How the corrective actions will be monitored to en the deficiencies will not recur, i.e. what quality ass program will be implemented?	sure	ıg
	year anniversary or3. The personnel fileincluded a date of h	e for registered nurse (RN # 1) ire of 11/04/2015. Further inel file lacked evidence of an		The Director of Human Resources or designee will aud quarterly 100% of all the branch personnel files to ensi- the performance reviews have been completed and file properly. The threshold is 100% so if the 100% was no during the review, the HR Director and HR Generalist collaboration with the Branch Clinical Manager will ensi- missing performance reviews are done immediately ar	ure that ed of met 10/31/2 in on-goin ure that	ng n audi tinue
	Performance on 08/ "FT, PT, and PRN e written evaluations of	cy's policy entitled personnel 23/2023 at 12:58 PM showed employees will receive annual on a calendar schedule between ecember 31st of each year."			ensure compliar sustaine	
	The findings were a the time of the revie	cknowledged and confirmed at w.				
H 162	3907.6 PERSONNE	iL	H 162	What corrective actions will be accomplished to ac the identified deficient practice?	Idress	
	the home care agen employee, within the	employment of each employee, icy shall verify that the e six months immediately of hire, has been screened for unicable disease.		The Director of QA and Clinical Education in collabora the Director of Human Resources will conduct a meetin the recruiters and HR generalist to discuss and reeduc the process of obtaining all renewable requirements pr start date. Documentation from previous employers for showing communicable status should be resulted with months of hire and must be done again post hire within months of start.	ng with iate on 10/31/2 ior to ilabs n 6 n 6	?3
		met as evidenced by: /iew and interview, the home		The reminders will be placed in Homecare Homebase renewable requirements with a timer to notify Patient S Coordinators that this person is due for lab to assess communicable disease status and will be a hard stop t scheduling the person to see clients	Services	
alth Regula	tion & Licensing Administr	ation			l.	

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	ROVIDER OR SUPPLIER	F RESOURCES 501 SCH		TATE, ZIP CODE T, SW SUITE 200 20024			
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H 162	Continued From page	ge 6	H 162	The Director of Human Resources will implement t addition to the policy by 10/31/2023	his new	10/31/23	
	employee was free within the six month employee's date of personnel files inclu s Clinical Educator, Findings included: A review of the fac	failed to verify that each of communicable diseases s immediately preceding the hire for one employee's ded in the sample, (the agency' Director/Quality Assurance). ility's personnel records was /2023 at 2:38 PM and revealed		What measures will be put into place or what s changes you will make to ensure deficient pract not recur? The HR Director will review the onboarding process recruiters and HR Generalists to ensure that all ne have documentation showing that they are free of communicable diseases within six months immedia preceding the employees date of hire . Recruiters will not schedule new hires for orientatic all required onboarding documents including documergarding communicable diseases are received. The HR Director or designee will audit all hires for	tice does as with the w hires will ately on unless ments	10/31/23 and on-going	
	The personnel file for Educator, Director/C hire date of 11/28/2 personnel file show was performed on 1 to her date of hire. During the Exit Inter Administrative Staff were referred to Titl Home Care Agency HCA to verify that e screened for and free	or the agency 's Clinical Quality Assurance included a 022. Further review of her ed a QuantiFERON Test that 2/29/2021, eleven months prior view on 08/24/2023, the acknowledged the findings and e 22 DCMR Chapter 39 for 's regulations that required the ach employee has been se of communicable disease mediately preceding the date of		of October to ensure all required on boarding docu obtained and filed on new hires record. How the corrective actions will be monitored to the deficiencies will not recur, i.e. what quality program will be implemented? The Director of QA and Clinical Education in collat with the Director of Human Resources will meet qu discuss audit results presented by the human reso support team. The findings both positive and negative will be disc monthly HR meetings ensuring that the team has to opportunity to correct the action in real time.	o ensure assurance poration jarterly to jurce cussed at	10/31/23 and on-going for quarters Random audits will continue quarterly to ensure compliance is sustained.	
H 163	guidelines issued by	Il be screened for ase annually, according to the / the federal Centers for d shall be certified free of	H 163	What corrective actions will be accomplished to the identified deficient practice? The Director of QA and Clinical Education in collate with the Director of Human Resources will conduct MS Teams meeting to discuss the new process of all annual communicable disease screenings for clithe skills fair in June of each year. The Director of Human Resources will add the scrutter to the annual skills fair packet by 10/31/2023 For each individual who does not have a current scompleted for 2023, Director of QA and Clinical Edwill have this completed by October 31, 2023.	poration t a virtual completing linicians at eening tool creening	10/31/23 10/31/23	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMI	SURVEY PLETED
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		WASHIN	GTON, DC	20024		
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H 163	Continued From page	ge 7	H 163	What measures will be put into place changes you will make to ensure def not recur?		
	Based on record rev care agency (HCA) employee was scree communicable disea	met as evidenced by: view and interview, the home failed to verify that each ened and certified free of ase annually for one of two RN #1) included in the sample.		The human resources support (infinite C monthly audit using the worker producti clinicians are up to date on annual scre- communicable diseases. The Director of QA and Clinical Educati the Director of Human Resources will m discuss audit results presented by the h support team. How the corrective actions will be mo the deficiencies will not recur, i.e. wh program will be implemented?	vity report to ensure all enings of on in collaboration with neet quarterly to numan resource	10/31/23 ar on-going
	conducted on 08/21 following: The personnel file for included a hire date of the file showed th screened for common During the Exit Inter	ility's personnel records /2023 at 2:11 PM revealed the or registered nurse (RN #1) of 11/04/2015. Further review hat the RN had not been unicable diseases since 2018. view on 08/24/2023, at 2:30 ive Staff acknowledged the		The Director of QA and Clinical Education Director of Human Resources will meet qu results presented by the human resource s This review will be done for at least 3 quart 100% and if the threshold is not met, the h team will be retrained and will be reminded of QA and Education and Director of Huma that the process is not being followed 100% The findings both positive and negative wil monthly HR meetings ensuring that the tea correct the action in real time.	arterly to discuss audit support team. ters threshold set at uman resource support I each time the Director an Resources determines %. I be discussed at	10/15/23 aı on-going
				What corrective actions will be accomp identified deficient practice?	lished to address the	
H 300	3912.2(d) PATIENT RESPONSIBILITIES Each home care ag		H 300	The Director of QA and Clinical Education the Director of Human Resources will can with the office team including the clinical generalist, to educate them on the impo with enforcing the policy on patient right	onduct a staff meeting al managers and HR rtance of compliance	10/15/23
	ensure that each pa services has the foll (d) To receive treatr consistent with the a with the patient's pla	tient who receives home care owing rights: nent, care and services agency/patient agreement and an of care;		The Directors will re-educate the office i disciplinary action plan that outlines the holding the clinicians responsible for for related to patient care. The progression warning, written warning, final warning, Depending upon how egregious the act harm that would be inflicted upon the pa- termination may be the only step. The Director of QA and Clinical Education the Director of Human Resources will co- mention and other the importance of the comparison.	e steps to follow when Illowing policies is as follows: verbal termination. is and the level of atient, immediate on in collaboration with onduct a field staff	
	Based on record rev	met as evidenced by: view and interview, it was home care agency (HCA)		meeting re-educating on the importance the following: The goal for a patient is to level of function realistically attainable a of the disability with	o return to the highest	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	.E CONSTRUCTION	(X3) DATE S COMF	URVEY PLETED
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TAG H 300	Continued From page failed to ensure that accordance with the evidenced by misse for two of nine active (Patients #5 and #7 Findings included: 1. On 08/23/2023 at #5's plan of care (Pe 07/16/2023 through diagnoses included congestive heart fai abnormalities of gai dementia, long term and wheelchair dep skilled nursing servi occupational therap aide services, two ti and once, one time with personal care, living (ADLs). Contin clinical record show services were not po 07/16/2023.	services were provided in plan of care (POC) as d home health aide (HHA) visits e patients in the sample	H 300	CROSS-REFERENCED TO THE APPRO DEFICIENCY) home health services. All clinician visits outlined frequency on the plan of care should be comple ordered. Patients/Caregivers should be contacte of 24 hours before the appointment and provide time frame of arrival for the appointment. This d will be adhered to by the discipline ordered. If th is missed due to changes in the patient's schedi other patient-related reasons, the discipline mus missed visit note, contact the physician or provid clinical manager alerting them of the missed visi notification of the physician or provider, and wha appointment will be rescheduled to. The Director of QA and Clinical Education in col the Director of Human Resources will provide ea with a link to access the regulatory policies of th Columbia for home care providers, specifically s the Health Occupations Revision Act HORA dc What measures will be put into place or what changes you will make to ensure deficient put not recur? Compliance with the completion of the following will be monitored monthly by the VP of Clinical O Director of QA and Clinical Education. If intervent completed or not noted in the clinical no-on-on- the importance of following the plan of care and the frequency as ordered in the plan of care, pro disciplinary action as outlined in the policy. Cor this intervention will be 100%. The VP of Clinical Operations, Director of QA, a Education in collaboration with the Director of H Resources will discuss all audits related to follow of care monthly in a separate leadership meetin whether policies are being followed and updatin	in the ted as d a minimum d a date and ate and time e appointment ule or any it submit a der and the t reason, at day the laboration with ach clinician e District of peaking on wh. t systemic ractice does interventions operations and tions are not e clinical ne to discuss completing ogressing to ppliance with nd Clinical uman ving the plan g, determining	DATE 10/31/23 at monthly on going
	#7's plan of care (Pe 07/03/2023 through diagnoses included pressure induced de chronic respiratory f hypertension, musc lymphedema, osteo anxiety disorder, ob hypothyroidism, dep oxygen, history of p falling, and long-terr POC indicated skille	DC) showed a duration period of 08/31/2023. The patient's stage II sacral pressure ulcer, eep tissue damage right heel,		The VP of Clinical Operations, Director of QA, a Education in collaboration with the Director of QA, a Education in collaboration with the Director of QA, a Education in collaboration with the Director of H Resources will discuss all audits related to follow of care monthly in a separate leadership meetin whether policies are being followed and updatin procedures as necessary to maintain the integri patient rights and responsibility policy.	y of the to ensure ty assurance nd Clinical uman ving the plan g, determining g policies and	10/31/23 ar monthly on- going Random audits will continue quarterly to ensure compliance i

