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-0010	A. BUILDING: _____ B. WING _____	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABA HOME HEALTH CARE	821 KENNEDY STREET, NW WASHINGTON, DC 20011

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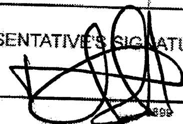
H 000	INITIAL COMMENTS An annual survey was conducted from February 4, 2014, through February 6, 2014, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to four hundred and sixty-three (463) patients and employs four hundred and fifty-two (452) staff. The findings of the survey were based observations, record reviews, interviews with current patients and staff. Please Note: Listed below are abbreviations used in this report. Skilled Nurse (SN) Plan Of Care (POC) Director of Nursing (DON) Home Care Agency (HCA) As Needed (PRN)	H 000		
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.	H 053	3903.2(c)(1) GOVERNING BODY The Administrator shall report this omission to the governing body during the next meeting. The administrator shall maintain "policy and procedure manual review and update" as an agenda item on all governing body meetings. The Governing Body shall review, evaluate and approve all policies governing the agency's operation during the next board meeting that will be scheduled by the administrator. The governing body shall sign the policy and procedures manual.	03/31/2014

Health Regulation & Licensing Administration

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



TITLE Administrator

(X6) DATE 2/27/14

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H 053	Continued From page 1 This Statute is not met as evidenced by: Based on interview and record review, it was determined that the Governing Body failed to review and evaluate on an annual basis all policies governing the agency's operation to determine if the services were appropriate, adequate, effective and efficient. The findings include: On February 4, 2014 at 10:00 a.m. the surveyor requested the HCA policy manual and a copy of the agency's annual report. The DON provided to the surveyor a policy manual that was approved on January 17, 2008 by the Medical Director, the Administrator and the Quality Improvement Coordinator, and a copy of the minutes of the annual meeting which was held on January 25, 2014. There was no documented evidence that the agency's policies were reviewed and approved since January 17, 2008. A face to face interview with the DON on February 4, 2014 at 11:00 a.m. confirmed that the HCA recently purchased updated manuals which were not reviewed and approved by the Governing Body at the time of the survey.	H 053		
H 199	3908.3(a) ADMISSIONS The agency shall evaluate each request for home care services according to the following criteria: (a) The ability of the program to provide or coordinate the services that the patient needs; This Statute is not met as evidenced by:	H 199 (1)		

