

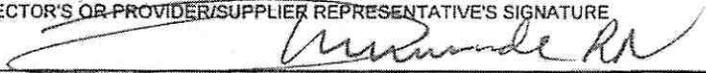
Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HCA-0024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/26/2013
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NAME OF PROVIDER OR SUPPLIER  GLOBAL HEALTHCARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEW YORK AVENUE, NE WASHINGTON, DC 20002
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H 000	INITIAL COMMENTS  An annual survey was conducted at your agency on July 24, 2013 and July 26, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of ten (10) clinical records based on a census of three hundred-fifty-two (352) patients and ten (10) personnel files based on a census of five hundred-thirty-four (534) employees. Observations and interviews were conducted in the patient homes during four (4) home visits and six (6) telephone calls were made to current patients.	H 000	H000  At the exit conference following the survey the surveyors pointed out their findings to the agency staff indicating that the deficiencies were minimal, However Agency administration and staff considered it important and went straight to work in order to ameliorate and correct the findings.	08/14/13
H 355	3914.3(d) PATIENT PLAN OF CARE  The plan of care shall include the following:  (d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies;  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the plan of care (POC) included a description of all durable medical equipment (DME) utilized for seven (7) of ten (10) in the sample (Patients #3, #4, #5, #6, #7, #9 and #10) and the facility failed to ensure the POC included the expected duration for nine (9) of 10 patients in the sample that required services of a personal care aide (PCA ). (Patients #2, #3, #4, #5, #6, #7, #8, #9 and #10)  The findings include:	H 355	The DON and Clinical director immediately scheduled an in- service training for all clinical staff and and Quality assurance personel for wednesday august 14th 2013 ( see attached)	

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE DIRECTOR (X6) DATE 9/6/13

Health Regulation & Licensing Administration

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H 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was conducted at your agency on July 24, 2013 and July 26, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of ten (10) clinical records based on a census of three hundred-fifty-two (352) patients and ten (10) personnel files based on a census of five hundred-thirty-four (534) employees. Observations and interviews were conducted in the patient homes during four (4) home visits and six (6) telephone calls were made to current patients.</p>	H 000	<p>H000</p> <p>At the exit conference following the survey the surveyors pointed out their findings to the agency staff indicating that the deficiencies were minimal, However Agency administration and staff considered it important and went straight to work in order to ameliorate and correct the findings.</p>	08/14/13
H 355	<p><b>3914.3(d) PATIENT PLAN OF CARE</b></p> <p>The plan of care shall include the following:</p> <p>(d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the plan of care (POC) included a description of all durable medical equipment (DME) utilized for seven (7) of ten (10) in the sample (Patients #3, #4, #5, #6, #7, #9 and #10) and the facility failed to ensure the POC included the expected duration for nine (9) of 10 patients in the sample that required services of a personal care aide (PCA ). (Patients #2, #3, #4, #5, #6, #7, #8, #9 and #10)</p> <p>The findings include:</p>	H 355	<p>The DON and Clinical director immediately scheduled an in- service training for all clinical staff and and Quality assurance personel for wednesday august 14th 2013 ( see attached)</p> <p><i>Receved 8/16/13</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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H 355	<p>Continued From page 1</p> <p>A. Review of the following plan of cares (POCs) on July 24, 2013, between 11:30 a.m. and 4:00 p.m., revealed no documented evidence of DME (durable medical equipment) as evidenced below:</p> <ol style="list-style-type: none"> <li>1. Patient #3's POC with certification period of February 14, 2013, through August 14, 2013, failed to include documented evidence of DME.</li> </ol> <p>Review of Patient #3's medical record on July 24, 2013, at approximately 11:45 a.m., revealed the facility's nurse marked the section "dependant on assistive devices" on the Nursing Visit Forms (NVFs) dated June 10, 2013 and July 8, 2013.</p> <ol style="list-style-type: none"> <li>3. Patient #4's POC with a certification period of March 2, 2013, through September 2, 2013, failed to include documented evidence of DME.</li> <li>4. Patient #5's POC with a certification period of May 8, 2013, through November 8, 2013, failed to include documented evidence of DME.</li> <li>5. Patient #6's POC with a certification period of March 10, 2013, through September 10, 2013, failed to include failed to include documented evidence of DME.</li> <li>6. Patient #7's POC with a certification period of June 28, 2013, through December 28, 2013, failed to include documented evidence of DME.</li> <li>7. Patient #9's POC with a certification period of May 19, 2013, through November 19, 2013, failed to include documented evidence of DME.</li> </ol> <p>Review of a Nursing Visit Form dated May 7, 2013, on July 24, 2013, at approximately 3:15 a.m., revealed that Patient #9 uses a cane to</p>	H 355	<p>H355</p> <p>corrective action: All DME`s in the Plan of Care for patient# 3,4,5,6, 7,9,10 have been corrected and updated to reflect all assistive devices. These corrective measures were also done in other POCs where applicable.</p> <p>Measures put in place : The DON conducted a continue education and or in service training for nurses and quality assurance personel and this trainings shall continue on a quartaly basis to make sure these deficincies does not re-occur</p> <p>( see attached copy of the in-service training and the sing-in sheet)</p> <p>Systemic changes: the agency`s computer soft ware system was adjusted to to reflect: these corrective measures</p> <p>( see attached POC pages)</p>	08/14/13

