GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

PRINTED: 01/29/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA0003	825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 A. BUILDING _____ B. WING _____	01/29/2010

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 survey was conducted at your agency on January 19, 2010, through January 20, 2010, 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 nine (9) clinical records, eight (8) personnel files and three (3) home visits. The findings of the survey were based on observations in the home, interviews with agency staff and patient interviews, as well as a review of patient and administrative records.	H 000	The VMT Home Health Agency makes its best efforts to operate in substantial compliance with both Federal and State Law. Submission of this 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 of Correction (POC) is prepared and/or executed solely becasuse it is required by Federal and State Law.	
H 158	3907.2(n) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (n) Documentation of liability insurance, if applicable. This Statute is not met as evidenced by: Based on record review and interview, the facility's personnel record failed to ensure documentation of liability insurance for one (1) of eight (8) contracted staff (physical therapist) in the sample. (Staff #2) The finding includes: Review of Staff #2's personnel record on January 19, 2010, at approximately 10:39 a.m., revealed a contract for physical therapy services. Continued review of the personnel record failed to evidence documentation that the physical therapist had liability insurance. During a face to face interview with the Vice	H 158	**H158 3907.2(n) PERSONNEL** VMT provides professional liability Insurance for its staff; however, the Physical Therapist has been educated regarding the personal liability insurance requirement. The Physical Therapist applied for liability insurance immediately. Monitoring of the Personnel file including the liability insurance will be done quarterly to ensure compliance.	2/28/10

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H 158	Continued From page 1 President of Operations, it was acknowledged at 11:44 a.m., that the personnel record for the physical therapist failed to provide evidence of liability insurance.	H 158		
H 162	3907.6 PERSONNEL At the time of initial employment of each employee, the home care agency shall verify that the employee, within the six months immediately preceding the date of hire, has been screened for and is free of communicable disease. This Statute is not met as evidenced by: Based on interview and record review, the facility's personnel record failed to ensure that one of the Registered Nurses had been screened for communicable diseases for one (1) of eight (8) staff in the sample. (Staff #8) The finding includes: Review of Staff #8's personnel record on January 19, 2010, at approximately 1:00 p.m., revealed the staff had a physical examination on file, however, at the time of the survey, there was no documented evidence that the staff had been screened for any communicable diseases. During a face to face interview with the Vice President of Operations, it was acknowledged at 3:32 p.m., that the physical examination for Staff #8 failed to provide evidence that she had been screened for any communicable diseases.	H 162	**H162 3907.6 PERSONNEL** Employee #8 had a physical; however, the Physician utilized their own history and physical form which did not include the "free of communicable disease requirement" VMT has a standard medical request form that staff can utilize for physicals. This form includes a space for the physician to acknowledge that the employee is free from communicable diseases. The VMT Home Health Agency provided the form to the employee. The employee is expected to return the form immediately for which the physician has documented that the employee is free from any communicable diseases and it will been placed in her file. The Personnel records are monitored Quarterly.	2/20/10
H 262	3911.2(b) CLINICAL RECORDS	H 262		

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H 262	Continued From page 2 Each clinical record shall include the following information related to the patient: (b) Source of referral, including date of discharge if from a hospital or extended care facility; This Statute is not met as evidenced by: Based on interview and record review, the agency's clinical record failed to include the source of referral for one (1) of nine (9) patients in the sample. (Patient #6) The finding includes: Review of Patient #6's medical record on January 19, 2010, at approximately 9:25 a.m., revealed the source of referral was not in the medical record. During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 9:30 a.m., it was acknowledged the source of referral was not in Patient #6's medical record. There was no documented evidence the source of referral was documented in the medical record.	H 262	**H262 3911.2(b) CLINICAL RECORDS** VMT's current intake form includes all necessary information including the referral source. VMT will re-educate all staff who take potential beneficiary information on its intake form to include the name and contact number of the referral source(s). The record was reviewed for patient #6 and the referral source is currently documented in the record. The Medical Record's Specialist will be responsible for ensuring that documentation is complete prior to completing the Beneficiary's chart.	2/5/10
H 274	3911.2(n) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (n) Type of medical equipment used by the patient; This Statute is not met as evidenced by: Based on interview and record review, the	H 274		