6899

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If continuation sheet 9 of 25

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION (X3) DATE CON	SURVEY IPLETED
		HCA-0080	B. WING	08/.	24/2023
ME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
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H 300	for five weeks effect personal care, hygie (ADLs). Continued of record showed that services were not p 07/30/2023 and 08/ On 08/24/2023 at 00 clinical operations we At the time of the su failed to ensure that	de services, two times a week tive 07/30/2023 to assist with ene, and activities of daily living review of Patient #7's clinical home health aide (HHA) rovided as ordered the weeks of	H 300	These reviews and meetings will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the clinical managers and HR Generalist team will be retrained and will be reminded each time the Director of QA and Education and Director of Human Resources determines that the process is not being followed 100%. The findings both positive and negative will be discussed at quarterly company executive meetings with the CEO and Senior Vice President.	
H 364	3914.3(m) PATIEN The plan of care sha (m) Emergency pro	all include the following:	H 364	What corrective actions will be accomplished to address the identified deficient practice? The Director of QA and Education will schedule a staff meeting by 10/11/2023. At that meeting, the 2 patients #7 & #8 will be discussed, and the clinicians assigned will amend the Plan of care to include the emergency protocols specific to the diagnoses. The amended plan of care will be sent to the PCP for signature and be made part of the original POC. The meeting will educate on the need to ensure that all emergency protocols under the emergency	10/31/23
	Based on record rev determined that the to include emergent diagnoses in the pla active patients inclu and #8). Findings included: 1. On 08/22/2023 at #7's plan of care (P 07/03/2023 through diagnoses included	met as evidenced by: view and interview, it was home care agency (HCA) failed cy protocols specific to patient's in of care (POC) for two of nine ded in the sample (Patients #7 c 02:30 am, review of Patient OC) showed a duration period of 08/31/2023. The patient's stage II sacral pressure ulcer, eep tissue damage right heel,		pathways in HCHB are individualized and specific as discussed with a provider about the patient's diagnoses. This includes but is not limited to weights for heart failure, blood pressure parameters for hypertension, pulse oximetry parameters for oxygen- dependent or respiratory-related diagnoses, glucose parameters for diabetics, and other diagnoses-related parameters necessary in the care of specific disease processes. The Director of QA and Education will educate the field staff that upon the start of care, recertification, resumption of care, and any change in condition, registered nurses, physical therapists, occupational therapists, and speech therapists case managing the client/beneficiary will reach out to the overseeing provider of the plan of care and discuss an individualized specific set of parameters related to the patient's disease processes and include these parameters in the plan of care on each patient. The clinical managers will continue the education on the importance of the specific disease parameters throughout November before each weekly case conference. The final date of completion for this teaching is October 31, 2023. The clinical manager or clinical quality team will assess for completion of patient-specific individualized emergency protocol parameters daily during the review of the OASIS documents received in the Homecare Homebase workflow.	

