STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA--0108	A. BUILDING: ______ B. WING ______	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDSTAR VNA, INC DBA MEDSTAR HEALTH	**4201 CONNECTICUT AVENUE, NW SUITE 2ND FLOOR WASHINGTON, DC 20008**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	INITIAL COMMENTS An annual licensure survey was conducted on 06/05/2023, 06/06/2023, 06/07/2023, 06/08/2023, 06/09/2023, 06/12/2023, and 06/13/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 380 patients and employed 57 staff. The findings of the survey were based on the review of administrative records, 25 active patient records, five discharged patient records, 14 personnel records, and a review of the agency's response to complaints and incidents received. The survey findings were also based on the completion of three patients' phone interviews. Listed below are abbreviations used throughout this report: ADL - Activities of Daily Living DON- Director of Nursing HHA - Home Health Aide HCA - Home Care Agency IADL- Instrumental Activities of Daily Living MCG - Microgram MG - Milligram OT - Occupational Therapist PCA - Personal Care Aide POC - Plan of Care PT - Physical Therapist	H 000		

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H 000	Continued From page 1 RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care	H 000		
H 362	3914.3(k) PATIENT PLAN OF CARE The plan of care shall include the following: (k) Safety measures required to protect the patient from injury; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the plan of care (POC) included safety measures to protect the patient from injury for one of 25 active patients in the sample (Patient #8). Findings included: On 06/07/2023 at 01:02pm, review of Patient #8's clinical record showed a plan of care (POC) with a duration period of 04/20/2023 through 06/18/2023, for skilled nursing (SN) services, home health aide (HHA) services, physical therapy (PT) services, and medical social work (MSW) services to assess, evaluate, and treat. The patient's diagnoses included hyperlipidemia, lung cancer, chronic kidney disease, generalized muscle weakness, abnormalities of gait and mobility, and a history of breast cancer. Continued review of the clinical record showed that the HHA visited the patient on 05/09/2023 and documented having smelled cigarette smoke and educated the patient that she could not be	H 362	3914.3(k): Agency failed to ensure that the plan of care (POC) included safety measures to protect the patient from injury for one of 25 patients in the sample (Patient #8). **Provider Plan of Correction:** Agency will reeducate clinical managers and staff on need to include oxygen safety measures, to protect the patient from injury, in the plan of care for all disciplines. Pt#8 was discharged by physical therapy on 6/6/23 with reinforcement of oxygen safety on the discharge visit; oxygen was added to the medication record. Clinical team was coached on the importance of including oxygen and oxygen safety in the plan of care. **Measures to prevent recurrence:** Quality Review Nurse team to ensure oxygen safety measures included in plan of care for all oxygen patients. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	9/15/23

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H 362	Continued From page 2 smoking in the house while on 2liters of oxygen. Again on 05/24/2023, the HHA visited the patient and documented the following: "On 2L [liter] of oxygen. Reminded her about smoking in home with oxygen and stated that [she] understood safety." Further review of the clinical records including the POC failed to include oxygen and its safety measures required to protect the patient from injury. Please note, the licensed practical nurse was documenting the patient's oxygen level during nursing visits and included that patient was on 2liters of oxygen. On 06/08/2023 at 04:21 pm, the Quality Assurance Director was made aware of the findings. She was going to investigate it. At the time of the survey, the home care agency failed to include in the plan of care, safety measures relative to oxygen usage to protect the patient from injury.	H 362	3914.3(m): Agency failed to include emergency protocols specific to patient's diagnoses in the plan of care (POC) for three of 25 active patients included in the sample (Patients #2, 5, and #9). **Provider Plan of Correction:** Leadership to ensure emergency protocols are included in the plan of care based on diagnosis for congestive heart failure (CHF) (unless unable to weigh), diabetes mellitus (DM) and patients on oxygen (or with respiratory disease processes). Education of clinical managers and clinical care team around: establishing protocols for emergency interventions. Action taken on patients identified: Patient #2: physician communication entered that patient did not monitor blood sugar or weight; patient had no further visits after 5/31/23 and was discharged from service. Patient #5: Agency provided scale for this patient; RN educated the patient on importance of monitoring and reporting necessary weight changes to physician. The team was coached on the need to include emergency protocols in the plan of care. Patient #9: At the time of discharge on 6/5/23, the patient was instructed on importance of SPO2 monitoring and reporting to the physician. Coaching provided to clinicians on the importance of monitoring SPO2 for patients on oxygen (or with respiratory disease process). **Measures to prevent recurrence:** Ongoing education around the importance of establishing emergency protocols for CHF, DM, patients using oxygen, and/or other respiratory patients, to ensure patient safety. Quality Review Nurse team to ensure emergency protocols are included on POC based on aforementioned diagnoses. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to include emergency protocols specific to patient's diagnoses in the plan of care (POC) for three of 25 active patients included in the sample (Patients #2, 5, and #9). Findings included:	H 364		**9/15/23**

