Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HCA-0060		05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMMACULATE HEALTH CARE SERVICES	2512 24TH STREET, NE WASHINGTON, DC 20018

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H 000	INITIAL COMMENTS A full survey was conducted on May 6, 2013, through May 7, 2013, at your new location at 2512 24th Street, N.E. to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of ten (10) clinical records based on a census of three hundred-twenty-four (324) patients, ten (10) personnel files based on a census of three hundred-ninety-three (393) employees. Observations and interviews were conducted in the patient homes during four (4) home visits and six (6) telephone calls were made to current patients.	H 000	Immaculate Health care Services, Inc. acknowledges the deficiencies cited during the survey conducted on May 6th 2013 through May 7th 2013, and will implement the following plan of corrections.	
H 355	3914.3(d) PATIENT PLAN OF CARE The plan of care shall include the following: (d) A description of the services to be provided, including: the frequency, amount, and expected duration; dietary requirements; medication administration, including dosage; equipment; and supplies; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the plan of care (POC) included a description of all durable medical equipment (DME) and supplies utilized for one (1) of ten (10) patients in the sample. (Patient #5) The finding includes: Review of Patient #5's plan of cares (POCs) dated October 18, 2013 through April 15, 2013 and April 19, 2013, through October 17, 2013 on	H 355	(H355) **Patient plan of care:** The Agency has addressed its policy on physician's orders/DME(durable medical equipment and is undergoing an in-service training for all clinicians on physician orders to include all medical supplies and pertinent diagnosis such as colostomy bag, and the need to comply with the regulatory guidelines. To ensure compliance with regulatory guidelines, the clinical nurse will review clinical files on a daily basis. The DON will randomly review 10% of clinical files weekly to ensure that treatment plans reflect pertinent diagnosis, and durable medical equipment. The identified Patient # 5 file has been reviewed and updated accordingly.	5/30/13

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H 355	Continued From page 1 May 6, 2013, at approximately 1:10 p.m., revealed no documented evidence of DME (durable medical equipment) and supplies. Review of Patient #5's Nursing Visit Notes (NVNs) dated March 22, 2013 and February 22, 2013, on May 6, 2013, at approximately 1:10 p.m., revealed that the patient utilizes a colostomy bag to collect bodily fluids from a stoma located on the left lower quadrant of the abdomen. During a face to face interview with the administrator and the director of nursing (DON) on May 6, 2013, at approximately 5:45 p.m., it was acknowledged that the description of all equipment and supplies were not documented on Patient #5's POC during the time of the survey. Further interview revealed that the nursing staff would be re-trained on how to document all DME and supplies utilized by the patients on the POC.	H 355	Patient # 5 who was found to be affected with the colostomy bag nurses notes without a diagnosis has been updated and diagnosis added to treatment plan with notification sent to primary physician. The acknowledgement of training done is signed by all identified clinicians who generates and receives verbal orders from doctors, including visiting nurses. The acknowledgement form on training will be documented on their respective personal file by 5-20-13.	5/30/13
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following: (g) Physical assessment, including all pertinent diagnoses; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the plan of care (POC) included all pertinent diagnoses for one (1) of ten (10) patients in the sample. (Patient #5) The finding includes: Review of Patient #5's plan of cares (POCs) dated October 18, 2013 through April 15, 2013	H 358	H- 358 3914.3 (g) Patient plan of care An extensive in- service training has been conducted for all Immaculate clinicians on plan of treatment to include all pertinent diagnosis, and complete physical assessment, this training will be completed and documented on clinicians personnel files by May 20th 2013. To ensure compliance with this condition of participation, IHCS office staff nurses will review 10% of files on a daily basis.	5/3013

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H 358	Continued From page 2 and April 19, 2013, through October 17, 2013 on May 6, 2013, at approximately 1:20 p.m., revealed Patient #5 had diagnoses that included bipolar disorder, arthropathy of the ankle, hypertension and vaginal wall prolapse. Review of Patient #5's Nursing Visit Notes (NVNs) dated March 22, 2013 and February 22, 2013, on May 6, 2013, between 1:25 p.m. and 1:30 p.m., revealed that the patient utilizes a colostomy bag to collect bodily fluids from a stoma located on the left lower quadrant of the abdomen. Further review revealed that the skilled nurse had instructed Patient #5 on performing colostomy care. During a face to face interview with the administrator and director of nursing (DON) on May 6, 2010, at approximately 5:30 p.m., it was acknowledged at the time of the survey there was no documented evidence that the colostomy was included on the POC. Further interview revealed that the nursing staff would be re-trained on how to document all pertinent diagnoses on the POC.	H 358	The Director of nursing will be responsible to randomly review 10% of clinical files on a weekly basis. The Administrator will randomly review 10% of clinical files on a monthly basis, and this will be conducted on an ongoing basis. The identified client #5 file has been reviewed and updated accordingly.	5/30/13
H 454	3917.2(d) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (d) Implementing preventive and rehabilitative nursing procedures; This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that preventive and rehabilitative nursing procedures were afforded to	H 454	. H454 3917.2 (D) SKILLED NURSING SERVICES IHCS has reviewed its policy (580) on Plan of treatment and has conducted an extensive educational in-service with all IHCS clinicians generating treatment plans to include preventive and rehabilitative nursing procedures. The educational in-service is ongoing and will be completed by 5-20-13.	5/30/13

