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	HCA-0054	A. BUILDING: _____ B. WING _____	05/09/2013

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H 000	INITIAL COMMENTS An annual survey was conducted at your agency from May 8, 2013, through May 9, 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 seventy-two (372) patients and ten (10) personnel files based on a census of three hundred-seventy-nine (379) 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	The VMT Home Health Agency makes its best efforts to operate in substantial compliance with both Federal and State law. A Statement of Deficiency (SOD) does not constitute an admission or agreement by any party, its Officers, Directors, employees, or agents as the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies Report. This SOD is prepared and/or executed solely because it is required by Federal and State law.	
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview the home care agency (HCA) failed to ensure the plan of care (POC) included emergency protocols for nine (9) of ten (10) patients in the sample. (Patients #2, #3, #4, #5, #6, #7, #8, #9 and #10) The findings include: Review of the following POCs on May 8, 2013, between 11:30 a.m. and 5:00 p.m., revealed no documented evidence that the POCs included an emergency protocol as evidenced below: 1. Patient #2's POC with a certification period of May 24, 2012 through November 23, 2013, failed to include an emergency protocol.	H 364	**H364 3914.3 Patient Plan of Care** 1. VMT has developed a template for the emergency plan to be included on the plans of care. (See attachment A). 2. The new emergency plan will be included on the POC for any new admissions, and recertifications beginning June 1, 2013.	

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H 364	Continued From page 1 2. Patient #3's POC with certification period of March 23, 2013 through May 21, 2013, failed to include an emergency protocol. 3. Patient #4's POC with certification period of January 15, 2013 through July 14, 2013 failed to include an emergency protocol. 4. Patient #5's POC with a certification period of February 3, 2013 through August 4, 2013, failed to include an emergency protocol. 5. Patient #6's POC with a certification period of April 9, 2013 through June 8, 2013, failed to include an emergency protocol. 6. Patient #7's POC with a certification period of November 17, 2012 through May 26, 2013, failed to include an emergency protocol. 7. Patient #8's POC with a certification period of March 21, 2013 through May 19, 2013, failed to include an emergency protocol. 8. Patient #9's POC with a certification period of March 19, 2013 through May 17, 2013, failed to include an emergency protocol. 9. Patient #10's POC with a certification period of March 29, 2013 through April 27, 2013, failed to include an emergency protocol. During a face to face interview with the administrator on May 8, 2013, at approximately 4:40 p.m., it was acknowledged the POC did not include an emergency protocol for Patient's #2, #3, #4, #5, #6, #7, #8, #9 and #10. The administrator indicated that the agency would add an addendum to the POC to include the	H 364	3. VMT will conduct quarterly audits of clinical records to monitor the compliance of the inclusion of the emergency protocol on the new and recertified plan of cares, beginning the third quarter of 2013, beginning July 1, 2013. A sample size of 10% will be assessed to determine compliance and will be the benchmark for any modification of the audits going forward. This audit will be overseen directly by the Clinical Administrator and the Director of Nursing or their designee. The results will be discussed in the quarterly Professional Advisory Committee meetings.	August 1, 2013

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H 364	Continued From page 2 aforementioned requirement for the physician's signature.	H 364	**H454 3917.2(d) Skilled Nursing Services** 1. After the survey, VMT purchased weight scales for the nursing staff. 2. On May 13, 2013, VMT notified the nursing staff to begin weighing and documenting beneficiary's weights on the monthly nurses notes. The weights will be done on any beneficiary that has a diagnosis that requires monthly weight management and that can safely stand on the scale provided. If unable to weigh the beneficiary, the staff will document the last reported weight from the beneficiary, if known, on the monthly visit note. 3. VMT will conduct quarterly audits of clinical records to monitor the compliance of the inclusion of the monthly weights on the monthly visit notes beginning the third quarter of 2013, beginning July 1, 2013. A sample size of 10% will be assessed to determine compliance and will be the benchmark for any modification of the audits going forward. This audit will be overseen directly by the Clinical Administrator and the Director of Nursing or their designee. The results will be discussed in the quarterly Professional Advisory Committee Meetings.	August 1, 2013
H 454	3917.2(d) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (d) Implementing preventive and rehabilitative nursing procedures; 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 preventive and rehabilitative nursing procedures were afforded to patients related to their health conditions, for one (1) of ten (10) patients in the sample. (Patient #5). The finding includes: Review of Patient #5's plan of care (POC) dated February 3, 2013 through April 4, 2013, on May 8, 2013, at approximately 3:10 p.m., revealed Patient #5 had diagnoses that included morbid obesity, diabetes mellitus type II, hypertension, lymphedema, asthma and left eye blindness. Review of Patient #5's Initial Health/Psychosocial Assessment Form (IH/PAF) dated February 7, 2011, on May 8, 2013, at approximately 3:15 p.m., revealed that the patient was five (5) feet, six (6) inches tall and weighed three hundred (300) pounds. Review of Patient #5's Nursing Visit Note/Aide Supervisory Visit (NVN/ASV) documents dated	H 454		