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H 364	Continued From page 3 1. On 06/06/2023 at 10:57 am, review of Patient #2's clinical record showed a Plan of Care (POC) with a duration period of 05/03/2023 through 07/01/2023. The patient's diagnoses included congestive heart failure, type II diabetes mellitus, asthma, constipation, chronic kidney disease, emphysema, glaucoma, hyperlipidemia, old myocardial infarction, schizoaffective disorder, and muscle weakness. The POC showed that the patient was receiving Lasix 40mg oral daily and Prednisone 10mg two tablets daily for one week and then one tablet oral for one week. Continued review of the POC lacked evidence of emergency protocols related to the patient's diagnoses of congestive heart failure and diabetes mellitus (e.g., weight and blood glucose ranges that may require emergency interventions). 2. On 06/07/2023 at 10:12 am, review of Patient #5's record showed plans of care (POC) with a duration period of 04/30/2023 through 06/28/2023. The patient's diagnoses included acute kidney failure, gastrointestinal hemorrhage, alcohol dependence, hypotension, lymphedema, type II diabetes mellitus, congestive heart failure, atrial fibrillation, thrombocytopenia, anemia, alcohol abuse, methicillin resistant staphylococcus. The POC showed that the patient was receiving Entresto 49mg-51mg tablet oral twice a day, Jardiance 25mg oral every day, and Torsemide 5mg oral one tablet every day for heart failure. Continued review of the POC lacked evidence of emergency protocols related to the patient's diagnosis of congestive heart failure (e.g., weight parameters that may require emergency interventions). 3. On 06/05/2023 at 12:55 pm, review of Patient #9's record showed a POC with a duration period	H 364		

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H 364	Continued From page 4 of 05/01/2023 through 06/29/2023. The patient's diagnoses included type II diabetes mellitus, chronic obstructive pulmonary disease, atrial fibrillation, hyperlipidemia, schizophrenia, cataract, dependence on supplemental oxygen, chronic systolic heart failure, and osteoarthritis. The POC showed that the patient was receiving Entresto 24mg-26mg tablet oral every 12 hours, Albuterol Sulfate HCA 90 mcg two puffs via inhalation twice daily, Budesonide-Formoterol HFA 160mcg-4.5mcg two puffs via inhalation twice a day, and supplemental oxygen, two liters via nasal canula continuously. Continued review of the POC lacked evidence of emergency protocols related to the patient's diagnosis of congestive heart failure and chronic obstructive pulmonary disease. On 06/05/2023 at 02:23 pm, the Quality Assurance Director was made aware of the findings. She provided a note from the physical therapist dated 05/10/2023 indicating the following: "Patient unable to be weighed because of above knee amputation." However, there was no documented evidence of alternative measures put in place to address the patient's heart failure. At the time of survey, the home care agency failed to ensure that the patient's plan of care included emergency protocols specific to patient's diagnoses for Patients #2, 5, and #9.	H 364		
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	H 366		

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H 366	Continued From page 5 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. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each patient's plan of care (POC) was approved and signed by a physician and/or designee within 30 days of the start of care (SOC) for five of 25 active patients in the sample (Patients #3, 6, 8, 13, and #18). Findings included: Review of the home care agency's (HCA) clinical records beginning 06/05/2023 through 06/13/2023 showed that the agency failed to ensure that the plans of care (POC) for Patients #3, 6, 8, 13, and #18 were reviewed and signed by a physician and/or designee within 30 days of the start of cares (SOCs). On 06/09/2023 at 4: 08 PM, the Quality Assurance Director acknowledged the findings. She expressed challenges in getting some of the physicians to sign the POCs despite multiple attempts. At the time of survey, the home care agency failed to ensure that the POCs for Patients #3, 6, 8, 13, and #18 were signed by the patient's physician within 30 days of the start of care.	H 366	3914.4: Agency failed to ensure that each patient's plan of care (POC) was approved and signed by a physician and/or designee within 30 days of the start of care (SOC) for five of 25 active patients in the sample (Patients #3, 6,8, 13, and #18). **Provider Plan of Correction:** Orders are sent to the provider for signature once completed. Orders not returned are refaxed. If not returned prior to 30 days, Document Specialist partners with provider staff to obtain signature. All patients noted have plans of care back signed by the provider and are uploaded to chart. **Measures to prevent recurrence:** Submit provider signature order trends not returned within 30 days to leadership monthly to mitigate issues by enlisting the support of physician liaison. **Quality Assurance Monitoring:** Weekly reports will be analyzed for all outstanding/unsigned orders by document tracking team and follow up calls will be made with non-compliant providers.	**9/15/23**
H 432	3916.2(b) SKILLED SERVICES GENERALLY	H 432		

