

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2013
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NAME OF PROVIDER OR SUPPLIER ALERE WOMEN'S AND CHILDREN'S HEALTH I	STREET ADDRESS, CITY, STATE, ZIP CODE 601 PENNSYLVANIA AVENUE, NW, SOUTH BLDG SUITE WASHINGTON, DC 20004
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H 000	<p>INITIAL COMMENTS</p> <p>An annual survey was conducted at your agency from December 17, 2013, through December 18, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides skilled nursing services to twenty-six (26) patients, employs ten (10) registered nurses (RN) and other administrative staff.</p> <p>The findings of the survey were based on a random sample of 10 clinical records and 10 personnel files. Observations and interviews were conducted in the patient homes during three (3) home visits and seven (7) telephone calls were made to current patients.</p> <p>Please Note: Listed below are abbreviations used in this report.</p> <p>Registered Nurse (RN) Home Care Agency (HCA) Director of Nursing (DON) Physician Plan of Treatment (PPOT) Patient Teaching Checklist (PTC) Comprehensive 17P Nursing Assessment (C17PNA)</p>	H 000	<p><i>Received 1/6/14</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
H 364	<p>3914.3(m) PATIENT PLAN OF CARE</p> <p>The plan of care shall include the following: (m) Emergency protocols; and...</p> <p>This Statute is not met as evidenced by: Based on record review and interview the HCA failed to ensure that the PPOT included specific instructions on the emergency protocol for ten (10) of 10 patients in the sample. (Patients #1,</p>	H 364		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Robin Stanley, RN
STATE FORM 6899

TITLE

DATE
1-6-2014

If continuation sheet 1 of 7

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H 364	<p>Continued From page 1</p> <p>#2, #3, #4, #5, #6, #7, #8, #9 and #10)</p> <p>The findings include:</p> <p>Review of the following PPOT on December 17, 2013 between 10:00 a.m. and 4:00 p.m., revealed that the PPOTs stated that "patient will be educated about and nursing personnel will follow company emergency protocols" as evidenced below:</p> <ol style="list-style-type: none"> 1. Patient #1's PPOT with a certification period of September 11, 2013, through February 26, 2014, failed to include specific instructions on the emergency protocol. 2. Patient #2's PPOT with a certification period of November 7, 2013, through April 24, 2014, failed to include specific instructions on the emergency protocol. 3. Patient #3's PPOT with certification period of November 22, 2013, through April 14, 2014, failed to include specific instructions on the emergency protocol. 4. Patient #4's PPOT with a certification period of October 15, 2013, through February 21, 2014, failed to include specific instructions on the emergency protocol. 5. Patient #5's PPOT with a certification period of November 17, 2013, through May 4, 2014, failed to include specific instructions on the emergency protocol. 6. Patient #6's PPOT with a certification period of October 8, 2013, through March 25, 2014, failed to include specific instructions on the emergency protocol. 	H 364	<p>What corrective action(s) will be accomplished to address the identified deficient practice;</p> <p>The PPOT will be rewritten to say, "Patient will be educated about, and nursing personnel will follow company emergency protocols, including activating the emergency medical system (911), if warranted."</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>The PPOT templates will be changed to reflect the changes that the DOH is requiring.</p>	<p>12/31/2013</p> <p>12/31/2013</p>

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H 364	<p>Continued From page 2</p> <p>7. Patient #7's PPOT with a certification period of August 29, 2013, through February 13, 2014, failed to include specific instructions on the emergency protocol.</p> <p>8. Patient #8's PPOT with a certification period of October 5, 2013, through February 28, 2014, failed to include specific instructions on the emergency protocol.</p> <p>9. Patient #9's PPOT with a certification period of October 30, 2013, through March 8, 2014, failed to include specific instructions on the emergency protocol.</p> <p>10. Patient #10's PPOT with a certification period of November 12, 2013, through April 29, 2014, failed to include specific instructions on the emergency protocol.</p> <p>During a face to face interview with the director of nursing (DON) on December 17, 2013, at approximately 3:30 p.m., it was acknowledged the POC did not include specific instructions on the emergency protocol for Patient's #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10. The DON indicated that the agency would add an addendum to the PPOT to include specific instructions on the emergency protocol for clinical staff to follow when in the home.</p>	H 364	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented;</p> <p>A quality assurance initiative is in place and will track for new mandatory information which is required by the DOH. It will be reviewed monthly and reported on quarterly.</p>	12/31/2013
H 459	<p>3917.2(i) SKILLED NURSING SERVICES</p> <p>Duties of the nurse shall include, at a minimum, the following:</p> <p>(i) Patient instruction, and evalutaion of patient instruction; and</p>	H 459		

