



GOVERNMENT OF
THE DISTRICT OF
COLUMBIA

CRFMR
Rev. 9/02

**DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:		Street Address, City, State, Zip Code:		Compliant Investigation Date:
TRISTATE HOME HEALTH AGENCY		6210 - A Chillium Place NW Washington, DC 20011		April 16-20, 2009
				Follow-up Dates(s):
Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
Title 22 Chapter 39	<p>The Health Regulation Licensing Administration (HRLA) received a request on April 14, 2009 via e-mail, from the Program Analyst Office of the City Administrator to investigate a complaint from a constituent, Caregiver #1. Caregiver #1 alleged that his mother, Patient #1 sustained a fall while under the care of a Home Health Aide (HHA) who was employed by the agency.</p> <p>Based on the above allegation, an investigation was initiated on April 14, 2009. Findings of the investigation substantiated that Patient #1 did fall. Also identified in this report are deficiencies that are incidental to the complainant's allegation.</p>		<p>6/1/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	

Name of Inspector

5/7/09

Date Issued

Facility Director/Designee

5/26/09

Date



GOVERNMENT OF
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**DEPARTMENT OF HEALTH
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3911. 2</p>	<p style="text-align: center;">3911 <u>CLINICAL RECORDS</u></p> <p>Each clinical record shall include the following information related to the patient:</p> <p>(k) Discharge summary, including the reason for termination of services and the effective date of discharge;</p> <p>Based on interview and record review, the agency failed to ensure documentation of the discharge summary, including the reason for termination of services and the effective date of discharge for one of one patient in the investigation. (Patient #1)</p> <p>The finding include:</p> <p>Interview with the Director of Nursing (DON) and the Director of Operations (DOO) on April 14, 2009 at approximately 3:54 PM revealed Caregiver #1 chose to use another home health care agency after Patient #1 was discharged from George Washington University Hospital (GWUH) on February 27, 2009. Further interview revealed Patient #1 was discharged from the agency,</p>		<p>Discharge of the patient from this agency was a decision taken by the patient and son following discharge from the hospital. A discharge OASIS was done on the patient following the discharge from the agency and was in the computer system. See attachment 1.</p>	<p>5/22/09</p>
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>however Home Health Aide (HHA) services were provided for a period of time until the new agency could provide services for Patient #1.</p> <p>Interview with Patient # 1 and Caregiver #1 on April 20, 2009, at approximately 8:30AM revealed they chose to use another home health care company after Patient #1 was discharged from GWUH on February 27, 2009.</p> <p>Review of Patient #1's clinical records on April 28, 2009, at approximately 7:08 PM revealed HHA timesheets dated March 2, 2009 through March 8, 2009, that were contracted from the agency.</p> <p>There was no documented evidence of the discharge summary, including the reason for termination of services and the effective date of discharge.</p> <p>(n) Type of medical equipment used by the patient;</p> <p>Based on interview and record review, the agency failed to document the type of medical equipment used for oxygen therapy by one of one patient in the investigation. (Patient #1)</p> <p>The finding includes:</p>			
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>During a home visit on April 20, 2009, at approximately 9:20 AM, Patient #1 was observed sitting in a wheelchair administering oxygen from an in-home oxygen tank via nasal cannula.</p> <p>Interview with Patient # 1 on April 20, 2009, at approximately 9:22 AM revealed Patient #1 self administers two liters of oxygen via nasal cannula when she becomes short of breath.</p> <p>Review of Patient #1's Home Health Certification and Plan of Care (POC) dated January 03, 2009 to March 3, 2009 on April 21, 2009 at approximately 9:10AM revealed Patient #1 had diagnoses that included Congestive Heart Failure(CHF) NOS hypertension and Diabetes Mellitus Type Two. Further review revealed safety measures included oxygen precautions.</p> <p>Review of physician's verbal orders dated January 3, 2009 and February 2, 2009, on April 24, 2009, at approximately 3:45 PM revealed no evidence of the type of oxygen equipment Patient #1 was ordered to use for oxygen therapy.</p> <p>Review of Patient #1's Home Health/ Home Care Aide Assignment Sheet dated January 3, 2009, on April 28, 2009, at approximately 3:48 PM revealed that the entry</p>		<p>This agency agrees with the findings of the surveyor. The admitting nurse indicated the patient's oxygen use on the Start of Care OASIS (Attachment 2) but failed to include it on the medication profile. An in-service will be held on 5/22/09 with all nurses to instruct them on the importance of listing all treatments a patient may be taking in the home. And the type of equipment used.</p>	<p>5/22/09</p>
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>for special equipment was blank.</p> <p>Review of Patient #1's Patient Profile document dated April 15, 2009, on April 28, 2009, at approximately 3:50 PM revealed the entry under general notes did not document the type of medical equipment Patient #1 was using in her home.</p> <p>There was no documented evidence in the clinical record of the type of medical equipment Patient #1 was using for oxygen therapy.</p> <p>(p) Results of diagnostic services;</p> <p>Based on interview and record review, the agency failed to ensure the results of diagnostic services for one of one patient in the investigation. (Patient #1)</p> <p>The finding includes:</p> <p>Interview with Registered Nurse (RN) #2 on April 15, 2009, at approximately 2:01 PM revealed RN #2 attempted three times unsuccessfully to draw Patient #1's blood on January 29, 2009.</p> <p>Review of RN #2's skilled nursing notes dated January 29, 2009, on April 28, 2009, at approximately 7:20 PM</p>			
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>confirmed RN #2 attempted three times unsuccessfully to draw Patient #1's blood.</p> <p>Review of RN #2's skilled nursing note dated February 2, 2009, on April 28, 2009, at approximately 7:30 PM revealed RN #2's was able to draw Patient #1's blood as ordered by the physician.</p> <p>Review of Patient # 1's physician's verbal orders dated January 23, 2009 on April 28, 2009 at approximately 7:40 PM revealed an order to draw blood for a lipid panel.</p> <p>Review of Patient # 1's laboratory studies dated January 30, 2009 on April 28, 2009 at approximately 7:45 PM revealed no documented evidence that a lipid panel had been performed.</p> <p>(q) Communications between the agency and all health care professionals involved in the patient's care;</p> <p>Based on interview and record review, the agency failed to ensure communications between the agency and all health care professionals involved in the patient's care was documented for one of one patient in the investigation. (Patient #1)</p>		<p>The verbal order that listed the lipid profile was transferred to the Laboratory request slip. Unfortunately the Lab. Did not perform the test and the results were sent to the physician and not to this agency. This agency never received a request from the physician for a repeat test for lipid profile and as a result the test was not done. An In-service will be held with all nurses on 5/22/09 instructing them on the importance of following up with the lab. And reviewing all lab results when received at this office.</p>	<p>5/22/09</p>
