Department of Health

Health Regulation & Licensing Administration Intermediate Care Facilities Division

PRINTED: 11/23/2011 FORM APPROVED

DATE

Health Regulation & Licensing Administration 899 North Capitol St., N.E. STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A RUILDING B. WING **HCA0003** 11/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX**

H 000 INITIAL COMMENTS

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An annual licensure survey was conducted from November 9, 2011, through November 16, 2011, to determine compliance with Title 22 DCMR, Chapter 39. The findings of the survey were based on a random sample of eleven 11) clinical records based on a census of two hundred-twenty four(224 patients, three (3) discharge records, twenty-one(21) personnel files based on a census of three-hundred ninety four 394 employees and three(3) home visit. The findings of the survey were based on staff interviews and review of clinical records.

REGULATORY OR LSC IDENTIFYING INFORMATION)

H 265 3911.2(e) CLINICAL RECORDS H 265

> Each clinical record shall include the following information related to the patient:

(e) Physician's orders;

This Statute is not met as evidenced by: Based on record review and interview, it was determined the Home Care Agency (HCA) failed to have a physician order for two (2) of eight (8)patient's record at the time of this survey. (Patient #4)

The finding includes:

1. On November 9, 2011, review of Patient #4's record, at approximately 1:30 p.m., revealed multiple nursing notes from August 21, 2011 through October 8, 2011 in which the agency's skilled nurse documented they performed wet to dry for a wound to patient's left buttocks.

Further review of the record revealed a plan of care (POC) for the certification period of August

The VMT Home Health Agency makes its best efforts to operate in substantial compliance with both Federal and State law. Plan of Correction (POC) does not Constitute an admission or agreement by any party, its officers, directors, employee or agents as the truth of the facts alleged or the validity of the conditions set forth alleged or the validity of the conditions set forth on the Statement of Deliciencies. This Plan of Care (POC) is prepared and/ or executed solely because it is required by Federal and State Law.

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

H265 3911.2(e) CLINICAL RECORDS

Patient #4: The assigned VMT nurse indicated that the MD gave a verbal order to change the wound dressing order to a normal saline wet to dry dressing change. In order to correct this deficiency, the MD was consulted by phone, confirmed the change, and signed an order on 11/11/2011, to reflect the correct wound care order.

In order to ensure that all clinical records are in compliance with statue 3911.2 (e), the DON will re-educate the professionals staff regarding the policy and procedure of dictating any verbal orders given by the MD. Any verbal orders must be submitted within 24 hours to the Director of Nursing (DON) and the office staff will fax the order to the MD to be confirmed and signed. Once the MD signs the order, the new order will be included in the following Plan of Care (POC), if applicable.

November 21, 2011

All assigned nurses will receive a new Plan of Care or a copy of any MD order change. The DON or his designee will review /monitor all wound notes monthly to ensure compliance.

