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 _____	02/01/2011

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VMT HOME HEALTH AGENCY	4201 CONNECTICUT AVE NW SUITE 200 WASHINGTON, DC 20008

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H 000	INITIAL COMMENTS An annual licensure survey was conducted from January 24, 2011, through February 1, 2011, 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 thirteen (13) active clinical records and two (2) discharge clinical records based on a census of two hundred forty eight (248) patients and twenty one (21) personnel files based on a census of two hundred seventy eight (278) employees and three (3) home visits. The deficiencies cited during the survey were based on interviews conducted with agency staff, patients and caregivers and 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. 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. Received 3/7/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
H 053	3903.2(c)(1) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: (1) The evaluation shall include feedback from a representative sample consisting of either ten percent (10%) of total District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patients. This Statute is not met as evidenced by: Based on a record review and interview, the Governing Body failed to ensure an evaluation to include feedback from a representative sample	H 053	**H053 3903.2 (c) (1) Governing Body** VMT Home Health Agency holds a Professional Advisory Committee (PAC) meeting quarterly to review patient records and policies & procedures of the agency. This meeting is attended by at least two members of the VMT Home Health Agency Governing Body (i.e. Board of Directors). Effective the next PAC meeting the Governing Body will assure that a minimum of 10% of the total clients are evaluated to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient.	

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H 053	Continued From page 1 consisting of either ten percent (10%) of total District of Columbia patients or forty (40) District of Columbia patients, regarding services provided to those patients. The finding includes: Review of the Board of Director meeting minutes dated September 2010, on February 1, 2011, at approximately 10:30 a.m., revealed no documented evidence of an evaluation from a representative sample regarding the services provided to patients. During a face to face interview with the clinical administrator on February 1, 2011, at approximately 11:00 a.m., she confirmed the findings.	H 053	This requirement of reviewing at least 10% of client population will be added to the VMT policy and procedure manual and will become part of the routine agenda for each quarterly PAC meeting. To assure that this deficient practice does not recur, VMT Board of Directors will discuss the outcome of PAC meetings during the board meetings to assure that this requirement is met during each PAC meeting.	3/15/2011
H 055	3902.2(c)(3) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: (3) A written report of the results of the evaluation shall be prepared and shall include recommendations for modifications of the agency's overall policies or practices, if appropriate. This Statute is not met as evidenced by: Based on a record review and interview, the Governing Body failed to include	H 055	**H 055 Governing Body 3902.2(c)(3)** During VMT Home Health Agency quarterly PAC meetings at least 10% of agency clients will be evaluated to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. The results of the evaluation will be documented including any recommendations or modification of overall policies or practices if necessary.	

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H 055	Continued From page 2 recommendations for modifications of the agency's overall policies or practices, if appropriate, in it's annual evaluation report. The finding includes: Review of the agency's policy and procedures manual on February 1, 2010, at approximately 9:30 a.m., revealed that the most recent review by the Governing Body had been performed in 2007. An interview with the clinical administrator at 9:50 a.m., revealed that she had reviewed the policies and written her thoughts on post-it notes. She stated that she wanted to present these policies recommendations to the agency's Governing Body for review and/or modifications. She acknowledged that the Governing Body had not received her recommendations.	H 055	To assure the deficient practice does not recur, the reports of the results will be sent to all members of the Board of Directors and a file will be kept of all PAC meeting client evaluation reports. This corrective action will be monitored by first reviewing the written reports of client evaluations from the previous PAC meeting. Before starting the review of client evaluation for the current PAC meeting the Board of Directors will assure that all results were documented and follow-up has occurred.	3/15/2011
H 056	3903.2(c)(4) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: (4) The evaluation report shall be presented to, and acted upon, by the governing body at least annually. The results of the action taken by the governing body shall be documented, maintained, and available for review by government officials. This Statute is not met as evidenced by:	H 056	**H 056 Governing Body 3903.2(c) (4)** The Board will annually review the VMT Home Health Agency policy and procedure book and sign off on any policy or procedure where changes were made. To assure this deficient practice does not recur, the Board will sign and date the policy and procedure book to indicate that all policies were reviewed.	

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H 056	Continued From page 3 Based on interview and record review, the Governing Body failed to conduct an annual evaluation of policies governing agency operations to ensure that concerns were acted upon and documented in a report which is maintained and available for review by government officials. The finding includes: During a face to face interview with the agency's president on February 1, 2011, at approximately 10:00 a.m., he stated that the annual board meeting was conducted in September 2010. Review of the Board of Directors meeting minutes on February 1, 2011, at approximately 10:10 a.m., revealed no evidence that an annual evaluation report was presented to Dr acted upon by the Governing Body.	H 056	Board meeting minutes are drafted after each meeting. The minutes from each meeting will address the action taken by the Board in regards to any policy and or procedure changes made in the Agency between Board meetings.	2/9/2011
H 149	3907.2(e) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (e) Health certification as required by section 3907.6; This Statute is not met as evidenced by: Based on a record review and interview, the agency failed to maintain accurate personnel records, to include documentation that all employees received a health certification at time of hire and annually thereafter, for five (5) of the twenty-one (21) employees in the sample. (Staff #2, #5, #6, #7 and #16) The findings include:	H 149	**H 149 3907.2 (e) Personnel** Employee #2 chest X-ray was submitted to VMT, by the staff member on February 14, 2011. Employee #5 PPD testing completed. March 2, 2011. Employee # 6 submitted the PPD results on February 2, 2011. Employee #7 Health clearance was submitted on February 4, 2011. Employee # 16 is no longer with the Agency. All HR files were reviewed and any file not in compliance is being brought to compliance. New hires will not start working until all of their health clearances are on file.	2/17/2011

