Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0014	A. BUILDING _____ B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDEAL NURSING SERVICES, INC	820 UPSHUR STREET, NW, 2ND FLOOR WASHINGTON, DC 20016

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H 000	INITIAL COMMENTS An annual survey was conducted at your agency from January 25, 2011, through January 25, 2011, 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 nineteen (19) active clinical records based on a census of one hundred-ninety eight (198) patients, two (2)discharge clinical records, thirty nine personnel files based on a census of two hundred ninety seven (297) employees, and three (3) home visits. The findings of the survey were based on observations in the home, interviews with agency staff and patient interviews as well as a review of patient and administrative records.	H 000	Recewed 2/28/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
H 122	3906.1(c) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (c) The manner in which services will be controlled, coordinated and evaluated by the primary home care agency; This Statute is not met as evidenced by: Based on staff interview and record review, the Home Care Agency (HCA) failed to ensure all contractor agreements outlined the manner in which services will be controlled, coordinated and evaluated for two of two contracted employee records reviewed. [Staff #6 and #7] The finding includes:	H 122		

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David J. Brantley-Gordon — TITLE Administrator — (X6) DATE 2/28/11

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

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H 122	Continued From page 1 Review of Staff #6 and #7 ' s personnel records on 2/2/2011, at approximately 10:45 a.m. revealed their contract failed to include provisions outlining how services will be controlled, coordinated and evaluated to ensure the health and safety of the patients. Interview with the facility ' s President and Director of Nursing on 2/2/2011, at approximately 4:30 p.m. confirmed the contract did not include the provisions outlined in this section.	H 122 H122	The agreement was revised to include section detailing the process for coordination of services. Each contractor was given a new agreement to sign and return by March 10, 2011. The new employee checklist was revised to include this documentation and will be reviewed within 30 days of hire by the HR director and quarterly by the QC. Compliance will be shared with governing body via annual report.	3/31/11
H 123	3906.1(d) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (d) The procedure for submitting clinical and progress notes, periodic patient evaluation, scheduling of visits, and other designated reports; This Statute is not met as evidenced by: Based on staff interview and record review, the Home Care Agency (HCA) failed to ensure all contractor agreements outlined the procedure for submitting clinical and progress notes, periodic evaluations, scheduling of visits for two of two contracted employees. [Staff #6 and #7] The finding includes: Review of Staff #6 and #7 ' s personnel records on 2/2/2011 at approximately 10:53 a.m. revealed their contracts failed to include provisions outlining the procedure for submitting clinical and	H 123		

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H 123	Continued From page 2 progress notes, periodic evaluation, scheduling of visits, and other designated reports. Interview with the facility ' s President and Director of Nursing on 2/2/2011 at approximately 4:35 p.m. confirmed the contract did not include the provisions outlined in this section, but they indicated the oversight would be corrected immediately.	H 123	H 123 The agreement was revised to include section detailing the process for progress notes, periodic evaluation, scheduling of visits, etc. Each consultant was given a new agreement to sign and return by March 10, 2011. Since March 2011 each employee is required to attend an orientation with quality consultant to discuss documentation requirements. A copy of the meeting is placed in the employee folder. Additionally each employee is given a copy of all relevant policies and templates and will be required to acknowledge receipt. The **new employee checklist** was revised to include a review of agreement, orientation and acknowledgement of receipt of policies and audit templates. Going forward personnel files will be reviewed within 30 days of hire by the HR director and quarterly by the QC. Compliance shared with governing body via annual report.	3/31/11
H 151	3907.2(g) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (g) Documentation of reference checks; This Statute is not met as evidenced by: Based on staff interview and record review, the Home Care Agency (HCA) failed to ensure that reference checks were completed and recorded in the personnel record of each staff as required by this section. [Staffs #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #19, #20, #21, #22, #23, #24, #25, #27, #29, #30, #31, #32, #33, #35, #39 and #40] The finding includes: Record review beginning on 1/25/2011, at 12:03 p.m. revealed twenty-eight (28) of thirty-three (33) records reviewed failed to reflect that reference checks were completed. Interview with the facility ' s staffing coordinator (SC) on 2/2/2011 ,at approximately 10:30 a.m. confirmed reference checks were not completed on any of the twenty-eight (28) staff mentioned above. The facility failed to ensure accurate	H 151	H 151 All personnel files currently have two references. The files will be reviewed and it will documented whether the reference on file is a professional or personal reference. The staff that do not have a personal reference on file will be sent a letter indicating that a personal reference is required by 03/31/11. The HR Director conducts a review of all new hires within 30 days utilizing the checklist. The QC will review a minimum of 20 charts at each visit to ensure checklist is completed. Results will be shared with governing body via the annual report.	03/31/11