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H 199	Continued From page 2 Based on observation, record review and interview, the HCA failed to ensure its program was able to provide or coordinate the services that the patients needed for five (5) of twenty (20) patients in the sample. (Patients #5, #6, #7, #8, and #10) The finding includes: 1. Review of Patient #5's POC with a certification period of September 5, 2013, to March 5, 2014, on February 5, 2014 at approximately 1:45 p.m., revealed the patient had diagnoses that included Congestive Heart Failure (CHF), Lymphodemia, Diabetes Mellitus (DM) and Glaucoma. The POC also contained a physician order for SN one time a month and PRN (as is necessary) for six (6) months to conduct complete system assessment, evaluate nutrition status, hydration and elimination status, teach disease process, medication side effects and compliance. Further review of Patient #5's clinical record revealed a note titled "suspension of services" dated October 7, 2013, which states "client was rushed to the hospital via ambulance on October 4, 2013." Further review of the clinical record revealed that the Registered Nurse (RN) visited the patient on October 29, 2013, with no mention of patient's hospitalization episode or reasons for hospitalization. Continued review of the Patient #5's clinical record revealed that the patient was again sent to the hospital on December 17, 2013. The RN visited the patient on January 5, 2014, and documented that the patient was hospitalized due to exacerbation of CHF. There was no additional visit in the clinical record to indicate that the nurse visited the patient after January 5, 2014 to teach	H 199	(1) 3908.3(a) ADMISSIONS The Registered Nurse(s) who provided care to patient # 5 were informed of the deficiency and given the opportunity to review their visit notes and the patient's medical needs. The RN has visited Patient # 5 and re-assessed the patient's need for skilled services to address the patient's medical conditions. A request for skilled nursing services (additional skilled nursing visits) was sent to patient #5's physician for approval of the service. The quality assurance staff are reviewing all clients' clinical records to ensure that all vital information is collected by the Registered Nurse during the admission visit and updated during all subsequent nursing visits. The quality assurance staff shall review all referrals and admission documentation to ensure that all patients' needs are address by the agency. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. The Assistant Director of Nursing (ADON) shall review any concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 199	Continued From page 3 disease management to prevent re-hospitalization. Additionally, there was no evidence of a weight either actual or reported in the client's clinical record. Face to Face interview with the DON on February 4, 2014, at 4:30 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to teach the patient effective disease management to prevent hospitalization. The DON also confirmed that the SN failed to address the patient's weight in the clinical record. A home visit was conducted to Patient #5 on February 6, 2014 at approximately 2:30 p.m. The surveyor found the patient sitting in a chair in the living room. The patient legs were grossly swollen (measuring approximately 28-30 inches in circumference around the mid-leg area) with dry scaly skin surface area and soiled bandages wrapped around the ankle. The patient stated to the surveyor that his hospitalizations were due to CHF and the edema in the legs was due to the Lymphodemia whereby the tissue fluid oozes through the skin. The Patient also stated that no nurse had visited him since January 5, 2014 to assist him with dressing changes to the legs which he cannot effectively perform due to its location. The surveyor called the DON from Patient #5's residence and was told that the agency will try to obtain orders from the physician for increased nursing visits to give skilled care to the patient. 2. Patient #6's POC with a certification period of October 18, 2013, to April 18, 2014, was reviewed on February 5, 2014 at approximately 2:10 p.m. The POC revealed the patient had diagnoses that included CHF, Hypertension and Obesity. The	H 199 (2)	3908.3(a) ADMISSIONS The RN was instructed on nursing care for a patient with a defibrillator. The RN was instructed to re-assess the patient's defibrillator during subsequent nursing visits and teach patient about the medical devise, as well as contact the patient's physician as needed for orders for additional nursing visits. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance staff shall review all referrals, post hospitalization orders and RN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 199	Continued From page 4 POC also contained a physician order for SN one time monthly and PRN for six (6) months to conduct complete system assessment, evaluate nutrition status, cardiopulmonary status, hydration and elimination status, teach disease process, medication side effects and compliance. Further review of Patient #6's clinical record revealed a note titled "suspension of services" dated October 18, 2013, which states "client went to the hospital. Client informed the office." Additional review of the clinical record revealed an RN note dated October 25, 2013, which indicated that the patient went to the hospital for a cardiac defibrillator implant. There was no documented evidence that the RN visited Patient #6 until November 26, 2013, following the October 25, 2013, visit to adequately monitor the patient. A face to Face interview with the DON on February 4, 2014, at 4:30 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to monitor the patient for negative outcomes. The DON also confirmed that the SN failed to address the patient's weight in the clinical record (an integral action in CHF management).	H 199		
	3. Patient #7's POC with a certification period of September 30, 2013, to March 30, 2014, was reviewed on February 5, 2014 at approximately 2:30 p.m. The POC revealed the patient had diagnoses that included Alzheimers, Hypertension, and Thyroid Problems. The POC also contained a physician order for SN one time monthly and PRN for six (6) months to conduct complete system assessment, evaluate nutrition status, cardiopulmonary status, hydration and elimination status, teach disease process,	H199 (3)	3908.3(a) ADMISSIONS SAME AS H199(2) above	03/31/2014

