Health Reaulat1on & Licensma Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0062	A. BUILDING: _____ B. WING _____	11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING UNLIMITED SERVICES	5140 NANNIE HELEN BURROUGH AVENUE, NE 1ST FLC WASHINGTON, DC 20019

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H 000	INITIAL COMMENTS An annual survey was conducted from October 28, 2013, through November 6, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to two hundred eighty-eight (288) patients and employs two hundred eighty-six (286) staff to include licensed nurses, home health aides, physical therapists, an occupational therapist and other administrative staff. The findings of the survey were based on a review of fifteen (15) current patients' records, five (5) discharged patients' records, twenty (20) personnel files, three (3) home visits and seventeen (17) telephone interviews with current patients. Please Note: Listed below are abbreviations used in this report. Home Care Agency (HCA) Home Health Aide (HHA) Every Day (QD) Plan of Care (POC)	H 000	Received 11/25/13 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities 899 North Capitol St. N.E. Washington, D.C. 20002	
H 260	3911.1 CLINICAL RECORDS Each home care agency shall establish and maintain a complete, accurate, and permanent clinical record of the services provided to each patient in accordance with this section and accepted professional standards and practices. This ELEMENT is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to maintain	H 260		

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H 260	Continued From page 1 accurate clinical records for one of twenty patients on the sample. (Patient #1) The finding includes: On October 28, 2013, at approximately 11:00 a.m., a review of Patient #1's record revealed a POC with certification period from September 29, 2013 to November 27, 2013. The POC documented that the patient had a diagnosis of paraplegia. Further review of the document, revealed skilled nursing notes dated October 2nd and 5th, 2013 in which the nurse documented the patient had an unsteady gait. During an interview with the clinical director on October 28, 2013, at approximately 11:30 a.m., the clinical director stated, "The nurse should have not documented the patient has an unsteady gait because the patient is non-ambulatory due to paraplegia. I will speak with the nurse."	H 260	H260 All notes for patient #1 have been corrected to reflect the appropriate diagnosis. All Nurses received an in-service on proper documentation of patients' diagnosis on the weekly nurse visit notes. To prevent such deficient practice from affecting all patients, Clinical Director/Assistant will review all nurses' notes weekly and PRN for appropriate documentation. All nurses notes not filled out appropriately will be returned to the designated nurse for correction. Clinical Director/Assistant/Office RN will QA 10% of all patients records monthly and will document all findings. Designated disciplines will be made aware of the findings for correction. Repeated wrong documentation by a nurse will result in suspension of the RN, reassignment of the patient to another RN and or termination of the RN from Nursing Unlimited Services, Inc. **See Attachment #1**	11/18/13-On-going
H 363	3914.3(1) PATIENT PLAN OF CARE The plan of care shall include the following: (I) Identification of employees in charge of managing emergency situations; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to identify personnel in charge of managing emergencies for four of twenty patients in the sample. (Patients #6 ,#9, #18 and #20)	H 363		

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H 363	Continued From page 2 The findings include: 1. On October 29, 2013, at approximately 10:00 a.m., review of Patient #6's record revealed a POC with certification period of August 23, 2013 to October 21, 2013, that failed to identify personnel in charge of emergencies. 2. On October 29, 2013, at approximately 11:00 a.m., review of Patient #9's record revealed a POC with certification period of August 26, 2013 to October 26, 2013, that failed to identify personnel in charge of emergencies. 3. On October 30, 2013, at approximately 11:00 a.m., review of Patient #18's record revealed a POC with certification period of August 26, 2013 to March 24, 2014, that failed to identify personnel in charge of emergencies. **4.** On October 30, 2013, at approximately 11:30 a.m., review of Patient #20's record revealed a POC with certification period of October 4, 2013 to April 1, 2014, that failed to identify personnel in charge of emergencies. During an interview with the deputy clinical director, on October 30, 2013, at approximately 11:55 a.m., the clinical director stated, " The POC's you looked at are old POC's that do not have the personnel who is in charge of emergencies on them but I will make sure to use our new POC's that have that information."	H 363	H363 Patient #6, # 9, #18, and #20 record has been updated post survey to reflect identification of the personnel in charge of emergencies to include dialing 911 in case of an emergency and to notify the designated supervising RN of all emergencies, personnel in charge of emergencies to also notify RN when patient runs out of medications for follow up with the Physician and or other family members or obtaining other community resources for assistance. To prevent this deficient practice from affecting all other patients, Clinical Director/Assistant will review all admission documents submitted to the office by the admitting disciplines for persons involved in emergent situations and or support person in the event that there is a health emergency and other preventive protocols. All persons/phone numbers identified in the admission package will be transposed to the plan of care and PCAs/patients/caregivers will be instructed on the emergency protocol. Clinical Director/Assistant/Office RN will QA 10% of all patients' records monthly for completeness of all documents and updates, all findings will be documented and forwarded to the Director of nursing for disciplinary action and for presentation in the PAC meeting for additional interventions to prevent such deficient practice from recurring. **See Attachment #2**	11/18/13-Ongoing
H 364	3914.3(m) PATIENT PLAN OF CARE	H 364		

