Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0004	A. BUILDING: _____ B. WING _____	09/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
T & N RELIABLE NURSING CARE	3500 18TH STREET WASHINGTON, DC 20018

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H 000	INITIAL COMMENTS On August 19, 2014, the Department of Health/Health Regulation and Licensing Administration received an e-mail complaint that identified patient care concerns. Based on the nature of the complaint, an investigation was conducted in conjunction with the Annual Licensure Survey from August 20, 2014, through September 2, 2014, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency (HCA) provides home care services to three hundred fourteen (314) patients and employs four hundred fifty-five (455) staff. The findings of the investigation and survey were based on observations, interviews, and reviews of administrative and clinical records. Please Note: Listed below are abbreviations used in this report. Department of Health Care Finance (DHCF) Director of Nursing (DON) Home Care Agency (HCA) Personal Care Aide (PCA) Plan of Care (POC) Allegation: The Agency failed to provide care in accordance with the patient's Plan of Care during the overnight shift. Findings: On September 2, 2014, at 7:20 a.m., an interview with PCA #11 at Patient #20's home revealed that he/she arrived at the Patient's residence at 7:00 a.m., and relieved the night PCA. Interview with	H 000	Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002 RECEIVED SEP 24 2014	

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H 000	Continued From page 1 Patient #20 confirmed that a PCA was with him/her during the night of September 1, 2014. On September 2, 2014, at approximately 9:20 a.m., a review of Patient #20's clinical record at the agency office revealed a POC dated June 23, 2014 through December 22, 2014, with a physician order for "PCA services twenty-four (24) hours a day, seven (7) days a week for six (6) months..." Further review of the clinical record revealed a document titled "On Hold Services Form" dated August 13, 2014, signed by the staffing coordinator. This document revealed that the PCA services were reduced from twenty-four (24) hours a day, seven (7) days a week, to sixteen (16) hours a day, seven days a week from August 13, 2014 through August 22, 2014. There was no evidence in the record of a physician's order to reduce the PCA hours from twenty-four (24) hours a day, seven (7) days a week, to sixteen (16) hours a day, seven days a week from August 13, 2014 through August 22, 2014. During an interview with RN #6 on September 2, 2014, at approximately 10:00 a.m., RN #6 acknowledged the following: 1. The agency had been providing twenty-four (24) hours, seven (7) days a week PCA services from April 1, 2014 to August 13, 2014, to Patient #20 without a Prior Authorization (PA) for the services because the DHCF failed to issue the PA in a timely manner. 2. On August 13, 2014, the agency received a letter from Qualis Health indicating that Patient #20's provider authorization for PCA service was reduced to sixteen (16) hours a day, seven (7) days a week effective April 1, 2014, to March 31, 2015.	H 000	The Physician verbal order for Patient # 20 was written to correct the PCA hours, sent and signed by Physician. **Please see Attachment #1**	9/3/14
			All office nurses were in-serviced again on physician verbal orders. To always leave a copy of the unsigned order in the patient record until the signed copy from the physician is filed. **Please see Attachment # 2**	9/19/14
			Two office nurses have been assigned to review 5% of beneficiaries' records every month to ensure compliance. The DON/Quality Assurance coordinator will review 10% of records every quarter to ensure effectiveness.	

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H 000	Continued From page 2 3. Following multiple emails to the DHCF on August 22, 2014, the agency received an email from the DHCF re-instating Patient #20's provider authorization for PCA services of twenty-four (24) hours a day, seven (7) days a week. RN #6 could not provide a physician's order to reduce PCA hours from twenty-four (24) hours, seven (7) days a week to sixteen (16) hours a day, seven (7) days a week effective August 13, 2014, to August 22, 2014. RN #6 acknowledged that Patient #20 failed to receive PCA services during the overnight shift from August 13, 2014, through August 22, 2014. Conclusion: The allegation was substantiated.	H 000		
H 260	3911.1 CLINICAL RECORDS Each home care agency shall establish and 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, it was determined that the agency failed to maintain accurate clinical records for six (6) of the nineteen (19) patients in the sample (Patients #7, #9, #10, #14, #15, and #16). The findings include: On August 22, 2014, attempts were made to	H 260	The nurse responsible for Plan of Cares and staffing coordinator who are responsible for updating patients' demographics have been in –serviced to review and update patients' demographics weekly in the process of executing their duties. The agency is installing a new software (Allegheny), which links all departments' activities and changes in one department will be reflected in the activities of all departments. The new software will become operational by the end of 2014 or early 2015.	9/19/1

