

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/23/2013
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NAME OF PROVIDER OR SUPPLIER VIZION ONE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6855 EASTERN AVENUE NW STE 350 WASHINGTON, DC 20012
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ISSUE PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IJ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETE
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H 000	INITIAL COMMENTS An annual survey was conducted at your agency from July 30, 2013 through August 28, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of fifty-one (51) clinical records based on a total patient census of one thousand one hundred ninety-two (1,192) patients. The findings of the survey were based on a random sample of sixty-two (62) personnel files based on twenty-seven (27) registered nurses (RNs), three (3) licensed practical nurses (LPNs), sixteen (16) agency home health aides (HHAs) and fourteen (14) contract HHAs. The agency had a total staff census of one thousand two hundred thirty-six (1,236) employees of which nine hundred fifty-four (954) were agency HHAs, two hundred eighty-two (282) contract HHAs and thirteen (13) administrative staff. Observations and interviews were conducted in the patient homes during ten (10) home visits and twenty-four (24) telephone calls were made to current patients.	H 000		
H 150	3907.2(f) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (f) Verification of previous employment. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that all personnel records of home health aides (HHAs) and nursing staff included documentation showing verification of previous employment, for seven (7) of thirty (30) HHAs and three (3) of	H 150	What action will be taken to correct the deficiency cited? At the initial review of the citations resulting from the annual survey conducted from July 30, 2013 through August 28, 2013, the agency's senior management, the Director of Nursing and the Director of Quality Assurance conducted an in-service training on August 26, 2013 to the Human Resource team on proper and accurate verification of previous employment, prior to hiring.	8/26/13

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

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TITLE

(X4) DATE

STATE FORM

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09/06/2013

Abdullah Kitwara
CEO VIZION ONE, HOME HEALTH SERVICES

Health Regulation & Licensing Administration

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H 000 INITIAL COMMENTS

An annual survey was conducted at your agency from July 30, 2013, through August 28, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of fifty-one (51) clinical records based on a total patient census of one thousand one hundred ninety-two (1,192) patients. The findings of the survey were based on a random sample of sixty-two (62) personnel files based on twenty-seven (27) registered nurses (RNs), three (3) licensed practical nurses (LPNs), sixteen (16) agency home health aides (HHAs) and fourteen (14) contract HHAs. The agency had a total staff census of one thousand two hundred thirty-six (1,236) employees of which nine hundred fifty-four (954) were agency HHAs, two hundred eighty-two (282) contract HHAs and thirteen (13) administrative staff. Observations and interviews were conducted in the patient homes during ten (10) home visits and twenty-four (24) telephone calls were made to current patients.

H 000

Received 9/6/13

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H 150 3907.2(f) PERSONNEL

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

(f) Verification of previous employment;

This Statute is not met as evidenced by:
Based on record review and interview, the home care agency (HCA) failed to ensure that all personnel records of home health aides (HHAs) and nursing staff included documentation showing verification of previous employment, for seven (7) of thirty (30) HHAs and three (3) of

H 150

What action will be taken to correct the deficiency cited?

At the initial review of the citations resulting from the annual survey conducted from July 30, 2013 through August 28, 2013, the agency's senior management, the Director of Nursing and the Director of Quality Assurance conducted an in-service training on August 26, 2013 to the Human Resource team on proper and accurate verification of previous employment, prior to hiring.

8/26/13

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H 150	<p>Continued From page 1</p> <p>twenty-seven (27) registered nurses (RNs) included in the sample. (HHAs/Staff #7, #11, #15, #19, #20, #21 and #24; and RNs/Staff #43, #46 and #50).</p> <p>The findings include:</p> <p>The home care agency's (HCA's) personnel records were reviewed on July 30, 2013, July 31, 2013 and August 1, 2013, between 9:30 a.m. and 4:00 p.m. There was no documented evidence that the HCA received verification of previous employment for Staff #7, #11, #15, #19, #20, #21, #24, #43, #46 and #50.</p> <p>During a face to face interview with the human resources director (HRD/ Staff #32) and the acting administrator (AA/Staff #31), on August 1, 2013, at approximately 11:10 a.m., the HRD indicated that there has ben attempts to verify previous employment and those attempts were documented on a spread sheet or electronically. At 11:20 a.m., Staff #33 stated that they would retrieve the aforementioned information and bring the documents for review. No additional information for the 10 aforementioned employees was presented before the survey ended.</p> <p>Review of a written policy entitled "Selection/Hiring of Personnel Policy Number C:3-004.1, on August 1, 2013, at approximately 1:00 p.m., indicated that "Two (2) references either by telephone and/or written, will be obtained prior to an offer of employment ... Verification of the above will be documented."</p> <p>At the time of the survey, the HCA failed to ensure all staff's personnel records met the requirements outlined in this section.</p>	H 150	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Quality Assurance is responsible for the corrective action, and has already conducted in-service training on verification of previous employment.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented on August 26, 2013 by the Director of Quality Assurance.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>There will be a 100% audit of current personnel files to ensure that the required documents, including verification of previous employment, are completed and documented on employee files. Any file missing verification of previous employment, or other required items will be immediately addressed by the Quality Assurance Director.</p>	
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H 152	Continued From page 2	H 152	What action will be taken to correct the deficiency cited?	8/26/13
H 152	<p>3907.2(h) PERSONNEL</p> <p>Each home care agency shall maintain accurate personnel records, which shall include the following information:</p> <p>(h) Copies of completed annual evaluations;</p> <p>This Statute is not met as evidenced by: Based on review of personnel records and interviews, the home care agency (HCA) failed to ensure that each personnel record of home health aides (HHAs) and nursing staff included annual performance evaluations, for twenty-eight (28) of sixty-two (62) employees who were hired more than twelve (12) months prior to the survey. (HHAs/Staff #2, #3, #4, #5, #6, #9, #10, #13, #14, #16, #17, #20, #21, #23, #24, #25, #26, #28 and #30; registered nurses (RNs/Staff #34, #36, #37, #40, #49, #51, #56, #57, #57, #58, #59, #60 and #62) and licensed practical nurses (LPNs/Staff #42 and #44).</p> <p>The findings include:</p> <p>The home care agency's (HCA's) personnel records were reviewed on July 30, 2013, July 31, 2013 and August 1, 2013, between 9:30 a.m. and 4:00 p.m. Of the sixty- two (62) personnel records reviewed, twenty-eight (28) employees had been employed for one (1) year or longer. There was no documented evidence that the 28 aforementioned employees had received performance evaluations.</p> <p>During a face to face interview with the acting administrator (AA/Staff #31), on July 31, 2013, at 4:59 p.m., the AA/Staff #31 stated that the HCA</p>	H 152	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Quality Assurance will be responsible to ensure annual evaluations are completed for all employees.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented August 26, 2013.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>The Quality Assurance Director has implemented a tracking system to identify all employees in need of annual evaluations to ensure that the deficiency does not re-occur. The Human Resource team will use the tracking system to alert the Director of Quality Assurance and the Director of Nursing at least 60 days in advance on upcoming annual evaluations.</p>	

