Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HCA-0059		05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDSTAR VISITING NURSE ASSOCIATION, IN	4301 CONNECTICUT AVENUE, SUITE 441 WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 000	INITIAL COMMENTS A full survey was conducted on May 20, 2013, through May 21, 2013, at your new location at 4301 Connecticut Avenue, N.W., Washington, D.C., 20008, Suite 441 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 fifteen (15) clinical records based on a census of four hundred-seven (407) patients and fifteen (15) personnel files based on a census of fifty-two (52) employees. Observations and interviews were conducted in the patient homes during four (4) home visits and eleven (11) telephone calls were made to current patients.	H 000	Received 6/5/13 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
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 one (1) of fifteen (15) patients in the sample. (Patient # 15) The finding includes: Review of Patient #15's plan of care (POC) dated April 2, 2013, through May 31, 2013, on May 20, 2013, at approximately 5:05 p.m., revealed the patient had diagnoses that included decubitus ulcers on the hip and heel, Diabetes Mellitus Type II, hypertension and West Nile fever. The skilled nurse was to instruct the patient/caregiver to	H 450	Operations Directors and Educator will re-educate clinicians on accurately documenting patient/caregiver instruction to weigh the patient daily when listed on the plan of care. Education guidance for skilled nursing visits will be to record the weight done by the patient/caregiver that visit day, or weigh the patient and record if not done. The physician should be notified and documented if it is not possible to weigh the patient at home or when the patient/caregiver is noncompliant in weights. Continues on page 2.	6/21/13

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H 450	Continued From page 1 weigh the patient every day. Review of Patient #15's Skilled Nurse Revisit Licensed Practical Nurse (SNRLPN) documents dated April 3, 5, 8, 10, 12, 17, 19, 22, 24, 26 and 29, 2013 and May 3, 6, 9, 10 and 13, 2013, on May 20, 2013, between 5:05 p.m. to 5:25 p.m., revealed no documented evidence the SN instructed the patient/caregiver to weigh the patient every day. Additionally there were no actual or reported weights documented on the aforementioned documents. During a face to face interview with the assistant regional manager on May 20, 2013, at approximately 7:05 p.m., it was acknowledged that the SN had not instructed the patient/caregiver to weigh Patient #15 every day according to the POC. Further interview revealed that the nursing staff would be re-trained on how to provide SN services in accordance with Patient #15's POC.	H 450	Education on accurately documenting patient/caregiver instruction to weigh the patient daily will be completed by 6/21/13. Compliance in documenting the individualized patient teaching will be monitored by the Operations Directors, Educator and/or Quality Specialist. The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory.	6/21/13
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 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 instructions were afforded to patients related to their health conditions, for three (3) of the fifteen (15) patients in the sample (Patient #2, #3 and #10). Additionally, the HCA	H 459	Operations Directors and Educator will re-educate clinicians on accurately documenting individualized patient teaching that is listed on the plan of care. The patient/caregiver teaching will take place each visit and the quantity of teaching during the skilled nursing visit will be dependent on patient/caregiver needs and their ability to learn or retain the information. In addition, the documented	6/21/13

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H 459	Continued From page 2 failed to provide evidence that the instructions given were understood, for 3 of the 15 patients in the sample. (Patient #2, #3 and #15) The findings include: The agency failed to ensure training and/or the evaluation of the training had been completed as prescribed. 1. Review of Patient #2's plan of care (POC) with a certification period of May 5, 2013, through July 3, 2013, on May 20, 2013, at approximately 11:30 a.m., revealed that the skilled nurse (SN) was to instruct the patient/caregiver on medication use, oxygen therapy, wound care, signs and symptoms of deteriorating condition and disease processes and pain management. Review of Patient #2's medical record on May 20, 2013, at approximately 11:35 a.m., revealed a SN Revisit Wound (SNRW) document dated May 8, 2013. The document indicated that the SN instructed the patient in wound care, signs and symptoms of infection and inflammation in the wound. Additionally, a review of a SNRW dated May 13,2013, revealed that the patient was instructed in congestive heart failure (CHF) management, activities, preparing a low sodium, fat, cholesterol diet, fluid restriction and safety management secondary to oxygen use in the home. The SN documented that the patient "stated understanding" of the aforementioned instructions. The SN however, failed to document the specific aspects of the aforementioned respective training's taught to the patient and the patient's specific level of understanding of the aforementioned health teachings. 2. Review of Patient #3's POC with a certification period of April 1, 2013, through May 30, 2013, on	H 459	response to teaching will be accurate as related to the patient teaching provided during the specific skilled nursing visit. Education will be completed by 6/21/13. Compliance in documenting the individualized patient teaching The Operations Director, Educator and/or Quality Specialist will be responsible for the ongoing review of documented teaching for completeness of the information. The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory.	6/21/13