1	A. BUILDING	B:	COMPLETED
HCA-0080	B. WING		08/24/2023
PROFESSIONAL HEALTHCARE RESOURCES WASHI	ADDRESS, CITY, S HOOL STREE NGTON, DC	T, SW SUITE 200 20024	I
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG 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 364 Continued From page 10 chronic respiratory failure with hypoxia, hypertension, muscle weakness, spinal stenosis, lymphedema, osteoarthritis, bipolar disorder, anxiety disorder, obstructive sleep apnea, hypothyroidism, dependence on supplemental oxygen, history of pulmonary embolism, history of falling, and long-term use of anticoagulants. The POC showed that the patient was receiving Xarelt 20mg orally daily. Continued review of the POC lacked evidence of emergency protocols related to the patient's risk of bleeding secondary to the long-term use of anticoagulants. 2. On 08/22/2023 at 01:09 pm, review of Patient #8's plan of care (POC) showed a duration period 07/26/2023 through 09/23/2023. The patient's diagnoses included dysphagia, other sequelae of nontraumatic intracranial hemorrhage, epilepsy, muscle weakness, encephalopathy, anemia, hypertension, hyperlipidemia, acid reflux, adjustment disorder with anxiety, and history of falling. The POC showed that the patient was receiving Keppra 750 mg oral twice daily and Lacosamide 150mg oral twice daily for seizures. Continued review of the POC lacked evidence of emergency protocols related to the patient's diagnosis of seizures. On 08/24/2023 at 09:54 am, the vice president of clinical operations was made aware of the findings. At the time of survey, the home care agency failed to ensure that the patient's plan of care included emergency protocols to properly manage the patients' diagnoses for Patients #7 and #8. 	o of s.	 What measures will be put into place or what system changes will you make to ensure deficient practice of not recur? The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will complete and review with the Clinical Manager monthly audits assessing 10 charts a month for patient-specific emergency protocol parameter compliance. The review of confirm 100% completion of patient-specific emergency protocol parameters. The results will be discussed with t clinical managers. The clinical managers will discuss the results in the weekly case conference meetings. How will the corrective actions be monitored to ensut the deficiencies will not recur, i.e. what quality assurprogram will be implemented? The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will m compliance on patient-specific emergency protocol parameters present in each medical record. Compliance by the above-named disciplines with the completion of patient-specific individualized emergency protocol parameters will be monitored and checked upor review of the documentation at the designated OASIS di points by the clinical manager will reach out to the clinicia on-on-one to discuss obtaining the parameters. Compliwith this intervention will be 100% by 10/31/23. The findings both positive and negative will be discussed weekly case conference meetings ensuring that the team has the opportunity to correct the action in real 	oes chart vill ne ance l at