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H 454	Continued From page 3 patients related to their health conditions, for one (1) of ten (10) patients in the sample (Patient #10). The finding includes: Review of Patient #10's plan of care (POC) dated March 4, 2013 through September 4, 2013, on May 6, 2013, at approximately 5:00 p.m., revealed Patient #10 had diagnoses that included morbid obesity, diabetes mellitus type II, hypertension and shortness of breath. Review of Patient #10's Clinical Note (CN) dated March 2, 2013, on May 6, 2013, at approximately 5:05 p.m., revealed that the "patient's edematous limbs are due to morbid obesity". There was no documented evidence that the nurse weighed Patient #10 during the physical assessment. Review of Patient #10's Nursing Visit Note (NVN) dated April 8, 2013, on May 6, 2013, at approximately 5:10 p.m., revealed that the "patient is morbidly obese, ambulates with [a] motor chair. Patient's mobility greatly impaired by obesity." There was no documented evidence that the nurse actually weighed Patient #10 or recorded the patient's reported weight during the physical assessment. During a face to face interview with the administrator and director of nursing (DON) on May 6, 2013, at approximately 5:42 p.m., it was acknowledged at the time of the survey there was no documented evidence that the nurse actually weighed Patient #10 or recorded the patient's reported weight during the physical assessment. Further interview revealed that the POC would be updated to include instructions for the nursing staff to weigh the patient or record the patient's	H 454	The completed educational signed training forms will be documented on each clinician's personal file by 5-30-13. The identified client # 10 file has been reviewed and updated accordingly. To ensure compliance with this condition of participation with the regulations, the Nursing office staff are reviewing all clinical files to reflect notation of all pertinent diagnosis and proper documentation of beneficiaries weight and pertinent information. The director of nursing and administrator are currently reviewing all client files to ensure compliance with this condition of participation. On an ongoing basis, the staff nurses will review nursing notes and treatment plans on a daily basis.	5/30/13

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H 454	Continued From page 4 reported weight from the primary care physician. Also the nursing staff would be re-trained on how to weigh and document the actual or reported weight on the CN and NVN.	H 454	The Administrator will randomly review 10% of clinical files on a monthly basis, and the Director of Nursing will review 10 % of files on a weekly basis	5/30/13
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on interview and record review, the home care agency's (HCA)skilled nursing staff failed to provide evidence that instructions were afforded to patients related to their health conditions, for four (4) of the ten (10) patients in the sample (Patient #2, #3, #4 and #8). Additionally, the HCA failed to provide evidence that the instructions given were understood, for two (2) of the 10 patients in the sample. (Patient #3 and #4) The findings include: The agency failed to ensure training and/or the evaluation of the training had been completed as prescribed. 1. Review of Patient #2's medical record on May 6, 2013, at approximately 11:00 a.m. revealed a plan of care (POC) with a certification period from May 2, 2013, through June 30, 2013. According to the POC, the skilled nurse (SN) was to teach medication actions, side effects and complications to report to the registered nurse and medical doctor. Continued review of Patient	H 459	H459 -3917.2 (SKILLED NURSING SERVICES) The agency has re-enforced its policy on patient education /instruction, evaluation/feedback- an extensive educational in-service is ongoing with all IHCSI clinicians to adhere with such policies and procedures, and such training will be completed by May 20th 2013. Acknowledgement of training will be placed on the clinician's personnel files by 5/30/13. **1.** Patient # 2 medical record has been reviewed and updated. The assigned Registered nurse assigned to this client has been counseled and retrained. Acknowledgement of training placed in her personal file effective May 14th 2013.	5/30/13 5/30/13