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>The findings include:</p> <p>1. Review of Patient # 1's Home Health Certification and Plan of Care (POC) dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:15 PM revealed the Primary Care Physician (PCP) orders included Home Health Aide (HHA) services 8 hours per day; 5 days per week for 9 weeks. The HHA duties included notifying the home health agency of any patient observed or reported falls. Further review revealed Patient #1's activities permitted the use of a wheelchair for mobility.</p> <p>Review of a compliant dated April 13, 2009 on April 14, 2009 at approximately 10:50 AM revealed Caregiver #1 alleged his mother; Patient #1 recently sustained a fall (date not stated) while under the care of a HHA who was employed by the agency.</p> <p>Interview with HHA #1 on April 15, 2009 at approximately 1:20 PM, revealed Patient #1 fell out of her wheelchair (date unknown) while she was in Patient #1's bedroom folding laundry. Further interview revealed that HHA #1 did not call the home health agency to inform the administrators of the fall.</p>			
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>Interview with Registered Nurse #2 (RN #2) on April 15, 2009 at approximately 2:01 PM revealed RN #2 received a call (date unknown) at approximately 3:50 PM, from HHA #1 who stated that Patient #1 had fallen. Further interview revealed RN #2 asked HHA #1 to remain in Patient #1's home until RN #2 arrived. However, RN #2 revealed that HHA #1 stated that she had to leave and go home. RN #2 indicated that he was unable to gain entrance into Patient #1's home because HHA #1 had left the home. RN #2 revealed that he returned to the home health agency.</p> <p>Interview with Patient #1 on April 20, 2009 at approximately 8:25 AM revealed Patient #1 fell half way out of her wheelchair onto the living room (sometime in February 2009) in an attempt to go to the bathroom while HHA #1 was out of the home on her lunch break. Patient #1 revealed she fell on her left side, hit the left side of her head on the wall and that the wheelchair fell across her left leg. Patient #1 revealed that she did not look at a clock or watch but estimated HHA #1 returned to the home approximately ½ hour later. Further interview revealed Patient #1 denied to HHA #1 that she was injured when HHA #1 assisted her back into her wheelchair. However after HHA #1 left, Patient #1's home at approximately 4:00 PM, Patient #1 stated that</p>			
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>she began to “ache on her left side and felt like she had bumped her head,” and called 911. Patient #1 further stated she was surprised that HHA #1 did not call the home health care agency to inform them that she had fallen out of her wheelchair.</p> <p>In an interview with the Director of Nursing (DON) and the Director of Operations (DOO) on April 14, 2009 at approximately 3:50 PM it was acknowledged the agency was not informed by HHA #1 or RN #2, Patient #1 had fallen out of her wheelchair. Further interview revealed that HHA #1 was suspended without pay for one week and re-trained on safety precautions.</p> <p>Review of the District of Columbia Fire and Emergency Medical Services Department (EMS) Report dated February 26, 2009 on April 23, 2009 at approximately 10:00 AM, revealed that paramedics responded to Patient #1’s home at 4:31 PM. Further review revealed Patient #1 complained of “left hip pain after falling part of the way out of her wheelchair.” Patient #1 was transported to George Washington University Hospital (GWUH) Emergency Department where she was evaluated and treated.</p> <p>Review of Patient # 1’s clinical records on April 23, 2009 at approximately 6:13 PM revealed no documented</p>		<p>Interview with the home health aide following the incident revealed that the patient did not fall out of the chair but tilted to the left side instead. Further interview with the HHA revealed that the patient stated that she was not hurt during the incident and the aide did not call the agency. The aide was counseled regarding the agency’s policy on the need to report all incidents to the agency and disciplinary action was taken to include an in-service on patient safety on March 20, 2009.</p>	<p>3/20/09</p>
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>evidence RN #2 communicated with the home health agency that Patient #1 had allegedly sustained a fall in her home.</p> <p>2. Review of a compliant dated April 13, 2009 on April 14, 2009 at approximately 10:50 AM revealed Caregiver #1 alleged his mother, Patient #1 recently sustained a fall (date not stated) while under the care of a Home Health Aide (HHA) who was employed by the agency.</p> <p>Interview with the DON on April 14, 2009 at approximately 3:32 PM revealed the agency did not communicate with the Primary Care Physician (PCP) that Patient #1 fell from her wheelchair on February 26, 2009.</p> <p>Interview with the PCP on April 20, 2009 at approximately 1:30 PM, revealed the home health agency had not informed the PCP, Patient #1 had fallen from her wheelchair on February 26, 2009.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:25 PM, revealed no documented evidence the home health agency communicated to the PCP that Patient #1 had fallen in her home from her wheelchair.</p> <p>3. Interview with the PCP on April 20, 2009 at</p>			
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>approximately 1:32 PM, revealed the home health agency had not informed him that Patient # 1 was transported by EMS to the GWUH Emergency Department on February 26, 2009 after a fall. Further interview revealed the PCP was not aware Patient #1 had been admitted to GWUH on February 27, 2009.</p> <p>In an interview with the DON on April 14, 2009 at approximately 3:32PM, it was acknowledged the agency did not communicate with the PCP that Patient #1 had fallen from her wheelchair and was transported by EMS to the GWUH Emergency Department on February 26, 2009 and subsequently admitted on February 27, 2009.</p> <p>Review of the EMS Report dated February 26, 2009 on April 23, 2009 at approximately 10:00 AM, revealed that paramedics responded to Patient #1's home at 4:31 PM. Further review revealed Patient #1 complained of "left hip pain after falling part of the way out of her wheelchair." Patient #1 was transported to GWUH Emergency Department where she was evaluated and treated.</p> <p>Review of Patient #1's hospital medical record dated February 27, 2009 on April 23, 2009, at approximately 12:30 PM, revealed Patient #1 was admitted on February 27, 2009 at 1:00 AM with diagnoses of shortness of</p>	<p>This agency was not aware of the patient falling and was sent to the ER by the caregiver and did not inform the PCP based on that lack of knowledge. An in-service will be held informing all nurses of the need to inform the PCP of any such incident as soon as the agency becomes aware of such incident.</p>	<p>5/22/09</p>
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**DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

