Received 3/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0059	A. BUILDING: _____ B. WING _____	02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDSTAR VISITING NURSE ASSOCIATION, IN(	4301 CONNECTICUT AVENUE, SUITE 441 WASHINGTON, DC 20008

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H 000	INITIAL COMMENTS An annual licensure survey was conducted from February 20, 2018, through February 28, 2018, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency's Regulations). The home care agency provides home care services to four hundred and forty-four (444) patients and employs sixty-two (62) staff. The findings of the survey were based on a review of administrative records, twenty (20) active patient records, five (5) discharged patient records, and ten (10) personnel records. The findings were also based on four (4) home visits,10 patient telephone interviews, and interviews with patients, family and staff. The following are abbreviations that may appear throughout the body of this report. HCA - Home Care Agency IADL - instrumental activities of daily living lbs - pounds POC - Plan of Care RN - Registered Nurse SN - Skilled Nurse	H 000		
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) active patients in the sample (Patient #6).	H 452		

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H 452	Continued From page 1 Findings included: On 02/20/18 at 1:30 PM, review of Patient #6's POC showed a certification period of 01/23/18 through 03/23/18. Patient #6 was 91 years old with diagnoses including type 2 diabetes, heart attack, hypertension, kidney disease, hyperlipidemia, and gait abnormalities. According to the POC, the patient was to receive SN services twice weekly for the first two (2) weeks, then weekly for three (3) weeks. Additionally, under the section "Supporting Documentation for Psychosocial Status" on the POC, it was documented that the patient was assessed to have a need for IADL assistance. On 02/27/18 at 1:00 PM, the surveyors conducted a home visit with Patient #6. During the home visit, Patient #6 admitted to being hard of hearing and visually impaired. The patient also said that there was a home health nurse that provided services after a recent hospitalization because of a heart attack. The patient said that although s/he was mostly independent, s/he could benefit from help with cleaning and cooking. Patient #6 stated that the nurse had to perform blood glucose tests, because s/he was unable to see the glucometer screen. Additionally, when asked to identify his/her current medication names, the patient said that s/he was unable to read the small print on the bottles. On 02/28/19 at 11:50 AM, an interview was conducted with the Director of Operations and Assistant Regional Director. After learning of the patient's home environment and status, the Director of Operations said that the HCA would refer Patient #6 for aide services.	H 452	**3917.2(b)** SN failed to coordinate care to receive aide service. (1 of 20 patients reviewed) Documented deficits identified by the SN at admission were: •A vision deficit; patient was unable to see glucometer screen and •Unable to read small print on medication bottles The patient provided return demonstration for both: •Medication administration; patient was able to identify medications with use of glasses and touching bottles. •Glucose monitoring; patient was performing glucose monitoring daily with use of a talking glucometer. A Home Health Aide was not ordered upon referral/admission. At Start of Care, when offered by the SN and the PT, the patient refused/declined HHA and OT services. He stated he did not need anyone to assist with personal care The patient's health status and blood sugar ranges were documented and within ordered parameters with no evidence of negative outcomes. Patient was reassessed on 3/7/18; a nurse reevaluated the patient's environment and independence in use of talking glucometer and safe medication administration. The patient refused homemaker and aide services, LifeLine/Emergency Services, and stated friend helps with transportation and he feels very supported by family and caregiver. **Provider Plan of Correction:** Education was initiated 2/28 with clinicians. Further education will be provided to clinicians to regarding identifying when to obtain referrals for additional internal and/or external resources or equipment, to be completed by 4/30/18. **Measures to prevent recurrence:** The following corrective measures were begun on 3/1/18 and will be completed by 4/30/18: •Edit EMR visit note to prompt internal and external referrals for additional care as appropriate to patient need and for special accommodations. •Ongoing education will be provided to clinicians to discuss identifying when to obtain referrals for additional internal and/or external resources **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted to ensure compliance.	4/30/18