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H 149	Continued From page 4	H 149	To ensure VMT is in compliance with all employees, HR is conducting audits and identifying any missing health certifications and will notify the staff. Any staff member outside of compliance will be removed from their current client caseload until that employee become compliant. This audit will be done quarterly.	2/17/2011

Review of the personnel records on January 28, 2011, beginning revealed no evidence of current health certification for Staff #2, #5, #6, #7 and #16.

H 152 3907.2(h) PERSONNEL

Each home care agency shall maintain accurate personnel records, which shall include the following information:

(h) Copies of completed annual evaluations;

This Statute is not met as evidenced by:
Based on a record review and interview, the agency failed to maintain accurate personnel records, to include documentation of annual performance evaluations, for four (4) of the twenty-one (21) employees in the sample (Staff #7, #8, #9 and #11)

The findings include:

Nine (9) HHAs were included in the sample of 21 employees. Review of the personnel records on January 26, 2011, beginning at 10:50 a.m.,failed to show evidence that an annual performance evaluation had been documented for Staff #7, #8, #9 and #11. During a face to face interview with the agency's human resources director, on January 28, 2011, at approximately 4:40 p.m., he acknowledged that the information was not available for review in the personnel records.

H 152

H152 3907.2 (h) Personnel

Staff members #7, 8, 9 and 11 will be evaluated by March 28, 2011. In order to ensure that all employees are in compliance with statute 3907.2(h), VMT will be streamlining the internal evaluation process. All HR files are being audited for accuracy.

The Home Health Agency Staff evaluations will be conducted over a three month period (April, May and June) of each year by the Staffing Coordinator, DON and Clinical Administrator.

All HR files will be audited periodically by the agency staff and every three months by HR, using the audit tool. The outcome of the audit will be reviewed by the Board of Governors and action will be taken when necessary.

3/ 28 /2011

H 157 3907.2(m) PERSONNEL

H 157

Each home care agency shall maintain accurate

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H 157	Continued From page 5 personnel records, which shall include the following information: (m) Documentation of acceptance or declination of the Hepatitis Vaccine; and... This Statute is not met as evidenced by: Based on a record review and interview, the agency failed to maintain accurate personnel records, to include documentation of acceptance or declination of the Hepatitis B vaccine, for ten (10) of the twenty-one (21) employees in the sample. (Staff #2, #3, #6, #7, #8, #9, #10, #11, #18 and #20) The findings include: On January 26, 2011, beginning at 10:50 a.m., review of personnel records revealed no documented evidence that Staff #2, #3, #6, #7, #8, #9, #10, #11,#18 and #20 had been presented with an opportunity to accept or decline the Hepatitis B vaccine. During a face to face interview with the agency's human resources director, on January 28, 2011, at approximately 4:40 p.m., he acknowledged that the information was not available for review in the personnel records.	H 157	**H 157 3907.2 (m) Personnel** Employees # 2 and 10 are no longer with the Agency. Employees #3, 6, 16 and 20 Acceptance and Declination of Hepatitis B Vaccine form has been signed and filed in employee's personnel record. STAFF #7, 8, 9 and 11 the contracting agency owner has been notified to submit form by March 28, 2011. All new employees with VMT will receive a copy of the Acceptance or Declination of Hepatitis B Vaccine form along with the new hire packet. When hired, the employee will submit the completed packet to HR on their hire date with VMT. HR and the immediate supervisor will ensure that the employee is compliant with statue 3907.2 (m), prior to receiving a client caseload by completing the personnel checklist. This information will be monitored by verifying the presence of all required documents as outlined in 3907.2 (a-n), including the Acceptance or Declination of Hepatitis B Vaccine form , as outlined on the personnel checklist by the HR. The HR personnel will maintain the tracking system (Tickler) to ensure that all employees have the Acceptance or Declination of Hepatitis B Vaccine form in their personnel records. The immediate supervisor, HR or Clinical Administrator will sign the checklist once all documents are present. The Board of Governors will be made aware of delinquency and for immediate action.	3/28 /2011
H 159	3907.3 PERSONNEL Each home care agency shall comply with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, D.C. Law 12-238, and subsequent amendments thereto, D.C. Official Code § 44-551 et seq.	H 159	**H 159 3907.3 Personnel** Staff #1, is no longer employed by the staffing agency. Employee #4, 11, 20, 21 initiated the FBI background check on site at VMT.	2/25 /2011