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H 199	Continued From page 5 medication side effects and compliance. Further review of Patient #7's clinical record revealed a communication note dated October 22, 2013, which states "Patient went to Providence Hospital." Additional review of the Patient #7's clinical record revealed a nursing note dated October 31, 2013, which states client went to the hospital with hematuria (blood in urine) and the doctor stated to hold the Pradaxa (an anticoagulant) for five (5) days. The next nursing visit was conducted on November 5, 2013. There was no evidence that the agency communicated with the physician the need to schedule the patient for close observation and teaching of disease management. A face to Face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to monitor the patient for negative outcomes.	H 199		
	4. Review of Patient #8's POC with a certification period of September 9, 2013, to March 9, 2014, on February 5, 2014 at approximately 2:10 p.m., revealed the patient had diagnoses that included Degenerative Joint Disease, Arthritis, GERD and Obesity. The POC also contained a physician order for SN one time a month and PRN for six (6) months to conduct complete system assessment, evaluate nutrition status, hydration and elimination status, teach disease process, medication side effects and compliance. Further review of Patient #8's clinical record revealed a SN note dated September 26, 2013 that states "Patient is undergoing daily radiation therapy for vaginal Cancer times 3 treatments.	H 199 (4)	3908.3(a) ADMISSIONS SAME AS H199(2) above	03/31/2014

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H 199	Continued From page 6 The last treatment will be on October 3, 2013, she (the patient) was educated to expect side effects of radiation therapy like....). There was no evidence that the RN visited the patient again until October 30, 2013. A face to face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to give adequate nursing care to the patient following the radiation treatments.	H 199		
	5. Patient #10 had a start of care of November 15, 2012. Patient #10's skilled and non-skilled records were reviewed during the survey. Patient #10's skilled POC with a certification period of December 24, 2013, to February 21, 2014, was reviewed on February 5, 2014 at approximately 3:10 p.m. The POC contained the diagnoses of Decubitus Ulcer -Leg, Colostomy, Osteoarthritis Multiple Sites, Tachycardia and Sacral Wound. The POC also contained a physician order for skilled nurse three (3) to six (6) times weekly for nine (9) weeks to clean sacral and right leg wounds with normal saline, apply Santyl, cover with dry dressing and secure with tape. Measure wounds weekly and teach family wound care. The POC contained no order for Foley Catheter care or management. Review of nurses' notes from December 24, 2013 through January 31, 2014 all states "dry dressings applied to sacral wounds because patient refuses Santyl ointment to sacral wound." There was no documented evidence that the physician was informed of the patient's refusal of Santyl ointment to the sacral wound.	H 199 (5)	3908.3(a) ADMISSIONS All staff that provide care to patient # 10 were given the opportunity to review the clinical records of the patient after they were informed of the deficiency. The RN reassessed patient # 10's medical needs and the patient's physician was contacted for orders on the supra-pubic catheter. The physician was notified of the patient's refusal of Santyl ointment treatment and wound care orders were clarified. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance team shall also ensure that all orders and notifications are forwarded to the patients' physicians immediately for review and approval. The quality assurance staff shall review RN and LPN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 199	Continued From page 7 Further review of the Patient #10's clinical record revealed a Resumption of Care OASIS that indicated the patient was hospitalized at Washington Hospital Center with a Urinary Tract Infection (date unknown) and was discharged to home with Intravenous Antibiotics on January 24, 2014. There was no documented evidence in the clinical record that the skilled nurse ever attempted Foley catheter change/care on the patient prior to the hospitalization. A face to face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to inform the physician of the patient's refusal of the Santyl dressings to the sacral wound. Additionally, the DON also admitted that there was no evidence that the skilled nurse ever addressed in their notes any Foley catheter change or management to the patient's Foley catheter form October 2013 to January 31, 2014. On February 6, 2014 a home visit was conducted to Patient #10 at approximately 11:00 a.m. During the home visit the surveyor noted that Patient #10 was no longer on intravenous medications and the patient had a supra-pubic Foley catheter instead of a intra-urethral Foley catheter. There was no documented evidence of collaboration of care for this catheter between the agency and the physician's office.	H 199		
H 261	3911.2(a) CLINICAL RECORDS Each clinical record shall include the following information related to the patient:	H 261		