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H 260	Continued From page 3 contact patients in the sample via telephone to obtain consent to conduct home visits. The telephone numbers listed on the POCs for six (6) of nineteen (19) patients (Patients #7, #9, #10, #14, #15 and #16) were incorrect. During an interview with the DON on August 25, 2014 at approximately 3:30 p.m., he/she acknowledged that the POCs for Patients #7, #9, #10, #14, #15, and #16 could have the wrong telephone numbers. The DON further stated "the agency's staffing coordinators usually have the Patients' correct information on an excel spread sheet which is updated often". The DON also said that he/she will ensure that the POC's are updated with the current information.	H 260	Another office employee has been assigned to call all clients/ responsible parties every quarter to verify any changes in their demographics and forward to the care plan nurse for updates to ensure effectiveness.	
H 300	3912.2(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (d) To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to implement their policy to ensure treatment, care and services were consistent with the patient's POC for two (2) of twenty (20) patients in the sample. (Patient # 10 and #20) The findings include: a. On August 21, 2014, at approximately 10:30	H 300		

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H 300	Continued From page 4 a.m., a review of Patient #10 ' s clinical record revealed a POC with a certification period of June 14, 2014, to December 14, 2014 with a physician order for PCA services sixteen (16) hours a day, seven (7) days a week for six (6) months. The duties of the PCA included " assisting the patient with ADL's ' , medication reminder, meals preparation, laundry, light housekeeping, and accompany client to medical appointments." Further review of Patient #10 ' s clinical record revealed signed timesheets by PCA #12, indicating that he/she was providing sixteen (16) hours a day, seven (7) days a week PCA services from July 14, 2014, through August 3, 2014. On August 21, 2014, at approximately 3:00 p.m., the DON and Administrator were interviewed regarding the PCA #12 providing (16) hours a day, seven (7) days a week services from July 14, 2014, through August 3, 2014. The Administrator acknowledged that PCA #12 provides sixteen (16) hours a day, seven (7) days a week to Patient #10. He/she also stated that when he/she "tries to send more than one aide to patients receiving such extended hours, the patient ' s often refuse more than one aide and the matter then goes before the ALJ [Administrative Law Judge] to have their request granted." On August 22, 2014, at approximately 3:00 p.m., a visit was conducted to the residence of Patient #10. Upon arrival PCA #12 was not in the residence. PCA #12 arrived at approximately 3:15 p.m., and stated " I was just getting something from my car " . During interview with Patient #10, it was determined that PCA #12 comes to work daily between the hours of 8:00 a.m. and 9:00 a.m., and leaves the client between the hours of 4:00 p.m., and 5:00 p.m.	H 300	All patients receives one on one training on their rights and responsibilities during admission assessments and ongoing monthly nursing visits. According to the RN monthly report and surveyor's report, patient # 10 is alert and oriented to person, place a time. Prior to April 5TH ,2014, three aides were working for this patient and PCA #12 was only working the weekend shift. On April 4th, 2014, patient #10 requested PCA #12 to replace the other two aides because of her excellent duties client stated. The agency has never received any complaints from patient # 10 about the PCA leaving before time.	