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H 454	Continued From page 3 April 29, March 14 and February 15, 2013, on May 8, 2013, between 3:15 and 3:30 p.m., revealed no documented evidence that the nurse actually weighed Patient #5 or recorded the patient's reported weight during the physical assessment. During a face to face interview with the administrator and director of nursing (DON) on May 8, 2013, at approximately 5:45 p.m., it was acknowledged at the time of the survey there was no documented evidence that the nurse actually weighed Patient #5 or recorded the patient's reported weight during the physical assessment. Further interview revealed that the POC would be updated to include instructions for the nursing staff to weigh the patient or record the patient's reported weight from the primary care physician. Also the nursing staff would be re-trained on how to weigh and document the actual or reported weight on the IH/PAF and NVN/ASV.	H 454		
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 four (4) of the ten (10) patients in the sample (Patient #2, #3, #4 and #8). Additionally, the HCA failed to provide evidence that the instructions	H 459	**H459 3917.2 (i)** **Skilled Nursing Services** **And** **H564 3923.3 (c)** **Physical Therapy Services** 1. A mandatory in-service has been scheduled for June 7th and June 12th, 2013, with the current Professional staff to include, RNs, LPNs, PT, and OT. This in-service will reinforce that the staff should identify what was taught to the beneficiary on each visit, the beneficiary's response to the teaching and/or the beneficiary's ability to do a repeat demonstration of the information taught.	

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H 459	Continued From page 4 given were understood, for two (2) of the 10 patients in the sample. (Patient #3 and #4) 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 medical record on May 8, 2013, at approximately 11:30 a.m. revealed a RN Monthly Visit Record/ Supervisory Visit Form (RNMVR/SVF) dated February 2, 2013. The document indicated that the nurse provided training on medication compliance with the associated risks and benefits. Additionally, review of a RNMVR/SVF dated January 11, 2013, indicated the patient was taught alternative pain techniques. The nurse 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 with the aforementioned health teachings. 2. Review of Patient #3's medical record on May 8, 2013, at approximately 11:50 a.m. revealed a Skilled Nursing Visit Note (SNVN) dated May 1, 2013. The document indicated that the nurse provided training on fall precautions. The nurse however, failed to document the specific aspects of the aforementioned training taught to the patient and the patient's specific level of understanding with the aforementioned health teaching. 3. Review of Patient #4's medical record on May 8, 2013, at approximately 12:50 p.m. revealed Nursing Visit Note/Supervisory Visit (NVN/SV) documents dated April 29 and February 16, 2013.	H 459	2. After the survey concluded, educational tools were provided to the professional staff that included resource websites and documentation examples. These tools will aide in systematically guiding the professional staff to individualize the teaching for each beneficiary as it relates to their specific disease process (es), medications, diet, etc. 3. VMT will conduct quarterly audits of clinical records to monitor the compliance that the professional staff is more specific in their teaching, the evaluation of the beneficiary's response to the teaching and that this information is documented, at each visit. This audit will be begin the third quarter of 2013, beginning July 1, 2013. A sample size of 10% will be assessed to determine compliance and will be the benchmark for any modification of the audits going forward. This audit will be overseen directly by the Clinical Administrator and the Director of Nursing or their designee. The results will be discussed in the quarterly Professional Advisory Committee Meetings. August 1, 2013	

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H 459	Continued From page 5 The documents, indicated that the nurse provided training on medication management. Additionally, review of a NVN/SV dated March 25, 2013, indicated the nurse instructed the patient to use a walker at all times to avoid falling. The nurse however, failed to document the specific medications taught to the patient and the patient's specific level of understanding with the respective aforementioned health teachings. 4. Review of Patient #5's medical record on May 8, 2013, at approximately 1:40 p.m. revealed a NVN/SV dated April 29, 2013. The document indicated that the nurse provided training on infection control related to the transmission of the influenza virus. The nurse however, failed to document which aspect of the aforementioned health teaching was understood by the patient/caregiver. There was no documented evidence that the nurse provided health teaching instructions to the patient/caregiver on March 19 and February 15, 2013. 5. Review of Patient #6's POC with a certification period of April 9, 2013 through June 8, 2013, on May 8, 2013, at approximately 2:55 p.m. revealed that the skilled nurse (SN) was to teach the patient/caregiver how to perform wound dressing in the absence of the nurse if needed. Review of SNVN dated April 15, 2013, indicated that the nurse provided training on wound care. The nurse however, failed to document the specific aspects of the wound care training that was taught to the patient and the patient's specific level of understanding with the respective aforementioned health teachings. 6. Review of Patient #7's medical record on May 8, 2013, at approximately 4:55 p.m. revealed SNVNs dated May 1, April 29, April 26, April 24	H 459		