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H 364	Continued From page 3 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 HCA failed to ensure that the POC included an emergency protocol for two of twenty patients in the sample. (Patients #6 and #9) The findings include: 1. On October 29, 2013, at approximately 10:00 a.m., review of Patient #6's record revealed a POC with certification period of August 23, 2013 to October 21, 2013, that failed to identify an emergency protocol. 2. On October 29, 2013, at approximately 11:00 a.m., review of Patient #9's record revealed a POC with certification period of August 28, 2013 to October 26, 2013, that failed to identify an emergency protocol. During an interview with the deputy clinical director, on October 30, 2013, at approximately 11:42 a.m., the clinical director stated, The POC's you looked at are old POC's that did not include our emergency protocol on them but I will make sure to use our new POC's that have that information."	H 364	H364 Patient # 6 and #9 records has been updated post survey to reflect identification of the personnel in charge of emergencies to include dialing 911 in case of an emergency and to notify the designated supervising RN of all emergencies, personnel in charge of emergencies to also notify RN when patient runs out of medications for follow up with the Physician and or other family members or obtaining other community resources for assistance. To prevent this deficient practice from affecting all other patients, Clinical Director/Assistant will review all admission documents submitted to the office by the admitting disciplines for persons involved in emergent situations and or support person in the event that there is a health emergency and other preventive protocols. All persons/phone numbers identified in the admission package will be transposed to the plan of care and PCAs/patients/caregivers will be instructed on the emergency protocol. Clinical Director/Assistant/Office RN will QA 10% of all patients' records monthly for completeness of all documents and updates, all findings will be documented and forwarded to the Director of nursing for disciplinary action and for presentation in the PAC meeting for additional interventions to prevent such deficient practice from recurring. **See Attachment #2, (Patient #6 and #9)**	11/18/13-On-going
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following:	H 453		

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H 453	Continued From page 4 (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA's nurse failed to ensure that patients needs were met in accordance with their POC, for four of twenty patients in the sample. (Patients #4, #5, #18 and #20) The findings includes: 1. On October 28, 2013, at approximately 2:10 p.m., review of Patient #4's record revealed a POC with certification period of August 1, 2013 to September 29, 2013. The POC reflected that the skilled nurse was to visit the patient seven (7) days a week for two (2) months to "cleanse left buttocks wound with normal saline, pat dry and apply Iodoform, cover with 4 x 4 and abd pad and secure with tape and measure wound weekly....." The record revealed daily nursing notes from August 1, 2013 to August 14, 2013 and from August 20, 2013 to September 27, 2013, in which the nurse documented the following "sacral wound cleaned with normal saline, packed with Dankin, applied a wet to dry dressing, cover with an abd pad and secured with tape." Further review of the record, failed to evidence the wound was measured during the week of August 18 th and the week of September 15th, 2013. During an interview with the owner on October 28, 2013, at approximately 1:00 p.m., it was revealed that the nurse used sacral and right buttocks interchangeably. The owner stated, "	H453	H453.1 Patient #4 has been changed post survey to reflect current wound care being provided for the patient All nurses received an in-service on wound documentation to reflect the type of wound, 3 dimensional wound measurement, accurate anatomical description of wound and to submit any verbal order changes in wound care to the office which will be faxed to the primary physician for signature. All signed orders will be made a part of the patient's permanent record. To prevent this deficient practice from recurring, the Clinical Director/Assistant will have monthly case conferences with all skilled nurses and will document all identified issues/problems and will follow up with resolution of all problems. Clinical Director/Assistant will review all skilled nursing notes weekly and will return all incomplete/inappropriately documented patient's care to the nurse for correction and all corrections will be returned back to the clinical office no later than 24hours after receipt of the incorrect document. Clinical Director/Assistant/Office RN will QA 10% of all skilled patients records for proper documentation and follow up of any physician orders. Clinical Director/Assistant will forward all findings to the Director of nursing for follow up at the quarterly PAC meeting for further intervention of identified problems. **See Attachment # 3**	11/18/13-On-going