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H 152	Continued From page 3 had not conducted performance evaluations for any staff during the past two (2) years. The AA stated that the agency's goal was to have every longtime employee receive a performance evaluation before the end of November 2013. At the time of the survey, the HCA failed to complete annual evaluations, for inclusion in their employees' personnel records.	H 152	See previous page.	
H 157	3907.2(m) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (m) Documentation of acceptance or declination of the Hepatitis Vaccine; and... This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HHA) failed to ensure that all personnel records maintained for home health aides (HHAs) included documentation of acceptance or declination of the Hepatitis B vaccine, for five (5) out of thirty (30) HHAs included in the sample. (Staff #4, #5, #10, #14 and #21) The findings include: 1. On July 30, 2013, at approximately 3:15 p.m., review of Staff #4's personnel record revealed that on May 23, 2011, the staff had been provided the option to accept or decline the Hepatitis B vaccine. The form that was signed, however, failed to reflect whether the vaccination was declined.	H 157	What action will be taken to correct the deficiency cited? Upon reviewing the citation, an in-service training was provided to the Human Resource staff on proper documentation of the Hepatitis B form. The cited staff HHA's #: 4, 5, 10, 14, and 21 were contacted and, have updated the Hepatitis B form on their files. Who is responsible to implement the corrective action? The Quality Assurance Director will be responsible and has already conducted an in-service on proper documentation on all employee files. When will the corrective action be implemented? The corrective action was implemented on August 26, 2013.	8/26/13

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H 157	<p>Continued From page 4</p> <p>2. On July 30, 2013, at approximately 3:20 p.m., review of Staff #5's personnel record revealed that on July 26, 2011, the staff was provided the option to accept or decline the Hepatitis B vaccine. The form that was signed, however, failed to reflect whether the vaccination was declined.</p> <p>3. On July 30, 2013, at approximately 5:00 p.m., review of Staff #10's personnel record revealed no documented evidence that the staff member had been given the opportunity to accept or decline the Hepatitis B vaccine.</p> <p>4. On July 31, 2013, at approximately 11:30 a.m., review of Staff #14's personnel record revealed that the staff member had signed a Hepatitis B vaccination form on April 19, 2011. The form, however, failed to reflect whether or not the vaccination was declined by staff.</p> <p>5. On July 31, 2013, at approximately 1:45 p.m., review of Staff #21's personnel record revealed that the staff member had signed a Hepatitis B vaccination form. The form, however, was not dated and it failed to reflect whether or not the staff declined the vaccination.</p> <p>During a face to face interview with the human resources director (HRD/ Staff #32) and the acting administrator (AA/Staff #31), on August 1, 2013, at 10:43 a.m., the HRD examined the aforementioned personnel records and acknowledged the findings. The AA/Staff #31, suggested that some of the employees might not have understood the issue and the human resources staff had not observed that the forms were not fully completed.</p>	H 157	<p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>The Quality Assurance Director will conduct an ongoing review of employee files to ensure accurate completion of all documents to include the acceptance or declination of Hepatitis B forms. All employees with incomplete Hepatitis B forms will be notified immediately by the Human Resources Team.</p>	
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H 157	Continued From page 5 Review of a written policy entitled "Abstract from the Policy and Procedures regarding declining Hepatitis B Vaccine" on August 1, 2013, at 11:01 a.m., stated "If the employee chooses not to participate in the Hepatitis B immunization program, the ...will have the employee sign a declination statement." At the time of the survey, the HCA failed to ensure all staff's personnel records met the requirements outlined in this section.	H 157	See previous page.	
H 163	3907.7 PERSONNEL Each employee shall be screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease. This Statute is not met as evidenced by: Based on review of personnel records and interview, the home care agency (HCA) failed to ensure that each employee was screened for communicable disease annually and certified free of communicable disease, for one (1) of twenty-seven (27) registered nurses (RNs) and one (1) of thirty (30) home health aides (HHAs) records in the sample. (RN #58 and HHA #27) The findings include: 1. Review of registered nurse (RN) #58's personnel file on July 31, 2013, at approximately 1:53 p.m., revealed no documented evidence of a current purified protein derivative (PPD) skin test and that RN#58 was free from communicable disease according to the guidelines issued by the	H 163	What action will be taken to correct the deficiency cited? The Quality Assurance team reviewed the deficiency. A current Purified Protein Derivative (PPD) skin test for RN # 58 have been obtained and filed in employee's personnel record. HHA # 27 has provided the agency with a health certificate indicating she is free of communicable disease. Who is responsible to implement the corrective action? The Quality Assurance Director will implement measures to ensure that the deficiency does not re-occur, and will be responsible to accurately organize all personnel documents and keep certificates of communicable disease in their respective files.	8/30/13

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H 163	Continued From page 6 federal Centers for Disease Control. During an interview with the director of nursing (DON) on July 31, 2013, at approximately 4:55 p.m., it was stated the agency would check further, to ascertain if the results of the PPD had been misfiled. However at the time of the survey, the DON did not submit the aforementioned document. 2. Review of home health aide (HHA) #27's personnel file on July 31, 2013, at approximately 4:20 p.m., revealed that she had received a diagnostic screening for Hepatitis antibodies in August 2012. The lab report reflected an abnormal ("positive") test result for Hepatitis A antibodies (Reference Range: negative). The lab report did not, however, indicate whether the employee was deemed free of communicable disease by a health professional. Continued review of HHA #27's personnel file revealed no documented evidence that she had been certified free of communicable disease. During a face to face interview with the human resources director (HRD/ Staff #32) on August 1, 2013, at 11:26 a.m., he examined HHA #27's file and confirmed the aforementioned findings. It was stated that they "would need a physician to give their determination" as to whether the aide was free of communicable disease. No additional information regarding HHA #27's health status was shared before the survey ended.	H 163	When will the corrective action be implemented? The Human Resource teams has filed the health certificates of RN # 58 and HHA # 27 respectively, and are reviewing all personnel files to ensure each contains the required health examination and statement of being free of communicable disease. What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action? The Human Resource team will ensure that as soon as there are new hires, those employee folders will immediately be transmitted to the office of the Quality Assurance Director. The Quality Assurance team will review 100% of all new personnel files to ensure accuracy and compliance on a quarterly basis.	
H 227	3909.2 DISCHARGES TRANSFERS & REFERRALS Each patient shall receive written notice of discharge or referral no less than seven (7)	H 227	What action will be taken to correct the deficiency cited?	

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H 227	<p>Continued From page 7</p> <p>calendar days prior to the action. The seven (7) day written notice shall not be required, and oral notice may be given at any time, if the transfer, referral or discharge is the result of:</p> <p>This Statute is not met as evidenced by: Based on record reviews and interviews, the home care agency (HCA) failed to provide seven (7) days written notice before discharging one (1) of ten (10) discharged patients. (Patient #37)</p> <p>The finding includes:</p> <p>On August 1, 2013, a review of Patient #37's record at approximately 9:45 a.m., revealed a discharge summary dated May 16, 2013, which documented Patient #37 was discharged on May 16, 2013. Further review of the document revealed the reason for discharge was that the patient was non-compliant with policy and the last date of service was March 2, 2013.</p> <p>During an interview with the assistant director of nursing (ADON) on August 1, 2013, at approximately 10:00 a.m., it was revealed that the patient was non-compliant with the agency's policy by refusing home health aide (HHA) services two (2) times.</p> <p>During an interview with the quality and assurance (Q & A) manager on August 1, 2013, at approximately 10:18 a.m., it was revealed that two different HHA's were sent to the patient's home and both were sent away by the patient. Also, the Q&A stated "both aides were sent away so literally it implies patient may not need</p>	H 227	<p>The Director of Nursing has implemented strategic methods to ensure that discharges are completed within the time frame established by state regulations and organizational policy. On 8/26/13, the Director of Nursing conducted an in-service of all nursing staff to re-emphasize the 7 day minimum requirement on discharges.</p> <p>Who is responsible to implement the corrective action?</p> <p>The Director of Nursing is responsible to implement this corrective action.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented on 8/26/13, and an in-service to the nursing staff was completed on the proper use of the discharge approval form.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>All discharges recommended by the nursing staff will be documented on the newly developed discharge form and submitted to the Director of Nursing for approval within 24 hours. The Quality Assurance Director will review 25% of all patients discharge records quarterly to ensure standards are met.</p>	8/26/13