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H 459	Continued From page 6 and April 22, 2013. The documents indicated that the nurse provided wound care as prescribed by the physician; however,the nurse failed to document the specific aspects of wound care training that was provided to the patient/caregiver. 7. Review of Patient #10's medical record on May 8, 2013, at approximately 5:15 p.m. revealed a SNVN dated April 2, 2013. The document indicated that the nurse provided specific blood pressure management instructions to the patient/caregiver; however, the nurse failed to document the patient's specific level of understanding with the respective aforementioned health teachings. During a face to face interview with the administrator and director of nursing (DON) on May 8, 2013, at approximately 6:00 p.m., it was acknowledged at the time of the survey there was no documented evidence that the agency's nursing staff ensured training and/or the evaluation of the training had been completed as prescribed. Further interview revealed that the nursing staff would be re-trained on how to document training and/or the evaluation of the training in the patient's medical record.	H 459	**H459 3917.2 (i)** **Skilled Nursing Services** **And** **H564 3923.3 (c)** **Physical Therapy Services** 1. A mandatory in-service has been scheduled for June 7th and June 12th, 2013, with the current Professional staff to include, RNs, LPNs, PT, and OT. This in-service will reinforce that the staff should identify what was taught to the beneficiary on each visit, the beneficiary's response to the teaching and/or the beneficiary's ability to do a repeat demonstration of the information taught.	
H 564	3923.3(c) PHYSICAL THERAPY SERVICES 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.	H 564		

Health Regulation & Licensing Administration

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H 564	Continued From page 7 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 the instructions given to treat the identified physical dysfunction were understood for two (2) of ten (10) patients in the sample. (Patient #8 and #9) The findings include: 1. Review of Patient #8's plan of care (POC) with a certification period of March 21, 2013 through May 19, 2013, on May 8, 2013, at approximately 4:10 p.m., revealed the patient had diagnoses that included late effect hemiplegia. Further review of the POC revealed that the physical therapist (PT) was to provide gait/balance training, functional mobility training, therapeutic exercises, home safety and fall prevention education and the use of adaptive devices. Continued review of Patient #8's record on May 8, 2013, at approximately 4:25 p.m., revealed Physical Therapy Revisit Notes (PTRNs) dated April 24, March 10 and March 20, 2013. The documents indicated that the PT provided the aforementioned instructions ; but failed to document the specific level of understanding with the aforementioned training. 2. Review of Patient #9's POC with a certification period of March 19, 2013 through May 17, 2013, on May 8, 2013, at approximately 4:35 p.m., revealed the patient had diagnoses that included difficulty walking. Further review of the POC revealed that the PT was to provide gait/balance training, functional mobility training, home safety and fall prevention education, therapeutic exercises and the use of adaptive devices. Continued review of Patient #9's record on May 8, 2013, at approximately 4:40 p.m., revealed	H 564	2. After the survey concluded, educational tools were provided to the professional staff that included resource websites and documentation examples. These tools will aide in systematically guiding the professional staff to individualize the teaching for each beneficiary as it relates to their specific disease process (es), medications, diet, etc. 3. VMT will conduct quarterly audits of clinical records to monitor the compliance that the professional staff is more specific in their teaching, the evaluation of the beneficiary's response to the teaching and that this information is documented, at each visit. This audit will be begin the third quarter of 2013, beginning July 1, 2013. A sample size of 10% will be assessed to determine compliance and will be the benchmark for any modification of the audits going forward. This audit will be overseen directly by the Clinical Administrator and the Director of Nursing or their designee. The results will be discussed in the quarterly Professional Advisory Committee Meetings. August 1, 2013	

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H 564	Continued From page 8 PTRNs dated May 3,April 22, April 15 and April 10, 2013. The documents indicated that the PT provided the aforementioned instructions; but failed to document the specific level of understanding with the aforementioned training. During a face to face interview with the administrator and director of nursing (DON) on May 8, 2013, at approximately 5:45 p.m.., it was acknowledged that the physical therapy staff would be re-trained on documenting the specific level of understanding of the aforementioned instructions given to Patient's #8 and #9.	H 564		