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H 432	Continued From page 6 Each home care agency shall develop written policies for documenting the coordination of the provision of different services. Written policies shall include, at a minimum, the following: (b) Communicating patient needs to agency personnel and identifying other agencies that can meet patient needs; This Statute is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the licensed professionals failed to communicate patient needs to agency personnel and identify other agencies that can meet the patient needs for three of 25 active patients in the sample (Patients #3, 13, and #18). Findings included: 1. On 6/6/23 at 01:36 pm at 10:58 AM, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 4/26/23 to 6/24/23 that indicated skilled nursing services (SN), physical therapy (PT) services, and occupational therapy (OT) services for disease management and treatment. The patient's diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, congestive heart failure, stage III chronic kidney disease, benign prostatic hyperplasia, hyperlipidemia, gout, gastro-esophageal reflux disease, history of falling, and long-term use of anticoagulants. Review of the records showed that the patient was hospitalized on 05/06/2023 and discharged on 05/08/2023 with resumption of care orders for the above services. The licensed practical nurse (LPN) saw the patient the next day	H 432	3916.2(b): Statute not met as evidenced by: licensed professionals failed to communicate patient needs to agency personnel and identify other agencies that can meet the patient needs for three of 25 active patients in the sample (Patients #3, 13, and #18) **Provider Plan of Correction:** Leadership to re-educate all clinical leaders and staff on PC 44.0_ Coordination of Services, to re-enforce expectations related to both internal referrals necessary to meet patient needs, and coordination with other agencies providing care to the patient for effective coordination of related services. Education to include expectation on documentation and timeliness of communication. **Measures to prevent recurrence:** Ongoing education regarding importance of timely and effective communication and coordination of patient needs both within the organization and all other agencies providing care. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	9/15/23

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H 432	Continued From page 7 on 05/09/2023 while PT documented a missed visit notification on 05/10/2023 assuming that patient was still in the hospital. Furthermore, OT documented a missed visit notification on 05/13/2023 with the assumption that patient was in the hospital even though PT did a resumption of care assessment on the patient on 05/12/2023. On 06/07/2023 at 11:14 am, the Quality Assurance Director was made aware of the findings. During interview, she confirmed that the patient was not in the hospital on 05/10/2023 or 05/13/2023. She had spoken with PT, who indicated having done a drive by to the patient's home and there was no answer. He assumed that patient was still in the hospital. The records failed to show documented evidence of communication of patient's needs among agency personnel. 2. On 06/08/2023 at 03:00 pm, review of Patient #13's clinical record showed a plan of care (POC) with a duration period of 04/14/2023 through 06/12/2023 that indicated skilled nursing services (SN), physical therapy (PT) services, and occupational therapy (OT) services for disease management and treatment. The patient's diagnoses included included chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, gout, chronic pain, spinal stenosis, and history of pulmonary embolism. Continued record review of the records showed a missed visit note from OT dated 04/21/2023 indicating "unable to reach patient on the phone. Please reassign for the week of 04/24/2023." There was no documented evidence that OT followed up with the patient that week. Furthermore, the record showed that the patient was hospitalized on 04/28/2023 with resumption of care orders dated 04/28/2023	H 432		

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H 432	Continued From page 8 indicating among others "OT evaluation and treatment for activities of daily living (ADL) training, instrumental ADL training, balance training, adaptive equipment training, therapeutic exercise, and home exercise program. Patient #13 never received OT services as ordered before the hospitalization and after his discharge from the hospital. On 06/09/2023 at 01:30 pm, the Quality Assurance Director was interviewed. She acknowledged that OT failed to evaluate the patient as ordered on 04/28/2023. She indicated the following after speaking with the nurse case manager: "The nurse did not know OT did not reschedule the visit. Patient #13 was discharged from the agency as of 06/05/2023. The records failed to show documented evidence of communication of patient's needs among agency personnel. 3. On 06/09/2023 at 10:37 am, review of Patient #18's record showed a POC with a duration period of 04/26/2023 through 06/24/2023 that indicated physical therapy (PT) services, occupational therapy (OT) services, and medical social work (MSW) services for disease management and treatment. The patient's diagnoses included multiple sclerosis, trigeminal neuralgia, prediabetes, spastic hemiplegia, constipation, and spondylosis without myelopathy. The patient was ordered occupational therapy (OT) evaluation and treatment one time for one week, two times for two weeks, and one time for one week effective 05/14/2023. Review of the records showed a "missed visit note" from OT indicating the following: "05/18/2023, missed visit. Patient requested delay in OT evaluation until week of 05/25/2023. Schedule coordinated with patient/caregiver. Next visit to be made on	H 432		

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H 432	Continued From page 9 05/25/2023...Faxed to NP [nurse practitioner]." Continued review of the records lacked documented evidence that the OT evaluated the patient on 05/25/2023 or any follow-up with the patient. On 06/09/2023 at 12:54 pm, the Quality Assurance Director was made aware of the findings. On 06/13/2023, the agency president provided a missed visit notification that was sent to the physician from OT dated 06/01/2023 and indicating the following: "Missed visit. Client requested visit for later date. Next visit to be made on 06/08/2023." Patient #18 was evaluated on 06/08/2023 by OT. Patient #18's record showed recurrent falls documented by PT on 05/02/2023, 05/09/2023, 05/29/2023, 06/06/2023, and 06/08/2023. Patient was evaluated by OT on 06/18/2023. The records failed to show documented evidence of communication of patient's needs among agency personnel. A phone interview with the patient on 06/15/2023 at 11:02 AM confirmed OT evaluation on 06/08/2023 and was pleased with the OT. However, the patient stated she "did not think she delayed the OT services." On 06/13/2023 at 03:30 pm, the Quality Assurance Director and the leadership team was made aware of the findings. At the time of the survey, the home care agency failed to ensure communication of patient's needs among agency personnel for Patients #3, 13, and #18.	H 432		
H 433	3916.2(c) SKILLED SERVICES GENERALLY Each home care agency shall develop written policies for documenting the coordination of the	H 433		