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H 227	<p>Continued From page 8 service."</p> <p>On August 1, 2013, at approximately 10:30 a.m., review of the the policy entitled "Informed Consent/Refusal of Treatment" failed to evidence the patient will be discharged if they refuse home health services 2 times.</p> <p>During an interview with the staffing coordinator on August 1, 2013, at approximately 1:10 p.m., revealed the following:</p> <ul style="list-style-type: none"> - Patient #37 was called on March 7, 2013, at which time the patient did not give an answer if he/she wanted to continue with HHA services. - Patient # 37 was called on March 15, 2013, to inquire about continuing HHA services at which time the patient made the staffing coordinator aware he/she would send a person to the agency that he/ she had selected to be his/her aide. - The person came to the agency on that same day, however the person was not certified as a home health aide. The information was then forwarded to the nursing department. <p>During an interview with the ADON on August 1, 2013, at approximately 1:19 p.m., the ADON indicated they would look for any communication nursing may have had with the patient from March 16, 2013 through May 16, 2013. No further documents were given to the surveyor.</p> <p>During a telephone interview with Patient #37 on August 11, 2013, at approximately 12:06 p.m., revealed the following:</p> <ul style="list-style-type: none"> - The last time the patient received any services 	H 227	See previous page.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 227	Continued From page 9 from the agency was on March 2, 2013. - The patient admitted to calling both the HHA and staffing coordinator and leaving several messages to inquire about HHA services. However, the HHA and the staffing coordinator did not return the calls. - The patient denied sending anyone to the agency to apply to be his/her aide. [It should be noted when the surveyor quoted the name of the person which was provided by the staff coordinator the patient stated "I don't know anyone by that name."] - The patient admitted an agency nursed called him/her in June 2013 and discharged him/her over the phone. The patient also indicated when he/she asked why was he/she being discharged and what was the nurse's name. The nurse hung up. - The patient admitted he/she received discharged papers in the mail on August 3, 2013.(One month after services were discontinued.)	H 227	See previous page.	
H 357	3914.3(f) PATIENT PLAN OF CARE The plan of care shall include the following: (f) Provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services; This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to ensure	H 357	What action will be taken to correct the deficiency cited? Upon reviewing the citation, the Director of Nursing conducted in-service training to nurses who handle client discharge procedures and patients' plan of care to guide them on the proper documentation of discharge planning.	8/26/13

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H 357	<p>Continued From page 10</p> <p>discharge planning was documented on the plan of care (POC) for three (3) of fifty (50) patients in the sample. (Patient #12, #15, and #17)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Patient #12's plan of care (POC) with a certification period of March 10, 2013 through September 9, 2013, on July 31, 2013, at approximately 1:10 p.m., failed to include provisions for discharge planning. 2. Review of Patient #15's POC with certification period of March 28, 2013 through September 28, 2013, on July 31, 2013, at approximately 3:00 p.m., failed to include provisions for discharge planning. 3. Patient #17's POC with certification period of May 19, 2013 through August 19, 2013, on July 31, 2013, at approximately 3:30 p.m., failed to include provisions for discharge planning. <p>During a face to face interview with the director of nursing (DON), on August 1, 2013, at approximately 5:50 p.m., it was acknowledged that the POC did not include provisions related to discharge planning for Patients #12, #15 and #17 on their current POC. Further interview revealed that the agency would provide training to the clinical staff on how to accurately assess and document the aforementioned patient's discharge planning on the POC.</p>	H 357	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Nursing is responsible for conducting monthly reviews of patient's records to ensure proper documentation of discharge planning.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented on August 26, 2013.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>There will be a 100% audit of all active patients plan of care to ensure discharge planning is documented on the plan of care.</p>	
H 358	<p>3914.3(g) PATIENT PLAN OF CARE</p> <p>The plan of care shall include the following:</p> <p>(g) Physical assessment, including all pertinent</p>	H 358	<p>What action will be taken to correct the deficiency cited?</p>	

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H 358	Continued From page 11 diagnoses; This Statute is not met as evidenced by: Based record review and interview, the Home Care Agency's Plan of Care (POC) failed to include all pertinent diagnoses for one (1) of fifty-one (51) patient in the investigation. (Patient #51) The finding includes: On August 22, 2013, review of Patient #51's records, starting at approximately 6:50 p.m., revealed a POC with certification period from April 17, 2013, through October 13, 2013. The POC indicated that the patient diagnoses included difficulty in walking, and indicated he uses a cane to assist him with ambulation. Further review of the record revealed a document entitled "Recertification" dated June 29, 2013 that included a nursing assessment and documented "bilateral lower extremities amputation." On August 22, 2013, a telephone interview with Patient #51 at approximately 7:00 p.m., revealed he uses a electric wheelchair because he had both legs amputated.	H 358	The deficiency was reviewed and, an in-service was conducted by the Director of Nursing to the entire nursing staff on the proper documentation of pertinent diagnosis on patient plan of care. Who is responsible to implement the corrective action? The Director of Nursing is responsible for conducting monthly reviews of patient records to ensure proper documentation of pertinent diagnosis. When will the corrective action be implemented? The corrective action was implemented on August 26, 2013. What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action? There will be a 100% audit of all active patient plan of care to ensure plan of care is completed accurately and standards are met.	8/26/13
H 359	3914.3(h) PATIENT PLAN OF CARE The plan of care shall include the following: (h) Prognosis, including rehabilitation potential; This Statute is not met as evidenced by: Based on record review and interview, the agency's plan of care (POC) failed to document	H 359	What action will be taken to correct the deficiency cited? This deficiency was reviewed and the Director of Nursing conducted an in-service on 8/26/13, stressing the importance of completing documentation of patient care on patient plan of care (POC) to include rehabilitation potential.	