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H 453	Continued From page 5 The nurse documented the wound was packed with Dankin and applied a wet to dry dressing but the order says the wound is to be packed with Iodoform and does not order a wet to dry dressing. I will check to see if the order had been changed and I will also check for the missing wound measurements notes." tt should be noted on October 29, 2013, the agency's deputy director gave the surveyor a physician order for wound care dated September 2, 2013 . However, the order was for the right leg and not the sacral area. 2. On October 28, 2013, at approximately 2:50 p.m., a review of Patient #5's record revealed a POC with certification period September 9, 2013 to November 7, 2013. The POC reflected that the skilled nurse was to visit the patient QD for nine weeks to provide wound care to right ankle. The record failed evidence that the nurse visited the patient on October 4th, 5th and 9th, 2013. On October 28, 2013, at approximately 3:00p.m., the owner stated, " I will look for the missing nurse notes." At the time of this survey exit, the owner failed to make the nursing notes available for review. 3. On October 30, 2013, at approximately 10:50 a.m., a review of Patient #18's record revealed a POC with certification period August 26, 2013 to March 24, 2014. The POC reflected that the skilled nurse was to visit with the patient one to two times a month for twenty-four weeks and the home health aide services were to be provided twelve hours a day, seven days a week for twenty-four weeks.	H 453	H453.2 Missing notes for patient #5 were filed in the wrong section of the patient's permanent record. All notes have been filed in the appropriate section post survey. All clerical staff received an in-service in the filing system abiding by the tabbing system of all patients records. To prevent this deficient practice from recurring, Clinical clerical personnel will file all documents in the appropriate section following the tabs and weekly filing should be initialed by the staff who is filling those documents/records. Clinical Director/Assistant/office RN will QA 10% of all patients records monthly, all inappropriate filing or missing notes will be documented for investigation. The filing clerk with the erroneous mistakes will be counseled and if this staff persistently make the same mistake, such staff will be terminated from the agency. **See Attachment #4** H453.3 Missing Visit note have been placed in Patient #18 permanent record, in addition to this a physician order has been obtained for the missed visits and has been placed in the patient's permanent record. To prevent such deficient practice from recurring all clinical staff received an in-service on the importance of missed visit forms and the on-hold forms.	11/15/13-On-going 11/15/13 On-going

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H 453	Continued From page 6 Further review of the record, failed to evidence the skilled nurse visited Patient #18 in September 2013. Additionally, HHA times sheets revealed the following: a). On September 12th, 23 rd, 26th and 27 th 2013, five hours of HHA services were provided; b). On September 9, 2013, eight hours of HHA services were provided ; and c). On October 3, 2013, seven hours of HHA services were provided. 4. On October30, 2013, at approximately 11:36 a.m., a review of Patient #20's record revealed a POC with certification period October 4, 2013 to April1, 2014. The POC reflected that the home health aide services were to be provided eight hours a day, seven days a week for six months. The record however, failed to evidence HHA services were provided from October 5th through 12th 2013. During an interview with the deputy clinical director on October 30, 2013, at approximately 1:10 p.m., the deputy clinical director stated, "I will check for the missing nursing note and HHA time sheets and fax them to you on October 31, 2013." It should be noted at the time of this survey the surveyor did not receive the missing documents.	H 453	The Clinical Director/Assistant/Office RN and designated clinical clerical staff will QA 10% of all patients records and will document all findings which will be forwarded to the Director of Nursing for presentation in the Quarterly PAC meeting for intervention for resolution of problem. **See Attachment #5** H453.4 Missing HHA timesheet for patient #20 from October 5th through the 12th have since been filed in the patient's permanent record. To prevent this deficient practice from affecting all patients all clinical clerical staff received an in-service on the importance of filing the right patient's notes in the right patient's permanent record. The Clinical Director will review 10% of all patients' records monthly and will document any abnormal findings, the clerical staff identified during this review process will receive counseling but after repeated errors, the staff will be terminated from the agency. All reports of abnormal findings will be forwarded to the Director of Nursing for further action and intervention. **See Attachment # 6**	11/15/13-On-going