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H 274	Continued From page 3 facility's clinical record failed to ensure documentation of all the medical equipment used by the patient for three (3) of nine (9) patients in the sample. (Patient #1, #4, and #9) The findings include: Review of Patient #1, #4, and #9's Home Health Certification and Plan of Care (POC) on January 19, 2010, approximately between 1:35 p.m.- 3:10 p.m., did not document all of the medical equipment used by the patients as evidenced by: a. Patient #1 utilizes a glucometer; b. Patient #4 utilizes hospital bed and raised toilet seat and c. Patient #9 utilizes a back brace During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 3:15 p.m., it was acknowledged all of the medical equipment used by the patients was not documented on the POC. There was no documented evidence all of the medical equipment used by the patients was on the POC.	H 274	**H274 3911.2(n) CLINICAL RECORDS** The Plan of Care for patient #1 was updated to include glucometer; for patient #4 to include hospital bed and raised toilet seat and for patient #9 to include back brace. The checking to ensure medical equipment is on the Plan of Care is a normal practice for the agency. The staff will be re-educated on this practice. The Director of Nursing and/or the Assistant Director of Nursing will double Check the Plan of Care to ensure that the medical equipment used by the beneficiary is listed on the plan of care prior to the the MD signing the document.	2/5/10
H 279	3911.2(s) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (s) Documentation of training and education given to the patient and the patient's caregivers. This Statute is not met as evidenced by: Based on interview and record review, the Home	H 279		

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H 279	Continued From page 4 Care Agency (HCA) failed to ensure documentation of training and education given to the patient and the patient's caregivers for one (1) of nine (9) patients in the sample. (Patient #3) The findings include: Review of Patient #3's, Nursing Visit Note/Aide Supervisory Visit notes dated September 28, 2009 and November 28, 2009, revealed no specific training and education given to the patient and the patient's caregiver on the patient's disease processes. During a face to face interview with Director of Nursing (DON) on January 19, 2010, at approximately 2:10 p.m., it was acknowledged the RN did not document the specific training and education given to Patient #3 and the caregiver on the disease processes. There was no documented evidence of the specific training and education given to the patient and the patient's caregiver.	H 279	**H279 3911.2(a) CLINICAL RECORDS** A review of patient #3's record was done to identify the patient's disease processes. The patient and patient's caregiver will be educated and the record will be documented. Educational materials will be given to the RN in the care package including reference material on the disease process as needed to ensure that the RN has the materials available at all times. The Director of Nursing and/or the Assistant Director of Nursing will ensure that the RN provides education to the beneficiary and caregiver.	2/20/10
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following: (g) Physical assessment, including all pertinent diagnoses; This Statute is not met as evidenced by: Based on interview and record review, the facility's Plan of Care (POC) failed to include all pertinent diagnoses for two (2) of nine (9) patients in the sample. (Patient #1 and #2) The findings include:	H 358		

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H 358	Continued From page 5 Review of Patient #1 and #2's Home Health Certification and Plan of Care (POC) revealed that all pertinent diagnoses was not included on the POC as evidence below: a. Review of Patient # 1's POC on January 19, 2010, at approximately 12:45 p.m., revealed the plan did not include the diagnosis of Hepatitis C. During a telephone interview with the Administrator and Director of Nursing (DON) on January 20, 2010, at approximately 1:45 p.m., it was acknowledged Patient # 1's POC did not include the diagnosis of Hepatitis C. b. Review of Patient # 2's POC on January 19, 2010, at approximately 12:45 p.m., revealed the plan did not include the diagnosis of Diabetes Mellitus. During a face to face interview with the DON on January 19, 2010, at approximately 1:25 p.m., it was acknowledged Patient # 12's POC did not include the diagnosis of Diabetes Mellitus.	H 358	**H358 3914.3(g) PATIENT PLAN OF CARE** A review of the medical record for patient # 1 and # 2 revealed that the diagnosis on The Plan of Care is the diagnosis that VMT is currently treating the beneficiary for. The Agency understands the importance of including all pertinent diagnosis on the POC and has updated the record to include all diagnosis. To ensure that pertinent diagnosis are not missed, the Director of Nursing and the Assistant Director of Nursing will review the POC for accuracy.	2/5/10
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.	H 366		