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H 359	<p>Continued From page 12</p> <p>the rehabilitation potential for two (2) of fifty (50) patients in the sample. (Patient #14 and #22)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Review of Patient #14's plan of care (POC) with certification period of June 24, 2013 through December 23, 2013, on July 31, 2013, at approximately 2:45 p.m., failed to include the rehabilitation potential for the patient. 2. Patient #22's POC with certification period of July 25, 2013 through January 24, 2013, on July 31, 2013, at approximately 3:54 p.m., failed to include the rehabilitation potential for the patient. <p>During a face to face interview with the clinical director on July 24, 2013, at approximately 4:40 p.m., it was indicated that the agency would provide training to the clinical staff on how to accurately assess and document Patient #14 and #22's rehabilitation potential on the POC.</p>	H 359	<p>Who is responsible to implement the corrective action?</p> <p>It is the responsibility of the Director of Nursing to ensure that proper documentation of patient rehabilitation potential is completed on patient plan of care.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented on August 26, 2013.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>The Director of Nursing will conduct monthly reviews on the plan of care and will ensure 100% audit of all active patients' plan of care to guarantee accurate and complete documentation of patients' care.</p>	
H 363	<p>3914.3(l) PATIENT PLAN OF CARE</p> <p>The plan of care shall include the following:</p> <p>(l) Identification of employees in charge of managing emergency situations;</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure the plan of care (POC) included the identification of all employees in charge of managing emergency situations for fifty (50) of fifty (50) patients in the sample. (Patients #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19,</p>	H 363	<p>What action will be taken to correct the deficiency cited?</p> <p>After reviewing the deficiency, the Professional Advisory Committee (PAC) amended the plan of care to include the RN as employee in charge of managing emergency situations while in patient home.</p>	8/28/13

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H 363	<p>Continued From page 13</p> <p>#20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49 and #50)</p> <p>The findings include:</p> <p>The home care agency's (HCA's) plan of cares (POC's) were reviewed on July 30, 2013, July 31, 2013 and August 1, 2013, between 9:30 a.m. and 4:00 p.m. The agency failed to ensure that the POC for 50 of 50 patients identified the registered nurses (RN) as one of the employees who would be in charge of managing emergency situations when they were in the patient's home as evidenced below:</p> <ol style="list-style-type: none"> 1. Patient #1's POC with certification period of January 28, 2013 through July 28, 2013, failed to include the identification of the RN in charge of managing emergency situations. 2. Patient #2's POC with certification period of January 28, 2013 through July 28, 2013, failed to include the identification of the RN in charge of managing emergency situations. 3. Patient #3's POC with certification period of June 23, 2013 through December 22, 2013, failed to include the identification of the RN in charge of managing emergency situations. 4. Patient #4's POC with certification period of January 13, 2013 through August 1, 2013, failed to include the identification of the RN in charge of managing emergency situations. 5. Patient #5's POC with certification period of June 13, 2013 through December 13, 2013, failed to include the identification of the RN in charge of 	H 363	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Nursing will ensure compliance to this practice.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action will be implemented on 9/30/13.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>Quality Assurance will conduct 25% quarterly reviews to insure plan of care includes the identification of all employees in charge of managing emergency situations.</p>	

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H 363	<p>Continued From page 14</p> <p>managing emergency situations.</p> <p>6. Patient #6's POC with certification period of March 21, 2013 through September 20, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>7. Patient #7's POC with certification period of March 19, 2013 through September 20, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>8. Patient #8's POC with certification period of February 9, 2013 through August 8, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>9. Patient #9's POC with certification period of June 19, 2013 through December 19, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>10. Patient #10's POC with certification period of March 6, 2013 through September 5, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>11. Patient #11's POC with certification period of March 17, 2013 through September 16, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>12. Patient #12's POC with certification period of March 10, 2013 through September 9, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>13. Patient #13's POC with certification period of April 29, 2013 through July 28, 2013, failed to include the identification of the RN in charge of</p>	H 363	See previous page.	

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H 363	<p>Continued From page 15</p> <p>managing emergency situations.</p> <p>14. Patient #14's POC with certification period of June 24, 2013 through December 23, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>15. Patient #15's POC with certification period of March 28, 2013 through September 28, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>16. Patient #16's POC with certification period of July 27, 2013 through January 27, 2014, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>17. Patient #17's POC with certification period of May 19, 2013 through August 19, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>18. Patient #18's POC with certification period of March 11, 2013 through September 10, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>19. Patient #19's POC with certification period of May 17, 2013 through November 11, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>20. Patient #20's POC with certification period of February 7, 2013 through August 8, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>21. Patient #21's POC with certification period of March 28, 2013 through September 28, 2013, failed to include the identification of the RN in</p>	H 363	See previous page.	

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H 363	<p>Continued From page 16</p> <p>charge of managing emergency situations.</p> <p>22. Patient #22's POC with certification period of July 25, 2013 through January 24, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>23. Patient #23's POC with certification period of June 22, 2013 through December 27, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>24. Patient #24's POC with certification period of June 23, 2013 through December 22, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>25. Patient #25's POC with certification period of July 26, 2013 through January 25, 2014, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>26. Patient #26's POC with certification period of March 27, 2013 through September 26, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>27. Patient #27's POC with certification period of April 1, 2013 through October 1, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>28. Patient #28's POC with certification period of February 27, 2013 through August 26, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>29. Patient #29's POC with certification period of April 25, 2013 through October 25, 2013, failed to</p>	H 363	See previous page.	
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H 363	<p>Continued From page 17</p> <p>include the identification of the RN in charge of managing emergency situations.</p> <p>30. Patient #30's POC with certification period of March 11, 2013 through September 11, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>31. Patient #31's POC with certification period of January 23, 2013 through July 26, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>32. Patient #32's POC with certification period of April 28, 2013 through October 27, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>33. Patient #33's POC with certification period of April 4, 2013 through October 4, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>34. Patient #34's POC with certification period of April 3, 2013 through October 4, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>35. Patient #35's POC with certification period of May 6, 2013 through November 5, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>36. Patient #36's POC with certification period of October 15, 2012 through April 14, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p>	H 363	See previous page.	

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H 363	<p>Continued From page 18</p> <p>37. Patient #37's POC with certification period of December 27, 2012 through July 26, 2013 , failed to include the identification of the RN in charge of managing emergency situations.</p> <p>38. Patient #38's POC with certification period of January 2, 2013 through June 2, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>39. Patient #39's POC with certification period of March 20, 2013 through September 20, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>40. Patient #40's POC with certification period of February 23, 2013 through August 22, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>41. Patient #41's POC with certification period of March 20, 2013 through September 20, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>42. Patient #42's POC with certification period of June 13 , 2013 through December 12, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>43. Patient #43's POC with certification period of June 9, 2013 through December 9, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>44. Patient #44's POC with certification period of February 28, 2013 through August 27, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p>	H 363	See previous page.	
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H 363	<p>Continued From page 19</p> <p>45. Patient #45's POC with certification period of January 22, 2013 through July 22, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>46. Patient #46's POC with certification period of December 16, 2012 through June 15, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>47. Patient #47's POC with certification period of March 1, 2012 through August 27, 2012, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>48. Patient #48's POC with certification period of July 19, 2012 through January 19, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>49. Patient #26's POC with certification period of April 11, 2013 through July 11, 2013, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>50. Patient #50's POC with certification period of February 26, 2013 through August 26, 2014, failed to include the identification of the RN in charge of managing emergency situations.</p> <p>During a face to face interview with the director of nursing (DON) on August 1, 2013, at approximately 5:00 p.m., it was indicated that the agency would add an addendum to the POC to include the identification of the RN in charge of managing emergency situations when the RN is</p>	H 363	See previous page.	