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H 433	Continued From page 10 provision of different services. Written policies shall include, at a minimum, the following: (c) Coordinating services with other agencies actively involved in the patient's care, through written communication and/or interdisciplinary conferences, in accordance with the patient's needs; and... This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to document coordination of services with other agencies providing care to three of 25 active patients in the sample (Patients #12, 22, and #25). Findings included: 1. On 06/08/2023 at 12:31 pm, review of Patient #12's clinical record showed a plan of care (POC) with a duration period of 05/16/2023 through 07/14/2023. The POC included a physician's order for skilled nursing visits once a week for nine weeks and physical therapy services twice a week for two weeks, once a week for one week, and twice a week for four weeks. Continued review of the records showed an OASIS note dated 05/16/2023 indicating the following: "Patient lives alone, PCA [personal care aide] present. Patient is dependent on caregiver for all ADLS/IADLS [activity of daily living/ instrumental activity of daily living]." Further review of the records failed to show documented evidence of coordination of services with the agency providing personal care services to ensure safety and continuity of care. On 06/08/2023 at 12:54 pm, the Quality Assurance Director acknowledged the findings.	H 433	3916.2(c): Agency failed to document coordination of services with other agencies providing care to three of 25 active patients in the sample (Patients #12, 22, and #25). **Provider Plan of Correction:** Leadership to re-educate all clinical leaders and staff on PC 44.0_ Coordination of Services, and the expectation to coordinate services with other agencies providing care to the patient for effective care coordination and continuity of related services. Education to include expectation on documentation and timeliness of communication. **Measures to prevent recurrence:** Ongoing education regarding importance of timely and effective communication and coordination of patient needs with all other agencies providing care. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	9/15/23

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H 433	Continued From page 11 2. On 06/12/2023 at 02:00 pm, review of Patient #22's clinical record showed a POC with a duration period of 05/04/2023 through 07/02/2023. The POC included physician's orders for skilled nursing services, physical therapy (PT) services, and occupational therapy (OT) services. The records showed that the patient had the diagnosis of end stage renal disease and was dependent on dialysis. Continued review of the records showed a PT note dated 05/05/2023 indicating that the patient was on dialysis three times a week and had a port on her left upper extremity. Further review of the records failed to show documented evidence of coordination of services with the dialysis center to ensure safety and continuity of care. Of note, patient was on a diabetic, low cholesterol and salt diet, and there was no evidence of communication with the dialysis center or the nephrologist to ensure that patient was on the appropriate diet due to the diagnosis of renal failure. 3. On 06/12/2023 at 09:35 pm, review of Patient #25's clinical record showed a POC with a duration period of 04/12/2023 through 06/10/2023. The POC included physician's orders for skilled nursing services, physical therapy (PT) services, and occupational therapy (OT) services. Continued review of the records showed a PT note dated 04/13/2023 indicating the patient was receiving 15 hours of personal care aide services seven days a week from [name of agency]. Further review of the records failed to show documented evidence of coordination of services with the agency providing personal care services to ensure safety and continuity of care. On 6/10/23 at 10:51 am, the Quality Assurance Director was made aware of the findings. She stated that the home care agency (HCA) would normally coordinate care with other agencies on	H 433		

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	HCA--0108	A. BUILDING: _____ B. WING _____	06/13/2023

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H 433	Continued From page 12 admission; however, there was no documented evidence to support her statement. At the time of the survey, the agency failed to coordinate services with agencies actively involved in providing care for Patients #12, 22, and #25.	H 433		
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 record review and interview, the home care agency (HCA) failed to ensure that the licensed professionals coordinated care with the physician's office for two of 25 active patients in the sample (Patients #13 and #20). Findings included: 1. On 06/08/2023 at 03:00 pm, review of Patient #13's clinical record showed a plan of care (POC) with a duration period of 04/14/2023 through 06/12/2023 for skilled nursing services (SN), physical therapy (PT) services, and occupational therapy (OT) services. The patient had diagnoses that included chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, gout, chronic pain, spinal stenosis, and history of pulmonary embolism. Continued record review showed resumption of care orders dated 04/28/2023 that included home health aide services (HHA) to support the patient with activities of daily living. Further review of the	H 452	3917.2(b): Agency failed to ensure that the licensed professionals coordinated care with the physician's office for two of 25 active patients in the sample (Patients #13 and #20). **Provider Plan of Correction:** Agency to re-educate clinical staff on necessary physician/ provider communication. To re-enforce all required communication with the physician/provider and expectations on documentation and/or updates to orders to ensure safe and appropriate care for the patient. **Measures to prevent recurrence:** Audit records to ensure adherence to the policy. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	**9/15/23**

