STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA0003	A. BUILDING _____ B. WING _____	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMT HOME HEALTH AGENCY	4201 CONNECTICUT AVE NW SUITE 200 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 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.	H 000	**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, employees 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 Deficiencies. This Plan of Care (POC) is prepared and/ or executed solely because it is required by Federal and State Law.**	
H 265	3911.2(e) CLINICAL RECORDS 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	H 265	**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. 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.	**November 21, 2011**

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H 265	Continued From page 1 11, 2011 through October 9, 2011 in which the physician ordered skilled nursing visits five to seven times a week for nine week, daily wound dressing and as needed, clean wound with normal saline apply santyl ointment as ordered by physician, cover 4x4 gauze and abd pad then tape. There was no documented evidence of a physician order for wet to dry dressings in the record at the time of this survey. During a face to face interview with the Clinical Administrator and DON on November 9, 2011 at approximately 12:15 p.m. they indicated there was a previous order for the skilled nurse to perform wet to dry dressings however, only the order for santyl ointment was in the current physician order.	H 265		
H 355	3914.3(d) PATIENT PLAN OF CARE The plan of care shall include the following: (d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies; This Statute is not met as evidenced by: Based on a record review and interview, it was revealed that the Home Care Agency (HCA) failed to include a description or frequency of services to be provided for five(5)of eight(8)plan of care's (POC's)in the sample. (Patient #2, #5, #6, and #7) The finding includes:	H 355	**H 355 3914.3(d) PATIENT PLAN OF CARE** 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 Director of Nursing (DON) of those changes	

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H 355	Continued From page 2	H 355		

1. On November 9, 2011, a review of patient #2's record at approximately 11:20 a.m. revealed a POC with a certification period July 31, 2011 through September 28, 2011 in which the physician ordered skilled nursing visits one (1) to three (3) times a week for nine (9) week to teach client/caregiver safety precautions/emergency plan-when to call VMT/911/MD as outlined in emergency handout. The record revealed multiple nursing notes from August 2, 2011 through September 23, 2011 in which the Home Care Agency's skilled nurses documented they performed wound care.

There was no documented evidence on patient #2's POC for the nurse to perform wound care.

During a face to face interview with the Clinical Administrator and DON on November 9, 2011 at approximately 12:15 p.m., they acknowledged the POC did not indicate that the skilled nurse was to perform wound care.

2. On November 10, 2011, a review of the patient #5's record at approximately 9:30 a.m. revealed a plan of care (POC) with certification period of August 13, 2011 through November 11, 2011 in which the physician ordered occupational therapy (OT) evaluation and treatment. The record revealed multiple OT notes from October 17,2011 through October 28,2011, however there was no documented evidence on patient #5's POC of the frequency for OT visits.

During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 10:30 a.m., they indicated the frequency for OT services had not been documented on the POC.

real-time. 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.

Patient #5: The occupational therapist (OT) evaluation and treatment order was noted on the original home health POC. What was not indicated on the home health POC was the frequency of the visits which is determined after the OT visits the patient and the needs are assessed. The OT POC was submitted after the home health POC was generated. The OT POC was not signed by the MD. In order to correct this deficiency, the OT POC, dated 9/20/2011, was faxed to the MD office for signature and the frequency of the visits will be documented on the following POC, if applicable.