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H 363	Continued From page 20 in the aforementioned patient's home.	H 363	See previous page.	
H 390	<p>3915.6 HOME HEALTH & PERSONAL CARE AIDE SERVICE</p> <p>After the first year of service, each aide shall be required to obtain at least twelve (12) hours of continuing education or in-service training annually, which shall include information that will help maintain or improve his or her performance. This training shall include a component specifically related to the care of persons with disabilities.</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency (HCA) failed to ensure each staff had obtained at least twelve (12) hours of continuing education or in-service training annually, for sixteen (16) of the nineteen (19) records of sampled home health aides who were hired more than 12 months prior to the survey. (Staff #2, #3, #6, #9, #10, #13, #14, #16, #17, #20, #21, #23, #24, #26, #28 and #30)</p> <p>The findings include:</p> <p>The home care agency's (HCA's) personnel records were reviewed on July 30, 2013, July 31, 2013 and August 1, 2013, between 9:30 a.m. and 4:00 p.m. Of the thirty (30) home health aides (HHAs) sampled, nineteen (19) employees had been on staff for two (2) years or longer. Review of those 19 personnel records revealed no evidence that sixteen (16) HHAs had obtained the required twelve (12) hours of continuing education or in-service training annually, as follows:</p>	H 390	<p>What action will be taken to correct the deficiency cited?</p> <p>The in-service certificates for HHA #s: 2, 3, 6, 9, 10, 13, 14, 16, 17, 20, 21, 23, 24, 26, 28, and 30 are on file and available for review.</p> <p>Who is responsible to implement the corrective action?</p> <p>The Director of Quality Assurance is responsible to implement measures to ensure that all employees' in-service certificates are accurately filed.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented 8/30/13.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>The Director of Quality Assurance will reinforce the importance of immediately filing training certificates upon completion of training sessions. In addition, the Human Resource Staff will submit folders of in-service training to the Director of Quality Assurance for review following each training session.</p>	8/30/13

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H 390	<p>Continued From page 21</p> <p>Staff #2 had three (3) hours of continuing education/in-service training documented;</p> <p>Staff #3 had six (6) hours of continuing education/in-service training documented;</p> <p>Staff #6 had 3 hours of continuing education/in-service training documented;</p> <p>Staff #9 had 3 hours of continuing education/in-service training documented;</p> <p>Staff #10 had 6 hours of continuing education/in-service training documented;</p> <p>Staff #13 had 6 hours of continuing education/in-service training documented;</p> <p>Staff #14 had 6 hours of continuing education/in-service training documented;</p> <p>Staff #16 had zero (0) hours of continuing education/in-service training documented;</p> <p>Staff #17 had ten (10) hours of continuing education/in-service training documented;</p> <p>Staff #20 had 0 hours of continuing education/in-service training documented;</p> <p>Staff #21 had 0 hours of continuing education/in-service training documented;</p> <p>Staff #23 had 6 hours of continuing education/in-service training documented;</p> <p>Staff #24 had 10 hours of continuing education/in-service training documented;</p>	H 390	See previous page.	

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H 390	<p>Continued From page 22</p> <p>Staff #26 had 0 hours of continuing education/in-service training documented;</p> <p>Staff #28 had 0 hours of continuing education/in-service training documented and</p> <p>Staff #30 had seven (7) hours of continuing education/in-service training documented.</p> <p>During a face to face interview with Staff #33 on July 31, 2013, at approximately 2:30 p.m., it was indicated that the HCA maintained computerized records of in-service training hours credited for each HHA. Staff #33 agreed to make those records available for verification purposes (request limited to only the sampled HHAs). On August 1, 2013, at 11:56 a.m., however, the acting administrator (AA/Staff #31) stated they were unable to provide the aforementioned computerized documentation for review. The AA/Staff #31 stated that it was possible that some in-service training certificates (hard copies) had been misplaced as they were transitioning personnel records from one system to another.</p> <p>At the time of the survey, the HCA failed to show evidence that all staff obtained the required 12 hours of continuing education or in-service training annually.</p>	H 390	See previous page.	
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H 451	<p>3917.2(a) SKILLED NURSING SERVICES</p> <p>Duties of the nurse shall include, at a minimum, the following:</p> <p>(a) Initial assessment and evaluation;</p> <p>This Statute is not met as evidenced by:</p>	H 451	<p>What action will be taken to correct the deficiency cited?</p> <p>The Director of Nursing conducted an in-service on the nursing process to include initial assessment and evaluations, emphasizing the importance of completing and accurately documenting patients care on Medicaid Personal Care Assessment Instruments.</p>	8/26/13
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H 451	<p>Continued From page 23</p> <p>Based on record reviews and interviews, it was determined that the agency's nursing staff were not completing the assessments and evaluations in there entirety for six (6) of fifty (50) patients in the sample. (Patient #4, #6, #14, #20, #21 and #25).</p> <p>The findings include:</p> <p>The home care agency's (HCA's) Medicaid Personal Care Assessment Instruments (MPCAI) were reviewed on July 30, 2013, July 31, 2013 and August 1, 2013, between 10:00 a.m. and 5:00 p.m. The agency's nurses failed to ensure that the MPCAI for six (6) of fifty (50) patients were completed in there entirety as evidenced below:</p> <ol style="list-style-type: none"> 1. Review of Patient #4's Medicaid Personal Care Assessment Instrument (MPCAI) dated July 10, 2013, revealed the agency's nursing staff failed to complete the sections entitled "Diagnoses and Medication Profile". There was no documented evidence that the patient's medications were listed. 2. Review of Patient #6's MPCAI dated June 12, 2013, revealed the agency's nursing staff failed to complete the sections entitled "Physical Health Assessment, Sensory Functions, Physical Status and Nutrition". 3. Review of Patient #14's MPCAI dated June 12, 2013, revealed MPCAI dated June 12, 2013, revealed the agency's nursing staff failed to complete the sections entitled "Special Instructions and Nutrition". 4. Review of Patient #20's MPCAI dated July 20, 	H 451	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Nursing is responsible for this action.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented on August 26, 2013.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>The Director of Nursing will review 25% of patient records quarterly to ensure that documentation of the patient's care on Medicaid Personal Care Instruments are complete in its entirety.</p>	

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H 451	<p>Continued From page 24</p> <p>2013, revealed the agency's nursing staff failed to complete the sections entitled "Special Instructions, Reason for Referral and Nutrition".</p> <p>5. Review of Patient #21's MPCAI dated March 28, 2013, revealed the agency's nursing staff failed to complete the section entitled "Diagnoses and Medication Profile" and documented "See plan of treatment (POT/or Medication Profile) in the section.</p> <p>6. Review of Patient #25's MPCAI dated June 28, 2013, revealed the agency's nursing staff failed to complete the sections entitled "Special Instructions, Reason for Referral, Primary Caregiver and Nutrition".</p> <p>During a face to face interview with the director nursing (DON) on August 1, 2013, at approximately 5:15 p.m., it was acknowledged at the time of the survey there was no documented evidence that the agency's nurses completed the MPCAI's in there entirety for the aforementioned patients. Further interview revealed that the nursing staff would be re-trained on how to assess and completely document on all sections of the MPCAI.</p>	H 451	See previous page.	
H 453	<p>3917.2(c) SKILLED NURSING SERVICES</p> <p>Duties of the nurse shall include, at a minimum, the following:</p> <p>(c) Ensuring that patient needs are met in accordance with the plan of care;</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the home</p>	H 453	<p>What action will be taken to correct the deficiency cited?</p> <p>The Registered Nurses were retrained on the process to follow when the client is not in compliance with receiving care. This training included monthly supervisory visits by the Registered Nurses to ensure that patients receive PCA services as prescribed by the referring physician and in accordance with the patient's plan of care.</p>	8/26/13