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H 261	Continued From page 8 (a) Admission data, including name, address, date of application, date of birth, sex, agency case number, next of kin or responsible party, date accepted by the agency to receive services, and source of payment, if applicable; This Statute is not met as evidenced by: Based on observation, record review and interview, it was determined that the agency failed to have accurate information regarding the patients' address in the clinical records for one (1) of twenty (20) patients. (Patient #7) The finding includes: On February 4, 2014, Patient #7's clinical record was reviewed at approximately 11:30 a.m. A decision was made to conduct a home visits to this patient on February 6, 2014, after the agency staff had obtained permission from the patient. On February 6, 2014, the surveyor arrived at Patient #7's residence at 9:15 a.m. as scheduled and got no answer from within the residence after knocking on the door for approximately 20 minutes. The neighbor living at the residence adjoining the address where Patient #7 lived, said no one lived in that home for the longest time. On February 6, 2014 at approximately 3:00 p.m. the surveyor contacted the DON and informed him/her what transpired during the visit to patient #7. The DON stated that the agency was not aware of the change of address for the Patient #7. On February 7, 2014 at approximately 2:00 p.m. a telephone interview was attempted with Patient #7 using the telephone number listed on the "Plan	H 261 (a)	3911.2 (a) CLINICAL RECORDS The staff who had entered the information incorrectly was given the opportunity to review the deficiency and correct the records. The typing error on patient # 7's record has been corrected. The street name has been corrected from "5th street" to "8th street". Patient # 7's telephone number has been updated to the current number. The quality assurance staff are reviewing all patients' records to ensure that all data were transcribed accurately. All discrepancies shall be forwarded to the ADON who will review then with respective staff monthly, then provide support and supervision as needed. Agency has bought a medical record software and staff are currently training to use electronic medical records. When it goes operational, it will eliminate significantly the possibility of transcription errors as nurses will enter and update client records in the field into the electronic records.	03/31/2014

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H 261	Continued From page 9 of Treatment", the document given to the surveyor that contained the patient's demographic information. The surveyor attempting the telephone interview was told by the individual answering the telephone that it was the wrong telephone number.	H 261		
H 352	3914.3(a) PATIENT PLAN OF CARE The plan of care shall include the following: (a) Physician orders for skilled services; This Statute is not met as evidenced by: Based on observation, record review and interview, the HCA failed to ensure the POC included physician orders for skilled nursing services for five (5) of twenty (20) patients in the sample. (Patients #5, #6, #7, #8 and #10). The findings include: 1. Review of Patient #5's POC with a certification period of September 5, 2013, to March 5, 2014, on February 5, 2014 at approximately 1:45 p.m., revealed the patient had diagnoses that included Congestive Heart Failure (CHF), Lymphodemia, Diabetes Mellitus (DM) and Glaucoma. The POC also contained a physician order for SN (skilled nurse) one time a month and PRN (as is necessary) for six (6) months to conduct complete system assessment, evaluate nutrition status, hydration and elimination status. Teach disease process, medication side effects and compliance. Further review of Patient #5's clinical record revealed a note titled "suspension of services"	H 352 (a)	3914.3(a) PATIENT PLAN OF CARE The Registered Nurse who provides care to patient # 5 was informed of the deficiency and given the opportunity to review his/her visit notes and patient's medical needs. The RN re-assessed the patient's need for skilled services and other vital information necessary for comprehensive care of the patient's medical conditions. A request for skilled nursing services (additional skilled nursing visits) was sent to patient #5's physician for approval of the service. The quality assurance staff are reviewing all client's clinical records to ensure that all vital information is collected by the Registered Nurse during the admission visit to the patient and during all nursing visits. The quality assurance staff shall review all referrals and admission documentation to ensure that all patients' needs are address by the agency. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. Nurses shall also be trained on accurately addressing all clients' needs on the plan of care. The Assistant Director of Nursing (ADON) shall review any concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 352	Continued From page 10	H 352		

dated October 7, 2013, which states "client was rushed to the hospital via ambulance on 10/4/13". Further review of the clinical record revealed that the Registered Nurse (RN) visited the patient on October 29, 2013, with no mention of patient's hospitalization episode or reasons for hospitalization.