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H 159	Continued From page 6 This Statute is not met as evidenced by: Based on record review and interview, the agency failed to comply with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, D.C. Law 12-238, and subsequent amendments thereto, D.C. Official Code 44-551 et seq., for five (5) of the nine (9) unlicensed personnel records in the sample. (Staff #1, #4, #11, #20 and #21). The findings include: Nine (9) non-licensed home health aides (HHAs) were included in the sample of 21 employees. Review of the personnel records on January 26, 2011 and January 26, 2011, revealed the following: 1. On January 26, 2011, at 10:50 a.m., the personnel record for Staff #1 reflected that criminal background checks had been obtained for Maryland and the District of Columbia on June, 7, 2010, and June 15, 2010, respectively. Further review of his record revealed that he had lived in Illinois. There was no evidence, however, of a criminal background check for the state of Illinois. 2. On January 26, 2011, at 12:45 p.m., the personnel record for Staff #4 reflected that criminal background checks had been obtained for the District of Columbia. Further review of her record, however, revealed that she lived in the state of Maryland. There was no evidence, however, of a criminal background check for the state of Maryland. 3. On January 28, 2011, at 11:16 a.m., the personnel record for Staff #11 reflected that a criminal background check had been obtained for	H 159	Staff that is required to have background checks will complete the FBI criminal background check or a comprehensive background check that meets the requirements in statue 3907.3, prior to being hired at VMT. All of VMT staff will be required to complete the FBI background check as opposed to the current VMT process. In order to ensure that VMT is currently compliant, all professional VMT staff will be required to undergo an Fel Criminal Background Check. VMT arranged for a private agency to come on site on February 25, 2011, to complete the preliminary process of the background check. All other staff who were unable to attend will be given instructions and directions on the process of completing the background check. 3/28/2011 A list of the current staff will be used as a sign-off list to identify any staff member that has not completed the NEW background check. Any staff member who fails to start the process of completing the background check will be removed from their client caseload until the process has been initiated. This compliance will be monitored during quarterly employee audits. 3 /28/2011	

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H 159	Continued From page 7 the District of Columbia on January 3, 2011. Further review of her record, however, revealed that she lived in the state of Maryland. There was no evidence of a criminal background check for the state of Maryland. 4. On January 28, 2011, at 3:49 p.m., the personnel record for Staff #20 reflected that a criminal background check had been obtained in the District of Columbia. Review of his resume and employment application form revealed that he had held positions in Virginia and had been employed in Maryland. There was no evidence, however, of criminal background checks for Virginia or Maryland. 5. On January 28, 2011, at 4:54 p.m., the personnel record for Staff #21 reflected that a criminal background check had been obtained in the District of Columbia. Review of her employment application revealed that she had been employed in both the District of Columbia and the state of Maryland. There was no evidence of a criminal background check for Maryland. During a face to face interview with the human resources director on January 26, 2011 at approximately 2:15 p.m., he stated that the agency sought criminal background checks from the jurisdiction in which an applicant resided and was unaware that the 7-year history should also include any jurisdiction in which an applicant had been employed.	H 159		
H 260	3911.1 CLINICAL RECORDS Each home care agency shall establish and	H 260		

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maintain a complete, accurate, and permanent clinical record of the services provided to each patient in accordance with this section and accepted professional standards and practices.

This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to maintain accurate clinical records, for two (2) of the fifteen (15) patients in the sample. (Patients #2, and #9)

The findings include:

1. On January 24, 2011, beginning at 11:20 a.m., review of Patient #2's record revealed the following:

a. A "Summary (Non-OASIS) form that was completed by a registered nurse (RN) on August 13, 2010, indicated that the patient was being discharged that day. The form did not, however, provide other relevant information, including notification of the physician, disciplines involved in Patient #2's care prior to discharge, reason for admission, summary of care, or her condition at discharge.

b. At approximately 1:15 p.m., continued record review revealed an "Assessment of Risk Factors for Hospitalization and Emergent Care" form that was signed by the physical therapist (PT) on January 11, 2011. Review of the form, however, revealed that the PT had written the patient's name on it and provided no other patient-related information on the form.

During a face to face interview with the director of nursing (DON) later that day, at approximately 2:10 p.m., he acknowledged the findings. He further indicated that the patient was recently

H 260 3911.1 Clinical Records

Client #2 was being discharged from skilled services only. The expectation is for all forms to be completed accurately. The staff member that completed this form is no longer an employee of VMT.

The Physical Therapist has completed the assessment form and resubmitted the form to VMT.

2/2/2011

Client #9: The Plan of Care for 12/14/10 to 2/11/11 was sent to the doctor and verified by Dr. [redacted] that Lantus 30 units SQ q HS was correct, also client is to take aspirin 81 mg po daily and multivitamin 1 tab po daily.

The ICD-9 code for diabetes type II has been add to the current Medicare and Waiver Plan of Cares. An in-service on documentation was done on 2/18/2011.

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re-admitted after spending 5 months in the hospital and was receiving PT and home health aide services.