Health Regulation & Licensing Administration

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

STATE FORM

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October 9, 2011 in whe skilled nursing visits lek for nine week, daily eeded, clean wound why santyl ointment as ox4 gauze and abd page of documented evider wet to dry dressings of this survey. The pool on November 9 of p.m. they indicated der for the skilled nursing dressings however, of the skilled nursing dressings however, or skilled nursing however.	five to wound with ordered by d then nce of a in the Clinical 2011 at there se to only the	H 355 3914.3(d) PATIENT PLAN OF	
thall include the follow of the services to be po- uency, amount, and e- equirements; medicati- cluding dosage; equipa- of review and interview Home Care Agency (Hoscription or frequer vided for five(5)of eigling the sample.	rovided, xpected con ment; and /: , it was HCA) ncy of	Patient #2: The assigned VMT wound nurse indicated that the MD requested an assessment and recommendation regarding the treatment of the wound. The nurse did not write her recommendations at that time yet began the dressing changes. The nurse gave the recommendations to the DON on 9/23/11. The MD was consulted, at that time, by the DON and confirmed the recommendations and orders and the new wound care orders were written and faxed to the MD for signature on 09/23/2011. At the time of the recertification period from 7/31/11 to 9/28/11, the verbal orders had not been written by the wound nurse. The wound nurse was counseled regarding the policy and procedure as it pertains to verbal orders. In order to ensure that all clinical records are in compliance with statue 3914.3 (d), the professional staff must document any verbal orders given by the MD and notify the	
	age 1 October 9, 2011 in whe skilled nursing visits ek for nine week, daily eeded, clean wound why santyl ointment as on a compared evider of this survey. The compared evider of the skilled nursing of this survey. The compared evider of the skilled nursing of the services to be proposed for the skilled nursing of the services to be proposed for the services to be proposed for the skilled nursing of the services to be proposed for the servic	age 1 H 265 October 9, 2011 in which the skilled nursing visits five to ek for nine week, daily wound eeded, clean wound with ly santyl ointment as ordered by x4 gauze and abd pad then no documented evidence of a r wet to dry dressings in the of this survey. ace interview with the Clinical DON on November 9, 2011 at 15 p.m. they indicated there der for the skilled nurse to r dressings however, only the ntment was in the current AT PLAN OF CARE AT PLAN OF CARE Of the services to be provided, nuency, amount, and expected equirements; medication cluding dosage; equipment; and of the services to be provided, nuency, amount, and expected equirements; medication cluding dosage; equipment; and of the services to be provided, nuency, amount, and expected equirements; medication cluding dosage; equipment; and of the services of the servic	age 1 H 265 October 9, 2011 in which the skilled nursing visits five to ek for nine week, daily wound eeded, clean wound with ly santyl ointment as ordered by x4 gauze and abd pad then no documented evidence of a r wet to dry dressings in the of this survey. ace interview with the Clinical DON on November 9, 2011 at 15 p.m. they indicated there der for the skilled nurse to r dressings however, only the entrment was in the current AT PLAN OF CARE AT S355 AT ST AND OF CARE AT PLAN OF CARE AT S355 AT ST AND OF CARE AT PLAN OF CARE AT PLA

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H 355	Continued From p	age 2	· · ·	H 355		
	1. On November #2's record at app a POC with a certi through September physician ordered three (3) times a vicient/caregiver saplan-when to call vicient/saplan-when t	r 9, 2011, a review of roximately 11:20 a.m. fication period July 3 er 28, 2011 in which the skilled nursing visits of veek for nine (9) week fety precautions/eme VMT/911/MD as outlinut. The record reveal otes from August 2, 2 er 23, 2011 in which the lilled nurses document care. Sumented evidence or nurse to perform wour acce interview with the DON on November 915 p.m., they acknown dicate that the skilled	revealed 1, 2011 ne one (1) to c to teach rgency ned in led 011 ne Home ted they Clinical 1, 2011 at wledged		real-time. Once the MD signs the order the new order will be included in the following Plan of Care (POC), if applicable. All assigned nurses will receive a new Plan of Care or a copy of any MD order change. The DON or his designee will review /monitor all wound notes monthly to ensure compliance.	e
	patient #5's record revealed a plan of period of August 2011 in which the therapy (OT) eval record revealed m 17,2011 through (was no document POC of the freque During a face to fadministrator and approximately 10:	10, 2011, a review of d at approximately 9:3 f care (POC) with cert 13, 2011 through Nov physician ordered ocuation and treatment nultiple OT notes from October 28,2011, howed evidence on patier ency for OT visits. ace interview with the I DON on November 130 a.m., they indicate services had not beer	of a.m. ification rember 11, cupational The October rever there at #5's Clinical 10, 2011 at ad the		Patient #5: The occupational therapist (OT evaluation and treatment order was noted of the original home health POC. What was no indicated on the home health POC was the frequency of the visits which is determined after the OT visits the patient and the needs assessed. The OT POC was submitted after the home health POC was generated. The OPOC was not signed by the MD. In order correct this deficiency, the OT POC, dated 9/20/2011, was faxed to the MD office for signature and the frequency of the visits with be documented on the following POC, if applicable.	n ot sare r - OT :

documented on the POC.