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H 452	Continued From page 13 records lacked evidence that HHA services were provided as ordered. On 06/09/2023 at 01:30 PM, the Quality Assurance Director was interviewed. She indicated after speaking with the nurse case manager that the patient declined the HHA services. The nurse had forgotten to document that the patient did not need the services. As a result, a late entry notification dated 06/09/2023 was sent to the physician that the patient declined the HHA services. 2. On 06/08/2023 at 01:23 pm, review of Patient #20's clinical record showed a POC with a duration period of 05/10/2023 through 07/08/2023 for PT services, OT, and speech therapy (ST) services. The patient had diagnoses that included Parkinson's disease, type II diabetes mellitus, glaucoma, gastroparesis, hypercholesterolemia, history of falling, mild cognitive impairment, hearing loss, and long-term use of oral hypoglycemic drugs. Continued record review showed that the referral order dated 04/25/2023 included home health aide services to support the patient with activities of daily living. However, the POC failed to include the HHA order, and ultimately there was no HHA services provided. On 06/08/2023 at 01:30 pm, the Quality Assurance Director was interviewed. She indicated that the physical therapist opened the case and stated that the patient did not need HHA services. There was no documented evidence in the clinical record that the PT followed up with the provider regarding the HHA services. At the time of the survey, the agency failed to ensure that the licensed professionals coordinated care with the physician's office.	H 452		

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H 453	Continued From page 14	H 453	3917.2(c): Agency failed to ensure skilled nursing services were provided in accordance with the patient's plan of care (POC) for four of 25 active patients (Patients #5, 12, 23, and #25). **Provider Plan of Correction:** Education of clinical managers and clinicians around following physician/provider orders established by POC including assessing and documenting random blood sugars on diabetic patients each visit (if a patient is monitoring their blood sugars) and reporting abnormal findings to physician/provider to determine if any interventions or updated orders are necessary. **Measures to prevent recurrence:** Optimize EMR by diagnosis of diabetes mellitis to prompt each clinician to assess and document random blood sugars each visit or properly document reason not taken. Include reeducation on necessary actions including notifying the physician/provider of abnormal findings. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	**9/15/23**
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 home care agency (HCA) failed to ensure skilled nursing services were provided in accordance with the patient's plan of care (POC) for four of 25 active patients in the sample (Patients #5, 12, 23, and #25). Findings included: 1. On 06/07/2023 at 10:12 am, review of Patient #5's clinical record showed a plan of care (POC) with a duration period of 04/30/2023 through 06/28/2023 that indicated skilled nursing (SN) services twice a week for one week and once a week for six weeks for assessment, implementation of interventions, teaching and reinforcement of disease management. In addition, the POC included an order for the nurse to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that the nurse visited the patient weekly as ordered with no evidence of assessing the patient's blood sugar to determine if interventions were warranted. 2. On 06/08/2023 at 12:31 pm, review of Patient #12's clinical record showed a plan of care (POC) with a duration period of 05/16/2023 through	H 453		

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H 453	Continued From page 15 07/14/2023. The patient had the diagnoses that included hypertensive heart disease with heart failure, congestive heart failure, type II diabetes mellitus, chronic pain, hyperlipidemia, ischemic cardiomyopathy, long term use of anticoagulants, and long-term use of insulin. The POC included a physician's order for skilled nursing visits once a week for nine weeks for assessment, implementation of interventions, teaching and reinforcement of disease management. In addition, the POC included an order for the nurse to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that the nurse visited the patient weekly as ordered with no evidence of assessing the patient's blood sugar to determine if interventions were warranted. 3. On 06/07/2023 at 02:48 pm, review of Patient #23's clinical record showed a plan of care (POC) with a duration period of 04/10/2023 through 06/08/2023 that indicated physical therapy services and skilled nursing services for disease management and treatment. The patient's diagnoses included type II diabetes mellitus, osteoarthritis, hypertension, asthma, gastro-esophageal reflux disease, lymphedema, morbid obesity, and long-term use of oral hypoglycemic drugs. In addition, the POC included an order for the licensed professional to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that the nurse visited the patient as ordered every week with no evidence of assessing the patient's blood sugar to determine if interventions were warranted. 4. On 06/12/2023 at 09:35 pm, review of Patient #25's clinical record showed a plan of care (POC)	H 453		

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H 453	Continued From page 16 with a duration period of 04/12/2023 through 06/10/2023. The patient's diagnoses included Alzheimer's disease, delusional disorders, hypothyroidism, type II diabetes mellitus, glaucoma, hypertension, and long-term use of oral hypoglycemic drugs. The POC included a physician's order for skilled nursing visits twice a week for one week and once a week for four weeks for assessment, implementation of interventions, teaching and reinforcement of disease management. In addition, the POC included an order for the nurse to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that the nurse visited the patient weekly as ordered with no evidence of assessing the patient's blood sugar to determine if interventions were warranted. On 06/13/2023 at 03:30 pm, the Quality Assurance Director and the leadership team was made aware of the findings. At the time of the survey, the home care agency failed to ensure that skilled nursing services were provided in accordance with the patient's POC for Patients #5, 12, 23, and #25.	H 453		
H 550	3922.1 OCCUPATIONAL THERAPY SERVICES If a home care agency provides occupational therapy services, it shall provide those services in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure occupational therapy (OT) services were provided in	H 550		