2. On January 24, 2011, beginning at 3:48 p.m., review of Patient #9's record revealed the following:

a. Patient #9 had a Plan of Care (POC) for the certification period July 17, 2010, through January 16, 201,1 on which a nurse documented her prescribed medications, including Lantus 30 cc, injected subcutaneously at bedtime, aspirin 81 mg by mouth once daily and a multi-vitamin without vitamin K by mouth once daily. A second POC for the certification period January 17, 2011, through July 16, 2011, reflected the same medications. However, review of a third POC (for skilled services) with a certification period October 14, 2010, through December 13, 2010, revealed that it failed to reflect the patient's prescribed aspirin and multi-vitamin without vitamin K. The third POC also indicated that she received Lantus 20 cc subcutaneously at bedtime.

b. Patient #9's three POCs listed above did not reflect a diagnosis of Diabetes Type II, even though the POCs included insulin injections every day at bedtime.

c. Patient #9's nursing assessment, dated October 15, 2010, indicated that she had been diagnosed with Diabetes Type II seven years earlier. The assessment further indicated "Diet: oral control." Review of the patient's POCs, however, revealed that she took Lantus 30 cc, injected subcutaneously, at bedtime. The Lantus was not reflected on the nursing assessment. A second nursing assessment, dated December

In order to ensure that all client clinical records are in compliance with statute 3911.1 VMT will reeducate and redirect the staff on how to complete the clinical forms and the importance of reviewing their documentation for accuracy prior to submission to the Agency.

2/18/2011

This report was shared with the professional staff electronically on March 3, 2011. Along with this information a copy of the Home Care Agency Regulations (51 D. C. Reg.2878) will be attached for a reference and resource for the staff.

All new professional staff will attend orientation that will focus on the clinical forms. The standard is to accurately complete all clinical forms and any submissions that fall below that standard will not be accepted. A copy of the Home Care Agency Regulations (51 D. C. Reg.2878) will be included in the new hire packet and will be discussed during orientation. The new hires will sign and acknowledge receipt of regulations. The above information will be given to all employees.

The DON will have an open forum at the next coordination of care meeting regarding the deficiency report. All clinical documents that are submitted to VMT will be monitored by the DON and/or designee for accuracy and completeness prior to filing the document into the client's permanent record.

3/18/2011

In streamlining this process the chart audit tool has been revised. This tool will allow for the DON or his designee to audit and file the document at the same time. All documents that are found to be below the VMT standard of accuracy and completeness will be giving back to the professional staff personnel to be completed and resubmitted within 48 hours.

In monitoring the admissions/recertification RNs, the DON will assess for the accuracy and completion of the Plan of Care (POC) prior to submission to MD for signature. Variances will be addressed and any re-education and feed-back will be communicated by the DON and/or the Clinical Administrator to the RNs and other professional staff. These issues will also have the governing board's attention and documented in board meeting minutes.

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H 269	Continued From page 10	H 269		

10, 2010, also failed to reflect the Lantus injections. The RN checked-off a box for "N/A - No injectable medications prescribed."

During a face to face interview with the DON on January 25, 2011 at approximately 11:15 a.m., he acknowledged the findings. He further indicated that the POC for skilled services (certification period October 14, 2010, through December 13, 2010) should have reflected 30 cc Lantus instead of 20 cc.

H 269 3911.2(i) CLINICAL RECORDS

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

(i) Documentation of supervision of home care services;

This Statute is not met as evidenced by:
Based on record review and interview, the agency failed to ensure documentation of supervision of home care services, for three (3) of the fifteen (15) patients in the sample. (Patients #4, #5 and #6)

The findings include:

1. On January 28, 2011, beginning at 3:15 p.m., review of Patients #4 and #5 records revealed a Plan of Care (POC) for the certification period of November 12, 2010, to May 11, 2011. The POC ordered the following: skilled nursing one visit monthly times 26 weeks for aide supervision, nursing assessment every visit, notify physician of health status changes and personal care aide (PCA) services three hours, three times a week for six months.

H269 3911.2 (i) Clinical Records

Client #4 and 5 - January and February visits were submitted after the exit interview and documented aide presence.

2/16/2011

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Further review of the records revealed no documented evidence of PCA supervision since Patient #4's start of care on November 12, 2010, nor was there documented evidence of PCA supervision from June 4, 2010 through October 2010 for Patient #6

2. On January 26 2011, beginning at 12:28 p.m., review of Patient #6's record revealed a Plan of Care (POC) for the certification period of August 18, 2010, to February 17, 2011. The POC ordered the following: skilled nursing one visit monthly times 26 weeks for aide supervision, nursing assessment every visit, notify physician of health status changes and PCA services twelve hours, seven days a week for six months

Further review of the record revealed skilled nursing monthly visits, had been completed by the nurse. There was no documented evidence in the patient's record, however, of PCA supervision from August 2010, through October 2010.

H 274 3911.2(n) CLINICAL RECORDS — H 274

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 agency's clinical records maintained for patients failed to ensure documentation of the type of medical equipment used by the patients, for two (2) of the fifteen (15) patients in the sample

Client #6-There was a missed visit for August 2010. From September 2010 through February 2011, Client #6 has aide supervision documentation for each monthly visit.