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H 151	Continued From page 3 documentation of all staff ' s references as required by this section.	H 151		
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 staff interview and record review, the Home Care Agency (HCA) failed to ensure that annual evaluations were completed and recorded in the personnel record of each staff as required by this section. [Staffs #10, #11 and #14] The finding includes: The facility failed to provide evidence that all staff were provided an annual evaluation as presented below: 1. Record review of Staff #14 ' s personnel file on 1/25/2011, at 12:00 p.m. revealed her last annual evaluation was dated 11/16/2009. 2. Record review of Staff #11 ' s personnel file on 1/25/2011, at 12:07 p.m. revealed her last annual evaluation was dated 10/05/2009. 3. Record review of Staff #10 ' s personnel file on 1/28/2011 at 10:13 a.m. revealed her last annual evaluation was dated 10/05/2009. Interview with the facility ' s staffing coordinator (SC) on 2/1/2011, at approximately 9:55 a.m. confirmed the staff members listed above needed	H 152	All past due evaluations were brought current on 2/25/11. Going forward the tracking of evaluations and other pertinent information will be done by HR Director via a **tracking log** , which will include evaluations, licenses, malpractice insurance, continuing education, CPR and health attestation within 30 days of hire and quarterly thereafter by the QC. Results of the audit will be shared with governing body via the annual report.	3/31/11

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H 152	Continued From page 4 to have updated evaluations. The facility failed to ensure accurate documentation of all staff ' s annual evaluations as required by this section.	H 152		
H 153	3907.2(i) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (i) Documentation of any required criminal background check; This Statute is not met as evidenced by: Based on staff interview and record review, the Home Care Agency (HCA) failed to ensure that the criminal background screening for all staff was completed and recorded in the personnel record of each staff as required by this section. [Staff #15] The finding includes: Record review of Staff #15 ' s employee record on 1/25/2011 ,at 12:27 p.m. revealed she had previously worked in Indiana and Nevada. There was no evidence that the criminal background check on file did not reflected that a search in those states was included in her background screening upon her hire. The only criminal background checks on file at the time of the inspection were for states of Maryland and the District of Columbia. The facility failed to ensure the criminal background checks for all staff were completed and recorded as required by this section.	H 153	H 153 Employee in question have submitted the required background checks. A comprehensive review is currently in progress to identify other employees who need additional criminal background checks. To date two employees were identified in a review of 50% of personnel files. The full review of all personnel files is expected to be completed by 03/31/11. The QC will review all new hires files that have occurred since the last visit and a sampling of 10 current employee files to ensure ongoing compliance. Results of the audits will be shared with the administrator via visit summary of findings.	03/31/11