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		(X3) DATE S COM	SURVEY PLETED
		HCA-0080	B. WING		08/2	4/2023
AME OF PI	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
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H 365	Continued From page	ge 11	H 365	What corrective actions will be accomplished t the identified deficient practice?	o address	
H 365	3914.3(n) PATIENT	PLAN OF CARE	H 365	The VP of Clinical Operations and Regulatory and		
		all include the following: ency of laboratory tests ordered,		Compliance and the Director of QA and Education a nursing meeting with the nursing staff inclusive of nurses and licensed practical nurses. At the same conference meeting, the clinicians assigned to pat be retrained on writing lab orders with specified fre The order will be amended by adding the frequence be sent to PCP for signature. The topic will be on 1 plan of care as it relates to lab orders. Education w completed on the proper way to write a laboratory	of registered care ient #4 will equency. by and will iollowing the <i>i</i> ill be	10/11/23
		met as evidenced by:		education session will be conducted on or by 10/11/2023.		
	determined that the to include the freque in the plan of care (F	view and interview, it was home care agency (HCA) failed ency of ordered laboratory tests POC) for one of nine active the sample (Patient #4).		The clinical manager will assess prior to approving written for labs for the following information. The for minimum requirements for lab orders are to be add ordered (i.e. CBC, CMP), route labs being obtaine central line or peripheral draw); reason for the labs diagnosis or diagnosis codes; the frequency with of Identifying information of provider spoken with: "Sp in Dr or provider's office	ollowing ded: Labs d (via s including luration; boke with	
	Findings included: Image: mage:	The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education 10 charts monthly for 100% compliance in the con the lab orders inclusive of the criteria described and discuss results with the clinical managers.	will review pletion of ove and	10/31/23 monthly		
	records showed and complete blood cour panel (CMP), ferritin Continued review of blood work was draw 08/03/2023, 08/10/2	lking, and history of falling. The order dated 07/12/2023 for a nt (CBC), complete metabolic a, and transferrin blood levels. The records showed that the wn on 07/20/2023, 07/27/2023, 2023, ad 08/17/2023. However, clude the frequency of labs		How the corrective actions will be monitored to the deficiencies will not recur, i.e. what quality program will be implemented? The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education 10 charts monthly for 100% compliance in the con the lab orders inclusive of the criteria described ab discuss results with the clinical managers. Complia this intervention will be 100% by 12/30/23. This review will be done for at least 3 quarters thre	will review poletion of love and ance with	10/11/23 on-going at least 3 quarters Random at will continu quarterly to ensure compliance sustained.
	clinical operations w	9:54 am, the vice president of vas made aware of the findings. y, the home care agency		100% and if the threshold is not met, the Clinical N be retrained and will be reminded each time the D QA and Education determines that the process is followed 100%. The findings both positive and negative will be disc weekly case conference meetings ensuring that th the opportunity to correct the action in real time.	rector of not being cussed at	รนรเสทายินี.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:)
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PROFESSIONAL HEALTHCARE RESOURCES 501 SCHOOL STREET, SW SUITE 200	3
PROFESSIONAL HEALTHCARE RESOURCES 501 SCHOOL STREET, SW SUITE 200	
PROFESSIONAL HEALTHCARE RESOURCES	
WASHINGTON, DC 20024	
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H 365 Continued From page 12 H 365	
failed to ensure that the patient's plan of care included the frequency of laboratory tests ordered for Patient #4. What corrective actions will be accomplished to address the identified deficient practice?	
 H 430 3916.1 SKILLED SERVICES GENERALLY Each home care agency shall review and evaluate the skilled services provided to each patient at least every sity-two (62) calendar days. A summary report of the evaluation shall be sent to the patient's physical. 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 an evaluation of skilled services was conducted every 62 calendar days, for four of nine active patients in the sample (Patients #3, 5, 7, and #8). Findings included: Review of the home care agency's (HCA's) records beginning 08/21/2023 at rogs 40/22/2023 at 09:54 am, the vice president of clinical operations was made aware of the findings. At the time of the survey, the home care agency failed to review and evaluate the provision of skilled services, in accordance with the regulations. On 08/24/2023 at 09:54 am, the vice president of clinical operations was made aware of the findings. At the time of the survey, the home care agency failed to review and evaluate the provision of skilled services, in accordance with the regulations. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency with the findings. At the time of the survey, the home care agency reviewed and evoluced the provision of skilled services with the clinical operations and Regulatory and Compliance and the clinical operations and Regulatory and Compliance and the clinical operations and Regulatory and	after om s will nue erly to e liance is
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H 430	This is a repeat defi 06/16/2022.	ciency from last survey	H 430	Compliance with the completion of the 62-day summary will be monitored monthly. If the 62-day summary notes are not present, the clinical manager will reach out to the clinician one-on-one to discuss the importance of completing the 62-day summary note. Compliance with this intervention will be 100% by 10/31/23. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met	10/31/23 and on-going for quarters Random audits will continue
Н 452	Duties of the nurse following: (b) Coordination of o This Statute is not Based on record rev care agency (HCA) nurse (SN) coordina office for one of nine (Patient #1). Findings included: On 08/21/2023 at 12 clinical record show duration period of 0 for skilled nursing (S for one week, two the and one time per we evaluate for needs r skilled nursing inter- assessment of body conditions, and inter The patient's diagno chronic kidney disea reflux, hyperlipidem chronic obstructive of falling. Continued nurse visited the patient	met as evidenced by: view and interview, the home failed to ensure that the skilled ated care with the physician's e active patients in the sample 2:03 pm, review of Patient #1's ed a plan of care (POC) with a 7/26/2023 through 09/23/2023, SN) services one time per week mes per week for two weeks, eek for five additional weeks to requiring physician's orders and ventions. Conduct a skilled v systems, evaluate co-morbid rvene to minimize complications bases included heart failure, ase, anemia, osteoarthritis, acid ia, disorders of adrenal gland, pulmonary disease, and history I record review showed that the tient on 08/02/2023 and cumented each time that the		 What corrective actions will be accomplished to address the identified deficient practice? The Clinical Manager and the Director of QA and Education will hold a staff meeting with the skilled nurses to retrain all of them or assessment, interventions, provision, and collaboration of care with the physician or provider. The skilled nurse as the case manager for the patient will lead communication and cooperative efforts in creating an interprofessional plan of care focused on outcomes engaging the physician or provider who oversees the plan of care. The skilled nurses assigned to each patient will notify the physicia or provider of any changes in condition noting in the chart who the spoke with and what the outcome of the communication is. The clinical Quality Assurance Process Improvement team will review 100% of all sudden changes in condition documentation, orders, and incident reports ensuring that communication has taken place with the provider. What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur? The clinical Quality Assurance Process Improvement team to discus the results of the audits for care coordination. The process will b implemented by 10/31/2023 How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented? The clinical manager will meet with the clinical Quality Assurance Process Improvement team will complete the 100% audit of all sudden changes in condition documentation, orders, and incident reports ensuring that communication has taken place with the provider. The clinical manager will meet with the clinical Quality Assurance Process Improvement team will complete the 100% audit of all sudden changes in condition documentation, orders, and incident reports ensuring that communication has taken place with the provider. The clinical manager will meet	 10/11/23. Random audits will continue quarterly to ensure compliance sustained. 10/31/23

STATEMEN	egulation & Licensing T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE S COMF	URVEY PLETED
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H 452	abdominal pain and Furthermore, the nu 08/15/2023 and not agitated. States she [hospital] 2 days ag medical advice. Der moment." There was no docur record that the nurs physician following hospitalization/ eme condition. On 08/24/2023 at 09 clinical operations we At the time of the su	prescribed a new medication. Irse visited the patient on ed the following: "Looks very e was evaluated and treated at o [8/13/23] but left against nies any symptoms at the mented evidence in the clinical e coordinated care with the the client's repeated ergency room visits and overall 9:54 am, the vice president of vas made aware of the findings.	H 452	This review will be done for at least 3 quarters the 100% and if the threshold is not met, the Clinica be retrained and will be reminded each time the and Education determines that the process is not followed 100%. The findings both positive and negative will be diversely case conference meetings ensuring that the opportunity to correct the action in real time.	l Manager will Director of QA ot being iscussed at	10/31/23 an on-going for at least 3 quarters Random audits will continue quarterly to ensure compliance is sustained
H 453	Duties of the nurse following: (c) Ensuring that pa accordance with the This Statute is not Based on record rev care agency (HCA) services were provid patient's plan of car	NURSING SERVICES shall include, at a minimum, the tient needs are met in a plan of care; met as evidenced by: view and interview, the home failed to ensure skilled nursing ded in accordance with the e (POC) for three of nine active ole (Patients #2, 3, and #5).	H 453	What corrective actions will be accomplished the identified deficient practice? The Clinical Manager and the Director of QA an will hold a staff meeting with all disciplines to ref on following the ordered frequency in the plan of as all other components of the plan of care inclu assessment, interventions, provision, and collab with the other disciplines and physician or provid Education will highlight the following: The goal it to return to the highest level of function realistica and within the context of the disability with home services. All clinician visits outlined in the freque plan of care should be completed as ordered. Pi Caregivers should be contacted a minimum of 2 the appointment and provided a date and time fi for the appointment. This date and time will be a the discipline ordered. If the appointment is miss changes in the patient's schedule or any other p reasons, the discipline must submit a missed vis contact the physician or provider and the clinica alerting them of the missed visit reason, notifica	d Education rain all of them f care as well ding oration of care ler. or a patient is ally attainable e health ncy on the atients/ 4 hours before ame of arrival dhered to by sed due to atient-related it note, manager tion of the	10/31/23