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Н 355	3. On November 1 patient #6's record revealed a plan of period of August 1 2011 in which the patient #7's record revealed management of patient #7's record revealed on the 4. On November 1 patient #7's record revealed a plan of period of July 16, 2011 in which the patient #7's record revealed a plan of period of July 16, 2011 in which the patient #7's record revealed management pool of the frequency for PT second revealed management pool of the frequency for patient #7's record revealed management pool of the frequency for PT second approximately 10:3 frequency for PT second patient #8's record record revealed management pool of the frequency for PT second patient #8's record patient #8's record revealed on the patient #8's record patie	0, 2011, a review of at approximately 9:5 care (POC) with certi 5, 2011 through Octobysician ordered physician ordered physician ordered physician ordered physician ordered physician evidence on equency for PT visits. The interview with the DON on November 1 to a.m., they indicate ervices had not been at approximately 10: care (POC) with cert 2011 through Septen ohysician ordered physician ordered physic	0 a.m. fication ober 11, ysical The August yever patient Clinical 0, 2011 at d the the 20 a.m. ification ober 13, ysical The July 26, ever there on #7's Clinical 10, 2011 at d the the 20 a.m. ification ober 13, ysical The July 26, ever there of #7's	H 355	In order to ensure that all clinical records are in compliance with statue 3914.3 (d), the OT POC, which notes the visit frequency, will be faxed to the MD office for signature and a copy of the OT POC will be placed in the Physician Order section of the client's medical record and the frequency will be no on the following POC, if applicable. Monitoring and compliance will be aided by the data entry staff, identifying and tracking all unsigned OT POC monthly. Thi data will be included in the weekly office meetings and allow for brainstorming and strategic thinking on how to maintain compliance. The data entry staff will notify the Administrator weekly on the status of all unsigned OT POC and the progress and plain if the POC remain unsigned after 20-25 day VMT will escalate the issues to VMT's Medical Director and request a doctor to doctor conference. Patients #6, #7 and #8: The Physical Therapist (PT) evaluation and treatment order was noted on the original POC. What was not indicated on the home health POC with the frequency of the visits which is determined after the PT visits the patient and the needs a assessed: The PT POC was submitted after thome health POC was generated. The PT POC was not signed by the MD. In order to compatible deficiency, the PT POC, dated 5/5/2011 was faxed to the MD office for signature and the frequency of the visits will be document on the following POC, if applicable.	November 10, 2011 s as as as c c c c c c c c c c c c c
	period of October 2011 in which the	8, 2011 through Dec physician ordered phation and treatment.	ember 6, ysical			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM HCA0003		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 11/16/2011	
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H 366	record revealed mutal, 2011 through there was no docur #8's POC of the free During a face to face Administrator and I approximately 10:3 frequency for PT sedocumented on the 3914.4 PATIENT F Each plan of care is by a physician with of care; provided, it personal care aide approved and significant registered nurse. If revised by a telephyshall be immediate	November 3, 201, homented evidence on paquency for PT visits. The interview with the COON on November 100 a.m., they indicated ervices had not been a POC.	Clinical 0, 2011 at 1 the d signed the start of care for eractice ated or one order and it	H 366	In order to ensure that all clinical records are in compliance with statue 3914.3 (d), the PT POC, which notes the visit frequency, will be faxed to the MD office for signature and a copy of the PT POC will be placed in the Physician Order section of the client's medical record and the frequency will be no on the following POC, if applicable. Monitoring and compliance will be aided by the data entry staff, identifying and tracking unsigned PT POC weekly. This data will be included in the weekly office meetings and allow for brainstorming and strategic thinking on how to maintain compliance. The data entry staff will notify the Administrator monthly on the status of all unsigned PT PO and the progress and plan. If the POC remain unsigned after 20-25 days VMT will escalate the issue to VMT's Medical Director and request a doctor to doctor conference.	ted November 10, 2011 all	
	Based on record redetermined that the failed to ensure the was approved by a with-in thirty (30) d for three (3) of four sample (Patient # 3). The findings included 1. On November 9 record at approximately pools with certificate	•	t was (HCA) re (POC) cian e (SOC) the atient #2's ealed a 2011		H 366 3914.4 PATIENT PLAN OF CARE Patients #2: POC was signed outside of the regulation requirement on 11/15/2011. Patient #3: POC was signed outside of the regulation requirement on 11/10/2011. Patient #7: POC was signed outside of the regulation requirement on 09/27/2011.		