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H 355	<p>Continued From page 2</p> <p>assist in ambulating.</p> <p>Observation during a home visit and a face to face interview with Patient #9 on July 26, 2013, at approximately 10:15 a.m., revealed that the patient utilizes a cane to ambulate in and outside of the home.</p> <p>8. Patient #10's POC with a certification period of February 2, 2013, through August 2, 2013, failed to include documented evidence of DME.</p> <p>Observation during a home visit and a face to face interview with Patient #10 on July 26, 2013, at approximately 12:35 a.m., revealed that the patient utilizes a motorized wheelchair in and outside of the home for mobility.</p> <p>During a face to face interview with the administrator on July 24, 2013, at approximately 4:35 p.m. and during a telephone interview on July 26, 2013, at approximately 1:05 p.m., it was indicated that the agency would provide training to the clinical staff on how to accurately document evidence of DME on Patient #3, #4, #5, #6, #7, #9 and #10's POC.</p> <p>B. Review of the following POCs on July 24, 2013, between 11:30 a.m. and 4:00 p.m., revealed no documented evidence the POC included the expected duration for personal care aide (PCA) services as evidenced by:</p> <p>1. Patient #2's POC with a certification period of June 19, 2013, through December 19, 2013, revealed PCA services eight (8) hours a day, seven (7) days a week, however the POC failed to include the expected duration for PCA services.</p>	H 355	<p>H355</p> <p>The QA department shall review all nurses documents prior to filling and nurses shall be called to make any corrections if need arises or even re-do the home visit to document evidence of DME if applicable.</p> <p>corrective action: All Plans of Care for patient # 2,3,4,5,6,7,8,9 and 10 have been corrected to indicate the expected duration of PCA services. example PCA services eight (8) hours a day five (5) days a week for six(6)months (see attached POC with these corrections)</p>	08/14/13