Health Regulation & Licensing Administratio STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		TE SURVEY COMPLETED
		HCA-0080	B. WING		8/24/2023
	ROVIDER OR SUPPLIER SIONAL HEALTHCARI	501 SCHO	OL STREE	TATE, ZIP CODE T, SW SUITE 200 20024	
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H 453	#2's clinical record s with a duration perio 08/23/2023 that indi services twice a wey week for one week to instructions and dise diagnoses included diabetes mellitus, st anemia, atrial fibrilla pulmonary disease, pacemaker, muscle Continued review of evidence that the SI week as ordered the Furthermore, the PC to report to the physioutside the following sugar less than 60 of visited the patient the 08/01/2023, 08/10/2	2 02: 35pm, review of Patient showed a plan of care (POC) od of 06/25/2023 through cated skilled nursing (SN) ek for eight weeks, and once a to conduct assessments, ease management. The patient's congestive heart failure, type II age 4 chronic kidney disease, tion, chronic obstructive insomnia, presence of cardiac weakness, and history of falling. the clinical record lacked N visited Patient #2 two times a e week of 07/09/2023. DC showed an order for the SN tician blood sugar levels that fell g parameters: "fasting blood or greater than 180." The nurse the following dates: 07/27/2023, c3, 08/15/2023, and 08/17/2023	H 453	The Patient Service Coordinators will run the client's last scheduled report and the agent summary report in Homeo Homebase daily to ensure that all visits assigned per frequency are completed. If the visits are not completed as ordered, the Patient Services Coordinator will alert the Clin Manager. The Clinical Manager will reach out to the clinic and discuss the rationale behind the missed visit, instructin the clinician to complete a missed visit coordination note, notify the physician, and reschedule the appointment with patient. What measures will be put into place or what systemic changes you will make to ensure deficient practice do not recur? The Clinical Manager or Clinical Quality Assurance Process Improvement team will run the agent summary and client's scheduled report weekly to assess that all visits scheduled being completed as ordered in the plan of care. The Clinical Quality Assurance Process Improvement tear will do a random selection of 10 charts and audit monthly to missed visit notes looking for the rationale for missed visit notification of missed visits to the physician or provider, ar that the visit was rescheduled with the patients. The Clinic QAPI team will also assess for the following of the plan of with all interventions outlined on the 485. The clinical manager will complete a monthly meeting with clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023.	ical an 19 the 25 s last are 10/31/23 a monthly or s, d al care the 10/31/23
	blood sugar to deter warranted. A home patient and her aide indicated that she w	an assessment of the patient's mine if interventions were visit was conducted with the on 08/23/2023 at 03:05pm. She as checking her blood sugar t find where one put her		deficiencies will not recur, i.e. what quality assurance program will be implemented? The clinical manager will complete a monthly meeting with clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023.	10/31/23 the
	needles. The aide ir the doctor's office to anyone. 2. On 08/21/2023 at #3's clinical record s with a duration perio	t find where she put her ndicated that the nurse called o inform them but could not get 04: 00 pm, review of Patient showed a plan of care (POC) od of 06/30/2023 through cated occupational therapy		Compliance with the completion of the following intervention will be monitored monthly by the VP of Clinical Operations Director of QA and Clinical Education. If interventions are completed or not noted in the clinician one-on-one to discu- tion importance of completing the frequency as ordered in plan of care. Compliance with this intervention will be 100° 10/31/23. This review will be done for at least 3 quarters threshold so 100% and if the threshold is not met, the Clinical Manager be retrained and will be reminded each time the Director of and Education determines that the process is not being	and on-going fr at least 3 quarters Random audits will continue quarterly to ensure compliance

6899

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COM	URVEY PLETED
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H 453	evaluation and treat included dysphagia and head cancer, ty hypertension, spina prostatic hyperplasi muscle weakness, s hyperlipidemia, hist attention to gastrost order for the nurse f sugar each visit and sugar levels that fel parameters: "fasting greater than 180." T following dates: 07/ 08/15/2023, and 08 assessment of the p determine if interver 3. On 08/23/2023 at #5's clinical record s with a duration perio 09/13/2023 that ind services three times times a week for on one week, and one	ge 16 a week for two weeks for tment. The patient's diagnoses , hypopharynx carcinoma, neck /pe II diabetes mellitus, II stenosis, emphysema, benign a, hypothyroidism, acid reflux, spondylosis, sacroiliitis, ory of falling, and encounter for tomy. Also, the POC showed an to perform finger stick blood d to report to the physician blood I outside the following g blood sugar less than 60 or The nurse visited the patients the 27/2023, 08/01/2023, 08/10/23, /17/2023 with no evidence of an batient's blood sugar to ntions were warranted. t 10: 23 am, review of Patient showed a plan of care (POC) od of 07/16/2023 through icated skilled nursing (nurse) s a week for three weeks, two we week, two times a week for time every two weeks for two round care and education	9	The findings both positive and negat weekly case conference meetings er the opportunity to correct the action i	nsuring that the team has	
	effective 08/06/2022 included type II diat failure, muscle wea mobility, glaucoma, insulin, history of fa stage II pressure un clinical record lacke	3. The patient's diagnoses betes mellitus, congestive heart kness, abnormalities of gait and dementia, long term use of lling, wheelchair dependent, and cer. Continued review of the ed evidence that the nurse visited ies a week as ordered during the	k			
	On 08/24/2023 at 0	1:30 pm, the vice president of				