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H 227	3909.2 DISCHARGES TRANSFERS & REFERRALS Each patient shall receive written notice of discharge or referral no less than seven (7) calendar days prior to the action. The seven (7) day written notice shall not be required, and oral notice may be given at any time, if the transfer, referral or discharge is the result of: This Statute is not met as evidenced by: Based on a record review and interview, it was revealed that the Home Care Agency (HCA) failed to provide seven (7) days written notice of discharge for one (1) of two (2) patient discharge records included in the sample. (Patient #1) The finding includes: On January 28, 2011, a record review of Patient #1's record at approximately 11:23 a.m., revealed a Home Health Aide (HHA)Weekly Visit form that revealed the patient's last day of service was on December 10, 2010. Further review of the record revealed there was no documented evidence of a seven (7) day written notice of discharge. Interview with the Billing Supervisor on January 31, 2011, at approximately 11:41 a.m., revealed she contacted the caregiver on December 9, 2010, to inform them that the patient's services would be terminated on December 10, 2010. Although the interview revealed that the caregiver was notified approximately two (2) weeks prior to	H 227 H 227	The agency policy on discharge was revised on 02/15/11 and documentation requirements shared with involved staff on 02/17/11. The QC will review all discharged records at each agency visit. Results of the audits will be shared with the Administrator via visit summary of findings.	03/31/11

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H 227	Continued From page 6 the patient's discharge, (via telephone), there was no documented evidence that the patient had been notified no less than seven days prior to her discharge. During a face to face interview with the Administrator and Director of Nursing (DON) on February 2, 2011, at approximately 2:37 p.m., the finding was acknowledged.	H 227		
H 267	3911.2(g) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (g) Medication sheet; This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency (HCA) failed to include relevant information on the patient's medication sheets for three (2) of the nineteen (19) patients included in the sample. (Patients #7, and #12) The findings include: 1. Review of Patient #7's Plan of Care (POC) on January 31, 2011, at approximately 2:47 p.m., revealed a Certification Period for September 25, 2010, through March 25, 2011. Further review of the POC revealed Patient #7 had been prescribed Zoloft 50 mg once a day (QD) since September 25, 2007. The patient's record also revealed a sheet entitled "Medication Profile." Review of the patient's Medication Profile revealed the HCA failed to ensure all of the patient's medications had been transcribed to include Zoloft 50 mg. Further review of the	H 267	The Clinical Director met with licensed staff to discuss results of the survey on 02/18/11. A focused review on medications was done on all currently skilled records on 2/17/11 and will be done monthly for next three months. Ongoing medication review will continue to be a component of the quarterly review of all skilled and 10% of non skilled records.Results of the audits will be shared with the administrator via the visit summary of findings.	03/31/11

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H 267	Continued From page 7 aforementioned document revealed no evidence that the medication had been discontinued. At the time of the survey, the HCA failed to ensure that Patient #7's Zoloft 50 mg was included on her Medication Profile. During a face to face interview with the Administrator and Director of Nursing (DON) on February 3, 2011 at approximately 2:37 p.m., the finding was acknowledged. 2. Review of Patient #12's record on February 2, 2011 at approximately 11:05 a.m., revealed a Plan of Care (POC) for the certification period of December 18, 2010, through February 15, 2011. The POC revealed the patient was ordered skilled nursing services for medication management. Further review of the POC revealed an Addendum to the plan of treatment which was a medical update. Review of the update revealed Levaquin 250 mg QD(once a day) x 7 days was ordered for Patient #12 on January 3, 2011. Interview with the DON on February 2, 2011 at approximately 3:08 p.m., revealed that the patient had an infection and the antibiotic Levaquin was ordered. Continued interview with the DON revealed the nurse probably forgot to transcribe the aforementioned medication onto the medication profile sheet. At the time of the survey, the HCA failed to include Patient #12's order for Levaquin 250 mg on her Medication Profile sheet.	H 267		
		H 267	Cross reference response to H267 finding #1.	03/31/11
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum,	H 453		