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H 355	Continued From page 3 3. On November 10, 2011, a review of the patient #6's record at approximately 9:50 a.m. revealed a plan of care (POC) with certification period of August 15, 2011 through October 11, 2011 in which the physician ordered physical therapy (PT) evaluation and treatment. The record revealed multiple PT notes from August 16 , 2011 through October 11, 201, however there was no documented evidence on patient #6's POC of the frequency for PT visits. During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 10:30 a.m., they indicated the frequency for PT services had not been documented on the POC. 4. On November 10, 2011, a review of the patient #7's record at approximately 10:20 a.m. revealed a plan of care (POC) with certification period of July 16, 2011 through September 13, 2011 in which the physician ordered physical therapy (PT) evaluation and treatment. The record revealed multiple PT notes from July 26, 2011 through September 8, 2011, however there was no documented evidence on patient #7's POC of the frequency for PT visits. During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 10:30 a.m., they indicated the frequency for PT services had not been documented on the POC. 5. On November 10, 2011, a review of the patient #8's record at approximately 10:20 a.m. revealed a plan of care (POC) with certification period of October 8, 2011 through December 6, 2011 in which the physician ordered physical therapy (PT) evaluation and treatment. The	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 noted 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. 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 weekly on the status of all unsigned OT POC and the progress and plan. If the POC remain unsigned after 20-25 days 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 was the frequency of the visits which is determined after the PT visits the patient and the needs are assessed. The PT POC was submitted after the home health POC was generated. The PT POC was not signed by the MD. In order to correct this deficiency, the PT POC, dated 5/5/2011, was faxed to the MD office for signature and the frequency of the visits will be documented on the following POC, if applicable.	**November 10, 2011**

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H 355	Continued From page 4 record revealed multiple PT notes from October 11, 2011 through November 3,.201, however there was no documented evidence on patient #8's POC of the frequency for PT visits. During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 10:30 a.m., they indicated the frequency for PT services had not been documented on the POC.	H 355	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 noted on the following POC ,if applicable. Monitoring and compliance will be aided by the data entry staff, identifying and tracking all 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 POC 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.	November 10, 2011
H 366	3914.4 PATIENT PLAN OF CARE Each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care; provided, however, that a plan of care for personal care aide services only may be approved and signed by an advanced practice registered nurse. If a plan of care is initiated or revised by a telephone order, the telephone order shall be immediately reduced to writing, and it shall be signed by the physician within thirty (30) days. This Statute is not met as evidenced by: Based on record review and interview, it was determined that the Home Care Agency (HCA) failed to ensure the patient's Plan of Care (POC) was approved by and signed by a physician with-in thirty (30) days of the start of care (SOC) for three (3) of fourteen (14) patients in the sample (Patient # 2, #3, #7) The findings include: 1. On November 9, 2011, a review of Patient #2's record at approximately 11:20 a.m. revealed a POC with certification period of July 21, 2011 through September 28, 2011. There was no	H 366	**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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H 366	Continued From page 5 documented evidence of a physician's signature at the time of this survey. During a face to face interview with the Clinical Administrator and DON on November 9, 2011 at approximately 12:15 p.m., it was acknowledged Patient #2's POC had not been signed by a physician at the time of this survey. 2. On November 9, 2011, a review of Patient #3's record at approximately 12:33 p.m. revealed a POC with certification period of July 16, 2011 through September 13, 2011. There was no documented evidence of a physician's signature at the time of this survey. During a face to face interview with the Clinical Administrator and DON on November 9, 2011 at approximately 1:00 p.m., it was acknowledged Patient #2's POC had not been signed by a physician at the time of this survey. 3. On November 10, 2011, a review of Patient's #7's record at approximately 10:20 a.m. revealed a POC with certification period July 16, 2011 through September 13, 2011. The physician signed the POC seventy-one days after the start of of care on September 27, 2011. There was no documented evidence the POC was signed by a physician thirty days after the start of care in the record at the time of this survey.	H 366	VMT implemented a new process to aid in the timely return of signed POCs by physicians. In order to ensure that all clinical records are in compliance with statue 3914.4, VMT has taken additional steps prior to the current survey to aid in maintaining compliance. These strategies are: 1. Each facsimile includes an alert document that quotes regulation 3914.4. 2. Each facsimile coversheet request either a signature or denial of services within the 30 day requirement. 3. A copy of the POC is provided to the patients prior to their doctor's appointments for review by MD and for signature. 4. Medical Director has/will contacted the physicians regarding unsigned POC. 5. All unsigned POC are re-faxed weekly for signature. Monitoring and compliance will be aided by the data entry staff, identifying and tracking all unsigned 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 weekly on the status of all unsigned POC and the progress and plan. If the POC remain unsigned after 20-25 days VMT will escalate the issues to VMT's Medical Director and request a doctor to doctor conference.	30, 2011
H 430	3916.1 SKILLED SERVICES GENERALLY 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.	H 430		