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H 300	Continued From page 5 On September 2, 2014, at approximately 7:10 p.m., another visit was conducted to the residence of Patient #10. Upon arrival, PCA #12 was not observed in the residence. Patient #10 stated during interview that " [PCA #12] left for the day between the hours of 4:00 p.m., and 5:00 p.m., as [he/she] usually does ". Patient #10 also stated that he/she " never " received sixteen (16) hours a day, seven (7) days a week service from PCA #12. When showed signed time sheets for sixteen (16) hours a day, seven (7) days a week, Patient #10 stated " it looks like my signature but was not aware of signing the [PCA #12 ' s] time sheet for sixteen (16) hours a day service ". b. On September 2, 2014, at approximately 9:20 a.m., a review of Patient #20's clinical record at the agency office revealed a POC dated June 23, 2014 through December 22, 2014, with a physician order for "PCA services twenty-four (24) hours a day, seven (7) days a week for six (6) months." Further review of the clinical record (#20) revealed a document titled "On Hold Services Form" dated August 13, 2014, and signed by the staffing coordinator. This document revealed that the PCA services were reduced from twenty-four (24) hours a day, seven (7) days a week, to sixteen (16) hours a day, seven days a week from August 13, 2014 through August 22, 2014. There was no evidence in the record of a physician's order to reduce the PCA hours from twenty-four (24) hours a day, seven (7) days a week, to sixteen (16) hours a day, seven days a week from August 13, 2014 through August 22, 2014. During an interview with RN #6 on September 2,	H 300	PCA # 12 was called for an interview concerning the allegation. PCA # 12 stated that she was at work on September 2 2014 for 16hours. During phone conversation, the sister of patient # 10 insisted to speak to the DON and stated that she arrived from Jamaica around the 4th of July, 2014 and PCA # 12 has never left the client before her shift ends (12:00am). The sister also stated that, the surveyor from Health regulation and Licensing did not come to the home on September 2nd 2014. However, three aides have been assigned to work morning, evening and weekend shifts for patient # 1. 9/26/14 Monthly nurse for patient # 10 has been in-serviced to reinforce the education on patient rights and responsibilities. 9/23/14 The compliance committee of the agency's compliance program will monitor aides' attendance to patient #10 as well as others per policy to ensure effectiveness.	

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H 300	Continued From page 6 2014, at approximately 10:00 a.m., RN #6 acknowledged the following: 1. The agency had been providing twenty-four (24) hours, seven (7) days a week PCA services from April 1, 2014 to August 13, 2014, to Patient #20 without a Prior Authorization (PA) for the services because the DHCF failed to issue the PA in a timely manner. 2. On August 13, 2014, the agency received a letter from Qualis Health indicating that Patient #20's provider authorization for PCA service was reduced to sixteen (16) hours a day, seven (7) days a week effective April 1, 2014, to March 31, 2015. 3. Following multiple emails to the DHCF on August 22, 2014, the agency received an email from the DHCF re-instating Patient #20's provider authorization for PCA services of twenty-four (24) hours a day, seven (7) days a week. RN #6 could not provide a physician's order to reduce PCA hours from twenty-four (24) hours, seven (7) days a week to sixteen (16) hours a day, seven (7) days a week effective August 13, 2014, to August 22, 2014. RN #6 also acknowledged that Patient #20 failed to receive PCA services during the night shift from August 13, 2014, through August 22, 2014.	H 300	Following the agency's policies and procedures, patient's services can be interrupted or terminated if payment for those services is not received from the patient or his/her payor. Patient #20 services were interrupted because the payor did not approve or pay the agency for over four(4) months. Patient's daughter was informed of the agency' decision to withdraw services and she cared for patient during that period.	
H 450	3917.1 SKILLED NURSING SERVICES Skilled nursing services shall be provided by a	H 450		

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H 450	Continued From page 7 registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, and in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the HCA failed to ensure skilled nursing services were provided in accordance with the POC for three (3) of seven (7) patients in the sample receiving wound care. (Patients #5, #8 and #9) The findings include: 1. On August 20, 2014, at approximately 12:30 p.m., review of Patient # 5's POC dated July 29, 2014 through September 26, 2014, revealed diagnoses that included a sacral ulcer. Further review of the POC revealed that the skilled nurse was to visit the patient five (5) to seven (7) times a week to "cleanse the sacral ulcer with 0.9% normal saline, apply silver sulfadiazine 1% dermally and cover with dressing until healed." On August 20, 2014, at approximately 12:30 p.m., review of skilled nursing notes dated August 1, 2014, through August 5, 2014, and August 7, 2014, through August 10, 2014, revealed that the skilled nurse was applying acetic acid to Patient #5's wound instead of silver sulfadiazine 1%, as ordered in the POC. Interview with the Administrator, DON and Nurse Coordinator on August 21, 2014, at approximately 3:00 p.m., revealed that the order for the acetic acid was mentioned on the POC in section 16 titled "Medication(s), (dose, route, frequency)", and is written as "Acetic acid topical 0.25% dermally for wound care". The Administrator, DON, and Nurse Coordinator acknowledged that	H 450		