Health R	egulation & Licensing	Administration					
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMB	FR.	· /	CONSTRUCTION	(X3) DATE S COMF	URVEY PLETED
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H 453	Continued From pag	ge 17		H 453			
	clinical operations a aware of the finding	nd administrator were m s.	ade				
	failed to ensure that	rvey, the home care age skilled nursing services nce with Patients #2, 3, a	were				
H 550	3922.1 OCCUPATIO	ONAL THERAPY SERVI	CES	H 550	What corrective actions will be accomplished to the identified deficient practice?	o address	
	therapy services, it s	cy provides occupationa shall provide those servic patient's plan of care.			The Clinical Manager and the Director of QA and E will hold a staff meeting with all disciplines to retrai on following the ordered frequency in the plan of ca as all other components of the plan of care includir assessment, interventions, provision, and collabora with the other disciplines and physician or provider	n all of them are as well ng ation of care	10/31/23
		met as evidenced by:			Education will highlight the following: The goal for a		
	care agency (HCA) therapy (OT) service with the patient's pla active patients in the Findings included: 1. On 08/21/2023 at #2's clinical record s	and record review, the he failed to ensure occupati es were provided in acco an of care (POC) for two e sample (Patients #2 an 02: 35pm, review of Pat showed a plan of care (P od of 06/25/2023 through	tient		to return to the highest level of function realistically and within the context of the disability with home h services. All clinician visits outlined in the frequenc plan of care should be completed as ordered. Patie Caregivers should be contacted a minimum of 24 h the appointment and provided a date and time fran for the appointment. This date and time will be adh the discipline ordered. If the appointment is missed changes in the patient's schedule or any other pati reasons, the discipline must submit a missed visit r the physician or provider and the clinical manager them of the missed visit reason, notification of the p provider, and what day the appointment will be res	ealth y on the ents/ nours before he of arrival ered to by I due to ent-related note, contact alerting physician or	
	08/23/2023 that indi- services once a wee for one week, once a a week for one weel exercise program ar and education to inc safety. The patient's heart failure, type II	cated occupational thera ek for one week, twice a a week for four weeks, a k to establish / upgrade h nd provide therapeutic ex crease independence and diagnoses included con diabetes mellitus, stage	apy (OT) week and once home kercises d ngestive 4		The Patient Services Coordinator will run the client scheduled report and the agent summary report in Homebase daily to ensure that all visits assigned p frequency are completed. If the visits are not comp ordered, the Patient Services Coordinator will alert Manager. The Clinical Manager will reach out to th and discuss the rationale behind the missed visit, i the clinician to complete a missed visit coordination notify the physician, and reschedule the appointme patient.	Homecare ber leted as the Clinical e clinician instructing n note, ent with the	on-going
		ase, anemia, atrial fibrilla oulmonary disease, insoi			What measures will be put into place or what sy changes you will make to ensure deficient prac not recur?	tice does	10/31/23 and weekly
	stion 9 Lipsesing Administ				The Clinical Manager or Clinical Quality Assurat Improvement team will run the agent summary and scheduled report weekly to assess that all visits sc	d client's last	
1ealth Regula	ation & Licensing Administra	ation					

6899

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMF	URVEY PLETED
		HCA-0080	B. WING		08/2	4/2023
	ROVIDER OR SUPPLIER	ERESOURCES 501 SCHO		TATE, ZIP CODE T, SW SUITE 200 20024		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
H 550	and history of falling clinical record lacket therapy as ordered therapy as ordered to Furthermore, the PC	ge 18 pacemaker, muscle weakness, . Continued review of the d evidence that the OT provided the week of 08/06/2023. DC included an order for the the patient's weight every visit	H 550	The Clinical Quality Assurance Process Improve will do a random selection of 10 charts and audit missed visit notes looking for the rationale for mi notification of missed visits to the physician or pr that the visit was rescheduled with the patients. ² Quality Assurance Process Improvement team v assess for the following of the plan of care with a interventions outlined on the 485. The clinical manager will complete a monthly me clinical Quality Assurance Process Improvement	monthly for ssed visits, ovider, and The Clinical vill also all eeting with the	10/31/23
	pounds within one d days for congestive showed that the OT following dates 06/2 07/05/2023, 07/13/2 08/03/2023, and 08/	cian of weight gain of two lay or five pounds within seven heart failure. The records visited Patient #2 on the 9/2023, 07/02/2023, 023, 07/20/2023, 07/27/2023, (15/2023 with no evidence of ht's weight to determine if rranted.		discuss the results of the audits. The process wi implemented by 10/31/2023. How the corrective actions will be monitored the deficiencies will not recur, i.e. what qualit program will be implemented? The clinical manager will complete a monthly me clinical Quality Assurance Process Improvement discuss the results of the audits. The process wi implemented by 10/31/2023.	I be to ensure y assurance eting with the team to	10/31/23 ai monthly
	#3's clinical record s with a duration peric 08/28/2023 that indi services once a wee and treatment. The dysphagia, hypopha cancer, type II diabe spinal stenosis, emp hyperplasia, hypoth weakness, spondylc history of falling, and gastrostomy. Contin showed a communic 03/02/2023 labelled door." On 03/06/202 evaluation reschedu schedule conflict. Pl of the clinical record followed up or evalu survey. On 08/24/2023 at 1	04: 00 pm, review of Patient showed a plan of care (POC) od of 06/30/2023 through cated occupational therapy (OT) ek for two weeks for evaluation patient's diagnoses included trynx carcinoma, neck and head betes mellitus, hypertension, obysema, benign prostatic yroidism, acid reflux, muscle osis, sacroiliitis, hyperlipidemia, d encounter for attention to ued review of the clinical record cation note from OT dated "missed visit, no answer at the 23, OT noted the following: "OT led due to patient cancellation/ hysician notified." Further review Is lacked evidence that OT tated the patient by the time of		Compliance with the completion of the following will be monitored monthly by the VP of Clinical C Director of QA and Clinical Education. If interven completed or not noted in the clinical records, the manager will reach out to the clinical none-on-or the importance of completing the frequency as o plan of care. Compliance with this intervention w 10/31/23. This review will be done for at least 3 quarters the 100% and if the threshold is not met, the Clinical be retrained and will be reminded each time the QA and Education determines that the process is followed 100%. The findings both positive and negative will be d weekly case conference meetings ensuring that the opportunity to correct the action in real time.	Deperations and tions are not e clinical ne to discuss rdered in the ill be 100% by reshold set at Manager will Director of s not being scussed at	10/31/23 a on-going fc at least 3 quadrants Random audits will continue quarterly tc ensure compliance is sustaine