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H 550	Continued From page 17 accordance with the patient's plan of care (POC) for seven of 25 active patients in the sample (Patients #2, 3, 8, 13, 18, 22, and #25). Findings included: 1. On 06/06/2023 at 10:57 am, review of Patient #2's clinical record showed a POC with a duration period of 05/03/2023 through 07/01/2023. The POC included physician's orders for occupational therapy (OT) services once a week for one week, twice a week for two weeks, and once a week for one week effective 05/14/2023. The records showed that the patient's diagnoses included congestive heart failure, type II diabetes mellitus, asthma, constipation, stage II chronic kidney disease, emphysema, glaucoma, hyperlipidemia, old myocardial infarction, schizoaffective disorder, and muscle weakness. Continued review of the records failed to show evidence that OT services were provided as ordered the week of 05/28/2023. On 06/15/2023 at 11:38 am, a phone interview was conducted with the patient. The latter indicated having received OT services two times only and was not sure when OT would come again. She was provided the agency's number for a follow up regarding the OT services. On 06/15/2023 at 03:30 pm, the Quality Assurance Director was made aware of the patient's concerns. She indicated that she would call the patient and follow up with OT. 2. On 06/06/2023 at 01:36 pm at 10:58 AM, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 4/26/23 to 6/24/23 that indicated skilled nursing, physical therapy services and occupational therapy services for evaluation and treatment. The patient's diagnoses included chronic	H 550	3922.1: Agency failed to ensure occupational therapy (OT) services were provided in accordance with the patient's plan of care (POC) for seven of 25 active patients (Patients #2, 3, 8, 13, 18, 22, and #25). **Provider Plan of Correction:** Leadership to ensure skilled services are provided in accordance with the POC; will include education for all skilled disciplines performing SOC ensure ordered disciplines are added to the 485 for assessment/evaluations or document order changes (or delay in service) in collaboration w/ the patient/patient rep/provider-physician. Leadership to review and implement schedule process updates to ensure all ordered disciplines assess/evaluate the patient, orders updated if necessary at time of SOC/ROC or any subsequent visit. Education will be provided to clinicians and schedulers to implement process updates. **Measures to prevent recurrence:** Ongoing education of staff around the importance of following POC, ensuring all ordered disciplines are assessed for need and orders included on POC, or addressed properly w/ physician and patient communication. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	**9/15/23**

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H 550	Continued From page 18 obstructive pulmonary disease, acute respiratory failure with hypoxia, congestive heart failure, stage III chronic kidney disease, benign prostatic hyperplasia, hyperlipidemia, gout, gastro-esophageal reflux disease, history of falling, and long-term use of anticoagulants. Further review of the records showed a missed visit note from OT dated 05/17/2023 indicating that the patient was in the hospital on 05/13/2023 and the doctor was notified on 05/19/2023. However, the patient was discharged from the hospital on 05/08/2023 and was seen by the skilled nurse on 05/09/2023. There was no evidence of OT follow-up or evaluation of the patient as ordered. On 06/07/2023 at 11:14 am, the Quality Assurance Director was made aware of the findings. During an interview, she confirmed that the patient was not in the hospital on 05/13/2023. She had spoken with PT, who indicated having done a resumption of care on the patient on 05/12/2023 and that the patient did not need OT services. However, he did not document it or notify the physician. A late entry dated 06/07/2023 was completed and sent to the physician notifying him that the patient did "not need OT services and to cancel the order." 3. On 06/07/2023 at 01:02pm, review of Patient #8's record showed a plan of care (POC) with a duration period of 04/20/2023 through 06/18/2023. The patient's diagnoses included hyperlipidemia, lung cancer, chronic kidney disease, generalized muscle weakness, abnormalities of gait and mobility, and history of breast cancer. The patient was ordered on 04/27/2023 physical therapy (PT) and occupational therapy evaluations and treatments. Review of the records showed a "missed visit note" from occupational therapist (OT) indicating the following: "04/30/2023, missed visit. I called	H 550		

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H 550	Continued From page 19 but no answer." Continued review of the records lacked evidence that OT notified the physician, nor did he/she evaluate or document the reason for the delay at the time of survey. On 06/07/2023 at 01:36 pm, the Quality Assurance Director was made aware of the findings. The latter consulted with the OT and stated the following: "OT did not remember the reason for the missed visit. The agency's operation's director reached out to PT, who stated that OT was not needed. He was going to write a note and notify the doctor. 4.On 06/08/2023 at 03:00 pm, review of Patient #13's clinical record showed a plan of care (POC) with a duration period of 04/14/2023 through 06/12/2023 for occupational therapy (OT) evaluation and treatment effective 04/23/2023. The patient's diagnoses included chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, gout, chronic pain, spinal stenosis, and history of pulmonary embolism. Continued record review of the records showed a missed visit note from OT dated 04/21/2023 indicating "unable to reach patient on the phone. Please reassign for the week of 04/24/23." There was no documented evidence that OT followed up with the patient that week. Furthermore, the record showed that the patient was hospitalized on 04/28/2023 with resumption of care orders dated 04/28/2023 indicating among others "OT evaluation and treatment for activities of daily living (ADL) training, instrumental ADL training, balance training, adaptive equipment training, therapeutic exercise, and home exercise program. On 06/09/2023 at 01:30 pm, the Quality Assurance Director was interviewed. She acknowledged that OT failed to evaluate the patient as ordered on 04/28/2023. Patient #13 was discharged as of	H 550		