Continued review of the Patient #5's clinical record revealed that the patient was again sent to the hospital on December 17, 2013. The RN visited the patient on January 5, 2014, and documented that the patient was hospitalized due to exacerbation of CHF. There was no additional visit in the clinical record to indicate that the nurse visited the patient after January 5, 2014 to teach disease management to prevent re-hospitalization. Additionally, there is no evidence of a weight either actual or reported in the client's clinical record.

A face to face interview with the DON on February 4, 2014, at 4:30 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to teach the patient effective disease management to prevent hospitalization. The DON also confirmed that the SN failed to address the patient's weight in the clinical record.

A home visit was conducted to Patient #5 on February 6, 2014 at approximately 2:30 p.m. The surveyor found the patient sitting in a chair in the living room. The Patient legs were grossly swollen (measuring approximately 28-30 inches in circumference around the mid-leg area) with dry scaly skin surface area and soiled bandages wrapped around the ankle. The patient stated to the surveyor that his hospitalizations were due to CHF and the edema in the legs was due to the

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H 352	Continued From page 11 Lymphodemia whereby the tissue fluid oozes through the skin. The Patient #5 also stated that no nurse visited him since January 5, 2014 to assist him with dressing changes to the legs which he cannot effectively perform due to its location. The surveyor called the DON from Patient #5's residence and was told that the agency will try to obtain orders from the physician for increased nursing visits to give skilled care to the patient. 2. Patient #6 POC with a certification period of October 18, 2013, to April 18, 2014, was reviewed on February 5, 2014 at approximately 2:10 p.m. The POC revealed the patient had diagnoses that included CHF, Hypertension and Obesity. The POC also contained a physician order for SN one time monthly and PRN for six (6) months to conduct complete system assessment, evaluate nutrition status, cardiopulmonary status, hydration and elimination status, teach disease process, medication side effects and compliance. Further review of Patient #6's clinical record revealed a note titled "suspension of services" dated October 18, 2013, which states "client went to the hospital. Client informed the office." Additional review of the clinical record revealed an RN note dated October 25, 2013, which indicated that the patient went to the hospital for a cardiac defibrillator implant. There was no documented evidence that the RN visited the Patient #6 until November 26, 2013, following the October 25, 2013, visit. A face to face interview with the DON on February 4, 2014, at 4:30 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to monitor the	H 352 H 352 (2)	3914.3(a) PATIENT PLAN OF CARE The RN was instructed on nursing care for a patient with a defibrillator. The RN was instructed to re-assess the patient's defibrillator during subsequent nursing visits and to teach the patient about the medical devise, as well as contact the patient's physician as needed to order additional nursing visits. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. Nurses shall also be trained on accurately addressing all clients' needs on the plan of care. The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance staff shall review all referrals, post hospitalization orders and RN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 352	Continued From page 12 patient for negative outcomes. The DON also confirmed that the SN failed to address the patient's weight in the clinical record. 3. Patient #7 POC with a certification period of September 30, 2013, to March 30, 2014, was reviewed on February 5, 2014 at approximately 2:30 p.m. The POC revealed the patient had diagnoses that included Alzheimer, Hypertension, and Thyroid Problems. The POC also contained a physician order for SN one time monthly and PRN for six (6) months to conduct complete system assessment, evaluate nutrition status, cardiopulmonary status, hydration and elimination status, teach disease process, medication side effects and compliance. Further review of Patient #7's clinical record revealed a communication note dated October 22, 2013, which states "Patient went to Providence Hospital." Additional review of the Patient #7's clinical record revealed a nursing note dated October 31, 2013, which states client went to the hospital with hematuria (blood in urine) and the doctor stated to hold the Pradaxa (an anticoagulant) for five (5) days. The next nursing visit was conducted on November 5, 2013. There was no evidence that the agency communicated with the physician need to skill the patient for close observation and teaching of disease management. Face to Face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to monitor the patient for negative outcomes. 4. Review of Patient #8's POC with a certification	H 352 (3)	3914.3(a) PATIENT PLAN OF CARE The RN was instructed to teach patient/caregiver on medication side effects including Pradaxa. The RN was instructed to re-assess the patient's knowledge of medication during subsequent nursing visits and to teach the patient about the medical devise, as well as contact the patient's physician as needed to order additional nursing visits. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. Nurses shall also be trained on accurately addressing all clients' needs on the plan of care. The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance staff shall review all referrals, post hospitalization orders and RN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 352	Continued From page 13 period of September 9, 2013, to March 9, 2014, on February 5, 2014 at approximately 2:10 p.m., revealed the patient had diagnoses that included Degenerative Joint Disease, Arthritis, GERD and Obesity. The POC also contained a physician order for SN one time a month and PRN for six (6) months to conduct complete system assessment, evaluate nutrition status, hydration and elimination status. Teach disease process, medication side effects and compliance. Further review of Patient #8's clinical record revealed a SN note dated September 26, 2013 that states "Patient is undergoing daily radiation therapy for vaginal Cancer X 3 treatments. The last treatment will be on 10/3/13 she was educated to expect side effects of radiation therapy like....). There was no evidence that the RN visited the patient again until October 30, 2013. A face to face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to obtain more visits to give adequate care to the patient following the radiation treatments.	H 352 (4)	3914.3(a) PATIENT PLAN OF CARE The RN who provided care to patient # 8 was informed of the deficiency noted by the surveyor. The RN was educated on the need to perform comprehensive assessments and then follow up with the patients' physicians to obtain skilled nursing visit orders to ensure that the clients' needs are addressed appropriately. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance staff shall review all referrals, post hospitalization orders and RN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014
	5. Patient #10 had a start of care of November 15, 2012. The Patient #10 skilled and non-skilled records were reviewed during the survey. Patient #10's skilled POC with a certification period of December 24, 2013, to February 21, 2014, was reviewed on February 5, 2014 at approximately 3:10 p.m. The POC contained the diagnoses of Decubitus Ulcer -Leg, Colostomy, Osteoarthritis Multiple Sites, Tachycardia and Sacral Wound. The POC also contained a	H 352 (5)	3914.3(a) PATIENT PLAN OF CARE The staff who provided care to patient # 10 were given the opportunity to review the clinical records of the patient and reassess the client after they were informed of the deficiency. The RN re-assessed patient # 10 and his/her medical needs and the patient's physician was contacted for supra-pubic catheter and the physician was notified of the patient's refusal of Santyl ointment treatment. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. CONTINUE ON PAGE 15	03/31/2014