6899

Health R	egulation & Licensing	Administration			-	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMF	URVEY PLETED
		HCA-0080	B. WING		08/2	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
PROFES	SIONAL HEALTHCARE	RESOURCES	OL STREET, TON, DC 20	SW SUITE 200 0024		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
H 550	reach out to the physe #3 for the needs for and get an order to se At the time of the su failed to ensure that	She stated that she would sical therapist to assess Patient occupational therapy services start if indicated. rvey, the home care agency occupational therapy services cordance with the plans of care	H 550			
H 560	If physical therapy so be provided in accor- care. This Statute is not Based on interview a care agency (HCA) of Therapy (PT) service with the patient's pla active patients in the and #8). Findings included: 1. On 08/21/2023 at #1's clinical record s with a duration perio 09/23/2023 that indic services one time perio a week for four weel weeks to establish / program, to provide tissue /joint mobiliza functional strength a	THERAPY SERVICES ervices are provided, they shall dance with the patient's plan of met as evidenced by: and record review, the home failed to ensure Physical es were provided in accordance n of care (POC) for six of nine e sample (Patient #1, 2, 4, 5, 7, 12:03 pm, review of Patient howed a plan of care (POC) d of 07/26/2023 through cated physical therapy (PT) er week for one week, two times (s, and one time a week for four upgrade home exercises therapeutic exercises and soft tion designed to restore nd range of motion. The patient ncluded heart failure, chronic		What corrective actions will be accomplished to the identified deficient practice? The Clinical Manager and the Director of QA and I will hold a staff meeting with all disciplines to retra on following the ordered frequency in the plan of cas all other components of the plan of care includi assessment, interventions, provision, and collabor with the other disciplines and physician or provide Education will highlight the following: The goal for to return to the highest level of function realistically and within the context of the disability with home f services. All clinician visits outlined in the frequence plan of care should be completed as ordered. Pati Caregivers should be contacted a minimum of 24 the appointment and provided a date and time frat for the appointment. This date and time will be add the discipline ordered. If the appointment is misse changes in the patient's schedule or any other pat reasons, the discipline must submit a missed visit the physician or provider and the clinical manager them of the missed visit reason, notification of the provider, and what day the appointment will be res The Patient Services Coordinator will run the clien scheduled report and the agent summary report in Homebase daily to ensure that all visits assigned frequency are completed. If the visits are not com ordered, the Patient Services Coordinator will aler Manager. The Clinical Manager will reach out to tt and discuss the rationale behind the missed visit, the clinician to complete a missed visit coordination notify the physician, and reschedule the appointm patient.	Education in all of them are as well ng ation of care r. a patient is y attainable eealth y attainable eealth y on the ents/ hours before me of arrival hered to by d due to ient-related note, contact alerting physician or scheduled to. t's last Homecare ber beted as t the Clinical ne clinician instructing n note,	10/31/23 10/31/23 and weekly on- going

6899

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		CORRECTION IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HCA-0080	B. WING		08/24/2023	
	ROVIDER OR SUPPLIER	501 SCHO	OL STREE	TATE, ZIP CODE T, SW SUITE 200 20024		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
H 560	disorders of adrenal pulmonary disease, review of the clinical services were provid 08/06/2023. 2. On 08/21/2023 at #2's clinical record s with a duration perio 08/23/2023 that indic services three times week for seven wee exercise program ar and soft tissue /joint restore functional str patient's diagnoses if failure, type II diabet kidney disease, ane obstructive pulmona of cardiac pacemake history of falling. Con record lacked evider provided as ordered Furthermore, the PC therapist to monitor and notify the physic pounds within one d days for congestive showed that the PT from 06/25/2023 to 0 assessing the patier intervention was wat A home visit was co on 08/23/2023 at 03 patient had bilateral indicated that she wat	is, acid reflux, hyperlipidemia, gland, chronic obstructive and history of falling. Continued record lacked evidence that PT ded as ordered the week of 02: 35pm, review of Patient howed a plan of care (POC) of of 06/25/2023 through cated physical therapy (PT) a week for one week, twice a ks to establish / upgrade home of provide therapeutic exercises mobilization designed to rength and range of motion. The included congestive heart tes mellitus, stage IV chronic mia, atrial fibrillation, chronic ry disease, insomnia, presence er, muscle weakness, and ntinued review of the clinical nee that PT services were the week of 07/02/2023. DC included an order for the the patient's weight every visit cian of weight gain of two ay or five pounds within seven heart failure. The records visited Patient #2 every week 08/14/2023 with no evidence of nt's weight to determine if rranted. nducted to the patient's home :05 pm. It was observed that the lower extremity edema. Patient as not weighing herself because nce as she could not stand too	H 560	 What measures will be put into place or what sy changes you will make to ensure deficient pract not recur? The Clinical Manager or Clinical Quality Assurance Improvement team will run the agent summary and ast scheduled report weekly to assess that all visits scheduled are being completed as ordered in the p The Clinical Quality Assurance Process Improvement will do a random selection of 10 charts and audit mmissed visit notes looking for the rationale for misse notification of missed visits to the physician or provint at the visit was rescheduled with the patients. The Quality Assurance Process Improvement team will assess for the following of the plan of care with all interventions outlined on the 485. The clinical manager will complete a monthly meetic clinical Quality Assurance Process Improvement te discuss the results of the audits. The process will be implemented by 10/31/2023. How the corrective actions will be monitored to the deficiencies will not recur, i.e. what quality a program will be implemented? The clinical manager will complete a monthly meetic clinical Quality Assurance Process Improvement tead iscuss the results of the audits. The process will be implemented by 10/31/2023. Compliance with the completion of the following intervent or of QA and Clinical Education. If intervent or completed or not noted in the clinical records, it manager will reach out to the clinical manager will reach out to the clinical Manager will be done for at least 3 quarters thres 100% and if the threshold is not met, the Clinical Mater and Clinical Education will be volval. The findings both positive and negative will be discress is no followed 100%. 	tice does Process client's an of care. ent team onthly for ed visits, ider, and e Clinical also ng with the am to e ensure assurance ng with the am to e erventions rations ratio	10/31/23 and weekly on- going 10/31/23 and monthly on- going Random audits will continue quarterly to ensure compliance is sustained. 10/31/23 10/31/23 10/31/23 10/31/23 and on-going for least 3 quarters Random audits will continue quarterly to ensure compliance is sustained.