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H 550	Continued From page 20 06/05/2023. As a result, a late entry notification dated 06/09/2023 was sent to the physician that there was "no OT evaluation scheduled, and patient declined OT services." 5. On 06/09/2023 at 10:37 am, review of Patient #18's record showed a POC with a duration period of 04/26/2023 through 06/24/2023. The patient's diagnoses included multiple sclerosis, trigeminal neuralgia, prediabetes, spastic hemiplegia, constipation, and spondylosis without myelopathy. The patient was ordered occupational therapy (OT) evaluation and treatment one time for one week, two times for two weeks, and one time for one week effective 05/14/2023. Review of the records showed a "missed visit note" from OT indicating the following: "05/18/2023, missed visit. Patient requested delay in OT evaluation until week of 05/25/2023. Schedule coordinated with patient/caregiver. Next visit to be made on 05/25/2023...Faxed to NP [nurse practitioner]." Continued review of the records lacked documented evidence that the OT evaluated the patient on 05/25/2023 or any follow-up with the patient. Patient #18 was evaluated on 06/08/2023 by OT. A phone interview with the patient on 06/15/2023 at 11:02 AM confirmed OT evaluation on 06/08/2023 and was pleased with the OT. However, the patient stated she "did not think she delayed the OT services." 6. On 06/12/2023 at 02:00 pm, review of Patient #22's clinical record showed a POC with a duration period of 05/04/2023 through 07/02/2023. The POC included physician's orders for skilled nursing services, physical therapy (PT) services, and occupational therapy (OT) services. The records showed that the patient's diagnoses included diabetes mellitus with hyperglycemia,	H 550		

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H 550	Continued From page 21	H 550		

hyperlipidemia, thrombocytopenia, gastro-esophageal reflux disease heart failure, end stage renal disease, hyperlipidemia, long term use of insulin, and dependence on renal dialysis. Continued review of the records failed to show evidence that OT services were provided as ordered at the time of survey. On 06/12/2023 at 03:12 pm, the Quality Assurance Director was made aware of the findings. She indicated that the orders on the POC should've stated for PT to evaluate for the need for OT as it was written on the referral orders.

7. On 06/12/2023 at 09:35 pm, review of Patient #25's clinical record showed a plan of care (POC) with a duration period of 04/12/2023 through 06/10/2023. The POC included physician's orders for occupational therapy (OT) services two times a week for three weeks effective 04/16/2023. Continued review of the records showed an OT note dated 05/10/2023 indicating the following: "Missed visit 05/04/2023 clinician unavailable. Schedule coordinated with patient/caregiver. Next visit to be made [blank]." Continued review of the records failed to show evidence that OT services were provided as ordered at the time of survey. There was no documented evidence that the OT follow-up with the patient or the physician.
On 06/10/2023 at 10:51 am, the Quality Assurance Director was made aware of the findings.

At the time of the survey, the home care agency failed to provide documented evidence that the occupational therapist provided services in accordance with the plans of care for Patients #2, 3, 8, 13, 18, 22, and #25.

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H 560	Continued From page 22	H 560	3923.1: Agency failed to ensure physical therapy (PT) services were provided in accordance with the patient's plan of care (POC) for four of 25 active patients (Patients #3, 5, 23, and #25).	
H 560	3923.1 PHYSICAL THERAPY SERVICES If physical therapy services are provided, they shall be provided in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure physical therapy (PT) services were provided in accordance with the patient's plan of care (POC) for four of 25 active patients in the sample (Patients #3, 5, 23, and #25). Findings included: 1. On 6/6/23 at 01:36 pm at 10:58 AM, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 4/26/23 to 6/24/23 that indicated physical therapy services one time per week for one week, two times a week for four weeks, and one time a week for one week. The patient's diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, congestive heart failure, stage III chronic kidney disease, benign prostatic hyperplasia, hyperlipidemia, gout, gastro-esophageal reflux disease, history of falling, and long-term use of anticoagulants. The physical therapy (PT) services included the following: evaluation, assessment, and treatment, patient instruction in transfer training for safe functional transfers, therapeutic exercise, functional mobility, and implementation of fall prevention program for safety. Further review of the records showed a missed visit note from PT dated 05/10/2023 indicating that the patient was in the hospital and the doctor was notified. However, the patient was discharged from the	H 560	**Provider Plan of Correction:** Provide reeducation to all clinical managers and PT staff around ensuring that all care ordered is provided in accordance with the patient's plan of care; and notification and/or collaboration with the physician/provider when indicated. **Measures to prevent recurrence:** Ongoing education with PT staff regarding following all orders in the plan of care and physician/provider notification when indicated. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	**9/15/23**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA--0108	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDSTAR VNA, INC DBA MEDSTAR HEALTH	4201 CONNECTICUT AVENUE, NW SUITE 2ND FLOOR WASHINGTON, DC 20008