2/28/2011

The Clinical Administrator communicated to all Professional staff in November 2010, the regulation that governs supervisory visits (3915.7) and the expectations moving forward with these visits. In order to maintain compliance with statue 3911.2, VMT RNs were notified to only make visits with clients during the hours that the PCA is working in an effort to complete the supervisory visit documentation. Re-education was necessary to clarify the role of the RN for the Medicaid and Waiver clients that require only monthly supervisory visits. The DON will reemphasize this status monthly and the plan of action to maintain compliance.

During orientation of new professional staff , the DON will discuss the purpose of supervisory visits, the role of the RN, and the documentation required.
In order to ensure each client is seen monthly the Administrative Assistant began tracking the Professional Staff visits in September 2010 using a call-in system called Google Voice. This tool helps VMT track the visits, real time, and also identifies the clients that may have not been seen within the month and allow for immediate intervention

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H 274	Continued From page 12 (Patients #4, and #6) The findings include: 1. Review of Patient #4's initial assessment dated November 12, 2010, revealed that the patient used a roller walker to assist her with ambulating. However, on January 28, 2011, at 2:30 p.m., review of Patient #4's Plan of Care (POC) for the certification period November 12, 2010, to May 11, 2011, failed to show evidence of medical equipment used by the patient. In an interview with the clinical administrator (CA) on January 29, 2011, at approximately 10:00 a.m., it was acknowledged that the type of medical equipment used by Patient #4 should be documented on the POC. 2. Review of Patient #6's POC dated from February 18, 2010, to February 17, 2011, on January 26, 2011, beginning at 12:28 p.m., revealed that the patient used a wheelchair and had a prosthesis for his left leg. Review of the POC did not show evidence of any medical equipment used by the patient. In an interview with the CA on January 27, 2011, at approximately 10:00 a.m., she acknowledged that the type of medical equipment used by Patient #6 should be documented on the POC.	H 274	**H274 3911.2 (n) Clinical Records** Client #4's POC has been updated and corrected as of February 24, 2011, and the new Durable Medical Equipment (DME) reconciliation form has been created and completed and placed in client's clinical record Client #6's POC has been updated and corrected as of February 24, 2011, and the DME reconciliation form has been completed and placed in client's clinical record. VMT Professional staff will document all DME on the POC. This information will be collected during all new client admissions and recertification. A new DME form has been developed to track and confirm all DME equipment in the client's home. VMT's intake-referral form has been modified to reflect any DME equipment in the client's home during the initial intake process. Beginning March 2, 2011, all Professional staff will receive a copy of the DME form to complete. In order to ensure that all new clients have a completed DME form, VMT will include this form in the admission packet. The form, like the intake-referral form, will become a permanent part of the client's clinical record. The Data Entry staff will maintain this census and track all DME forms that are returned for the current clients. The DME form will be a part of the chart audit tool and will be monitored monthly by the office staff during filing and chart audits.	
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.	H 279		3/2011

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H 279	Continued From page 13	H 279		

This Statute is not met as evidenced by:
Based on interview and record review, the agency failed to ensure documentation of training and education given to the patient and/or the patient's caregiver, for three (3) of the fifteen (15) patients in the sample. (Patients #5, #12 and #13)

The findings include:

1. Review of Patient # 5's Plan of Care (POC) dated May 4, 2010 to October 3, 2010, on January 28, 2011, beginning at 2:30 p.m., revealed the patient had diagnoses that included hypertension and Diabetes Mellitus and was ordered a low sodium diet. Further review revealed the patient was dependant on the home health aide (HHA) for all activities of daily living.

Review of registered nurse (RN) monthly notes dated from May 2010, through October 2010, on January 28, 2011, at 3:10 p.m., revealed no training and education given to the patient or the patient's caregivers.

Interview with the Clinical Administrator on January 28, 2011, at approximately 4:10 p.m., confirmed the findings.

2. Review of Patient #12's POC's dated November 20, 2010 to January 18, 20100 and November 20, 2010 to May 19, 2011, on January 25, 2011, beginning at 11:40 a.m., revealed the patient had diagnoses that included pariph vascular disorder, arthritis, hypertension, and hyperlipidemia and was ordered a low fat, low sodium diet. Further review revealed the patient received assistance from a HHA.

H279 3911.2 (s) Clinical Records

Client #5-The RN that was assigned to the client no longer works for VMT. The client has had monthly visits from November to current date. These visits all include teaching and education of the client and/or caregiver.

Client # 12's record revealed that training was done on medication and not diet. On February 22, 2011, the RN assigned to client #12 was notified to diversify the teaching to include dietary restrictions and recommendations.