6899

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION (X3) D	ATE SURVEY COMPLETED
		HCA-0080	B. WING		08/24/2023
AME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	•	00/24/2020
ROFES	SIONAL HEALTHCAR	E RESOURCES 501 SCH	OOL STREET, S	W SUITE 200	
		WASHIN	GTON, DC 200		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H 560	Continued From pa	ge 21	H 560		
		operations was made aware of 28/2023 at 01:30 pm.			
	#4's clinical record = with a duration perio 09/10/2023 that ind services two times a / upgrade home exec therapeutic exercise mobilization design and range of motion included chronic ob heart failure, osteoa benign prostatic hyp anemia, kidney can difficulty walking, ar review of the clinical services were provi of 07/23/2023 and 0		r		
	#5's clinical record = with a duration perio 09/13/2023 that ind services one time a times a week for six home exercise prog exercises and soft t designed to restore motion. The patient diabetes mellitus, c weakness, abnorma glaucoma, dementia history of falling, wh pressure ulcer. Corr	t 10: 23 am, review of Patient showed a plan of care (POC) od of 07/16/2023 through icated physical therapy (PT) week for one week and two weeks to establish / upgrade gram, provide therapeutic issue /joint mobilization functional strength and range o 's diagnoses included type II ongestive heart failure, muscle alities of gait and mobility, a, long term use of insulin, heelchair dependent, and stage thinued review of the clinical ence that PT services were	П		

6899

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING			
		HCA-0080			08/	/24/2023
ME OF PF	ROVIDER OR SUPPLIER		DRESS, CITY, STATE OOL STREET, S			
ROFESS	SIONAL HEALTHCAR	E RESOURCES	GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
H 560	Continued From pa	ge 22	H 560			
	#7's plan of care (P 07/03/2023 through physical therapy (P four weeks and one effective 07/03/202 exercise program, p and soft tissue /join restore functional s patient's diagnoses pressure ulcer, pres damage right heel, hypoxia, hypertensis stenosis, lymphede disorder, anxiety dis hypothyroidism, dej oxygen, history of p falling, and long-ter Continued review o evidence that PT se during the week of 6. On 08/22/2023 a #8's plan of care (P 07/26/2023 through physical therapy (P effective 08/13/202 included dysphagia intracranial hemorrf weakness, encepha hyperlipidemia, acid anxiety, and history the clinical record la evaluated the patie survey. There was	t 01:09 pm, review of Patient POC) showed a duration period of 09/23/2023 that indicated T) evaluation and treatment 3. The patient's diagnoses a, other sequelae of nontraumation hage, epilepsy, muscle alopathy, anemia, hypertension, d reflux, adjustment disorder with of falling. Continued review of acked evidence that PT nt as ordered by the time of no documentation that could	e d d			
		for the delay. Home visit 3/2023 at 04:09 pm with Patient evealed				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		``'	LE CONSTRUCTION (X3) DATE CO	SURVEY MPLETED
		HCA-0080	B. WING	08/	/24/2023
	ROVIDER OR SUPPLIER	STREET ADI		TATE, ZIP CODE I, SW SUITE 200	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H 560	their dissatisfaction scheduled a visit th (08/23/2023) with t pm. By the time of 25 pm, PT was a n agency on 08/24/2 as scheduled. Inste rescheduled for 08 On 08/24/2023 at 0 clinical operations aware of the finding At the time of the s failed to ensure tha	h with PT. They indicated that PT he same day as surveyors he family between 2 pm and 4 home visit completion around 04: o show. A follow up with the 023 confirmed that PT did not go ead, the PT evaluation was /28/2023. 01:30 pm, the vice president of and administrator were made gs. survey, the home care agency at physical therapy services were ance with the plans of care for	H 560		
H 580	SERVICES If speech language provided, they shall the patient's plan of This Statute is no Based on interview care agency (HCA) (ST) services were patient's plan of ca patients in the sam Findings included: On 08/23/2023 at 1 clinical record show	t met as evidenced by: and record review, the home failed to ensure speech therapy provided in accordance with the re (POC) for one of nine active	H 580	 What corrective action(s) will be accomplished to address the identified deficient practice: The Clinical Manager and the Director of QA and Education will hold a staff meeting with the clinicians to retrain all of ther in assessing and providing the patient speech therapy services and ensuring the implementation of the order as part of the plan of care . The Patient Services Coordinator will ensure that when order are written for speech therapy that the patient will be assigned a Speech therapist and that all required visits are scheduled according to the plan of care. Speech therapist assigned to the patient will provide the therapy needed as part of the plan of care What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur: The Clinical Manager will review 100% all Admission orders t ensure and approve that all disciplines including Speech therapy ordered as part of the plan of care are identified and assigned to execute the orders. 	 10/31/23 on-going Random audits will continue quarterly ti ensure compliand sustained 10/30/23 and on-goi Random au

TATEMENT OF DEFICIENCIE ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED 08/24/2023		
	HCA-0080	B. WING				
AME OF PROVIDER OR SUPPLIER STREET ADDR			• DRESS, CITY, STATE, ZIP CODE			
	501 SCI		, SW SUITE 200			
ROFESSIONAL REAL	HCARE RESOURCES WASHIN	NGTON, DC 2	20024			
PREFIX (EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	CTION SHOULD BE THE APPROPRIATE		
time a week weeks for th swallowing that include heart failure gait and mo use of insuli pressure uld record lacke services we of 08/06/202 On 08/24/20 clinical oper aware of the At the time of failed to ens	or speech therapy (ST) services one for one week and one time every three ee weeks to evaluate and treat hpairment. The patient had diagnoses type II diabetes mellitus, congestive muscle weakness, abnormalities of ility, glaucoma, dementia, long term , history of falling, and stage II er. Continued review of the clinical devidence that speech therapy (ST) e provided as ordered during the weel 3. 23 at 01:30 pm, the vice president of tions and administrator were made	s K	How is the corrective action(s) will be monito ensure that the deficient practice will not recu quality assurance program will be implement The Clinical Manager will review 100% all 485 ge the patients to ensure that all appropriate orders such as Speech Therapy when required, are incl order with the appropriate frequencies before ap The QA reviewers will do the next level review 10 orders to ensure that PCP orders for speech therapist followed, assigned to Speech therapist and sche appropriately. If the Clinical Manager review does not meet 100 the CM and the Director of Education and QA wi the clinicians involved to ensure that the staff are compliance with the regulations.	ur, i.e. what ed. for disciplines uded in the proving. 00% of all apy are duled 0% threshold, I retrain all	10/31/23 and on-going for quarters. Random audits will continue quarterly to ensure compliance is sustained.	