

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2010
NAME OF PROVIDER OR SUPPLIER HEALTH MANAGEMENT, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 VERMONT AVENUE, NW, SUITE 810 WASHINGTON, DC 20005		
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H 000	INITIAL COMMENTS An annual survey was conducted at you agency on May 19, 2010 through May 21, 2010, to determine your compliance with 22 DCMR, Chapter 39 Home Care Agencies Regulations. The findings of the survey were based on random sample of 20 clinical records based on a census of 250 patients, 20 personnel files based on a census of 235 employees and five (5) home visits. The findings of the survey were based on observations in the patient homes, interviews with the patients, with agency staff, as well as review of patient, employee and administrative records.	H 000	<i>Received 6/21/10</i> GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
H 148	3907.2(d) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (d) Documentation of current CPR certification, if required; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to maintain accurate personnel records, which included documentation of current CPR certification for two (2) of twenty (20) employees in the sample. (Physical Therapist (PT) #1 and Registered Nurse (RN) #4) The findings include: 1. A review of PT #1's personnel file on May 19, 2010 at approximately 2:25 p.m. revealed no documented evidence of a current CPR certification. Further review of the record revealed a CPR card with the expiration date of	H 148	H 148 Documentation of CPR Required credentials for all staff are maintained in the electronic HHC system and monitored on a monthly basis. Personnel are notified one month in advance of the expiration of a required credential. Personnel not presenting required credentials are pulled from the field and not allowed to return until current credentials are on file. A 100% review of all required credentials was conducted during the period 10-17 June 2010. As of June 17, 2010, recording of current credentials for all personnel was verified by the Executive Director.	6/25/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE

TITLE

EXECUTIVE DIRECTOR

(X6) DATE

JUN 21, 2010

STATE FORM

6899

PZEJ11

If continuation sheet 1 of 8

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H 148	Continued From page 1 July 2006. 2. A review of RN #1's personnel file on May 19, 2010 at approximately 2:28 p.m. revealed no documented evidence of a current CPR certification. Further review of the record revealed a CPR card with the expiration date of September 2008. On May 19, 2010, at approximately 3:00 p.m., the office manager was interviewed to ascertain if the aforementioned staff had been trained in CPR. The office manager acknowledged that the above staff had not provided evidence of current CPR training.	H 148		
H 152	3907.2(h) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (h) Copies of completed annual evaluations; This Statute is not met as evidenced by: Based on record review and interview, the agency failed to have annual evaluations for two (2) of twelve (20) employees in the sample. (LPN #1 and LPN #2) The findings include: 1. On May 19, 2010, at approximately 1:00 p.m. review of the LPN #1's personnel file revealed there was no documented evidence of a current annual evaluation in the record. Further review of the file revealed that LPN#1 last annual evaluation was dated April 3, 2009. In a face to face interview with the Office Manager on the	H 152	H 152 3907.2 (h) Personnel Annual Evaluations At the time of the inspection, all annual evaluations had been completed however, one was not signed by the employee and another had not been placed in the employee's personnel file. Annual and 90 day evaluations are tracked on the HHC system. One month prior to the due date, the Executive Director is given a list of personnel due for an evaluation. The appropriate evaluator is notified and the response tracked by the Administrative Coordinator. During the period 10-17 June 2010, a 100% audit of records was conducted. As of June 17, 2010, all but one evaluation had been completed, signed by the employee and filed. The remaining evaluation was mailed to the employee to sign and return.	6/25/10

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H 152	Continued From page 2 same day at approximately 2:45 p.m., she acknowledged that the annual evaluation had not been completed. 2. On May 19, 2010, at approximately 1:00 p.m. review of the LPN #2's personnel file revealed no documented evidence of an annual evaluation. Further review of the file revealed LPN #2 was hired on September 4, 2008. In a face to face interview with the Office Manager on the same day at approximately 2:45 p.m., she acknowledged that the annual evaluation had not been completed.	H 152		
H 260	3911.1 CLINICAL RECORDS 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. This ELEMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the agency failed to maintain accurate clinical records for one (1) of twenty (20) patients in the sample. (Patient #2) The findings include: Review of Patient #2's clinical record on May 20, 2010 at approximately 11:00 a.m. revealed the patient received skilled nursing services for supervision of the personal care aid and to conduct teaching on his/her disease process. Further review of the record revealed no nursing notes present. In a face to face interview with the Clinical Manager on the same day, it was acknowledged that the nursing notes were not in	H 260	H 260 3911.1 Clinical Records HMI Policy 4040 dictates that clinical notes are due weekly, no later than close of business Monday. Clinicians who have not turned in paperwork by then are called and also reported to the Clinical Director. In this case, the submissions of this nurse are now monitored by the Director of Operations. Most of her PCA supervisory caseload has been transferred to another nurse. As of June 15, 2010, all her nursing notes had been submitted. This will be monitored on a weekly basis. The charts of all patients seen by her were reviewed to be sure that all required paperwork had been submitted.	6/15/10