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H 450	Continued From page 8 the skilled nurse failed to apply silver sulfadiazine 1% as ordered in the POC. 2. On August 20, 2014, at approximately 1:15 p.m., Review of Patient # 8 ' s POC dated July 19, 2014, through September 16, 2014, revealed diagnoses that included bilateral lower extremities ulcers. Further review of the POC revealed that the skilled nurse was to visit the patient five (5) to seven (7) times a week to "cleanse bilateral leg ulcers with 0.9% normal saline/soap and water, soak and apply acetic acid to wound. Apply gentamycin cream to wound with each dressing change and cover with dressing until resolved." On August 20, 2014, at approximately 1:15 p.m., review of skilled nursing notes dated August 6, 2014, through August 9, 2014, and August 11, 2014, through August 12, 2014, revealed that the skilled nurse cleansed the wound with soap and water and applied gentamycin cream instead of acetic acid as ordered in the POC. 3. On August 20, 2014, at approximately 2:00 p.m., review of Patient # 9 ' s POC dated July 14, 2014 through September 11, 2014, revealed diagnoses that included pressure ulcers. Further review of the POC revealed that the skilled nurse was to visit the patient five (5) to seven (7) times a week to "cleanse the multiple wounds with 0.9% normal saline, pat dry, apply hydrogel and santyl ointment and wrap with dressing until healed." On August 20, 2014, at approximately 2:00 p.m., review of skilled nursing notes dated August 8, 2014 through August 12, 2014, and August 16, 2014, revealed that the skilled nurse applied hydrogel to the Patient #7's wounds instead of hydrogel and santyl ointment, as ordered in the POC.	H 450	Verbal orders were prepared and signed by the physicians to correct this deficiency. See attachment #3 The RN responsible for skilled services has been in-serviced to thoroughly review all POCs when signing to ensure that all physician orders are transcribed accurately and correctly documented in the nurses' notes. The Quality Assurance (QA) audit quarterly to ensure effectiveness.	8/29/14

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H 450	Continued From page 9 During an interview on August 21, 2014, at approximately 3:30 p.m., the Administrator, DON and Nurse Coordinator acknowledged that the skilled nurse failed to perform wound care in accordance with the POC. The DON stated that an immediate in-service will be conducted with the nurses to ensure that the physicians' orders are followed.	H 450		
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 determined that the skilled nurse failed to ensure that the patient's needs were met in accordance with their POC for two (2) of twenty (20) patients in the sample. (Patient #10 and #20) The findings includes: a. On August 21, 2014, at approximately 10:30 a.m., a review of Patient #10 ' s clinical revealed a POC with a certification period of June 14, 2014, to December 14, 2014. The POC contained physician's orders for "RN visit every month and as needed for a period of six (6) months for assessment of all systems and supervision of the home health aides". Further review of Patient #10's clinical record	H 453		