Launch Microsoft Office Outlook.Ink

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>breath and lower leg edema.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:13 PM revealed no documented evidence that the home health agency communicated to the PCP that Patient #1 was transported by EMS to the GWUH Emergency Department on February 26, 2009, and subsequently admitted on February 27, 2009.</p> <p>4. Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009, on April 14, 2009 at approximately 4:15 PM revealed Patient # 1 had an order for physical therapy evaluation and treatment. Interview with the Physical Therapist on April 15, 2009, at approximately 1:45 PM revealed that the Physical Therapist had communicated to the agency via telephone (date unknown) that Caregiver #1 refused to allow the Physical Therapist to come to Patient #1's home to perform a physical therapy evaluation. Further interview revealed the Physical Therapist did not document in the clinical record Caregiver #1's refusal to allow the Physical Therapist to come to Patient #1's home to perform a physical therapy evaluation.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:03 PM revealed no documented evidence Patient #1 had received a physical therapy</p>	<p>The physical therapy referral was sent to the contracting physical therapist who, when interviewed, stated that the caregiver refused the services of the physical therapist. This was not communicated to this office and the physician was not notified. An in-service was held with the physical therapist who was instructed on the importance of informing this office and the PCP of any such incident.</p>	<p>5/22/09</p>
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**DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>evaluation.</p> <p>There was no evidence in the clinical record the Physical Therapist involved in the patient's care communicated with the agency that Patient #1 had not received a physical therapy evaluation and treatment according to the POC.</p> <p>5. Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009, on April 14, 2009 at approximately 4:15 PM revealed Patient # 1 had an order for occupational therapy evaluation and treatment.</p> <p>Interview with the DOO on April 15, 2009, at approximately 3:45 PM revealed if the Physical Therapist recommended Patient #1 for occupational therapy services, a referral would be made to the occupational therapist.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:03 PM revealed no documented evidence Patient #1 had received an occupational therapy evaluation. There was no evidence the Physical Therapist communicated to the home health agency that Patient #1 had not received a referral for an occupational therapy</p>		<p>It is the practice that after the physical therapist conducts their evaluation the need for occupational therapy is established. Because the physical therapist could not see the patient due to the caregiver's denial of the service, occupational therapy could not be provided. An in-service will be conducted on 5/22/09 to instruct clinical staff on the need to inform the physician on the change in the plan of treatment and/or obtain a verbal order to cancel the service.</p>	<p>5/22/09</p>
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**DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>evaluation and/or treatment according to the POC.</p> <p>6. Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:15 PM revealed Patient # 1 had an order for physical therapy evaluation and treatment.</p> <p>Interview with the PCP on April 20, 2009 at approximately 1:30 PM revealed that the Home Health Care Agency had not communicated with the PCP that Patient #1 had not received a physical therapy evaluation and/or treatment as ordered.</p> <p>Interview with the Physical Therapist on April 15, 2009, at approximately 1:47 PM revealed that the Physical Therapist had not communicated to the PCP that Patient #1 had not received a physical therapy evaluation and/or treatment according to the POC.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:03 PM revealed no documented evidence the home health agency communicated with the PCP that Patient #1 had not received a physical therapy evaluation and/or treatment according to the POC.</p>		<p>See Previous Plan of Correction for #5.</p>	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>7. Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:15 PM revealed Patient # 1 had an order for an occupational therapy evaluation and treatment.</p> <p>Interview with the PCP on April 20, 2009 at approximately 1:30 PM revealed the home health agency had not communicated with him that Patient #1 had not received an occupational therapy evaluation and/or treatment as ordered.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:03 PM revealed no documented evidence the home health agency had communicated to the PCP that Patient #1 had not received an occupational therapy evaluation and/or treatment as ordered.</p> <p>(s) Documentation of training and education given to the patient and the patient's caregivers.</p> <p>Based on interview and record review, the agency failed to ensure documentation of training and education given to the patient and the patient's caregivers for one of one patient in the investigation. (Patient #1)</p>		<p>See Plan of Correction for #5</p>	
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**DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>The findings include:</p> <p>1. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 15, 2009, 2009 at approximately 3:30 PM revealed Patient #1 had diagnoses that included Congestive Heart Failure (CHF), Hypertension and Diabetes Mellitus Type II without complications. Further review revealed Patient #1 was to be instructed on her 2 GM/1500 calorie American Diabetic Association (ADA) diet.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 9:35 AM revealed Patient # 1 and Caregiver #1 was not given instruction on Patient #1's prescribed 2 GM/ 1500 calorie ADA diet.</p> <p>Review of Patient # 1's skilled nursing visit note dated January 21, 2009, on April 24, 2009, at approximately 10:40 AM revealed Patient #1 was instructed to consume a low salt diet, to read all food labels and watch out for words such as "salt or sodium", to avoid foods high in sodium including ham, hot dogs, bacon and chips. Further review revealed no documentation of training and</p>		<p>Patient and caregiver were instructed on low sodium diet per nurses' notes. Patient was discharged from agency early in the episode; therefore, instructions could not be completed. However, in-service on 5/22/09 included emphasis on documentation including medication teaching whenever performed.</p>	<p>5/22/09</p>
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**DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>education given to Patient #1 and Caregiver #1 related to Patient #1's 2 GM/1500 calorie ADA diet.</p> <p>There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the patient's 2 GM/1500 calorie ADA diet.</p> <p>2. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009, on April 15, 2009, 2009 at approximately 3:32 PM revealed Patient #1 had diagnoses that included Congestive Heart Failure (CHF), Hypertension and Diabetes Mellitus Type II without complications. Further review revealed Patient #1 was to be instructed on her hydration needs.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 9:36 AM revealed Patient # 1 and Caregiver #1 was not given instruction on Patient #1's hydration needs.</p> <p>Review of Patient # 1's skilled nursing visit notes dated January 9, 2009 to February 11, 2009, on</p>			
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>April 24, 2009, at approximately 10:43 AM revealed no documentation of training and education given to Patient #1 and Caregiver #1 related to Patient #1's hydration needs.</p> <p>There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the patient's hydration needs.</p> <p>3. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009, on April 15, 2009, 2009 at approximately 3:33 PM revealed Patient #1 had diagnoses that included Congestive Heart Failure (CHF), Hypertension and Diabetes Mellitus Type II without complications. Further review revealed Patient #1 was to be instructed on her exercise needs.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 9:37 AM revealed Patient # 1 and Caregiver #1 was not given instruction on Patient #1's exercise needs.</p> <p>Review of Patient # 1's skilled nursing visit notes dated January 9, 2009 to February 11, 2009, on</p>		<p>See previous statement on incomplete episode of care.</p>	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