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H 430	Continued From page 6	H 430	**H 430 3916.1 SKILLED SERVICES GENERALLY**	

This Statute is not met as evidenced by:
Based on record review and interview the home care agency (HCA) failed to have documented evidence of reviews and evaluations of the skilled services provided to patient's at least every sixty-two days or that a summary report of the evaluation was sent to the patient's physician for seven(7) of eight (8)patient's in the sample. (Patient#1, #2, #3, #4, #5, #6, and #7)

The findings include:

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,

VMT humbly notes a typo in this deficiency. The statement speaks to Patient #7 in the summary. Number 6 and 7 in this deficiency references Patient #6 twice and omitted Patient #7. VMT is confident after the exit conference that Number 7 should reference Patient number 7 and the documentation submitted is in relation to Patient #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 order to correct this deficiency the nurses were contacted to retrieve the date that the summary 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.

Monitoring and compliance will be aided by the DON or his designee by reviewing the 62-day 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.

November 30, 2011

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H 430	Continued From page 7 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. In addition there was no documented evidence the HCA reviewed and evaluated the skilled services that had been provided. During a face to face interview with the DON on November 9, 2011 at approximately 12:25 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not been done at the time of this survey. 3. On November 9, 2011, a record review of patient #3's record at approximately 12:30 p.m. revealed a plan of care (POC) for the certification period of July 16 ,2011 through September 13, 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 emergency handout. In addition there was no documented evidence the HCA reviewed and evaluated the skilled services that had been provided. During a face to face interview with the DON on November 9, 2011 at approximately 1:15 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not been done at the time of this survey. 4. On November 9, 2011, a record review of patient #4's record at approximately 1:30 p.m. revealed a plan of care (POC) for the certification period of August 11, 2011 through October 9, 2011 in which the physician ordered skilled nursing visits five to seven times a week for nine	H 430	Patients #2, #3, and #6 became compliant with statue 3916.1 on 11/10/2011. The assigned nurses were contacted regarding the missing 62-day summaries. The nurses emailed the copies to the office for submission during the survey period. VMT targets the even-months on or about the 10th day of that month to fax the 62-day summaries to the physicians. These reports are generated by the professional staff and will be sent to the physician every 60-62 days. The DON or his designee will track these reports by generating a skilled census on the designated submission months. This report will then be used to track the 62-day summary reports submissions. In order ensure compliance and monitor the compliance the report should be submitted between the 8th and 10th day of every even month. These reports will then be placed in the Clinical Collaboration section of the patient's medical record along with the fax confirmation sheet. Patients #5 and #7 became compliant with statue 3916.1 on 11/18/2011. The assigned nurses were contacted regarding the missing 62-day summaries. The nurses emailed the copies to the office for submission during the survey period. DON will re-educate the nursing staff on the process, regulation and requirements of submitting the 62-day summaries timely. VMT targets the even-months on or about the 10th day of that month to fax the 62-day summaries to the physicians. In order ensure compliance and monitor the compliance the report should be submitted between the 8th and 10th day of every even month. These reports are generated by the professional staff and will be sent to the physician every 60-62 days.	December 10, 2011 November 21, 2011