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H 453	<p>Continued From page 25</p> <p>care agency's (HCA's) nurse failed to ensure that patient needs were met in accordance with the plan of care (POC) for four (4) of fifty (50) patients in the sample. (Patient #30, #32, #44 and #48)</p> <p>The findings include:</p> <p>1. On July 31, 2013, at approximately 1:41 p.m., review of Patient #30's plan of care (POC) with a documented certification period of March 12, 2013, to September 11, 2013, revealed the skilled nurse was to visit the patient's home every thirty (30) days to conduct assessments of all systems and provide supervision of the personal care aide (PCA). According to the POC, PCA services were to be provided eight (8) hours a day, seven (7) days a week.</p> <p>Further review of the record failed to provide evidence that PCA services were provided on March 31, 2013 and April 6, 2013. Additionally, there was no documented evidence the skilled nurse visited the patient in June 2013.</p> <p>During an interview with the director of nursing (DON) on August 1, 2013 at approximately 9:30 a.m., it was indicated she was unable to find PCA time sheets for March 31, 2013 and April 6, 2013. Further interview, revealed that there was a nursing communication log dated July 2, 2013, in which the nurse stated "missed visit" for skilled nursing in June 2013.</p> <p>2. On July 31, 2013, at approximately 6:00 p.m., review of Patient #32's POC, with a documented certification period of April 28, 2013, to October 27, 2013, revealed the skilled nurse was to visit the patient's home every 30 days to conduct assessments of all systems and provide</p>	H 453	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Nursing is responsible for the implementation of this corrective action.</p> <p>When will the corrective action be implemented?</p> <p>The corrective action was implemented on August 26, 2013.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>Monthly reviews of patient's records will be conducted by the nursing team. This is to make sure that supervisory visits by Registered Nurses are current and PCA services are provided in accordance with patient's plan of care. For any interruption of services a "missed visit form" will be required to be completed by the primary nurse. They will notify the primary care physician, and the Director of Nursing will address the issue immediately to avoid re-occurrence.</p>	
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H 453	<p>Continued From page 26</p> <p>supervision of the personal care aide. According to the POC, PCA services were to be provided 8 hours a day, six (6) days a week. Further review of the record failed to provide evidence that PCA services were provided on May 6, 2013 through May 14, 2013.</p> <p>During an interview with the DON on August 1, 2013 at approximately 9:51 a.m., revealed PCA service was not provided from May 6, 2013 through May 14, 2013, because the plan of treatment (POT) was not signed by the physician.</p> <p>3. On July 31, 2013, at approximately 6:20 p.m., review of Patient #44's POC, with a documented certification period of February 28, 2013, to August 27, 2013, revealed the skilled nurse was to visit the patient's home every 30 days to conduct assessments of all systems and provide supervision of the personal care aide. According to the POC, PCA services were to be provided 8 hours a day, 7 days a week.</p> <p>Further review of the record failed to provide evidence that the skilled nurse visited the patient in March 2013.</p> <p>During an interview with the DON on August 1, 2013 at approximately 1:49 p.m., it was indicated the skilled nursing note would be located and provided to the surveyor for review. (It should be noted the skilled note for March 2013 was not received).</p> <p>4. On August 1, 2013, at approximately 2:30 p.m., review of Patient #48's POC with a documented certification period of January 20, 2013, to July 19, 2013, revealed the skilled nurse was to visit the patient's home every 30 days to conduct</p>	H 453	See previous page.	

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H 453	Continued From page 27 assessments of all systems and provide supervision of the personal care aide. According to the POC, PCA services were to be provided 6 hours a day, 7 days a week. Further review of the record failed to provide evidence that the skilled nurse visited the patient after July 19, 2012. (It should be noted the patient was discharged on February 14, 2013). During an interview with the DON on August 1, 2013 at approximately 2:00 p.m., it was indicated that the agency was unable to provide evidence that the skilled nurse visited the patient after July 19, 2012.	H 453	See previous page.	
H 454	3917.2(d) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (d) Implementing preventive and rehabilitative nursing procedures; This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that preventive and rehabilitative nursing procedures were afforded to patients related to their health conditions, for five (5) of fifty (50) patients in the sample. (Patient #3, #6, #14, #20 and #25). The findings include: 1. Review of Patient #3's plan of care (POC) with certification period of June 23, 2013 through	H 454	What action will be taken to correct the deficiency cited? After reviewing this deficiency, the Director of Nursing held an in-service training on the entire nursing process. This training ensures that patient complete physical assessments, preventative and rehabilitative nursing procedures are afforded to patients relative to their health conditions. Furthermore, the agency has purchased weighing scales for the field nurses to make certain that the patient's weights are accurately measured and documented.	8/26/13

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H 454	<p>Continued From page 28</p> <p>December 22, 2013, on July 30, 2013, at approximately 1:10 p.m., revealed Patient #3 had diagnoses that included breast neoplasm, depression, acid reflux, hypertension and asthma. Further review revealed that the registered nurse (RN) was to assess all systems.</p> <p>Review of Patient #3's Medicaid Personal Care Assessment Instrument (MPCAI) dated June 14, 2013, on July 30, 2013, at approximately 1:25 p.m., revealed that the patient was five (5) feet inches tall and weighed one hundred forty-five (145) pounds.</p> <p>Review of Patient #3's Nursing Visit Note (NVN) dated June 23, 2013, on July 30, 2013, at approximately 1:15 p.m., revealed no documented evidence that the RN actually weighed Patient #3 or recorded the patient's reported weight during the physical assessment in order to assess/monitor body functions.</p> <p>2. Review of Patient #6's POC with certification period of March 21, 2013 through September 20, 2013 on July 30, 2013, at approximately 2:00 p.m., revealed the seventy-two (72) year old patient had diagnoses that included a sprained back, calcified tendonosis and pre-glaucoma. Further review of the POC revealed the RN was to assess all systems.</p> <p>Review of Patient #6's MPCAs dated June 12, 2013 and March 14, on July 30, 2013, between 2:15 p.m. and 2:20 p.m., revealed no documented weights or heights recorded. Further review revealed the patient was assessed to have bi-lateral lower extremity edema.</p> <p>Review of Patient #6's NVNs dated May 23, 2013, April 14, 2013 and February 10, 2013 on July 30,</p>	H 454	<p>Who is responsible to implement the corrective action?</p> <p>The Director of Nursing is responsible for implementation of this corrective action.</p> <p>When will the corrective action be implemented?</p> <p>The in-service training was completed on 8/26/13 and the weighing scales have been ordered with expected delivery date of 9/30/13.</p> <p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>Weighting scales will be provided to the nurses by the Director of Nursing to measure and document patient weights on the monthly nursing visits notes. The nursing staff will review monthly visit notes to make sure standards are met.</p>	
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H 454	<p>Continued From page 29</p> <p>2013, between 2:25 p.m. and 2: 30 p.m., revealed no documented evidence that the RN actually weighed Patient #6 or recorded the patient's reported weight during the physical assessment.</p> <p>3. Review of Patient #14's POC with certification period of June 24, 2013 through December 23, 2013, on July 31, 2013, at approximately 2:05 p.m., revealed the patient had diagnoses that included malignant hypertension, asthma, malaise and fatigue. Further review of the POC revealed the RN was to assess all systems.</p> <p>Review of Patient #14's MPCAls dated June 12, 2013, at approximately 2:50 p.m., on July 31, 2013, at approximately 2:15 p.m., revealed revealed that the patient was five (5) feet seven (7) inches tall , however no weight was recorded. Further review revealed that the patient was recently diagnosed with diabetes mellitus.</p> <p>Review of Patient #14's NVN dated July 13, 2013, on July 31, 2013, at approximately 4:35 p.m., revealed no documented evidence that the RN actually weighed Patient #14 or recorded the patient's reported weight during the physical assessment in order to assess/monitor body functions.</p> <p>4. Review of Patient #20's POC with certification period of February 7, 2013 through August 8, 2013, on July 31, 2013, at approximately 4:10 p.m., revealed the patient had diagnoses that included Human Immunodeficiency Virus (HIV), weight loss, diarrhea, insomnia and schizophrenia. Further review of the POC revealed the RN was to assess all systems.</p> <p>Review of Patient #20's MPCAls dated July 20, 2013, on July 31, 2013, at at approximately 4:15</p>	H 454	See previous page.	