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H 459	Continued From page 5 #2's record on May 6, 2013, at approximately 11:05 a.m., revealed a Nursing Visit Note Visit (NVN) dated April 15, 2013. The form indicated that the SN provided education on how to administer a Zanaflex 2 (two) milligram tablet twice a day by way of the gastric tube; but failed to document instructions on Zanaflex's medication actions, side effects and complications to report to the registered nurse and medical doctor. 2. Review of Patient #3's medical record on May 6, 2013, at approximately 11:21 a.m. revealed a POC with a certification period from April 3, 2013, through July 1, 2013. According to the POC, the SN was to provide education to the family as needed. Review of Patient #3's NVN dated April 3, 2013, on May 6, 2013, at approximately 11:25 a.m., revealed that the SN instructed the licensed practical nurse (LPN) and caregiver on oxygen therapy and the emergency protocol. The SN however, failed to document the specific aspects of oxygen therapy or emergency protocol that was taught to the patient. Additionally, review of Patient #3's NVN dated March 3, 2013, on May 6, 2013, at approximately 11:45 a.m., revealed that the patient receives gastric tube feedings. The SN instructed the licensed practical nurse (LPN) and caregiver on elevating the head of the patient's bed during feedings; however the SN failed to instruct the LPN and family member on keeping the bed elevated thirty (30) minutes after the feeding. Review of Patient #3's Nursing Flow Sheets (NFS) dated April 11 and 12, 2013, on May 6, 2013, at approximately 11:55 a.m., revealed that the LPN documented under patient education exercise program and aspiration precautions respectively however instructed the licensed	H 459	To ensure compliance, the staff nurse will review nurses' notes on a daily basis to make sure that nurses document specific instructions of a medication to include actions and side effects to report to the RN and the primary physician. The Director of nursing will randomly review 10% of clinical files on a weekly basis. Immaculate Agency has conducted an in-service for all its clinicians on patient education/instruction evaluations and specific feedback from client with proper documentation The agency has re-addressed its policy on respiratory therapy/equipment, such as oxygen therapy, emergency protocol, and gastric tube feedings for all its clinicians. Acknowledgement of such training by the clinicians will be completed by 5/20/13, and signed documents will be placed on their employee files by 5-30-13. **2.** Patient # 3 medical record has been reviewed and updated, to include keeping the bed elevated to 35-45 degree during G-Tube feedings .The assigned LPN has been counseled and retrained. On respiratory therapy/ equipment and G-tube feeds. Her acknowledgement of training form placed in her personal file on 5-14-13. The staff nurse will review clinical files on a daily basis to include specific instructions on level of understanding by the client .The DON will randomly review 10% of clinical files on a weekly basis to ensure compliance.	5/30/13 5/30/13

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H 459	Continued From page 6 practical nurse (LPN) and caregiver on oxygen therapy and the emergency protocol. The SN however, failed to document the specific level of understanding with the aforementioned health teachings. 3. Review of Patient #4's NVN dated April 15, 2013, on May 6, 2013, at approximately 1:05 p.m., revealed that the SN documented that the patient was instructed on the signs and symptoms of Lisinopril 5 (five) milligrams. The SN however, failed to document the specific level of understanding with the aforementioned health teaching. 4. Review of Patient #5's Nursing Visit Note (NVN) dated March 22, 2013, on May 6, 2013, at approximately 1:25 p.m., revealed that the SN instructed the patient on "colostomy care and medication expiration dates". The SN however, failed to document the specific aspects of colostomy care and medication management related to expiration dates that was taught to the patient. 5. Review of Patient #8's NVN dated April 15, 2013, on May 6, 2013, at approximately 3:45 p.m., revealed that the SN instructed the caregiver on button gastric tube care, The SN, however, failed to document the specific aspects of button gastric tube care that was taught to the caregiver. During a face to face interview with the administrator and director of nursing (DON) on May 6, 2013, at approximately 5:46 p.m., it was acknowledged at the time of the survey there was no documented evidence that the agency's nursing staff ensured training and/or the evaluation of the training had been completed as	H 459	**3.** Patient #4 medical record reviewed and updated. The assigned RN has been counseled and retrained on the policy of medication instructions and evaluation. The acknowledgement of training has been documented on her personal file on 5-14-13. To ensure compliance the Director of nursing and administrator are currently reviewing all clinical files to ensure compliance. And this will be done on an ongoing basis. The administrator will randomly review 10 % of files on a monthly basis and the DON will randomly review 10% of files on a weekly basis, the quality assurance staff will monitor on a daily basis. **4.** Patient # 5 clinical record has been reviewed and updated, a notification sent to the doctor to include added diagnosis of colostomy bag. The identified nurse and all immaculate clinicians have been retrained on pertinent diagnosis, medication management, colostomy care management and proper documentation. The director of nursing is responsible to monitor this condition of participation and the administrator will randomly review 10 % of clinical records to ensure compliance. The acknowledgement of clinicians signed training documents will be placed in their personnel file by 5-20-13. **5.** Patient #8 : The agency has re-enforced its policy on Gastric-tube care and management. An In-service training has been conducted for the identified RN and all IHCSI clinicians to adhere to Gastric-tube care / management. Acknowledgement of training by the clinicians signed forms will be documented on their employee files.	5/30/13 5/30/13 5/30/13

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H 459	Continued From page 7 prescribed. Further interview revealed that the nursing staff would be re-trained on how to document training and/or the evaluation of the training according to the POC.	H 459	On an ongoing basis this will be monitored by the quality assurance staff. A thorough review of the clinical record of patient # 8 has been done and the plan of care updated.	5/30/13