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H 453	Continued From page 8 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 a record review, the Home Care Agency's (HCA's) nurse failed to ensure that patient needs are met in accordance with the plan of care (POC) for two (2) of the (19) patients included in the sample. (Patients #9 and #11) The findings include: 1. Review of Patient #9's record on February 1, 2011, at approximately 11:57 a.m., revealed a Plan of Care (POC) for the certification period of December 20, 2010, through February 17, 2011. The POC revealed the patient was referred for diabetic management. Further review of the order, revealed " to report Blood Sugar (BS)over 200 and under 60 to the patient's Primary Care Physician (PCP). A review of a "Follow-Up Skilled Nursing Note dated December 20, 2010, revealed Patient #9 and the patient's caregiver was instructed to contact patient's Medical Doctor (MD) if her BS was over 250. Continued review of the nursing note revealed the client verbalized understanding in reference to contacting her MD for BS over 250. A face to face interview was conducted with the Director of Nursing (DON) on February 1, 2011 at approximately 11:57 a.m. The DON verified that the POC ordered for Patient #9's BS to be reported if over 200 and under 60 to the PCP. At the time of the survey, the HCA's nurse failed	H 453	H 453 The Clinical Director met with licensed staff to discuss results of the survey on 02/18/11. A focused review following the POC was done on all current skilled records on 02/17/11. The QC will continue to monitor the record for accuracy and appropriate content for next three months and then quarterly thereafter. Results of the audits will be shared with the administrator via the visit summary of findings.	03/31/11

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H 453	Continued From page 9 to ensure Patient #9's needs were met in accordance to her POC. 2. Review of Patient #11's record on February 1, 2011, at approximately 2:54 p.m., revealed a Plan of Care (POC) for the certification period of September 21, 2010, through March 21, 2011. According to the POC the patient was diagnosed with Diabetes and prescribed a low sodium, low carb diet. The POC revealed orders to review diet and instruct on medications, assess medication and diet compliance. Review of the nursing visit notes dated September 27, 2010, October 22, 2010, November 15, 2010, December 16, 2010, and January 10, 2011, revealed that the nurse provided instructions to use safety for oxygen use for fire and burns. None of the aforementioned notes addressed the patient's diet. A face to face interview was conducted with the Director of Nursing (DON) on February 2, 2011 at approximately 2:37 p.m. verified the assigned nurse failed to address the patient's diet. At the time of the survey, the HCA's nurse failed to ensure Patient #11's needs were met in accordance to her POC.	H 453	Cross reference response to H453 finding #1.	03/31/11
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and	H 459		

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H 459	Continued From page 10 This Statute is not met as evidenced by: Based on interview and a record review, the facility's skilled nursing staff failed to ensure patient instruction, and evaluation of patient instruction for one (1) of the nineteen (19) patients included in the sample. (Patient #9) The finding includes: Review of Patient #9's record on February 1, 2011, at approximately 11:57 a.m., revealed a Plan of Care (POC) for the certification period of December 20, 2010, through February 17, 2011. The POC revealed the patient was referred for diabetic management. Further review of the order, revealed " to report Blood Sugar (BS)over 200 and under 60 to the patient's Primary Care Physician (PCP). A review of a "Follow-Up Skilled Nursing Note dated December 20, 2010, revealed Patient #9 and the patient's caregiver was instructed to contact patient's Medical Doctor (MD) if her BS was over 250. Continued review of the nursing note revealed the client verbalized understanding to contact her MD if her BS was over 250. A face to face interview was conducted with the Director of Nursing (DON) on February 1, 2011 at approximately 11:57 a.m. The DON verified that the POC ordered for Patient #9's BS to be reported if over 200 not 250 to the PCP. At the time of the survey, the HCA's nurse failed to ensure Patient #9 was instructed to report her BS when it was over 200 instead of 250 as ordered.	H 459		
		H 453	The Clinical Director met with licensed staff to discuss results of the survey on 02/18/11. A focused review following the POC was done on all current skilled records on 02/17/11. The QC will continue to monitor the record for accuracy and appropriate content for next three months and then quarterly thereafter. Results of the audits will be shared with the administrator via the visit summary of findings.	03/31/11