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H 430	Continued From page 8 week, daily wound dressing and as needed, clean wound with normal saline apply santyl ointment as ordered by physician, cover 4x4 gauze and abd pad then tapped. skilled nursing to teach client/care giver safety precautions/emergency plan- when to call VMT/911/MD as outlined in emergency handout. In addition there was a 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. During a face to face interview with the Clinical Administrator and DON on November 9, 2011 at approximately 1:15 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not been done at the time of this survey. 5. On November 10, 2011, a record review of patient #5's record at approximately 9:30 a.m. revealed a plan of care (POC) for the certification period of September 13, 2011 through November 11, 2011 in which the physician ordered skilled nursing visits one (1) to three (3)week for nine (9)weeks. skilled nursing to teach client/care giver safety precautions/emergency plan- when to call VMT/911/MD as outlined in emergency handout, physical therapy and occupational therapy to evaluate and treat, there was no documented evidence the HCA reviewed and evaluated the skilled services that had been provided. During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 1:15 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not been done at the time of this survey.	H 430	The DON or his designee will track these reports every scheduled month by generating a skilled census report. This report will then be used to track the 62-day summary reports submissions. These reports will then be placed in the Clinical Collaboration section of the patient's record with the fax confirmation stapled to the report. Patient #1, #2, #3,#4,#5,#6 and #7 In order to remedy the missing fax confirmations, the 62-day summaries were re-faxed to the physician on 11/10/2011 and 11/11/2011 and the fax confirmation sheet was stapled to the reports and placed in the Clinical Collaboration section of the patient's medical record. In order to ensure that all clinical records are in compliance with statue 3916.1, VMT targets the even-months on or about the 10th day of that month to fax the 62-day summaries to the physicians. In order ensure compliance and monitor the compliance the report should be submitted between the 8th and 10th day of every even month. These reports are generated by the professional staff and will be sent to the physician every 60-62 days. The DON or his designee will track these reports every scheduled month by generating a skilled census report. This report will then be used to track the 62-day summary reports submissions. These reports will then be placed in the Clinical Collaboration section of the patient's record along with the fax confirmation report.	December 10, 2011

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(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 430	Continued From page 9	H 430		

6. On November 10, 2011, a record review of patient #6's record at approximately 9:50 a.m. revealed a plan of care (POC) for the certification period of August 13, 2011 through October 11, 2011 in which the physician ordered skilled nursing visits one (1) to three (3)week for nine (9)weeks. skilled nursing to teach client/care giver safety precautions/emergency plan- when to call VMT/911/MD as outlined in emergency handout, physical therapy and occupational therapy to evaluate and treat, there was no documented evidence the HCA reviewed and evaluated the skilled services that had been provided.

During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 1:15 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not been done at the time of this survey.

7. On November 10, 2011, a record review of patient #6's record at approximately 9:50 a.m. revealed a plan of care (POC) for the certification period of July 16, 2011 through September 13, 2011 in which the physician ordered skilled nursing visits one (1) to three (3)week for nine (9)weeks. skilled nursing to teach client/care giver safety precautions/emergency plan- when to call VMT/911/MD as outlined in emergency handout, physical therapy and occupational therapy to evaluate and treat, there was no documented evidence the HCA reviewed and evaluated the skilled services that had been provided.

During a face to face interview with the Clinical Administrator and DON on November 10, 2011 at approximately 1:15 p.m., indicated a summary report reviewing and evaluating the skilled services provided had not been done at the time

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA0003	A. BUILDING _____ B. WING _____	11/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMT HOME HEALTH AGENCY	4201 CONNECTICUT AVE NW SUITE 200 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 430	Continued From page 10 of this survey.	H 430		
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, 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 record review and interview, it was revealed the Home Care Agency failed to ensure the patient need were met in accordance with the plan of care for one (1)of eight(8) patients in the sample. (Patient #3) The findings include: On November 9, 2011, a record review of patient #3's record at approximately 12:30 p.m. revealed a plan of care (POC) for the certification period of July 16 ,2011 through September 13, 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 emergency handout. Further review of the record revealed there was no documented evidence the skilled nurse visited 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	H 453	**H453 3917.2 (c) SKILLED NURSING VISITS** Patient #3 did not received visits from July 31, 2011 to August 6, 2011, August 7, 2011 to August 13, 2011 and August 14, 2011 to August 20, 2011. The expectation is for all forms to be completed accurately and timely. VMT is aware of this issue and has taken corrective action which was completed on November 21, 2011. RN has submitted missed visits for the above dates. In order to ensure that all clinical records are in compliance with statue 3917.2(c), the DON or his designee will track the RN visits daily through VMT's call –in system. This tracking system will identify clients with missed visits and alert the DON that missed visits have occurred and missed visit documentation should be submitted. Monitoring and compliance will be aided by the DON or his designee through tracking the visits monthly through the VMT call-in system and notifying the nursing staff of any missing visits noted. This data will be included monthly office meetings and allow for brainstorming and strategic thinking on how to maintain compliance. The DON will notify the Administrator monthly on the status all missed visits and trends.	**November 30, 2011**