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H 352	Continued From page 14 physician order for skilled nurse three (3) to six (6) times weekly for nine (9) weeks to clean sacral and right leg wounds with normal saline, apply Santyl, cover with dry dressing and secure with tape. Measure wounds weekly and teach family wound care. The POC contained no order for Foley Catheter care or management. Review of nurses' notes from December 24, 2013 through January 31, 2014 all states "dry dressings applied to sacral wounds because patient refuses Santyl ointment to sacral wound." There was no documented evidence that the physician was informed of the patient's refusal of Santyl ointment to the sacral wound. Further review of the Patient #10's clinical record revealed a Resumption of Care OASIS that indicated the patient was hospitalized at Washington Hospital Center with a Urinary Tract Infection (date unknown) and was discharged to home with Intravenous Antibiotics on January 24, 2014. There was no documented evidence in the clinical record that the skilled nurse ever attempted Foley change/care on the patient prior to the hospitalization. A face to face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to inform the physician of the patient's refusal of the Santyl dressings to the sacral wound. Additionally, the DON also admitted that there was no evidence that the skilled nurse ever addressed in their notes any Foley catheter change or management to the patient's Foley catheter form October 2013 to January 31, 2014.	H 352	CONTINUED FROM PAGE 14 The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance team shall also ensure that all orders and notifications are forwarded to the patients' physicians immediately for review and approval. The quality assurance staff shall review RN and LPN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 352	Continued From page 15 On February 6, 2014 a home visit was conducted to Patient #10 at approximately 11:00 a.m. During the home visit the surveyor noted that the Patient #10 was no longer on intravenous medications and the patient had a supra-pubic Foley catheter instead of a intra-urethral Foley catheter. There was no documented evidence of collaboration of care for this catheter between the agency and the physician's office.	H 352		
H 452	3917.2(b) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (b) Coordination of care and referrals; This Statute is not met as evidenced by: Based on observation, record review, and interview the agency's nurse failed to ensure coordination of care and to make referrals for one (1) of twenty (20) patients in the survey sample. (Patient #10) The finding includes: Patient #10 had a start of care of November 15, 2012. Patient #10's skilled and non-skilled records were reviewed during the survey. Patient #10's skilled POC with a certification period of December 24, 2013, to February 21, 2014, was reviewed on February 5, 2014 at approximately 3:10 p.m. The POC contained the diagnoses of Decubitus Ulcer -Leg, Colostomy, Osteoarthritis Multiple Sites, Tachycardia and Sacral Wound. The POC also contained a physician order for skilled nurse three (3) to six	H 452	3917.2 (b) SKILL NURSING SERVICES The staff who provided care to patient # 10 were given the opportunity to review the clinical records of the patient and reassess the client after they were informed of the deficiency. The RN re-assessed patient # 10 and his/her medical needs and the patient's physician was contacted for supra-pubic catheter and the physician was notified of the patient's refusal of Santyl ointment treatment. All nurses will be trained on comprehensive client assessments and documentation during the next nurses meeting that will be scheduled by the Director of Nursing. The quality assurance staff are reviewing all clients' clinical records to ensure that the nurses are conducting and documenting a comprehensive assessment of clients' medical needs during all nursing visits. The quality assurance team shall also ensure that all orders and notifications are forwarded to the patients' physicians immediately for review and approval. The quality assurance staff shall review RN and LPN visit notes to ensure that the agency addresses all clients' needs, and report any compliance issues to the ADON. The ADON shall review all concerns with respective RNs monthly and as needed. He/she shall provide support and supervision when there is need.	03/31/2014