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING **HCA0003** 11/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 366 Continued From page 5 H 366 VMT implemented a new process to aid in the documented evidence of a physician's signature timely return of signed POCs by physicians. In at the time of this survey. order to ensure that all clinical records are in compliance with statue 3914.4, VMT has taken additional steps prior to the current During a face to face interview with the Clinical survey to aid in maintaining compliance. Administrator and DON on November 9, 2011 at These strategies are: approximately 12:15 p.m., it was acknowledged Patient #2's POC had not been signed by a Each facsimile includes an alert physician at the time of this survey. document that quotes regulation 3914.4. Each facsimile coversheet request 2. On November 9, 2011, a review of Patient #3's either a signature or denial of record at approximately 12:33 p.m. revealed a services within the 30 day POC with certification period of July 16, 2011 requirement. through September 13, 2011. There was no A copy of the POC is provided to documented evidence of a physician's signature the patients prior to their doctor's appointments for review by MD at the time of this survey. and for signature. During a face to face interview with the Clinical Medical Director has/will contacted Administrator and DON on November 9, 2011 at the physicians regarding unsigned POC. approximately 1:00 p.m., it was acknowledged 5. All unsigned POC are re-faxed Patient #2's POC had not been signed by a weekly for signature. physician at the time of this survey. · 30, 2011 Monitoring and compliance will be aided by 3. On November 10, 2011, a review of Patient's the data entry staff, identifying and tracking all #7's record at approximately 10:20 a.m. revealed unsigned POC weekly. This data will be a POC with certification period July 16, 2011 included in the weekly office meetings and through September 13, 2011. The physician allow for brainstorming and strategic thinking signed the POC seventy-one days after the start on how to maintain compliance. The data of of care on September 27, 2011. There was no entry staff will notify the Administrator documented evidence the POC was signed by a weekly on the status of all unsigned POC and physician thirty days after the start of care in the the progress and plan. If the POC remain record at the time of this survey. unsigned after 20-25 days VMT will escalate the issues to VMT's Medical Director and request a doctor to doctor conference. H 430 3916.1 SKILLED SERVICES GENERALLY H 430 Each home care agency shall review and evaluate the skilled services provided to each patient at least every sixty-two (62) calendar days. A summary report of the evaluation shall be

sent to the patient's physician.

PRINTED: 11/23/2011 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING _ HCA0003 11/16/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY **WASHINGTON, DC 20008** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 430 H 430 Continued From page 6 H 430 3916.1 SKILLED SERVICES **GENERALLY** VMT humbly notes a typo in this deficiency. This Statute is not met as evidenced by: The statement speaks to Patient #7 in the Based on record review and interview the home summary. Number 6 and 7 in this deficiency care agency (HCA) failed to have documented references Patient #6 twice and omitted Patient evidence of reviews and evaluations of the #7. VMT is confident after the exit conference skilled services provided to patient's at least that Number 7 should reference Patient every sixty-two days or that a summary report of number 7 and the documentation submitted is the evaluation was sent to the patient's physician in relation to Patient #7. for seven(7) of eight (8)patient's in the sample. (Patient#1, #2, #3, #4, #5, #6, and #7) Patients #1 and #4: The date of the nurse's last visit was noted on the 62-day summary but the actual date of completion was omitted. In The findings include: order to correct this deficiency the nurses were contacted to retrieve the date that the summary 1. On November 9, 2011, a record review of

patient #1's record at approximately 10:30 a.m. revealed a plan of care (POC) for the certification period of August 31,2011 through October 28. 2011 in which the physician ordered weekly skilled nursing visits one (1) to three (3) times a week to teach client/care giver safety precautions/emergency plan- when to call the agency/911 as outlined in the emergency handout. There was a document in the record entitled "Summary of Care for Medicare Clients" which was undated. Additionally, there was no evidence the summary had been sent to the patient's physician.