Launch Microsoft Office Outlook.Ink

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>April 24, 2009, at approximately 10:44 AM revealed no documentation of training and education given to Patient #1 and Caregiver #1 related to Patient #1's exercise needs.</p> <p>There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the patient's exercise needs.</p> <p>4. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009, on April 24, 2009 at approximately 12:30 PM revealed Patient #1 was ordered Nitroglycerin Patch 0.4mg once a day every 12 hours for the management of angina.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 9:38 AM revealed Patient # 1 and Caregiver #1 was not given instruction on Patient #1's prescribed Nitroglycerin Patch 0.4mg.</p> <p>Review of Patient # 1's clinical nursing notes dated January 9, 2009 to February 11, 2009, on April 24, 2009 at approximately 12:40 PM did not reveal documentation of training and education given to the patient and the patient's caregivers on</p>	<p>See previous statement on incomplete episode of care.</p>	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the administration of Carvedilol 6.25 mg.</p> <p>6. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009, on April 24, 2009 at approximately 12:32 PM revealed Patient #1 was ordered Sertraline HCL (Zoloft) 50 mg every day every day for management of depression.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 9:40 AM revealed Patient # 1 and Caregiver #1 was not given instruction on Patient #1's prescribed Zoloft 50 mg tablet for the management of depression.</p> <p>Review of Patient # 1's clinical nursing notes dated January 9, 2009 to February 11, 2009, on April 24, 2009 at approximately 12:41 PM did not reveal documentation of training and education given to the patient and the patient's caregivers on Zoloft's dosage, frequency, and duration, route of administration, and side effects.</p>		<p>See previous statement on incomplete episode of care.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>There was no evidence in the clinical record documenting training and education given to the patient and the patient's caregivers on the administration of Zoloft 50 mg tablet.</p> <p>7. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009, on April 24, 2009 at approximately 12:32 PM revealed Patient #1 was ordered Nexium 40 mg every day for the management of gastritis.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 9:41 AM revealed Patient # 1 and Caregiver #1 was not given instruction on Patient #1's prescribed Nexium 40 mg.</p> <p>Review of Patient # 1's clinical nursing notes dated January 9, 2009 to February 11, 2009, on April 24, 2009 at approximately 12:41 PM did not reveal documentation of training and education given to the patient and the patient's caregivers Nexium's dosage, frequency, and duration, route of administration, and side effects.</p> <p>There was no evidence in the clinical record documenting training and education given to the</p>		<p>See previous statement on incomplete episode of care.</p>	
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3914.3</p>	<p>patient and the patient's caregivers on the administration of Nexium 40 mg.</p> <p style="text-align: center;">3914</p> <p style="text-align: center;"><u>PATIENT PLAN OF CARE</u></p> <p>The plan of care shall include the following:</p> <p>(d) A description of the services to be provided, including: equipment [*2891]</p> <p>Based on interview and record review, the agency failed to ensure a description of the type of medical equipment used for oxygen therapy on the plan of care for one of one patient in the investigation. (Patient #1)</p> <p>The finding include:</p> <p>During a home visit on April 20, 2009, at approximately 9:20 AM, Patient #1 was observed sitting in a wheelchair administering oxygen from an in-home oxygen tank via nasal cannula.</p>			
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INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>Interview with Patient # 1 on April 20, 2009, at approximately 9:22 AM revealed Patient #1 self administers two liters of oxygen via nasal cannula when she becomes short of breath.</p> <p>Review of Patient #1's Home Health Certification and Plan of Care (POC) dated January 03, 2009 to March 3, 2009 on April 21, 2009 at approximately 9:10AM revealed Patient #1 had diagnoses that included Congestive Heart Failure(CHF) NOS hypertension and Diabetes Mellitus Type II without complications. Further review revealed safety measures that included oxygen precautions.</p> <p>There was no documented evidence in the plan of care of the description of the equipment Patient #1 was using for oxygen therapy.</p> <p>(I) Identification of employees in charge of managing emergency situations;</p> <p>Based on interview and record review, the agency failed to ensure identification of employees in charge of managing emergency situations on the Home Health Certification and Plan of Care (POC) for one out of one patients in the investigation.</p>		<p>See Previous Plan of Correction on Oxygen order and documentation.</p>	
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