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H 454	<p>Continued From page 30</p> <p>p.m., revealed no documented weight or height. Further review revealed the patient had an abnormal weight loss and was very confused and forgetful.</p> <p>Review of Patient #20's NVN dated June 22, 2013, on July 31, 2013, at approximately 4:25 p.m., revealed no documented evidence that the RN actually weighed Patient #20 or recorded the patient's reported weight during the physical assessment in order to assess/monitor body functions.</p> <p>5. Review of Patient #25's POC with certification period of July 26, 2013 through January 25, 2014, on July 31, 2013, at approximately 4:40 p.m., revealed the patient had diagnoses that included epilepsy, malignant hypertension, bipolar disorder and depression. Further review of the POC revealed the RN was to assess all systems.</p> <p>Review of Patient #25's MPCAI dated June 28, 2013, on July 31, 2013, at at approximately 4:45 p.m., revealed no documented weight or height. Further review revealed the patient had chronic knee pain and was confused and forgetful.</p> <p>Review of Patient #25's NVN dated July 15, 2013, on July 31, 2013, at approximately 4:50 p.m., revealed no documented evidence that the RN actually weighed Patient #25 or recorded the patient's reported weight during the physical assessment in order to assess/monitor body functions.</p> <p>During a face to face interview with the director nursing (DON) on August 1, 2013, at approximately 5:10 p.m., it was acknowledged at the time of the survey there was no documented evidence that the nurse actually weighed Patient</p>	H 454	See previous page.	
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H 454	Continued From page 31 #3, #6, #14, #20 and #25 or recorded the patient's actual or reported weight during the physical assessment. Further interview revealed that the POC would be updated to include instructions for the nursing staff to weigh the patient or record the patient's reported weight from the primary care physician. Also the nursing staff would be re-trained on how to weigh and document the actual or reported weight on the NVN.	H 454	See previous page.	
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that specific instructions were afforded to patients related to their health conditions, for nine (9) of the fifty (50) patients in the sample (Patient #6, #10, #11, #12, #17, #18, #20, #21 and #25). Additionally, the HCA failed to provide evidence that the instructions given were understood, for eighteen (18) of the 50 patients in the sample. (Patient #3, #6, #7, #8, #9, #10, #11,#12,#14, #17, #18, #20, #21, #22, #25, #31, #40 and #50) The findings include: The agency's nursing staff failed to ensure the training and evaluation of the training had been	H 459	What action will be taken to correct the deficiency cited? After reviewing the deficiency, an in-service was conducted for all nursing staff on patient teaching and understanding of the instructions given. Specific emphasis was placed on proper documentation of specific instruction given to patient, based on their health conditions, and patient's specific level of understanding of the instructions. Who is responsible to implement the corrective action? The Director of Nursing is responsible for the implementation of this corrective action. When will the corrective action be implemented? The corrective action was implemented on 8/26/13. A follow-up process will begin with the September 2013 nursing visit notes.	8/26/13