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H 355	<p>Continued From page 3</p> <p>2. Patient #3's POC with certification period of February 14, 2013, through August 14, 2013, revealed PCA services 8 hours a day, 7 days a week, however the POC failed to include the expected duration for PCA services.</p> <p>3. Patient #4's POC with a certification period of March 2, 2013, through September 2, 2013, revealed PCA services six (6) hours a day, five (5) days a week, however the POC failed to include the expected duration for PCA services.</p> <p>4. Patient #5's POC with a certification period of May 8, 2013, through November 8, 2013, revealed PCA services 8 hours a day, 7 days a week, however the POC failed to include the expected duration for PCA services.</p> <p>5. Patient #6's POC with a certification period of March 10, 2013, through September 10, 2013, revealed PCA services 8 hours a day, 7 days a week, however the POC failed to include the expected duration for PCA services.</p> <p>6. Patient #7's POC with a certification period of June 28, 2013, through December 28, 2013, revealed PCA services 8 hours a day, 7 days a week, however the POC failed to include the expected duration for PCA services.</p> <p>7. Patient #8's POC with a certification period of June 1, 2013, through December 1, 2013, revealed PCA services four (4) hours a day, three (3) days a week, however the POC failed to include the expected duration for PCA services.</p> <p>8. Patient #9's POC with a certification period of May 19, 2013, through November 19, 2013, revealed PCA services 8 hours a day, 7 days a week, however the POC failed to include the</p>	H 355	<p>H355</p> <p>Measures put in place: The DON and the clinical director conducted an in-service with all clinical staff to assure all POCs indicate the expected duration for PCA services. The DON will make sure that these deficiencies do not re-occur.</p> <p>systemic changes: the agency computer system software has been updated to reflect the expected duration for PCA services on all Plans of Care.</p> <p>The POCs for patient # 2, 3, 4, 5, 7, 8, 9 and 10 has been updated to indicate the expected duration for PCA services. (see attached copies)</p>	08/14/13

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H 355	<p>Continued From page 4</p> <p>expected duration for PCA services.</p> <p>9. Patient #10's POC with a certification period of February 2, 2013, through August 2, 2013, revealed PCA services 8 hours a day, 5 days a week, however the POC failed to include the expected duration for PCA services.</p> <p>During a face to face interview with the clinical director on July 24, 2013, at approximately 4:25 p.m., it was indicated that the agency would provide training to the clinical staff on how to accurately document Patient #2, #3, #4, #5, #7, #8, #9 and #10's expected duration for PCA services on the POC.</p>	H 355		
H 359	<p>3914.3(h) PATIENT PLAN OF CARE</p> <p>The plan of care shall include the following:</p> <p>(h) Prognosis, including rehabilitation potential;</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the agency's plan of care (POC) failed to include the rehabilitation potential for one (1) of ten (10) patients in the sample. (Patient #6)</p> <p>The finding includes:</p> <p>Review of Patient #6's POC with a certification period of March 10, 2013, through September 10, 2013, on July 24, 2013, at approximately 1:30 p.m., revealed the POC failed to include the rehabilitation potential for the patient.</p> <p>During a face to face interview with the clinical director on July 24, 2013, at approximately 4:40</p>	H 359	<p>H359</p> <p>Durring the survey, the POC for patient#6 failed to include the rehabilitation potential for the patient.</p> <p>corrective measure: POC for patient # 6 has been updated to include prognosis and rehabilitation potential for the patient. ( see attached copy) This correction has also been made on all other POC where applicable and shall be applied henceforth as indicated. the DON and clinical director conducted an in-</p>	8/14/13

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H 359	Continued From page 5  p.m., it was indicated that the agency would provide training to the clinical staff on how to accurately assess and document Patient #6's rehabilitation potential on the POC.	H 359	service training with all clinical staff on how to accurately assess and document rehabilitation potential on all plans of care.	
H 459	<p><b>3917.2(i) SKILLED NURSING SERVICES</b></p> <p>Duties of the nurse shall include, at a minimum, the following:</p> <p>(i) Patient instruction, and evalutaion of patient instruction; and</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that specific instructions were afforded to patients related to their health conditions, for two (2) of the ten (10) patients in the sample (Patient #7 and #9). Additionally, the HCA failed to provide evidence that the instructions given were understood, for four (4) of the ten (10) patients in the sample. (Patient #6, #7, #9 and #10)</p> <p>The findings include:</p> <p>The agency failed to ensure the evaluation of the training had been completed as prescribed.</p> <p>1. Review of Patient #6's POC with a certification period of March 10, 2013, through September 10, 2013, on July 24, 2013, at approximately 1:30 p.m., revealed the patient had impaired skin integrity related to Diabetes Mellitus. Review of Patient #6's medical record on July 24, 2013, at approximately 1:40 p.m., revealed a Nursing Visit</p>	H 459	<p>(see attached higlight of topics covered durring the training and participants sign in sheet)</p> <p>Henceforth , the clinical director will re-assure that these deficiencies does not re-occur. moving foward in-service training will be conducted on a quarterly basis with clinical staff to train on how to accurately assess and document rehabilitation potentials on all plans of care.</p> <p>H459</p> <p>durring the survey, the agency acknowledged that specific training and/or evaluation of training for clinical staff have not been met as prescribed for the afformentioned patients.</p>	