During a face to face interview with the Clinical Director and DON on November 9, 2011 at approximately 12:25 p.m., they acknowledged they did not have a confirmation fax page to indicated the document had been faxed to the patient's physician.

2. On November 9, 2011, a record review of patient #2's record at approximately 11:20 a.m. revealed a plan of care (POC) for the certification period of July 31,2011 through September 28,

was completed. To mitigate this from reoccurring, the forms have been revised to clearly reflect the date of completion and the date of last nurse visit.

In order to ensure that all clinical records are in compliance with statue 3916.1, the revised forms will be distributed to the nursing staff and this form will be implemented with the next scheduled 62-day summary submission which is December 2011.

November 30, 2011

Monitoring and compliance will be aided by the DON or his designee by reviewing the 62day summary submissions, on the scheduled months, to ensure the completeness and accuracy prior to faxing the summary to the patient's physician. The facsimile confirmation sheet will be stapled to the report and placed in the clinical coordination section of the medical records.

Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING HCA0003 11/16/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) H 430 H 430 Continued From page 7 Patients #2, #3, and #6 became compliant with statue 3916.1 on 11/10/2011. The assigned 2011 in which the physician ordered weekly nurses were contacted regarding the missing skilled nursing visits one (1) to three (3) times a 62-day summaries. The nurses emailed the week to teach client/care giver safety copies to the office for submission during the precautions/emergency plan- when to call the survey period. agency/911 as outlined in the emergency handout. In addition there was no documented VMT targets the even-months on or about the evidence the HCA reviewed and evaluated the 10th day of that month to fax the 62-day skilled services that had been provided. summaries to the physicians. These reports are generated by the professional staff and will be During a face to face interview with the DON on sent to the physician every 60-62 days. December 10, 2011 November 9, 2011 at approximately 12:25 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not The DON or his designee will track these been done at the time of this survey. reports by generating a skilled census on the designated submission months. This report 3. On November 9, 2011, a record review of will then be used to track the 62-day summary patient #3's record at approximately 12:30 p.m. reports submissions. In order ensure revealed a plan of care (POC) for the certification compliance and monitor the compliance the period of July 16,2011 through September 13, report should be submitted between the 8th and 10th day of every even month. These reports 2011 in which the physician ordered weekly will then be placed in the Clinical skilled nursing visits one (1) to three (3) times a Collaboration section of the patient's medical week to teach client/care giver safety record along with the fax confirmation sheet. precautions/emergency plan- when to call the agency/911 as outlined emergency handout. In Patients #5 and #7 became compliant with addition there was no documented evidence the statue 3916.1 on 11/18/2011. The assigned HCA reviewed and evaluated the skilled nurses were contacted regarding the missing services that had been provided. 62-day summaries. The nurses emailed the copies to the office for submission during the During a face to face interview with the DON on survey period. November 9, 2011 at approximately 1:15 p.m., DON will re-educate the nursing staff on the indicated a summary report reviewing and process, regulation and requirements of evaluating the skilled services provided had not submitting the 62-day summaries timely. VMT been done at the time of this survey. targets the even-months on or about the 10th day of that month to fax the 62-day summaries 4. On November 9, 2011, a record review of to the physicians. In order ensure compliance patient #4's record at approximately 1:30 p.m. and monitor the compliance the report should revealed a plan of care (POC) for the certification be submitted between the 8th and 10th day of

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period of August 11, 2011 through October 9,

nursing visits five to seven times a week for nine

2011 in which the physician ordered skilled

November 21, 2011

every even month. These reports are generated

by the professional staff and will be sent to the

physician every 60-62 days.