3915.11	<p>The finding includes:</p> <p>Review of Patient # 1's Home Health Certification and Plan of Care (POC) dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:18 PM revealed the identification of employees in charge of managing emergency situations was not documented.</p> <p>Interview with the DON on April 14, 2009 at approximately 4:30 PM revealed that the agency did not document the identification of employees in charge of managing emergency situations on the Home Health Certification and POC.</p> <p>There was no evidence that the agency documented the identification of employees in charge of managing emergency situations on the Home Health Certification and POC.</p> <p>(m) Emergency protocols</p> <p>Based on interview and record review, the agency failed to ensure emergency protocols were documented on the Home Health Certification and POC for one out of one patient in the investigation.</p> <p>The finding includes:</p>		<p>The Director of Nursing was instructed on 5/22/09 to include on the Plan of Treatment (485) "Identification of Employees in charge of managing emergency situations." This information is provided in the patient's handbook which is given to, and explained to patients/caregivers on admission.</p>	5/22/09
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3915.7</p>	<p>Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:19 PM revealed emergency protocols were not documented on the Home Health Certification and POC.</p> <p>Interview with the DON on April 14, 2009 at approximately 4:21 PM revealed that the agency did not document emergency protocols on the Home Health Certification and POC. Further interview revealed all safety measures were documented on the POC.</p> <p>There was no evidence that the agency documented emergency protocols on the Home Health Certification and POC.</p> <p style="text-align: center;">3915</p> <p style="text-align: center;"><u>HOME HEALTH AND PERSONAL CARE</u> <u>AIDE SERVICES</u></p> <p>Each home health or personal care aide shall be supervised by a registered nurse or other health professional for performing tasks specific to that profession. On-site supervision of skilled services shall</p>		<p>See 3419 (L).</p>	
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>take place at least once every two (2) weeks.</p> <p>Based on interview and record review, the agency failed to ensure the home health aide was supervised by a registered nurse and on-site supervision of skilled services took place at least once every two (2) weeks for one out of one patient in the sample.</p> <p>The finding includes:</p> <p>Interview with Home Health Aide (HHA) #1 on April 15, 2009 at approximately 1:30 PM revealed HHA #1 was assigned to care for Patient #1 on February 25, 2009 and was not given any supervision or instructions by a registered nurse regarding Patient #1's medical or nursing needs. Further interview revealed HHA #1 was not aware Patient #1 was on oxygen therapy or had Type II Diabetes.</p> <p>Interview with RN #2 on April 15, 2009, at approximately 2:00 PM revealed RN #2 provided skilled nursing services to Patient #1 three times. RN #2 acknowledged that he had not given HHA #1 any instructions on Patient #1's nursing needs.</p>			
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3915.8</p>	<p>Interview with RN #1 on April 15, 2009, at approximately 2:20 PM revealed RN #1 provided skilled nursing services for Patient #1 until she turned the case over to RN # 2 on February 11, 2009. Further interview revealed RN #1 had not supervised or given HHA #1 any instructions on Patient #1's nursing needs. However, RN #1 revealed that she had provided supervision for several of Patient #1's home health aides during the certification period.</p> <p>Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 15, 2009, 2009 at approximately 3:30 PM revealed Patient #1 was to receive services from a Home Health Care Aide (HHA) eight hours a day, five days a week for nine weeks.</p> <p>Review of Patient #1's Home Health Aide Supervisory Visit Form dated January 30, 2009 on April 29, 2009, at approximately 3:35 PM revealed HHA #2 was present in the home and following the plan of care.</p> <p>There was no documented evidence in the clinical record that the home health aides were supervised by a registered nurse on-site at least once every</p>		<p>Registered nurses were instructed on the importance of supervising the home health aides every two weeks during an in-service that was conducted on 5/22/09 (see attached sign in sheet)</p>	<p>5/22/09</p>
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>two weeks.</p> <p>Home health or personal care service activities that are performed by an aide shall be explained to the patient by the registered nurse or other health professional, as authorized by a physician and in accordance with the plan of care.</p> <p>Based on interview and record review, the agency failed to ensure the home health care service activities that were performed by an aide was explained to the patient by the registered nurse as authorized by a physician and in accordance with the plan of care for one of one patient in the investigation. (Patients #1)</p> <p>The finding includes:</p> <p>Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 15, 2009, 2009 at approximately 3:30 PM revealed Patient #1 was to receive services from a Home Health Care Aide (HHA) eight hours a day, five days a week for nine weeks.</p> <p>Review of Patient #1's skilled nursing visit notes dated February 9, 2009, through February 11,</p>		<p>On admission instructions to patients and caregivers are done regarding the services of the home health aides, and a copy of the home health aide assignment sheet is completed and given to the patient and caregiver by the RN admitting the patient.</p>	