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H 459	<p>Continued From page 6</p> <p>Form (NVF) dated June 28, 2013. The document indicated that the nurse taught the patient on the importance of maintaining skin integrity due to the possibility of poor circulation related to diabetes. The nurse documented that the patient "understood the teaching by verbalizing understanding". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teaching.</p> <p>2. Patient #7's POC with a certification period of June 28, 2013, through December 28, 2013, on July 24, 2013, at approximately 2:10 p.m., revealed the patient had impaired walking related to osteoarthritis. Review of Patient #7's medical record on July 24, 2013, at approximately 2:20 p.m., revealed a NVF dated June 4, 2013. The document indicated that the nurse instructed the patient to wear well-fitting shoes and advised the patient to dangle their legs over the side of the bed for a few minutes before standing. The nurse however, failed to document the rational for the aforementioned teachings. The nurse documented that the patient "verbalized understanding". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>3. Patient #9's POC with a certification period of May 19, 2013, through November 19, 2013, on July 24, 2013, at approximately 3:00 p.m., revealed the patient had impaired physical mobility. Review of Patient #9's medical record on July 24, 2013, at approximately 3:10 p.m., revealed a NVF dated June 5, 2013. The document indicated that the nurse instructed the patient to initiate pain control as directed before starting range of motion excercises. The nurse</p>	H 459	<p>The DON and clinical director conducted an in-service training for all skilled nursing/clinical staff on 08/14/13 to educate on patient instruction and evaluation of patient instruction. The RN supervisors for patient # 7 and 9 were specifically trained to document evidence that indicates specific instructions were afforded to patients related to their health conditions and to provide written evidence that the instructions were understood by the patients. Skilled nursing staff were also trained to limit their teaching on one unit per visit so that patient can have a better understanding.</p> <p>The RN supervisors for patient #6,7,9 and 10 were specifically tranined to properly document patients specific level of understanding of health teaching.</p>	8/14/13

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H 459	<p>Continued From page 7</p> <p>however, failed to document the rational for the aforementioned teaching. The nurse documented that the patient "verbalized understanding". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>4. Patient #10's POC with a certification period of February 2, 2013, through August 2, 2013, on July 24, 2013, at approximately 3:35 p.m., revealed the patient had hypoglycemia. Review of Patient #10's medical record on July 24, 2013, at approximately 3:54 p.m., revealed a NVF dated June 18, 2013. The document indicated that the nurse instructed the patient on the signs and symptoms of hyperglycemia such as hunger, shakiness and light headedness. Additionally the nurse instructed the patient to monitor their blood glucose level. The nurse documented that the patient "verbalized understanding". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>During a face to face interview with the administrator and clinical director on June 24, 2013, at approximately 5:00 p.m., it was acknowledged there was no documented evidence that the agency's nursing staff ensured specific training and/or that the evaluation of the training had been completed as prescribed for the aforementioned patient's. Further interview revealed that the nursing staff would be re-trained on how to accurately document training and/or the evaluation of the training in the patient's medical record.</p>	H 459	<p>H459</p> <p>Durring the nurses in-service training of 08/14/2013, the nurses were trained by the clinical director on appropriate nursing diagnosis to be reflected in their teaching and to include measurable evaluation. Henceforth, all nurses notes MUST indicate patient`s understanding of teaching. (see attached in-service training topic of 8/14/13)</p> <p>The direcor of nursing and the clinical director will conduct quarterly in-service with all clinical staff to train on how to accurately document patient teaching and/or the evaluation of the training in the patient`s medical record.</p>	8/14/13
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