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H 452	Continued From page 16	H 452		

(6) times weekly for nine (9) weeks to clean sacral and right leg wounds with normal saline, apply Santyl, cover with dry dressing and secure with tape. Measure wounds weekly and teach family wound care. The POC contained no order for Foley Catheter care or management.

Review of nurses' notes from December 24, 2013 through January 31, 2014 all states "dry dressings applied to sacral wounds because patient refuses Santyl ointment to sacral wound." There was no documented evidence that the physician was informed of the patient's refusal of Santyl ointment to the sacral wound.

Further review of the Patient #10's clinical record revealed a Resumption of Care OASIS that indicated the patient was hospitalized at Washington Hospital Center with a Urinary Tract Infection (date unknown) and was discharged to home with Intravenous Antibiotics on January 24, 2014.

There was no documented evidence in the clinical record that the skilled nurse ever attempted Foley change/care on the patient prior to the hospitalization.

A face to face interview with the DON on February 4, 2014, at 4:35 p.m. confirmed that the agency should have communicated with the physician to inform the physician of the patient's refusal of the Santyl dressings to the sacral wound. Additionally, the DON also admitted that there was no evidence that the skilled nurse ever addressed in their notes any Foley catheter change or management to the patient's Foley catheter form October 2013 to January 31, 2014.

On February 6, 2014 a home visit was conducted

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H 452	Continued From page 17 to Patient #10 at approximately 11:00 a.m. During the home visit the surveyor noted that the Patient #10 was no longer on intravenous antibiotic and the patient had a supra-pubic Foley catheter instead of a intra-urethral Foley catheter. There was no documented evidence of collaboration of care for this catheter between the agency and the physician's office.	H 452		