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3915. 11</p>	<p>2009, on April 29, 2009, at approximately 8:15 PM revealed the home health care service activities that were performed by an aide was not explained to Patient #1 by the registered nurse as authorized by a physician and in accordance with the plan of care.</p> <p>There was no evidence home health care service activities that were performed by the HHA was explained to the patient by the RN or other health professional, as authorized by a physician and in accordance with the POC.</p> <p>(f) recording, and reporting the patient's physical condition, behavior, or appearance;</p> <p>Based on interview and record review, the agency failed to ensure the Home Health Aide (HHA) recorded and reported the patient's physical condition, behavior, or appearance for one of one patient in the investigation. (Patient # 1)</p> <p>The finding include:</p> <p>Review of a compliant dated April 13, 2009 on April 14, 2009 at approximately 10:50 AM revealed Caregiver #1</p>			
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>alleged his mother; Patient #1 recently sustained a fall (date not stated) while under the care of a HHA who was employed by the Tristate Home Health Agency.</p> <p>Interview with HHA #1 on April 15, 2009, at approximately 1:20 PM, revealed Patient #1 fell out of her wheelchair (date unknown) while she was in Patient #1's bedroom. Further interview revealed that HHA #1 did not call the home health agency to inform the administrators that Patient #1 had fallen out of her wheelchair or document the incident on the timesheet or clinical record.</p> <p>Interview with Registered Nurse #2 (RN #2) on April 15, 2009, at approximately 2:01 PM revealed RN #2 received a call (date unknown) at approximately 3:50 PM, from HHA #1 who stated that Patient #1 had fallen out of her wheelchair.</p> <p>Interview with Patient #1 on April 20, 2009, at approximately 8:25 AM revealed Patient #1 fell half way out of her wheelchair onto the carpeted living room floor (sometime in February 2009) in an attempt to go to the bathroom while HHA #1 was out of the home. Patient #1 revealed she fell on her left side, hit the left side of her head on the wall and that the wheelchair fell across her left leg. Further interview revealed Patient #1 denied to</p>			
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3917.2</p>	<p>HHA #1 that she was injured when HHA #1 assisted her back into her wheelchair. Patient #1 further stated she was surprised that HHA #1 did not call the home health care agency to inform them that she had fallen out of her wheelchair.</p> <p>In an interview with the Director of Nursing (DON) and the Director of Operations (DOO) on April 14, 2009 at approximately 3:50 PM it was acknowledged the agency was not informed by HHA #1 verbally or in writing when Patient #1 fell out of her wheelchair.</p> <p>There was no documented evidence the HHA recorded and/or reported the patient sustained a fall in her home.</p> <p style="text-align: center;">3917</p> <p><u>SKILLED NURSING SERVICES</u></p> <p>(c) Skilled nursing services shall be provided in accordance with the patient's plan of care.</p> <p>Based on interview and record review, the agency failed to ensure that skilled nursing services were provided in accordance with the patient's plan of care for one of one patient in the investigation. (Patient # 1)</p>		<p>See previous Plan of Correction on Home Health Aide reporting incidents to agency.</p>	
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>The findings include:</p> <p>Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 15, 2009, 2009 at approximately 3:30 PM revealed Patient #1 was to receive skilled observation of all systems, assessed for signs and systems of hypertensive crisis, hypoglycemia, hyperglycemia, assessed for pain and evaluate pain management. Patient #1 was to be instructed on pain management, nutrition, hydration, life style modification and integrate all phases of care with patient and all disciplines involved in Patient #1's care. for one to three times a week for nine weeks.</p> <p>Review of skilled nursing notes on April 29, 2009, at approximately 5:20 PM revealed the RN #1 documented skilled nursing visits to Patient # 1's home on January 9, 21, 27, 29, 30, 2009 and February 9 and 11, 2009.</p> <p>Review of skilled nursing notes on April 29, 2009, at approximately 5:22 PM revealed the RN #2 documented skilled nursing visits to Patient # 1's home on February 2 and 9, 2009.</p> <p>Interview with RN #1 on April 15, 2009 at approximately 2:25 PM, revealed Patient #1 was hospitalized from February 2 through February 6, 2009.</p>		<p>Skilled nursing care could not be provided as ordered because the patient was hospitalized and the caregiver would not always allow the skilled nurse to visit the patient. An in-service was conducted on 5/22/09 and the nurses were instructed on the importance of documenting missed visits when visits were</p>	<p>5/22/09</p>