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H 459	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the HCA skilled nursing staff failed to provide evidence that specific instructions were afforded to patients related to their health conditions, medication actions and side effects for nine (9) of the ten (10) patients in the sample (Patient #1, #2, #3, #4, #5, #7, #8, #9, and #10).</p> <p>The findings include:</p> <p>The agency's nursing staff failed to ensure that specific instructions were provided to the patients during the weekly SN visits as evidenced by:</p> <p>1. Review of Patient #1's PPOT on December 17, 2013, at approximately 10:45 a.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments.</p> <p>Review of Patient #1's C17PNAs dated October 10, 17, 24, 31, 2013, November 7, 14, 21, 27, 2013 and December 15, 2013, revealed no documented evidence that the RN provided instructions on medication actions and side effects and high risk pregnancy education.</p> <p>2. Review of Patient #2's PPOT on December 17, 2013, at approximately 11:00 a.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments. Review of Patient #2's C17PNAs dated November 27, 2013, and December 3, 2013, revealed no documented evidence that the RN provided instructions on medication actions, side effects and high risk</p>	H 459	<p>What corrective action(s) will be accomplished to address the identified deficient practice;</p> <p>After the initial nursing visit checklist is filled out, the nurse doing the nursing visit will document weekly all educational topics reviewed with patient and the patient's response to the teaching. In addition, all medication actions and side effects will be reviewed weekly.</p>	12/31/2013
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H 459	<p>Continued From page 4</p> <p>pregnancy education.</p> <p>3. Review of Patient #3's PPOT on December 17, 2013, at approximately 11:30 a.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments. Review of Patient #3's C17PNAs dated December 5 and 12, 2013, revealed no documented evidence that the RN provided instructions on medication actions, side effects and high risk pregnancy education.</p> <p>During interview with Patient #3 on December 18, 2013, at approximately 11:45 a.m. it was determined that the RN had not provided instructions on medication actions, side effects and high risk pregnancy education since the RN's initial visit on November 27, 2013.</p> <p>4. Review of Patient #4's PPOT on December 17, 2013, at approximately 11:50 a.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments. Review of Patient #4's C17PNAs dated October 31, 2013, November 7, 14, 21, 27, 2013, December 5 and 12, 2013, revealed no documented evidence that the RN provided instructions on medication actions, side effects and high risk pregnancy education.</p> <p>During interview with Patient #4 on December 18, 2013 at approximately 1:45 p.m. it was determined that the RN had not provided instructions on medication actions, side effects and high risk pregnancy education since the RN's initial visit on October 24, 2013. Additionally, Patient #4 stated that the RN administered the medication by injection and left within 10 minutes of arrival.</p>	H 459	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>The director will have a staff meeting with educators to inform them of changes in completing the nursing visit form. An email will also be sent. The process will be reviewed at monthly staff meetings. The director will review each nursing visit form submitted for the inclusion of the educational session taught.</p>	12/31/2013

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H 459	<p>Continued From page 5</p> <p>5. Review of Patient #5's PPOT on December 17, 2013, at approximately 12:15 p.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments. Review of Patient #5's C17PNAs dated November 30, 2013, December 6 and 11, 2013, revealed no documented evidence that the RN provided instructions on medication actions, side effects and high risk pregnancy education.</p> <p>During interview with Patient #5 on December 18, 2013 at approximately 10:00 a.m. it was determined that the RN had not provided instructions on medication actions, side effects and high risk pregnancy education since the RN's initial visit on November 21, 2013.</p> <p>6. Review of Patient #7's PPOT on December 17, 2013, at approximately 1:00 p.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments. Review of Patient #7's C17PNAs dated December 7 and 15, 2013, revealed no documented evidence that the RN provided instructions on medication actions and side effects and high risk pregnancy education.</p> <p>7. Review of Patient #8's PPOT on December 17, 2013, at approximately 1:30 p.m., revealed that the RN was to provide weekly skilled visits for teaching, medication administration and perform labor/high risk pregnancy assessments. Review of Patient #8's C17PNAs dated October 30, 2013, November 6, 14 and 28, 2013, December 4 and 11, 2013, revealed no documented evidence that the RN provided instructions on medication actions and side effects and high risk pregnancy education.</p>	H 459	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented;</p> <p>A quality assurance initiative will be developed tracking all nursing visits submitted for the documentation of educational teaching. It will be tracked monthly and reported on quarterly.</p>	12/31/2013

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H 459	<p>Continued From page 6</p> <p>8. Review of Patient #9's PPOT on December 17, 2013, at approximately 2:00 p.m., revealed that the RN was to provide weekly skilled visits for teaching, medication administration and perform labor/high risk pregnancy assessments. Review of Patient #9's C17PNAs dated November 1, 17 and 24, 2013, December 1, 8 and 15, 2013, revealed no documented evidence that the RN provided instructions on medication actions and side effects and high risk pregnancy education.</p> <p>9. Review of Patient #10's PPOT on December 17, 2013, at approximately 2:30 p.m., revealed that the RN was to provide weekly skilled visits for medication administration and perform labor/high risk pregnancy assessments.</p> <p>Review of Patient #10's C17PNAs dated November 21 and 27, 2013, December 5 and 12, 2013, revealed no documented evidence that the RN provided instructions on medication actions, side effects and high risk pregnancy education.</p> <p>During a face to face interview with the DON on December 18, 2013 at approximately 12:35 p.m., it was revealed that unless there was a change in Patient #1, #2, #3, #4, #5, #7, #8, #9, #10's condition the RNs would not provide or document instructions on medication actions, side effects and high risk pregnancy education after the initial assessment. Further interview revealed that the agency would provide inservice to the RNs on how to provide instructions to the patients on medication actions, side effects and high risk pregnancy education during each weekly skilled nursing visit.</p>	H 459		
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