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H 279	Continued From page 14 Review of the RN's notes dated November 13, 2010, December 3, 2010 and December 12, 2010, revealed no training and education given to the patient or the patient's caregivers regarding her prescribed diet. 3. Review of Patient #13's POC's dated February 24, 2010 to February 28, 2011, on January 24, 2011, beginning at 1:40 p.m., revealed the patient had diagnoses that included heart disease, diabetes, hypertension and abnormal gait. Further review of the POC indicated that the client used a cane, walker and wheelchair for mobility. The POC further indicated that the physical therapist would provide training on therapeutic exercise and provide teaching on functional mobility, home safety, and effective and safe use of the adaptive devices. The POC further revealed that the patient received assistance from an HHA, eight hours per day, seven days a week. Review of physical therapy visiting notes dated from March 10, 2010, through January 13, 2011, revealed no training and education given to the patient or the patient's caregiver.	H 279	Client #13 On February 2, 2011, the Physical Therapist was interviewed and the findings were discussed. The therapist indicated that she does educate or re-educate the client each visit. The Physical Therapist acknowledged that she failed to document her teaching. VMT has reformatted its following visit forms: Skilled Nursing, Medicaid Supervisory, Medicaid Waiver Supervisory, and Physical Therapy. These forms have been revised to be user-friendly and clearly outline education documentation that is needed. On February 14, 2011, the Professional staff was given the new visit forms and was educated on how to complete the forms by the DON. The new forms will be used starting March 1, 2011. All education and teaching documentation will be reviewed by the DON or designee for accuracy and completeness prior to the weekly filing of documents in the clinical records. All documents that are below the VMT standard of accuracy and completeness will be given back to the professional staff personnel to be completed and resubmitted within 48 hours.	
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 15 This Statute is not met as evidenced by: Based on record review and interview, the agency failed to ensure each patient's plan of care was approved and signed by a physician within thirty days of the start of care, for three (3) of the fifteen (15) patients in the sample. (Patients #2, #9, #13,) The findings include: 1. On January 24, 2011, beginning at 11:20 a.m., review of Patient #2's record revealed the following: a. She had a plan of care (POC) for the certification period of June 15, 2010 to August 13, 2010. Further review of the POC revealed the physician approved and signed it on September 21, 2010, which was ninety-eight (98) days after the start of care. 2. On January 25, 2011, at approximately 10:50 a.m., review of Patient #9's POC for the certification period.October 16, 2010 to December 14, 2010 (for skilled nursing services) revealed that it had not been signed, to date. 3. On January 24, 2011, beginning at 1:40 p.m., review of Patient #13's record revealed that POCs had not been signed within thirty (30) days of the start of care, as follows a. POC certification period August 24, 2010 to February 23, 2011, was signed on November 5, 2010 During a face to face interview with the DON on January 28, 2011, at approximately 2:55 p.m., he confirmed the findings.	H 366	**H366 3914.4 Patient Plan of Care** Clients #2 and 13 were signed but outside the regulation requirement. In regards to Client #9, the client's POC was resubmitted and the physician returned the signed POC. VMT has implemented a new process to improve the timely return of signed POCs by physicians. The admission/recertification nurse is allotted 24-48 hours to return the admission/recertification documentation to the office. Once the documents are returned they are screened by the DON or his designee for accuracy and completeness. These documents will be inputted into the VMT computer system within 24 hours. Compliance will be aided by the Data Entry staff identifying and tracking all unsigned POC on a daily basis. This data will be included in the daily office meetings and allow for brainstorming and strategic thinking of how to maintain compliance. During this information sharing, trends that are revealed will be considered during the prioritization of POC. The Data Entry staff will notify the Administrator on a weekly basis of the status of all unsigned POCs and the progress and plan. The Clinical Administrator developed a spreadsheet to monitor the progress and success of the strategy in place.	2/5/2011

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H 399	3915.10(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Personal care aide duties may include the following: (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, the agency failed to ensure personal care aides (PCA's) recorded and reported on the patient's physical condition, behavior or appearance, for four (4) of the fifteen (15) patients in the sample. (Patients #3, #6, #7 and #11) The findings include: Review of Patients #3, #6, #7 and #11's medical records from January 24, 2011 through January 28, 2011, revealed that their assigned PCA's had not recorded and reported the patient's physical condition, behavior, or appearance to the agency. During a face to face interview with the clinical administrator on February 1, 2010, at approximately 9:20 a.m., she stated that the PCA's hired through an contracting agency were not using the appropriate form. Further interview indicated that she would ensure that all PCA's would use the appropriate form to record and report the patient's physical condition, behavior and appearance.	H 399	**H399 3915.10(f)** Client #3- all documentation from March 2010, to present has the required element. Client #6 and 7- The contracted staffing agency owner was notified of the deficiencies and requirements for compliance. A revised copy of the Home Health Aide-Employee Timesheet and the Home Health Agency Regulations was once again given to the staffing agency owner on February 4, 2011. Client #11- the staff member did not accurately complete the activity record prior to submission. The staff member was notified of their documentation issues in-serviced on Monday February 28, 2011, on acceptable and required documentation. VMT currently has a PCA activity record that is compliant with the regulations 3915.10 (f). The PCA activity record and the weekly timesheet have been condensed into one form. On February 19, 2011, VMT PCA staff attended an in-service that re-educated and instructed the staff on the new activity record. All PCAs that will be working with a VMT client will use the agency form that speaks to the language in regulation 3915.10(f). All subcontracting staffing agencies will be provided this document. **3/27/2011** The Finance Department will not process any timesheet after March 27, 2011, that does not meet regulation 3915.10 (f). Any timesheets that do not reflect the updated form will be returned to VMT staff or the contracting staffing agency for correction, resubmission and processing.	
H 430	3916.1 SKILLED SERVICES GENERALLY Each home care agency shall review and	H 430		