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H 452	Continued From page 2 At the time of survey, the SN failed to coordinate care for Patient #6 to receive aide services.	H 452	**3917.2(c)** SN failed to ensure that each patient was assessed as indicated in the Plan of Care for 2 of 20 patients I. Pt #11 was admitted for: Surgical wound dressings Hypertensive heart Chronic kidney disease, dialysis-dependent MVNA recognized that the glucometer was not functioning, instructed patient to obtain a new glucometer, followed up, and reported situation to MD. The patient was instructed on the importance of obtaining a working glucometer. The patient was being seen in dialysis three times/week where the blood glucose was being monitored. The patient's health status and blood sugar ranges as reported by patient were documented and within ordered parameters with no evidence of negative outcomes. **Provider Plan of Correction:** Leadership to set expectations with clinicians and provide guidelines and resources for assisting patients in obtaining glucometer. Counseling with individual RN to be completed by 3/30/18. Education began on 2/28/18 on diabetic assessment and identification of appropriate orders, and will be completed by 4/30/18 regarding follow-up actions related to needed supplies i.e., guidance for if/when patient does not have a glucometer or supplies, and documentation of individualized care plans that reflect the specific needs of the patient. **Measures to prevent recurrence:** The following corrective measures were begun on 3/1/18 and will be completed by 4/30/18: Edit EMR visit note to include prompts for additional referrals and physician notification when diabetic patient is not taking blood sugars Education on diabetic assessment, identification of appropriate orders, follow up actions related to needed supplies and documentation of individualized care plans that reflect the specific needs of the patient. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted to ensure compliance.	4/30/18
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, the SN failed to ensure that each patient was assessed as indicated in the POC for two (2) of twenty (20) active patients in the sample (Patients #8 and 11). Findings included: I. On 02/21/18 at 2:02 PM, review of Patient #11's POC, with a certification period of 01/23/18 through 03/23/18, documented that the SN was to perform skilled nursing visits three (3) times per week. According to the POC, the nurse was to provide Patient #11 teaching regarding diabetic care, and provide treatment if the patient's blood sugar was outside of the prescribed ranges. Review of the SN visit notes dated 01/23/18, 01/25/18, 01/27/18, 01/30/18, 02/01/18, 02/03/18 and 02/06/18 showed that the nurse failed to assess the patient's blood sugar level during those visits. It should be noted that the SN documented on 02/06/18 that the patient's personal glucometer was broken, and that the patient's physician was notified.	H 453		

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H 453	Continued From page 3 During an interview on 02/22/18 at 10:42 AM, the Quality Assurance RN said that the patient was noncompliant. She also stated that the agency's nurses did not perform blood glucose tests on patients. However, they would have the patient perform a self blood glucose test and record the results. At the time of the survey, the HCA's SN failed to ensure that Patient #11's blood glucose level was assessed during each skilled visit. II. On 02/22/18 at 11:32 AM review of Patient #8's POC, with a certification period of 12/29/17 through 02/26/18, documented that the SN was to perform skilled nursing visits two (2) times per week, for the first week, and weekly thereafter. According to the POC, the nurse was to review the client's weight log and notify the physician of weight loss or gain greater than five (5) pounds in one week. Review of the SN visit notes showed the following: 01/14/18 - The documented weight was 158 lbs The patient was noted to be hospitalized at some time after this visit; 01/28/18 - Patient #8 resumed home care following hospitalization. The documented weight was 158 lbs; 01/31/18 - The documented weight was 159 lbs; 02/02/18 - The documented weight was 137 lbs; 02/05/18 - The documented weight was 136 lbs; and 02/08/18 - The documented weight was 136 lbs. During an interview on 02/23/18 at 10:12 AM, the Quality Assurance RN said that the patient was hospitalized and had fluid removed from the body during the hospitalization. Although the	H 453	II. Patient #8 Milrinone patient was admitted for diuresis, however, the expected diuresis did not occur in the hospital. The addition of the new med (Torsemide) did take effect after hospital discharge. Weight loss was confirmed with the clinician who verified during the survey that he did weigh the pt and did notify the physician and the physician indicated this was an expected weight loss, as evidenced by a late entry during survey on 2/23/18 for the 2/2/18 visit. **Provider's Corrective Action:** Education began on 2/28/18 on CHF patient assessment; continued education to be conducted with all clinicians regarding weighing and documenting weights on CHF patients and MD notification and documentation of such according to parameters and completed by 4/30/18. Counseling with individual clinician on importance of timely documentation was conducted on 2/23/18. **Measures to prevent recurrence**: Ongoing education and reinforcement of importance with all clinicians regarding weighing and documenting weights on CHF patients and MD notification according to parameters **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted to ensure compliance.	4/30/18

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H 453	Continued From page 4 documented weights did not indicate that the patient had lost weight while hospitalized, she stated that there was "some planned weight loss expected" due to the removal of fluid. The record failed to provide documented evidence that the nurse notified the physician of Patient #8's twenty-two (22) pound weight loss over 2 days. At the time of the survey, the HCA's SN failed to contact the patient's physician after the patient's 22-pound weight loss.	H 453		