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H 459	Continued From page 3 May 20, 2013, at approximately 12:30 p.m., revealed that the SN was to instruct the patient/caregiver on all aspects of diabetes management including the signs and symptoms of hypoglycemia and hyperglycemia foot care, blood sugar monitoring, diet and medication. Review of Patient #3's medical record on May 20, 2013, between 12:40 p.m. to 12:45 p.m., revealed SNRW documents dated April 2 and 7, 2013. The documents indicated that the SN instructed the patient in signs and symptoms of hypoglycemia, hyperglycemia, foot care, diet and skin care. The SN documented that the patient was able to "verbalize most of the teachings and instructions". The SN however, failed to document the specific aspects of the aforementioned respective training's taught to the patient/caregiver and the patient/caregiver's specific level of understanding of the aforementioned health teachings.	H 459	Operations Directors and Educator will re-educate clinicians on accurately documenting individualized patient teaching that is listed on the plan of care. The patient/caregiver teaching will take place each visit and the quantity of teaching during the skilled nursing visit will be dependent on patient/caregiver needs and their ability to learn or retain the information. In addition, the documented response to teaching will be accurate as related to the patient teaching provided during the specific skilled nursing visit. Education will be completed by 6/21/13. Compliance in documenting the individualized patient teaching The Operations Director, Educator and/or Quality Specialist will be responsible for the ongoing review of documented teaching for completeness of the information. The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory.	6/21/13
	3. Review of Patient #10's POC with a certification period of April 9, 2013, through June 7, 2013, on May 20, 2013, at approximately 12:55 p.m., revealed that the SN was to instruct the patient/caregiver on medication use, respiratory and cardiovascular disease management, signs and symptoms of deteriorating condition and disease processes, diet and pain management. Review of Patient #10's medical record on May 20, 2013, between 4:25 p.m. to 4:48 p.m., revealed a Skilled Nurse Revisit IV with Lab (SNRIWL) document dated April 22, 2013. The document indicated that the SN instructed the patient in medication compliance, hydration, signs and symptoms of infection, handwashing after intravenous (IV) medication, monitoring temperature, nutrition to promote wound healing and hydration. The SN documented that the patient was able to "verbalize understanding". The SN however, failed to document the specific		Operations Directors and Educator will re-educate clinicians on accurately documenting individualized patient teaching that is listed on the plan of care. The patient/caregiver teaching will take place each visit and the quantity of teaching during the skilled nursing visit will be dependent on patient/caregiver needs and their ability to learn or retain the information. In addition, the documented response to teaching will be accurate as related to the patient teaching provided during the specific skilled nursing visit. Education will be completed by 6/21/13. Compliance in documenting the individualized patient teaching The Operations Director, Educator and/or Quality Specialist will be responsible for the ongoing review of documented teaching for completeness of the information. The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory.	6/21/13

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H 459	Continued From page 4 aspects of the aforementioned respective training's taught to the patient/caregiver and the patient/caregiver's specific level of understanding of the aforementioned health teachings. Additionally, a review of a SNRIWL document dated May 6, 2013, revealed no evidence that the SN provided health teaching instructions to Patient #10 according to the POC. 4. Review of Patient #15's POC with a certification period of POC dated April 2, 2013, through May 31, 2013, on May 20, 2013, at approximately 5:45 p.m., revealed that the SN was to instruct the patient/caregiver on wound care. Review of Patient #15's medical record on May 20, 2013, at approximately 5:46 p.m., revealed a SNRW document dated May 1, 2013. The document indicated that the SN instructed the patient/caregiver about the importance of keeping pressure off the sacral area to promote wound healing and to prevent skin breakdown. The SN did not document documented the patient's specific level of understanding of the aforementioned health teaching. During a face to face interview with the assistant regional manager on May 20, 2013, at approximately 6:30 p.m., it was acknowledged at the time of the survey 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.	H 459	Operations Directors and Educator will re-educate clinicians on accurately documenting individualized patient teaching that is listed on the plan of care. The patient/caregiver teaching will take place each visit and the quantity of teaching during the skilled nursing visit will be dependent on patient/caregiver needs and their ability to learn or retain the information. In addition, the documented response to teaching will be accurate as related to the patient teaching provided during the specific skilled nursing visit. Education will be completed by 6/21/13. Compliance in documenting the individualized patient teaching The Operations Director, Educator and/or Quality Specialist will be responsible for the ongoing review of documented teaching for completeness of the information. The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory.	6/21/13
H 564	3923.3(c) PHYSICAL THERAPY SERVICES	H 564		