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H 260	Continued From page 3 the record. In a face to face interview with the Registered Nurse on the same day at approximately 2:10 p.m. she acknowledged the poor nursing practice and indicated that she knew that the nursing notes should be submitted weekly and had not done so. There was no documented evidence the HCA's nurse maintained all clinical records accurately.	H 260		
H 351	3914.2 PATIENT PLAN OF CARE The plan of care shall be approved by the patient's physician. This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to insure that the Plan of Care (POC) was approved by the physician for eight (8) of twenty (20) patients. (Patients #1,#2, #3, #6, #12, #14, #15, and #19) The finding includes: Review of patient records on beginning May 19, 2010, through May 20, 2010, revealed that the plan of care had not been approved for the aforementioned patients. Interview with the Clinical Director on May 20, 2010, revealed that the HCA was in the process of faxing POC's to the physicians, however at the time of the survey, the aforementioned patient records failed to have signed POC's as required.	H 351	H 351 3914.2 Patient Plan of Care Plan of Care not approved by the patient's physician. Upon receipt of the referral with doctor's order for home care, a clinician does an assessment. Then the POC is prepared and faxed or mailed to the doctor. If a response is not received in one week, the doctor's office is called. Receipt of signed POCs is recorded and monitored by the Administrative Assistant and status is reported to the Dffice Manager who then notifies the Clinical Director if the POC has not been returned. The Clinical Director then contacts the physician. In extreme cases, another physician is identified or treatment is discontinued until a signed POC is obtained.	6/18/10
H 366	3914.4 PATIENT PLAN OF CARE Each plan of care shall be approved and signed by a physician within thirty (30) days of the start	H 366		

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H 366	<p>Continued From page 4</p> <p>of care; provided, however, that a plan of care for personal care aide services only may be approved and signed by an advanced practice registered nurse. If a plan of care is initiated or revised by a telephone order, the telephone order shall be immediately reduced to writing, and it shall be signed by the physician within thirty (30) days.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility's Plan of Care (POC) was not approved and signed by a physician within thirty (30) days of the start of care for two (2) of twenty ((20) patients in the sample. (Patient #13 and Patient #20)</p> <p>The findings include:</p> <p>1. Review of Patient #13's POC dated December 29, 2009, through June 26, 2010, on May 20, 2010, at approximately 11:50 a.m., revealed the POC was not approved and signed by a physician within thirty (30) days of the start of care for skilled nursing services twice every month and home health aide services eight (8) hours a day times for seven (5) days and four (4) hours a day on weekends.</p> <p>During a face to face interview with the Clinical Manager on the same day at approximately 2:25 p.m., it was acknowledged the POC was not approved and signed by a physician within thirty (30) days of the start of care.</p> <p>There was no documented evidence the POC was approved and signed by a physician within thirty (30) days of the start of care.</p>	H 366	<p>H 366 3914.4 Patient Plan of Care POC not signed by the physician within 30 days of start of care.</p> <p>The system for obtaining a POC signed by the physician within 30 days of start of care is outlined in the response to finding H 366 3914.4. All POCs are either faxed or mailed to the physician and the response is monitored by the Administrative Assistant. When a physician cannot be located, an attempt is made to find another primary physician. On occasion, the Clinical Director will enlist the help of the family to obtain a signature. In extreme cases, care is discontinued or the patient is sent to a hospital until a signature is obtained.</p>	6/18/10