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H 366	Continued From page 6 This Statute is not met as evidenced by: Based on interview and record review, the agency's Plan of Care (POC) was not approved and signed by a physician within thirty (30) days of the start of care for two (2) of nine (9) patients in the sample. (Patient #1 and #4) The findings include: Review of Patient #1 and #4's Plan of Care (POC) on January 19, 2010, approximately between 12:15 p.m.,- 1:35 p.m., revealed the POC was not approved and signed by a physician within thirty (30) days of the start of care, however skilled nursing services was being implemented according to the POC as evidenced by: a. Patient #1's POC dated November 30, 2009 and b. Patient #4's POC dated December 8, 2009. During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 1:45 p.m., it was acknowledged the POC was not approved and signed by a physician within thirty (30) days of the start of care for Patient #1 and #4. There was no documented evidence the POC was approved and signed by a physician within thirty (30) days of the start of care.	H 366	**H366 3914.4 PATIENT PLAN OF CARE** The Plan of Care for patient # 1 and # 4 has been signed by the physician. VMT has several mechanisms to ensure the physicians are notified within the 30 day time frame to sign the beneficiaries POC. Those procedures include but are not limited to the following: 1) Call the Physician's office; 2) fax the POC and follow up with a call; 3) mail the POC and follow up with a call and 4) take the POC to the physician's office for signature. For all documentation needing a Physician's signature, VMT calls the Physician's office 2-4 times per week; fax multiple copies of the POC at least twice per week; and during the third and fourth week attempt to take the POC to the Physician's office. Finally, the VMT staff contact the Medical Director when necessary.	2/5/10
H 411	3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following:	H 411		

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H 411	Continued From page 7 (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to ensure home health aides recorded, and reported on the patient's physical condition, behavior or appearance for six (6) of nine (9) patients in the sample. (Patient #2, #3,#4, #5, #6, and #9). The findings include: Review of Patient #2, #3,#4, #5, #6, and #9's medical records on January 19, 2010, approximately between 11:40 a.m.- 1:05 p.m., revealed the home health aides had not recorded and reported the patient's physical condition, behavior, or appearance to the agency. During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 1:35 p.m., it was acknowledged the home health aides had not recorded and reported the patient's physical condition, behavior, or appearance to the agency. There was no documented evidence the home health aides recorded and reported the patient's physical condition, behavior, or appearance to the agency.	H 411	**H411 3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE** VMT has changed its Home Health Aide Activity Record to more visibly reflect the results of the patient's physical condition, behavior and appearance. The new form will be utilized immediately. A memo of the change will be sent to all HHAs. The Aides will also be educated regarding the Form.	2/12/10
H 456	3917.2(f) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following:	H 456		

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H 456	Continued From page 8 (f) Supervision of services delivered by home health and personal care aides and household support staff, as appropriate; This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure the nurse supervised services delivered by the home health aide (HHA) , as appropriate for one (1) of nine (9) patients in the sample. (Patient #6) The finding includes: Review of Patient # 6's Home Health Certification and Plan of Care (POC) dated September 24, 2009, to March 22, 2010, on January 19, 2010, at approximately 11:10 a.m., revealed the Registered Nurse (RN) was to supervise the HHA monthly. Review of Patient # 6's medical record on January 19, 2010, at approximately 11:15 a.m., did not reveal any RN supervisory notes for the months of October, November and December, 2009. During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 11:30 a.m., it was acknowledged the RN did not have any supervisory notes in Patient #6's medical record for the aforementioned months. There was no documented evidence the nurse supervised services delivered by the home health aide.	H 456	**H456 3917.2 (f) SKILLED NURSING SERVICES** While Patient #6's medical record did not document the supervisory visits they had been done. The Director of Nursing and/or the Assistant Director of Nursing will continue to inform the RN's document their supervisory visits for the home health aide. The VMT's supervisory form has the appropriate space for the RN to document. The RNs will have a schedule of when Home health aides should be supervised. The Director of Nursing and/or the Assistant Director of Nursing will verify that the RN has completed the visits and the documentation of the visits prior to including the RN notes in the beneficiary's chart.	2/5/10
H 457	3917.2(g) SKILLED NURSING SERVICES	H 457		