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>Interview with the Director of Nursing (DON) on April 15, 2009, at approximately 3:55 PM revealed nursing services may not have been provided in accordance with the patient's plan of care because Caregiver #1 would not always allow the nurses in Patient #1's home.</p> <p>There was no evidence in the clinical record that skilled nursing services were provided in accordance with the patient's plan of care.</p> <p>(f) Supervision of services delivered by home health aides as appropriate;</p> <p>Based on interview and record review, the agency failed to ensure supervision of services delivered by home health aides for one of one patient in the investigation.</p> <p>The finding includes:</p> <p>Interview with Home Health Aide (HHA) #1 on April 15, 2009 at approximately 1:30 PM revealed HHA #1 was assigned to care for Patient #1 on February 25, 2009 and was not given any supervision or instructions by a registered nurse regarding Patient #1's medical or nursing needs.</p>		not made.	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>Further interview revealed HHA #1 was not aware Patient #1 was on oxygen therapy or had Type II Diabetes until informed by the investigator.</p> <p>Interview with RN #2 on April 15, 2009, at approximately 2:00 PM revealed RN #2 provided skilled nursing services to Patient #1 three times. RN #2 acknowledged that he had not supervised HHA #1 or given her any instructions on Patient #1's nursing needs.</p> <p>Interview with RN #1 on April 15, 2009, at approximately 2:20 PM revealed RN #1 provided skilled nursing services for Patient #1 until she turned the case over to RN # 2 on February 11, 2009. Further interview revealed RN #1 had not supervised or given HHA #1 any instructions on Patient #1's nursing needs. However, RN #1 revealed that she had provided supervision for several of Patient #1's home health aides during the certification period.</p> <p>Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 15, 2009, 2009 at approximately 3:30 PM revealed Patient #1 was to receive services from a HHA eight hours a day, five days a week for nine weeks.</p>			
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>Review of Patient #1's skilled nursing visit note dated February 9, 2009 on April 29, 2009, at approximately 11:15 AM revealed the HHA was instructed to provide Patient #1 rest periods, to call 911 if shortness of breath was severe and to use oxygen as ordered.</p> <p>Review of Patient #1's Home Health Aide Supervisory Visit Form dated January 30, 2009 on April 29, 2009, at approximately 3:35 PM revealed HHA #2 was present in the home and followed the POC.</p> <p>There was no documented evidence in the clinical record of appropriate supervision of services delivered by home health aides to meet the patient's needs.</p> <p>(i) Patient instruction, and evaluation of patient instruction</p> <p>Based on interview and record review, the agency failed to ensure skilled nurses provided patient instruction and evaluation of patient instruction for one of one patient in the investigation. (Patient #1)</p> <p>The findings include:</p>		<p>See Plan of Correction for supervision of Home Health Aides.</p>	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>1. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 29, 2009, at approximately 8:09 PM revealed Patient #1 was to receive instructed on pain management.</p> <p>Review of Patient # 1's skilled nursing visit note dated January 9, 2009, at approximately 8:14 PM revealed Patient #1 was instructed to take pain medication before pain becomes severe. Further review revealed the evaluation of patient instruction indicated Patient #1 verbalized "understanding".</p> <p>There was no evidence the skilled nurse documented the specific patient instruction that was being evaluated.</p> <p>2. Review of Patient # 1's Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 29, 2009, at approximately 8:17 PM revealed Patient #1 was to receive instructed on nutrition.</p> <p>Review of Patient # 1's skilled nursing visit note dated January 21, 2009, on April 29, 2009, at approximately 8:20 PM revealed Patient #1 was instructed to elevate her feet on a stool when up in a chair or on a pillow when in bed to help reduce</p>		<p>An In-service was conducted on 5/22/09 for all clinical staff and instructions were given on the need to document "What did the patient verbalized understanding about".</p> <p>All aspects of the plan of care was discussed with the at the in-service on 5/22/09 and nurses were instructed to document all teaching in their clinical notes as it appears on the Plan of Care.</p>	<p>5/22/09</p> <p>5/22/09</p>
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>swelling, to consume low salt diet, to read all food labels and watch out for words such as “salt or sodium”, to avoid foods high in sodium including ham, hot dogs, bacon and chips. Further review revealed the evaluation of patient instruction indicated Patient #1 verbalized “understanding”.</p> <p>There was no evidence the skilled nurse documented the specific patient instructions that were being evaluated.</p> <p>3. Review of Patient # 1’s Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 29, 2009, at approximately 8:25 PM revealed Patient #1 was to receive instructed on life style modification for proper disease management.</p> <p>Review of Patient # 1’s skilled nursing visit note dated January 27, 2009, on April 29, 2009, at approximately 8:27 PM revealed Patient #1 was instructed to elevate her feet on a stool and to continue to elevate them when in bed to reduce swelling, to reduce salt intake, to read all food labels and watch out for words such as “salt or sodium”, and instructed Caregiver #1 to administer medications as ordered. Further review revealed the evaluation of patient instruction indicated Patient #1 and Caregiver #1 verbalized</p>		<p>See above.</p>	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>“understanding”.</p> <p>Review of Patient # 1’s Transfer to Inpatient Facility (no Discharge) Version document dated February 2, 2009, on April 29, 2009, at approximately 8:30 PM revealed Patient # 1 was transported via EMS to Providence Hospital Emergency Department. Further review revealed Patient #1 was admitted to the hospital for evaluation and treatment of lower leg edema and was discharged on February 6, 2009.</p> <p>There was no evidence the skilled nurse documented the specific patient instructions that were being evaluated.</p> <p>4. Review of Patient # 1’s Home Health Certification and POC dated January 3, 2009 to March 3, 2009 on April 29, 2009, at approximately 8:40 PM revealed Patient #1 was to receive instructed on life style modification for proper disease management.</p> <p>Review of Patient # 1’s skilled nursing visit note dated January 29, 2009, on April 29, 2009, at approximately 8:27 PM revealed Patient #1 was instructed to deep breathe and instructed on the rational for having her blood drawn.</p> <p>There was no evidence the skilled nurse evaluated the</p>		<p>See Above.</p>	