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H 430	Continued From page 17 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. This Statute is not met as evidenced by: Based on record review and interview, the agency failed to review and evaluate the skilled services provided each patient, and to send a summary report to the physician, for eight (8) of the fifteen (15) patients in the sample. (Patients #4, #5, #6, #7, #9, #11, #13 and #14) The findings include: 1. On January 28, 2011, beginning at 2:30 p.m., review of Patient #4 and #5 records revealed their plans of care (POC) had ordered skilled nursing services. (SN) to "visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." Continued review of Patient #4's clinical records revealed no documented evidence that the agency had reviewed and evaluated the skilled service provided to the patient, at least every sixty-two calendar days, nor had a summary report of the evaluation been sent to the patient's physician. 2. On January 28, 2011, beginning at 1:30 p.m., review of Patient s record revealed POCs with certification periods from May 4, 2010 to October 3, 2010, and October 4, 2010 to May 3, 2011. The POC ordered SN to "visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." Continued review of Patient #5's clinical records revealed no documented evidence that the agency had reviewed and	H 430	**H430 3916.1 Skilled Services Generally** Clients # 4, 5, 6,7,9,11,13, and 14 became compliant with statue 3916.1 on February 25, 2011 for all skilled client summaries. By March 4, 2011, all skilled care summaries will be faxed to the physicians. An in-service was done on Monday February 18, 2011, about the skilled summary regulation and requirements. VMT has targeted the even months on or about the 10th day of that month to fax the skilled summaries to the physicians. These reports are generated by the Professional staff and will be sent to the physicians, via fax, every 60-62 days. The first business day of the even months, the DON will generate a census of all skilled clients. As the professional staff completes and submits the summaries to VMT, the office staff will fax the reports to the physicians. Along with the summary, the facsimile confirmation sheet will be stapled to the summary and placed in the client's clinical record in the coordination of care section of the clinical record. This summary submission will be included on the monthly audit tool for tracking.	

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H 430	Continued From page 18 evaluated the skilled service provided to the patient at least every sixty-two calendar days, nor had a summary report of those evaluations been sent to the patient's physician. 3. On January 26, 2011, beginning at 12:28 p.m., review of Patient #6's record revealed POCs with certification periods from February 18, 2010 to August 17, 2010, and August 18, 2010 to February 17, 2011. Both POCs ordered SN "one visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." Continued review of Patient #6's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician. 4. On January 26, 2011, beginning at 10:15 a.m., review of Patient #7's record revealed POCs with certification periods from March 1, 2010 to August 31, 2010, and September 1, 2010 to February 28, 2011. The POCs ordered SN to "visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." Continued review of Patient #7's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician. 5. On January 24, 2011, beginning at 3:48 p.m., review of Patient #9's record revealed a POC with a certification period from July 17, 2010 to January 16, 2011. The doctor ordered skilled nursing (SN) to "visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." In addition, another POC with a certification period from October 14, 2010 to	H 430		

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December 13, 2010, ordered SN "1-3 times weekly for 9 weeks" to "observe, evaluate, teach signs and symptoms of infection... teach the patient" on proper wound care. Continued review of Patient #9's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician.

6. On January 26, 2011, beginning at 2:11 p.m., review of Patient #11's record revealed POCs with certification periods from November 20, 2010 to January 18, 2011, and January 19, 2011 to March 18, 2011. The POCs ordered SN: "1-3 times a week for 9 weeks, assess and observe all body systems, wound care and teaching on signs and symptoms of infection, hypertension and abnormal gait and Aide supervision." Continued review of the patient's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician.

7.a. On January 24, 2011, beginning at 1:40 p.m., review of Patient #13's record revealed POCs with certification periods from February 24, 2010 to August 23, 2010, and August 24, 2010 to February 23, 2011.. The POCs ordered SN to "visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." Continued review of the patient's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician.

b. On January 24, 2011, beginning at 1:40 p.m., review of Patient #13's record revealed POCs with certification periods from June 14, 2010 to August 13, 2010, August 13, 2010 to October 11,