OKBV11

Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 11/16/2011 HCA0003 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY **WASHINGTON, DC 20008** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) H 430 H 430 Continued From page 8 week, daily wound dressing and as needed, clean The DON or his designee will track these reports every scheduled month by generating a wound with normal saline apply santyl ointment skilled census report. This report will then be as ordered by physician, cover 4x4 gauze and used to track the 62-day summary reports abd pad then tapped, skilled nursing to teach submissions. These reports will then be client/care giver safety precautions/emergency placed in the Clinical Collaboration section of plan- when to call VMT/911/MD as outlined in the patient's record with the fax confirmation emergency handout. In addition there was a stapled to the report. document entitled "Summary of Care for Medicare Clients" which was undated, there was no evidence the summary had been sent to the patient's physician. Patient #1, #2, #3, #4, #5, #6 and #7 In order to remedy the missing fax During a face to face interview with the Clinical confirmations, the 62-day summaries were Administrator and DON on November 9, 2011 at re-faxed to the physician on 11/10/2011 and approximately 1:15 p.m., indicated a summary 11/11/2011 and the fax confirmation sheet report reviewing and evaluating the skilled was stapled to the reports and placed in the services provided had not been done at the time Clinical Collaboration section of the patient's of this survey. medical record. 5. On November 10, 2011, a record review of In order to ensure that all clinical records are patient #5's record at approximately 9:30 a.m. in compliance with statue 3916.1, VMT targets revealed a plan of care (POC) for the certification the even-months on or about the 10th day of that month to fax the 62-day summaries to the period of September 13, 2011 through November physicians. In order ensure compliance and 11, 2011 in which the physician ordered skilled monitor the compliance the report should be nursing visits one (1) to three (3)week for nine submitted between the 8th and 10th day of (9)weeks, skilled nursing to teach client/care giver every even month. These reports are safety precautions/emergency plan- when to call generated by the professional staff and will be VMT/911/MD as outlined in emergency handout. sent to the physician every 60-62 days. physical therapy and occupational therapy to Jecember 10, 2011 evaluate and treat, there was no documented The DON or his designee will track these evidence the HCA reviewed and evaluated the reports every scheduled month by generating a skilled services that had been provided. skilled census report. This report will then be used to track the 62-day summary reports During a face to face interview with the Clinical submissions. These reports will then be placed in the Clinical Collaboration section of Administrator and DON on November 10, 2011 at the patient's record along with the fax approximately 1:15 p.m., indicated a summary confirmation report. report reviewing and evaluating the skilled services provided had not been done at the time

of this survey.

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Health Regulation & Licensing Administration								
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VMT HOME HEALTH AGENCY		Υ	4201 CONNECTICUT AVE NW SUITE 200 WASHINGTON, DC 20008					
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H 430	Continued From pa	age 9		H 430				
	patient #6's record revealed a plan of period of August 13 2011 in which the nursing visits one (9)weeks, skilled n safety precautions/VMT/911/MD as or physical therapy are evaluate and treat, evidence the HCA skilled services the During a face to fa Administrator and approximately 1:15 report reviewing ar	0, 2011, a record reviat approximately 9:50 care (POC) for the complete (POC) for the compl	0 a.m. ertification ber 11, illed for nine /care giver en to call handout, py to ented ated the Clinical 0, 2011 at ummary ed					
	patient #6's record revealed a plan of period of July 16, 2 2011 in which the nursing visits one (9)weeks. skilled mage safety precautions VMT/911/MD as ophysical therapy are evaluate and treat evidence the HCA skilled services the During a face to fa Administrator and approximately 1:18 report reviewing at	0, 2011, a record revit at approximately 9:5 care (POC) for the complete control of the	0 a.m. ertification ber 13, illed for nine /care giver en to call handout, apy to hented ated the l. Clinical 0, 2011 at ummary led		,			

Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING **HCA0003** 11/16/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) H 430 H 430 Continued From page 10 of this survey. H 453 H453 3917.2 (c) SKILLED NURSING H 453 3917.2(c) SKILLED NURSING SERVICES **VISITS** Duties of the nurse shall include, at a minimum, Patient #3 did not received visits from July 31, the following: 2011 to August 6, 2011, August 7, 2011 to August 13, 2011 and August 14, 2011 to (c) Ensuring that patient needs are met in August 20, 2011. The expectation is for all accordance with the plan of care; forms to be completed accurately and timely. VMT is aware of this issue and has taken corrective action which was completed on This Statute is not met as evidenced by: November 21, 2011. RN has submitted Based on record review and interview, it was missed visits for the above dates. revealed the Home Care Agency failed to ensure the patient need were met in accordance In order to ensure that all clinical records are with the plan of care for one (1)of eight(8) in compliance with statue 3917.2(c), the DON patients in the sample. (Patient #3) or his designee will track the RN visits daily through VMT's call -in system. This The findings include: tracking system will identify clients with missed visits and alert the DON that missed visits have occurred and missed visit On November 9, 2011, a record review of patient documentation should be submitted. November 30, 2011 #3's record at approximately 12:30 p.m. revealed a plan of care (POC) for the certification period Monitoring and compliance will be aided by of July 16, 2011 through September 13, 2011 in the DON or his designee through tracking the which the physician ordered weekly skilled visits monthly through the VMT call-in system nursing visits one (1) to three (3) times a week to and notifying the nursing staff of any missing teach client/care giver safety visits noted. This data will be included precautions/emergency plan- when to call the monthly office meetings and allow for agency/911 as outlined emergency handout. brainstorming and strategic thinking on how to maintain compliance. The DON will notify Further review of the record revealed there was the Administrator monthly on the status no documented evidence the skilled nurse visited all missed visits and trends. the patient the weeks of July 31, 2011 through August 6, 2011, August 7, 2011 through August 13, 2011 and August 14, 2011 through August 20,2011 at the time of this survey. During a face to face interview with the Clinical

Administrator and DON on November 9, 2011 at approximately 1:15 p.m., they indicated the skilled

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Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 11/16/2011 **HCA0003** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4201 CONNECTICUT AVE NW SUITE 200** VMT HOME HEALTH AGENCY WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ΙĐ (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 453 H 453 Continued From page 11 nursing notes may have been filed in another patient's record. H 459 H 459 3917.2(i) SKILLED NURSING SERVICES H 459 3719.2 (i) SKILLED NURSING **SERVICES** Duties of the nurse shall include, at a minimum, the following: Patient #2: Nursing staff completed teaching on each of the visits from 8/2/11 to 9/23/11. (i) Patient instruction, and evalutaion of patient The nurse did not indicate the evaluation of the instruction; and teaching. The nurse was notified of the omission of evaluation of teaching and the personnel corrective action was done on 11/21/11. This Statute is not met as evidenced by: In order to ensure that all clinical records are Based on record review and interview, the Home in compliance with statue 3919.2(i), an in-Care Agency's (HCA) skilled nursing staff failed service will be conducted by the DON, with to ensure evaluation of patient instruction for the professional staff, regarding teaching and one(1) of fourteen(14) patients in the sample. the evaluation of the teaching by 12/16/11. (Patient #2) Prior to this in-service, and email will be sent to communicate the teaching and evaluation The findings include: expectations. This email will assist in ensuring that all teaching and evaluations done on the On November 9, 2011, a record review of patient monthly visits prior to 12/16/11 will be compliant. The current nurse visit form will be #2's record at approximately 11:20 a.m. revealed revised and clearly identify a section that will skilled nursing notes dated from August 2, 2011 allow for the evaluation of the teaching to be through September 23, 2010 in which the skilled documented nurse provided teaching to patient #2. Additionally, there was no documented evidence November 21, 2011 Monitoring and compliance will be aided by the skilled nurse evaluated the teaching provided the DON or his designee for accuracy, to patient #2. completeness. The DON or his designee will review the submitted visit notes and ensure During a face to face interview with the Clinical that all information required is documented. Administrator/ DON on November 9, 2011 at DON will lead spot audits of patient's records approximately 12:15 p.m., they indicated the to ensure that the patient's records are agency's skilled nurses did not evaluate the compliant and complete. teaching they provided.

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Health Regulation & Licensing Administration

TITLE

(X6) DATE