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H 459	<p>Continued From page 32</p> <p>completed as evidenced by:</p> <ol style="list-style-type: none"> 1. Review of Patient #3's medical record on July 30, 2013, at approximately 11:24 a.m., revealed a Nursing Visit Note (NVN) dated May 15, 2013. The document indicated the nurse taught the patient safety precautions such as using a cane when ambulating and to request assistance when needed. The nurse documented that "patient verbalized understanding of the teachings". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings. 2. Review of Patient #6's medical record on July 30, 2013, at approximately 11:40 a.m., revealed a NVN dated May 20, 2013. The document indicated the nurse taught the patient on pain management, fall and safety precautions. The nurse documented that the patient "verbalizing understanding of the instructions". The nurse however, failed to document the specific aspects of the aforementioned respective training's taught to the patient and the patient's specific level of understanding of the aforementioned health teachings. 3. Review of Patient #7's medical record on July 30, 2013, at approximately 12:20 p.m., revealed a NVN dated July 23, 2013. The document indicated the nurse taught the patient and the home health aide (HHA) handwashing as a means of infection control. The nurse documented that "both verbalized understanding of the instructions". The nurse however, failed to document the patient's/HHA's specific level of understanding of the aforementioned health teaching. 	H 459	<p>What is the monitoring process put into place to ensure implementation and effectiveness of the corrective action?</p> <p>The nursing staff will review completed nursing visits notes beginning September 2013 to ensure patients' teaching and evaluation of the teaching, is completed on nursing visit notes. Director of Nursing will particularly emphasize on specific teachings and, specific level of patients' understanding of the teachings.</p>	
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H 459	<p>Continued From page 33</p> <p>4. Review of Patient #8's medical record on July 30, 2013, at approximately 12:40 p.m., revealed a NVN dated June 4, 2013. The document indicated that the patient complained of having a poor appetite. The nurse instructed the patient to try eating more fruits and vegetables. The nurse documented that the patient "verbalized understanding". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>5. Review of Patient #9's medical record on July 30, 2013, at approximately 12:50 p.m., revealed a NVN dated July 11, 2013. The document indicated the patient complained of not sleeping well at night. The nurse instructed the patient to drink warm milk and not to sleep much during the day. The nurse documented that the patient "verbalized understanding". The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>6. Review of Patient #10's medical record on July 30, 2013, at approximately 1:05 p.m., revealed a NVN dated July 12, 2013. The document indicated the nurse taught the patient to use pain medication as ordered and to report persistent symptoms to the doctor and fall prevention was emphasized. The nurse however, failed to document the specific aspects of the aforementioned respective training's taught to the patient and the patient's specific level of understanding of the aforementioned health teachings.</p> <p>7. Review of Patient #11's medical record on July 30, 2013, at approximately 1:05 p.m., revealed a NVN dated June 20, 2013. The document</p>	H 459	See previous page.	
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H 459	<p>Continued From page 34</p> <p>indicated the nurse taught the patient to follow up with the physician and continue to take medications as prescribed. The nurse documented the patient verbalized understanding on medications, diets and physician's orders. The nurse however, failed to document the specific aspects of the aforementioned respective training's taught to the patient and the patient's specific level of understanding of the aforementioned health teachings.</p> <p>8. Review of Patient #12's medical record on July 30, 2013, at approximately 1:25 p.m., revealed a NVN dated July 1, 2013. The document indicated the nurse instructed the patient on the side effects of nicotine from cigarettes. The nurse documented that the patient verbalized understanding of the instructions. The nurse however, failed to document the specific aspects of the aforementioned respective training's taught to the patient and the patient's specific level of understanding of the aforementioned health teaching.</p> <p>9. Review of Patient #17's medical record on July 31, 2013, at approximately 2:25 p.m., revealed a NVN dated May 21, 2013. The document indicated the patient was evaluated to adhere to all medications and treatments. The nurse documented the patient verbalized understanding of the instructions. The nurse however, failed to document any specific aspects of medication and treatment instructions taught to the patient and the patient's specific level of understanding of the aforementioned health teachings.</p> <p>10. Review of Patient #18's medical record on July 31, 2013, at approximately 3:30 p.m., revealed a NVN dated July 4, 2013. The document indicated the patient was provided</p>	H 459	See previous page.	
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H 459	<p>Continued From page 35</p> <p>medication teaching on the importance of taking Human Immunodeficiency Virus (HIV) medications. The nurse documented the patient verbalized understanding of the instructions. The nurse however, failed to document any specific aspects of medication instructions taught to the patient and the patient's specific level of understanding of the aforementioned health teaching.</p> <p>11. Review of Patient #20's medical record on July 31, 2013, at approximately 3:30 p.m., revealed a NVN dated June 22, 2013. The document indicated the patient was instructed on infection and safety precautions. The nurse documented the patient "stated understanding". The nurse however, failed to document any specific aspects of infection and safety precautions taught to the patient and the patient's specific level of understanding of the aforementioned health teachings.</p> <p>12. Review of Patient #21's medical record on July 31, 2013, at approximately 3:55 p.m., revealed a NVN dated June 24, 2013. The document indicated the patient was instructed on the importance of exercise. The nurse documented that the patient stated understanding of the teaching. The nurse however, failed to document any specific aspects of the rational for the patient to exercise and the patient's specific level of understanding of the aforementioned health teaching.</p> <p>13. Review of Patient #22's medical record on July 31, 2013, at approximately 4:15 p.m., revealed a NVN dated June 12, 2013. The document indicated the patient and HHA were instructed on clearing a pathway and removing small objects and rugs to prevent falling. Further</p>	H 459	See previous page.	
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H 459	<p>Continued From page 36</p> <p>review revealed that the patient was instructed to follow doctors appointments. The nurse documented that the patient and HHA verbalized understanding. The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>14. Review of Patient #24's medical record on July 31, 2013, at approximately 4:15 p.m., revealed a NVN dated June 14, 2013. The document indicated that the patient complained of pain in the extremities and was instructed to schedule an appointment with the physician. Further review revealed the patient was instructed on using pain relievers and rest. The nurse documented that the patient verbalized understanding. The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>15. Review of Patient #25's medical record on July 31, 2013, at approximately 4:35 p.m., revealed a NVN dated July 15, 2013. The document indicated that the nurse instructed the patient to continue to take medications as ordered and on time. The nurse documented that the patient verbalized understanding. The nurse however, failed to document the specific aspects of the aforementioned medication training taught to the patient and the patient's specific level of understanding of the aforementioned health teaching.</p> <p>16. Review of Patient #50's medical record on July 31, 2013, at approximately 5:35 p.m., revealed a NVN dated July 20, 2013. The document indicated that the patient has edema in the lower extremities and that the nurse</p>	H 459	See previous page.	
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H 459	<p>Continued From page 37</p> <p>instructed the patient to elevate their legs when sitting and to wear TED stockings (anti-embolism stockings) when going out the house. The nurse documented that the patient verbalized understanding. The nurse however, failed to document the patient's specific level of understanding of the aforementioned health teachings.</p> <p>During a face to face interview with the director of nursing (DON) on August 1, 2013, at approximately 5:30 p.m., it was acknowledged there was no documented evidence that the agency's nursing staff ensured specific training and/or that the evaluation of the training had been completed as prescribed for the aforementioned patient's. Further interview revealed that the nursing staff would be re-trained on how to accurately document training and/or the evaluation of the training in the patient's medical records.</p> <p>17. On July 31, 2013, at approximately 5:30 p.m., a review of Patient #31's record revealed monthly skilled nursing notes dated from January 17, 2013 through June 12, 2013, in which the nurse documented teaching was provided on physiology/disease process, diet and safety factors. However, there was no documented evidence of the evaluation of the teaching provided on the specific areas of physiology/disease process, diet and safety factors.</p> <p>18. On August 1, 2013, at approximately 10:30 a.m., a review of Patient #40's record revealed monthly skilled nursing notes dated from February 4, 2013 through July 8, 2013, in which the nurse documented teaching was provided on</p>	H 459	See previous page.	

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H 459	<p>Continued From page 38</p> <p>physiology/disease process, diet and safety factors. However, there was no documented evidence of the evaluation of the teaching provided on the specific areas of physiology/disease process, diet and safety factors.</p> <p>During an interview with the DON and the assistant director of nursing (ADON) on August 1, 2013, at approximately 2:45 p.m., it was revealed that the skilled nurses do not document understanding of specific teaching but they do document "verbalized understanding" as a general statement for all teaching provided.</p>	H 459	See previous page.	
H 999	<p>FINAL OBSERVATIONS</p> <p>The following allegation was made during the survey process. Although the allegation could not be substantiated, it is recommended that this area be reviewed and a determination be made regarding appropriate actions to prevent a reoccurrence.</p> <p>On August 1, 2013, at approximately 9:45 a.m., a review of Patient #37's record revealed a plan of care (POC) with a documented certification period from December 27, 2012 through July 26, 2013, ordered skilled nursing services one time monthly for assessment of all systems and supervision of personal care aide.</p> <p>Further review of the record revealed monthly skilled nursing notes. The last note was dated April 6, 2013. All nursing notes included vital sign assessments and were signed by a male nurse. It should be noted, except for the Medicaid recertification nursing assessment, the monthly nursing notes were not signed by the patient.</p>	H 999	<p>Patient #37 was admitted to the agency on 12/28/11 for personal care services with diagnoses of Schizo-affective Disorder, Depressive Disorder, Spasm of Muscle, Post Traumatic Stress Disorder, and Abdominal Pain of the Left Lower Quadrant, Obesity, Back Ache and Leg Pain.</p> <p>The patient care assistance (PCA) services were provided to patient #37 and nursing supervisory monthly visits were completed according to the plan of care.</p> <p>The agency did not receive any complaints of service irregularities by patient #37.</p>	

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H 999	<p>Continued From page 39</p> <p>During a telephone interview with Patient #37 on August 21, 2013, at approximately 2:30 p.m., the patient indicated, the skilled nurse never visited her since she moved in October 2012. She was asked to explain her signature on the Medicaid recertification nursing assessment, dated January 7, 2013. She stated that on occasions she accompanied her home health aide to the agency to pick-up time sheets. At that time, while sitting in the car, the male nurse would have her to sign papers and would ask her how she felt. The patient stated emphatically that there was no home visits by the male nurse and at no time was her vital signs assessed by the male nurse.</p> <p>The male nurse was interviewed on August 23, 2013 to ascertain the date of the last home visit. The nurse stated that the last home visit to the patient was in April 2013. He stated that there was attempts to visit the patient in May and June, but he was unsuccessful. He was also asked if he had contact with the patient at the agency or while the patient was in a car. He state no. He noted that the patient was discharged in May 2013 for not allowng home health aides into her home.</p> <p>The allegation of no home visits by the nurse from October 2013 to April 2013 could not be substantiated.</p>	H 999	See previous page.	
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ABDALLAH KITWAKA
~~SA [Signature]~~ 09/06/2013