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H 453	Continued From page 10 revealed a physician order for PCA services sixteen (16) hours a day, seven (7) days a week for six (6) months. The duties of the PCA included " assisting the patient with ADL's ' , medication reminder, meals preparation, laundry, light housekeeping, and accompany client to medical appointments." Additionally, review of Patient #10 ' s clinical record revealed signed timesheets by PCA #12, indicating that he/she was providing sixteen (16) hours a day, seven (7) days a week PCA services from July 14, 2014, through August 3, 2014. On August 21, 2014, at approximately 3:00 p.m., the DON and Administrator were interviewed regarding the PCA #12 providing (16) hours a day, seven (7) days a week services from July 14, 2014, through August 3, 2014. The Administrator acknowledged that PCA #12 provides sixteen (16) hours a day, seven (7) days a week to Patient #10. He/she also stated that when he/she "tries to send more than one aide to patients receiving such extended hours, the patient ' s often refuse more than one aide and the matter then goes before the [Administrative Law Judge] ALJ to have their request granted". On August 22, 2014, at approximately 3:00 p.m., a visit was conducted to the residence of Patient #10. Upon arrival PCA #12 was not in the residence. PCA #12 arrived at approximately 3:15 p.m., and stated " I was just getting something from my car ". During interview with Patient #10, it was determined that PCA #12 comes to work daily between the hours of 8:00 a.m. and 9:00 a.m., and leaves the client between the hours of 4:00 p.m., and 5:00 p.m. On September 2, 2014, at approximately 7:10	H 453	All patients/family members receive one on one training on their rights and responsibilities during admission assessments and ongoing monthly nursing visits. One of their responsibilities is to inform the agency of employees' misconduct and any complaints regarding their services. No complaints have been received by the visiting nurse or management staff of the agency from this patient and none of the above lives with her. However, patient #10 and family were instructed again to report to the agency if the aides comes to work late or leave early. All visiting nurses will be in-serviced to reinforce the education on patient rights and responsibilities.	

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H 453	Continued From page 11 p.m., another visit was conducted to the residence of Patient #10. Upon arrival, PCA #12 was not observed in the residence. Patient #10 stated during interview that " PCA #12 left for the day between the hours of 4:00 p.m., and 5:00 p.m., as [he/she] usually does " . Patient #10 also stated that he/she " never " received sixteen (16) hours a day, seven (7) days a week service from PCA #12. When showed signed time sheets for sixteen (16) hours a day, seven (7) days a week, Patient #10 stated " it looks like my signature but I was not aware of signing the [PCA #12 's] time sheet for sixteen (16) hours a day service ". The skilled nurse failed to provide adequate supervision to ensure that Patient #10 received sixteen (16) hours a day, seven (7) days a week PCA service in accordance with the POC. b. On September 2, 2014 at approximately 9:20 a.m. a review of Patient #20's clinical record revealed a POC with a certification period of June 23, 2014, through December 22, 2014, with a physician order for "RN visit every month and as needed for a period of six (6) months for assessment of all systems and supervision of the home health aides". The POC also contained an order for "PCA services twenty-four (24) hours a day, seven (7) days a week for six (6) months, to assist the Patient with ADL's, medication reminder, meals preparation, laundry, light housekeeping, and accompanying client to medical appointment". Further review of Patient #20's clinical record revealed a document titled "On Hold Services Form" signed by the staffing coordinator dated August 13, 2014 that indicated the PCA service had been reduced from twenty-four (24) hours a	H 453	The Physician verbal order for Patient # 20 was written to correct the PCA hours, sent and signed by Physician. **Please see Attachment #1** All office nurses were in-serviced again on physician verbal orders to always leave a copy of the unsigned order in the patient record until the signed copy from the physician is filed. The QA coordinator will review 10% of records every quarter for effectiveness. Also, he visiting and office nurses were aware of patient #20 change of hours. This was not a lack of supervision, but a payment problem from the payor.	11/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0004	A. BUILDING: _____ B. WING _____	09/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
T & N RELIABLE NURSING CARE	3500 18TH STREET WASHINGTON, DC 20018

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H 453	Continued From page 12 day, seven (7) days a week, to sixteen (16) hours a day, seven days a week from August 13, 2014 through August 22, 2014. There was no physician order in the clinical record (#20) to reduce the PCA hours. During an interview with RN #6 on September 2, 2014, at approximately 10:00 a.m., RN #6 acknowledged that the services had been reduced to sixteen (16) hours a day, seven days a week from August 13, 2014 through August 22, 2014. RN #6 also acknowledged that there was no physician order to reduce the hours. The nurse failed to provide adequate supervision to ensure that Patient #20 received twenty-four (24) hours a day, seven (7) days a week PCA service in accordance with the POC.	H 453		