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H 564	Continued From page 5 The licensed physical therapist shall: (c) Monitor and assess the degree to which therapy treats the identified physical dysfunction or the degree to which pain associated with movement is reduced. This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)physical therapy staff failed to provide evidence that varied instructions were given to treat the identified physical dysfunction and were understood for two (2) of fifteen (15) patients in the sample. (Patient #7 and #8) The findings include: 1. Review of Patient #7's plan of care (POC) with a certification period of May 1, 2013 through June 29, 2013, at approximately 2:30 p.m., revealed the patient had diagnoses that included difficulty walking and was prescribed physical therapy (PT) for once a week times one (1) week and then two (2) times a week for six (6) weeks. Additionally the PT was to instruct the patient in the care and use of equipment, instruct in a home exercise program, provide training on safety and fall precautions, gait and transfer training and strengthening exercises. Review of Patient #7's medical record on May 20, 2013, between 2:35 p.m. to 3:00 p.m., revealed PT Revisit (PTR) notes dated May 3,10,13 and May 17, 2013. However, on the aforementioned dates the PT did not vary the instructions during the visits. The PT also provided the same instructions verbatim to the patient on "safety and fall precautions".	H 564	The Rehab Operations Director and Educator will re-educate clinicians on accurately documenting individualized patient therapy, safety and fall prevention teaching as relates to the patient specific condition. The patient/caregiver teaching will take place each therapy visit and will be dependent on patient/caregiver needs and their ability to learn or retain the information. In addition, the documented response to teaching will be accurate as related to the specific patient teaching provided during the physical therapy visit. Education will be completed by 6/21/13. The documentation survey findings will be reviewed with the individual therapist and education as described above by 6/14/13. Compliance in documenting the individualized patient safety, fall prevention and therapy teaching will be monitored by the Rehab Operations Director, Educator and/or Quality Specialist. Periodic on-going therapy documentation review will be completed on the individual PT Continues on page 7.	6/21/13 6/14/13

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H 564	Continued From page 6 Additionally, the documents also revealed that the patient "verbalized understanding of the aforementioned training's but would need further instructions for independence". The PT failed to document the specific level of understanding of the aforementioned training's. 2. Review of Patient #8's plan of care (POC) with a certification period of May 21, 2013 through June 19, 2013, at approximately 3:10 p.m., revealed the patient had diagnoses that included gait abnormality and was prescribed physical therapy (PT) for four (4) times a week for 2 weeks and then three (3) times a week for one (1) week. Additionally the PT was to instruct the patient in the care and use of equipment, provide training on safety measures, fall and joint replacement precautions, gait/transfer training and strengthening exercises. Review of Patient #8's medical record on May 20, 2013, between 3:15 p.m. to 3:55 p.m., revealed PT Revisit (PTR) notes dated April 25, 2013 and May 3,7 and 9, 2013. However, on the aforementioned dates the PT did not vary the health teaching instructions during the prescribed visits. The PT also provided the same instructions verbatim to the patient on "safety, fall and joint replacement precautions". Additionally, the documents also revealed that the patient "verbalized understanding of the aforementioned training's but would need further instructions for independence". The PT failed to document the specific level of understanding of the aforementioned training's. During a face to face interview with the assistant regional manager on May 20, 2013, at approximately 7:00 p.m., it was revealed that the PT staff would be re-trained on how to vary instructions given to treat the identified physical dysfunctions and the specific level of	H 564	noted in patient #7 and 8. -The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory. The Rehab Operations Director and Educator will re-educate clinicians on accurately documenting individualized patient therapy, safety and fall prevention teaching as relates to the patient specific condition. The patient/caregiver teaching will take place each therapy visit and will be dependent on patient/caregiver needs and their ability to learn or retain the information. In addition, the documented response to teaching will be accurate as related to the specific patient teaching provided during the physical therapy visit. Education will be completed by 6/21/13. The documentation survey findings will be reviewed with the individual therapist and education as described above by 6/14/13. Compliance in documenting the individualized patient safety, fall prevention and therapy teaching will be monitored by the Rehab Operations Director, Educator and/or Quality Specialist. Periodic on-going therapy documentation review will be completed on the individual PT noted in patient #7 and 8. -The education and oversight has been approved by the Regional Operations Director and the Sr. Director Compliance/Regulatory.	6/21/13 6/14/13

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H 564	Continued From page 7 understanding of the instructions given to treat the identified physical dysfunctions of Patient #7 and #8.	H 564		