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H 453	Continued From page 11 nursing notes may have been filed in another patient's record.	H 453		
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 record review and interview, the Home Care Agency's (HCA) skilled nursing staff failed to ensure evaluation of patient instruction for one(1) of fourteen(14) patients in the sample. (Patient #2) The findings include: On November 9, 2011, a record review of patient #2's record at approximately 11:20 a.m. revealed skilled nursing notes dated from August 2, 2011 through September 23, 2010 in which the skilled nurse provided teaching to patient #2. Additionally, there was no documented evidence the skilled nurse evaluated the teaching provided to patient #2. During a face to face interview with the Clinical Administrator/ DON on November 9, 2011 at approximately 12:15 p.m., they indicated the agency's skilled nurses did not evaluate the teaching they provided.	H 459	**H 459 3719.2 (i) SKILLED NURSING SERVICES** Patient #2: Nursing staff completed teaching on each of the visits from 8/2/11 to 9/23/11. The nurse did not indicate the evaluation of the teaching. The nurse was notified of the omission of evaluation of teaching and the personnel corrective action was done on 11/21/11. In order to ensure that all clinical records are in compliance with statue 3919.2(i), an in-service will be conducted by the DON, with the professional staff, regarding teaching and the evaluation of the teaching by 12/16/11. Prior to this in-service, and email will be sent to communicate the teaching and evaluation expectations. This email will assist in ensuring that all teaching and evaluations done on the monthly visits prior to 12/16/11 will be compliant. The current nurse visit form will be revised and clearly identify a section that will allow for the evaluation of the teaching to be documented Monitoring and compliance will be aided by the DON or his designee for accuracy, completeness. The DON or his designee will review the submitted visit notes and ensure that all information required is documented. DON will lead spot audits of patient's records to ensure that the patient's records are compliant and complete.	**November 21, 2011**

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R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and review of personnel records, the Home Health Agency (HHA) failed to ensure a criminal background check had been obtained before employing or using the contract services of an unlicensed person, for 1 out of 21 employees. (Staff#10). The finding includes: Review of personnel records on November 15, 2011, beginning at approximately 11:00 a.m., revealed that Staff #10's record did not contain a criminal background check . This was acknowledged by the agency Director of Nursing (DON), on the day of the review. Additional information was provided before the survey ended that a request had been for the document.	R 122	**R122 4701.2 BACKGROUND CHECK REQUIREMENTS** Staff #10 was hired on 1/26/11. At that time the staff member completed a Washington, DC police clearance that was clear. After the last survey in February 2011, VMT decided to require all HHA to have a FBI background check. Once the HHA completed the fingerprinting with the approved vendor VMT receives a cover letter notifying VMT that the process has been completed and the background check is in process. The staff removed the initial police clearance report from the personnel record once we received the police clearance. A request was made to Staff #10 to bring in a copy of the police clearance to ensure that the personnel record is complete. Staff #10 has supplied VMT with a copy of her police clearance. In order to ensure that all clinical records are in compliance with statue 4701.2, the VMT has contacted all aides that VMT is pending the final FBI background check and requested a copy of their previous police clearance so that VMT will have a completed personnel record until the FBI background check is completed. Monitoring and compliance will be aided by the Staffing Coordinator through the use of the personnel spreadsheet that outlines the compliance requirements. The spreadsheet is monitored daily and staff is notified of required documents 1-2 months prior to the expired dates.	**January 4, 2012**