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3922.4</p>	<p>Interview with the Director of Nursing (DON) and the Director of Operations (DOO) on April 14, 2009 at approximately 3:54 PM revealed Caregiver #1 chose to use another home health care company after Patient #1 was discharged from George Washington University Hospital (GWUH) on February 27, 2009. Further interview revealed Patient #1 was discharged from the agency; however home health aide services were provided for a period of time until the new agency could provide services for Patient #1.</p> <p>Interview with Patient # 1 and Caregiver #1 on April 20, 2009, at approximately 8:30AM revealed confirmed they chose to use another home health care company after Patient #1 was discharged from GWUH on February 27, 2009.</p> <p>Review of Patient #1's skilled nursing notes date January 9, 2009, through February 11, 2009, on April 29, 2009, at approximately 6:01 PM no evidence of discharge planning.</p> <p>There was no documented evidence in the clinical record that skilled nursing services provided discharge planning.</p>		<p>Patient was discharged prior to end of episode therefore discharge planning could not be fully accomplished.</p>	
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HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p style="text-align: center;">3922</p> <p style="text-align: center;"><u>OCCUPATIONAL THERAPY SERVICES</u></p> <p>The occupational therapist shall conduct an initial evaluation;</p> <p>Based on interview and record review, the agency failed to ensure an initial occupational therapy evaluation was provided in accordance with the patient's plan of care for one of one patient in the investigation. (Patient # 1)</p> <p>The finding include:</p> <p>Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:15 PM revealed Patient # 1 had an order for occupational therapy evaluation and treatment.</p> <p>Interview with the DOO on April 15, 2009, at approximately 3:45 PM revealed if the Physical Therapist recommended Patient #1 for occupational therapy services, a referral would be made to the occupational therapist.</p>		<p>See previous plan of correction on therapy services.</p>	
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INTERMEDIATE CARE FACILITIES DIVISION**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<p>3923.3</p>	<p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:03 PM revealed no documented evidence Patient #1 had received an occupational therapy evaluation.</p> <p>There was no documented evidence an occupational therapy evaluation had been conducted according to the POC.</p> <p style="text-align: center;">3923</p> <p><u>PHYSICAL THERAPY SERVICES</u></p> <p>If physical therapy services are provided, they shall be provided in accordance with the patient's plan of care.</p> <p>The licensed physical therapist shall: [*2900]</p> <p>(a) Conduct an initial physical therapy evaluation and assessment of the patient prior to the provision of physical therapy services;</p> <p>Based on interview and record review, the agency failed to ensure an initial physical therapy evaluation and</p>		<p>See previous Plan of Correction on therapy services.</p>	
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DEPARTMENT OF HEALTH
HEALTH REGULATION & Licensing ADMINISTRATION
INTERMEDIATE CARE FACILITIES DIVISION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	<p>assessment of the patient were provided in accordance with the patient's plan of care for one of one patient in the investigation. (Patient # 1)</p> <p>The findings include:</p> <p>Review of Patient # 1's Home Health Certification and POC dated January 03, 2009 to March 3, 2009 on April 14, 2009 at approximately 4:15 PM revealed Patient # 1 had an order for a physical therapy evaluation.</p> <p>Interview with the Physical Therapist on April 15, 2009, at approximately 1:45 PM revealed Caregiver #1 refused to allow the Physical Therapist to come to Patient #1's home to perform a physical therapy evaluation (date unknown). Further interview revealed the Physical Therapist did not document in the clinical record Caregiver #1's refusal to allow the Physical Therapist to come to Patient #1's home to perform a physical therapy evaluation.</p> <p>Review of Patient # 1's clinical records on April 23, 2009 at approximately 6:03 PM revealed no documented evidence Patient #1 had received a physical therapy evaluation according to the POC.</p>		<p>To prevent recurrence of this deficiency and to ensure this agency stays in compliance with this plan of correction the following steps were taken: (a) In-Service was given to the home health aides on May 2, 2009 and again on May 23, 2009 on patient safety and the need to report any such incidence to this agency. This training will be continuous until all the home health aides are in-serviced. (b) An in-service was held with all nurses on May 22, 2009 to discuss the findings of the complaint and to instruct the nurses on the topics covered in the Statement of Deficiencies as mentioned in this Plan of Correction.</p> <p>The Quality Assurance Committee shall be responsible to ensure that the skilled staff follow the plan of care and document all care and teaching explicitly. Any deficient findings will be reported to the Administrator and Director of Nursing who will ensure compliance.</p>
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