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H 457	Continued From page 9 Duties of the nurse shall include, at a minimum, the following: (g) Recording progress notes at least once every thirty (30) calendar days and summary notes at least once every sixty-two (62) calendar days; This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure the nurse recorded progress notes at least once every thirty (30) calendar days for one (1) of nine (9) patients in the sample. (Patient #5) The finding includes: Review of Patient # 5's Home Health Certification and Plan of Care (POC) dated November 15, 2009, to January 14, 2010, on January 19, 2010, at approximately 10:50 a.m., revealed the Registered Nurse (RN) was to provide skilled nursing services one (1) to three (3) times a week for nine (9) weeks. Review of Patient # 5's medical record on January 19, 2010, at approximately 10:55 a.m., did not reveal any RN progress notes for the aforementioned certification period. During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 11:00 a.m., it was acknowledged the RN had not recorded progress notes at least once every thirty (30) calendar days in Patient # 6's medical record. There was no documented evidence the nurse recorded progress notes at least once every thirty (30) calendar days in the patient's medical	H 457	**H457 3917.2(g) SKILLED NURSING SERVICES** Patient # 5 was seen one to three times a week as required. An RN Progress Note has been documented in the record. The RN was re-educated regarding this requirement. The Director of Nursing and/ or the Assistant Director of Nursing will continue to check the RN visits to ensure that the RN is abiding by the orders on the POC as it pertains to the frequency of beneficiary visits. A grid will be utilized to monitor the RN visits for each patient. This grid will be utilized to ensure that the RN progress notes that are due during the certification period prior to including the notes in the beneficiary's chart.	2/5/10

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H 457	Continued From page 10 record.	H 457		
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 facility's skilled nursing staff failed to ensure documentation of patient instruction, and evaluation of patient instruction for one (1) of nine (9) patients in the sample. (Patient #1) The findings include: 1. Review of Patient # 1's Home Health Certification and Plan of Care (POC) dated November 30, 2009, through January 29, 2010, on January 19, 2010, at approximately 1:36 p.m., revealed the Registered Nurse (RN) was to instruct Patient #1 on medication compliance, side effects, when to take medications and to evaluate the effectiveness of the medications. Review of skilled nursing notes dated December 28, 2009, on January 19, 2010, at approximately 1:38 p.m., revealed " instructed client on the use of cyclobenzaprine for muscle spasms and Lyrica for peripheral neuropathy". During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 1:50 p.m., it was acknowledged	H 459	**H459 3917.2(i) SKILLED NURSING SERVICES** The Registered Nurse provided education on the medications; however, did not include that the patient was specifically instructed on the patient's medication compliance, side effects and when to take the medication. The RNs will be re-educated that when the skilled nurse is instructing the patient on the use of medication, the skilled nurse will document the specifics of medication compliance, side effects and when to take the medication. All RN's will receive a memo reiterating the importance of ensuring that this is documented. The Director of Nursing and/or the Assistant Director of Nursing will monitor the skilled nursing documentation for accuracy including the documentation of medication instruction.	2/19/10

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H 459	Continued From page 11 the skilled nursing staff did not specifically instruct the patient on medication compliance, side effects and when to take medications. There was no documented evidence of the specific patient instructions taught or evaluated on medication management.	H 459		
H 560	3923.1 PHYSICAL THERAPY SERVICES If physical therapy services are provided, they shall be provided in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure physical therapy services are provided in accordance with the patient's plan of care for one (1) of nine (9) patients in the sample. (Patient #8) The finding includes: Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated December 11, 2009, to February 10, 2010, on January 19, 2010, at approximately 10:25 a.m., revealed the patient had listed under Durable Medical Equipment (DME) a wheelchair and a walker. Further review revealed the Physical Therapist (PT) was to instruct Patient #8 on the safe and effective use of adaptive devices. Review of Patient # 8's Physical Therapy Revisit Notes dated December 16, 21 and 30, 2009 and January 4, 2010, on January 19, 2010, at approximately 11:10 a.m., revealed no Patient #8 was not instructed on the safe and effective use of adaptive devices.	H 560	**H560 3923.1 PHYSICAL THERAPY SERVICES** Patient #8 has been instructed on the safe Effective use of adaptive devices. A set of guidelines will be provided to the Physical Therapist to ensure that Medical equipment is discussed with the patient including the safe and effectiveness of the equipment. These guidelines will also include that the documentation must be specific and include the patient's understanding of the device through return demonstration. The Patient will be instructed to sign that they understand the use of the equipment.	2/19/10

Health Regulation 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 _____	01/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMT HOME HEALTH AGENCY	4201 CONNECTICUT AVE NW SUITE 200 WASHINGTON, DC 20008

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H 560	Continued From page 12 During a face to face interview with the Director of Nursing (DON) on January 19, 2010, at approximately 10:30 a.m., it was acknowledged Patient #8 was not instructed on the safe and effective use of adaptive devices. according to the POC. There was no documented evidence the patient was instructed on the safe and effective use of adaptive devices according to the POC.	H 560		