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H 366	Continued From page 5 2. Review of Patient #20's POC dated December 17, 2009, through June 16, 2010, on May 20, 2010, at approximately 1:00 p.m., revealed the POC was not approved and signed by a physician within thirty (30) days of the start of care for skilled nursing services every month and home health aide services eight (8) hours a day times for seven (7) days. During a face to face interview with the Clinical Manager on the same day at approximately 2:00 p.m., it was acknowledged the POC was not approved and signed by a physician within thirty (30) days of the start of care. There was no documented evidence the POC was approved and signed by a physician within thirty (30) days of the start of care.	H 366		
H 450	3917.1 SKILLED NURSING SERVICES Skilled nursing services shall be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, and in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure Skilled nursing services were provided in accordance with the patient's plan of care (POC) for two (2) of twenty (20) patients in the sample. (Patients #6 and #14) The findings include: 1. Review of Patient #14's clinical records on May 20, 2010 at approximately 11:30 a.m. revealed that the nurses drew blood for PT and	H 450	H 450 3917.1 Skilled Nursing Services Blood draw without a doctor's order. As a result of the finding, the charts of all patients receiving long-term care were reviewed to determine if a similar problems existed. None were found. Effective 15 June, 2010, the Office Manager) audits all long-term client recertifications to ensure that all required continuing procedures are included on the 485 which is reviewed by the Clinical Director before being sent to the physician for signature.	6/18/10

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H 450	Continued From page 6 INR on February 2, 2010, March 11, 2010 and May 5, 2010. Further review of the record failed show evidence that the physician had ordered the laboratory studies. In a face to face interview with the Clinical Director on the same day at approximately 1:40 a.m. it was acknowledged that there was no order for the test in the record. 2. The HCA failed to have evidence that the Registered Nurse (RN) supervised the practice of the Licensed Practical Nurse (LPN) as evidenced by the following: Review of Patient #6's record revealed a POC dated May 13, 2010 through July 11, 2010. The POC indicated that the patient received skilled nursing services seven days a week for wound care. Review of the record revealed that the wound care was provided by an LPN. Further review of the record failed to show evidence that the RN supervised the practice of the LPN. In a face to face interview with the Clinical Director on the same day at 1:45 p.m. it was acknowledged that the record did not have nursing supervision notes.	H 450	No evidence that the LPN was being supervised by an RN The RN supervisory visit is recorded on the SANTRAX system however it was not being recorded or filed in the patient's file. Effective June 15, 2010, a new LPN Supervision Form was created. A spreadsheet has been created to monitor required LPN supervisory visits. It is maintained by the Office Manager. If visits are not recorded, the Clinical Director is notified to ensure that the visit is made, recorded and filed in the client's record.	6/25/10
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on interview and record review, the Home	H 453	H 453 3917.2 (c) Skilled Nursing Services (c) Ensuring that patient needs are met in accordance with the plan of care,	6/18/10

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H 453	<p>Continued From page 7</p> <p>Care Agency's (HCAs) failed to ensure that patient needs are met in accordance with the plan of care (POC) for one (1) of (20) patients in the sample. (Patient #18)</p> <p>The findings include:</p> <p>During the review of Patient #18's clinical record on May 20, 2010 at approximately 3:00 p.m. revealed a POC for the certification period of December 15, 2009 through June 15, 2010. The POC indicated that the patient received personal care aid (PCA) services eight (8) hours a day seven (7) days per week. Review of the PCA service documentation on the same day at approximately 3:10 p.m. failed to show evidence that the PCA provided the services seven days a week as required by the POC.</p> <p>In a face to face interview with the clinical manager on May 20, 2010 at approximately 3:30 p.m. it was acknowledged that the PCA documentation did not show evidence that the services were being provided as ordered.</p>	H 453	<p>Personal Care Aide attendance is tracked on the SANTRAX call in system. If the PCA does not sign in, the patient is called by the Staffing Coordinator no later than 0900 to determine if the PCA is at the client's home and if not, if the client wants a fill-in. If a fill-in is not requested or cannot be provided, a Patient Care Coordination Form is to be completed to account for the absence of services that day. The Patient Care Coordination Form is filed in the patient's record. The Patient Care Coordination Form is also compared with the PCA time sheet to ensure that bills are not submitted for hours not worked. In this case, the Patient Care Coordination form was with the Billing Officer and had not been filed in the patient's record. When the Administrative Assistant files PCA Task Sheets, she is to check to see if all scheduled visits are accounted for. If not she is to check with the Billing Officer to see if there is a Patient Care Coordination form. If not, she is to notify the Office Manager who will obtain the form.</p>	