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H 560	Continued From page 23 hospital on 05/08/2023 and was seen by the skilled nurse on 05/09/2023. On 06/07/2023 at 11:14 am, the Quality Assurance Director was made aware of the findings. During interview, she confirmed that the patient was not in the hospital on 05/10/2023. She had spoken with PT, who indicated having done a drive by to the patient's home and there was no answer. He assumed that patient was still in the hospital. PT did a resumption of care assessment on the patient on 05/12/2023. 2. On 06/07/2023 at 10:12 am, review of Patient #5's clinical record showed a POC with a duration period of 04/30/2023 through 06/28/2023 that indicated physical therapy services once a week for two weeks, twice a week for three weeks, and once a week for one week effective 05/07/2023. The PT services included the following: evaluation, assessment, and treatment; patient instruction in transfer training for safe functional transfers, therapeutic exercise; functional mobility; and implementation of fall prevention program for safety. In addition, the POC included an order for the therapist to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that the PT visited the patient on 05/10/2023, 05/17/2023, and 05/22/2023 with no evidence of assessing the patient's blood sugar to determine if interventions were warranted. Please note on 05/22/2023, PT documented the following: "Patient never takes his sugar" and on 05/24/2023 "Patient not required to take [his] sugar." There was no documented evidence that PT notified the physician. 3. On 06/07/2023 at 02:48 pm, review of Patient #23's clinical record showed a POC with a duration period of 04/10/2023 through 06/08/2023	H 560		

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H 560	Continued From page 24 that indicated physical therapy services two times per week for seven weeks for evaluation, assessment, and treatment, patient instruction in transfer training for safe functional transfers, therapeutic exercise, functional mobility, and implementation of fall prevention program for safety. The patient's diagnoses included type II diabetes mellitus, osteoarthritis, hypertension, asthma, gastro-esophageal reflux disease, lymphedema, morbid obesity, and long-term use of oral hypoglycemic drugs. In addition, the POC included an order for the therapist to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that PT visited the patient as ordered every week with no evidence of assessing the patient's blood sugar to determine if interventions were warranted. 4. On 06/12/2023 at 09:35 pm, review of Patient #25's clinical record showed a POC with a duration period of 04/12/2023 through 06/10/2023. The POC included physician's orders for physical therapy (PT) services once a week for two weeks and two times a week for two weeks for evaluation, assessment, and treatment, patient instruction in transfer training for safe functional transfers, therapeutic exercise, functional mobility, and implementation of fall prevention program for safety. The patient's diagnoses included Alzheimer's disease, delusional disorders, hypothyroidism, type II diabetes mellitus, glaucoma, hypertension, and long-term use of oral hypoglycemic drugs. In addition, the POC included an order for the therapist to record and report to the physician random blood sugar levels less than 60 or greater than 300. Further review of records showed that PT visited the patient as ordered every week with no evidence of assessing the patient's blood	H 560		

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 560	Continued From page 25 sugar to determine if interventions were warranted. On 06/13/2023 at 03:30 pm, the Quality Assurance Director and the leadership team was made aware of the findings. At the time of the survey, the home care agency failed to ensure that physical therapy services were provided in accordance with the plans of care for Patients #3, 5, 23, and #25.	H 560		
H 580	3925.1 SPEECH LANGUAGE PATHOLOGY SERVICES If speech language pathology services are provided, they shall be delivered in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure speech therapy (ST) services were provided in accordance with the patient's plan of care (POC) for one of 25 active patients in the sample (Patient #20). Findings included: On 06/08/2023 at 01:23 pm, review of Patient #20's clinical record showed a plan of care (POC) with a duration period of 05/10/2023 through 07/08/2023 for speech therapy (ST) services one time a week for one week, two times a week for one week, and one time a week for one week to evaluate and treat. The patient had diagnoses that included Parkinson's disease, type II diabetes mellitus, glaucoma, gastroparesis,	H 580	3925.1: Agency failed to ensure speech therapy (ST) services were provided in accordance with the patient's plan of care (POC) for one of 25 active patients (Patient #20). **Provider Plan of Correction:** Provide reeducation to all clinical managers and ST staff around ensuring that all care ordered is provided in accordance with the patient's plan of care; and any deviation in frequency is reported to physician/provider timely. **Measures to prevent recurrence:** Ongoing education with ST staff regarding following all orders in the plan of care and reporting any deviation in frequency to provider timely. **Quality Assurance Monitoring:** Quarterly audits (10 random charts per quarter) will be conducted by Quality team or designee to ensure compliance.	**9/15/23**

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	HCA--0108	A. BUILDING: _____ B. WING _____	06/13/2023

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H 580	Continued From page 26 hypercholesterolemia, history of falling, mild cognitive impairment, hearing loss, and long-term use of oral hypoglycemic drugs. Continued review of the clinical record failed to show evidence that speech therapy (ST) services were provided as ordered during the week of May 21, 2023. On 06/08/2023 at 01:30 pm, the Quality Assurance Director was made aware of the findings. On 06/09/2023 at 10:07 am, the latter submitted a late entry note dated 06/08/2023 notifying the doctor of the missed visit. At the time of the survey, the home care agency failed to ensure that speech therapy services were provided in accordance with the plan of care for Patient #20.	H 580		