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H 430	Continued From page 20 2010, and October 13, 2010 to December 11, 2010. The POCs ordered physical therapy 1-2 times a week for 6-9 weeks, and teaching on transfer techniques, home safety, functional mobility, etc... Continued review of the patient's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician. 8. On January 26, 2011, beginning at 9:21 a.m., review of Patient #14's record revealed a POC with a certification period from August 24, 2010 to February 23, 2011. The POC ordered SN to "visit monthly times 26 weeks, 1-2 visits as needed for complications and Aide supervision, nursing assessment with every monthly visit ..." Continued review of the patient's clinical records revealed no evidence that the agency reviewed and evaluated skilled services provided, nor sent summary reports to the physician. When interviewed together on January 28, 2011, at approximately 1:00 p.m., the clinical administrator and the director of nursing acknowledged that to date, the agency had not evaluated the skilled services provided their patients on a routine basis nor had they prepared summary reports at least every 62 days to send to the patients' physicians.	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;	H 453		

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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 453	Continued From page 21 This Statute is not met as evidenced by: Based on record review and interview, the agency failed to show evidence that each patient's needs were met in accordance with the plan of care, for three (3) of the fifteen (15) patients in the sample. (Patients #7, #9 and #11) The findings include: 1. On January 26, 2011, beginning at 10:15 a.m., review of Patient #7's record revealed a plan of care (POC) with a certification period from September 1, 2010 to February 28, 2011, that included the following: Home health aid (HHA) 12 hours, seven days a week for six months; Master Social Worker (MSW) 12 hours, as needed annually to assist with community resources; Skilled nursing one visit monthly, two visits as needed for complications/Aide supervision; Notify physician of health status change. Further review of the record did not reflect evidence of MSW services. 2. On January 24, 2011, beginning at 3:48 p.m., review of Patient #9's record revealed a POC with a certification period from October 14, 2010 to December 13, 2010 that included the following: "Skilled nurse (SN): visit the patient 1-3 times per week for 9 weeks for home care; SN: visit 1 monthly visit, 2 visits as needed for complications/Aide supervision; SN will teach client/care giver safety precautions/emergency plan - when to call VMT/911/MD as outlined in emergency handout; Observe, evaluate, teach signs and symptoms of infection ; SN will teach patient/care giver to keep the dressing clean, dry	H 453	**H453 3917.2(c) Skilled Nursing Services** Client # 7 is an EPD waiver client, as such, the Case Managers do not document in the clinical record. Client #7's POC was revised to indicate that the Case Manger's documentation can be found in CaseNet. Client #9 did not receive visits from November 5, 2010 through November 25, 2010. VMT was aware of this issue prior to the survey and had taken corrective action with the nurse on November 30, 2010. Client # 11, the client did not have a wound but their POC indicated wound care. The staff was in-serviced on individualizing the POC to the client's needs. The POC was corrected and the physician was notified of the clarification via a MD order on January 26, 2011. VMT has instructed the admission/recertification nurse to individualize the orders, goals, teaching and outcomes for each client. The information from the nurse will be communicated, via the admission and recertification documentation, to the Data Entry staff for input into the individualized PDC. All recertification POCs that are generated in the future will now have an entry for the assigned case managers and outline that the case manager's documentation will be found in CaseNet and not the clinical record. The POC will be reviewed by the DON or his designee for accuracy, completeness and congruency of the client's diagnosis, medications, activity level, nutritional status, DME supplies, physician orders, discharge and goals prior to signing off on the POC and faxing to the physician. The Administrative Assistance will continue to monitor VMT's professional staff call-in system and track the visits daily. A report will be generated on or about the 20th of each month to assess the clients that have not been seen for the month by the professional staff. A report of concerns will be elevated to the President.	

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 _____	02/01/2011

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H 453	Continued From page 22 at all times; SN will teach patient/care giver how to properly do the wound care. At 4:41 p.m., further review of Patient #9's clinical record revealed that the skilled nurse documented home visits on October 16, 22, 29, and November 5, 2010. The nurse then documented weekly visits on November 25, December 3 and 10, 2010. There was no documented evidence, however, that the patient received skilled nursing services from November 5 through november 25, 2010. When interviewed on January 28, 2010, at approximately 9:40 a.m., the clinical administrator (CA) and the director of nursing (DON) acknowledged the findings. 3. On January 24, 2011, beginning at 3:48 p.m., review of Patient #11's record revealed POCs with certification periods from November 20, 2010 to January 18, 2011 and January 19, 2011 to March 18, 2011, that included the following: "Skilled nurse (SN): visit the patient 1-3 times per week for 9 weeks for home care;SN to assess and observe all body systems; instruct patient on new or changed medication;Teach signs and symptoms of hypertension, wound and abnormal gait; Inform patient of risk factors associated with these disease conditions; Notify physician if temperature is greater and 101.50 degrees;SN using aseptic techniques, cleanse sacral ulcer with wound cleanser, Teach patient signs and symptoms of infection; and visit 1 monthly visit, 2 visits as needed for complications/Aide supervision; When to call VMT/911/MD as outlined in emergency handout; At 4:41 p.m., further review of Patient #11's	H 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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H 453	Continued From page 23 clinical record revealed that the skilled nurse documented home visits. However the documentation did not evidence wound care treatment. Interview with the CA and the DON on January 28, 2010, at approximately 4:00 p.m., revealed that Patient #11 did not have a wound so she did not, therefore, receive wound care treatment. There was no documented evidence, however, that the patient's needs were met in accordance with her POC.	H 453		