

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/04/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>T &amp; N RELIABLE NURSING CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 18TH STREET WASHINGTON, DC 20018</b>
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H 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was conducted from October 1, 2013, through October 8, 2013, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provided home care services to five hundred-twenty (520) patients and employs seven hundred-sixty-nine (769) staff to include licensed nurses, home health aides and other administrative staff. The findings of the survey were based on a review of twenty-four (24) current patients' records, five (5) discharge patients' records, twenty-five (25) personnel files, eight (8) home visits and fifteen (15) current patients interviews via telephone.</p> <p>Additionally, in conjunction with the survey one complaint was investigated and revealed the following:</p> <p>On October 3, 2013, the investigations were concluded and the following finding was identified related to the complainant's allegation:</p> <p>Allegation #1: Since April 2013, Patient #1 was not provided Home Health Aide (HHA) services on the weekend as required by the plan of care (POC) since.</p> <p>Conclusion: This allegation was unsubstantiated. Interview and record review with Patient #1 confirmed that since April 2013, Patient #1 requested that HHA services be placed on hold for the weekend until further notice.</p>	H 000	<p style="text-align: center;"><i>Received 10/25/13</i></p> <p style="text-align: center;"><b>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</b></p>	
H 450	<p><b>3917.1 SKILLED NURSING SERVICES</b></p> <p>Skilled nursing services shall be provided by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, and</p>	H 450		

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Agnes M... [Signature]*

TITLE

*Director*

(X6) DATE

*10/21/13*

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H 450	<p>Continued From page 1</p> <p>in accordance with the patient's plan of care.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure skilled nursing services were provided in accordance with the patient's plan of care (POC) for one (1) of four (4) patients in the sample receiving wound care. (Patient #3)</p> <p>The finding includes:</p> <p>Review of Patient #3's POC with a documented certification period of September 20, 2013 through November 18, 2013, on October 3, 2013, at approximately 11:30 a.m., revealed the patient had diagnoses that included a cervical five (5) spinal cord nerve injury with a left buttock pressure ulcer. Further review revealed the SN was to visit the patient four (4) to 5 times a week for nine (9) weeks. Additionally, the SN was to cleanse the coccyx wound with .09% normal saline solution, pat the area dry, apply Aquacel dressing and cover the wound with a 4 by 4 gauze on each visit.</p> <p>Review of Patient #3's nursing visit notes (NVNs) dated September 23 and 28, 2013, on October 3, 2013, at approximately 11:50 a.m., revealed no documented evidence that wound care management was performed by the SN 4 to 5 times during the week of September 22, 2013, according to the POC.</p> <p>Review of Patient #3's Sixty (60) Day Summary Report dated September 9, 2013, on October 3, 2013, at approximately 12:10 p.m., revealed "client has a cervical 5 spine cord injury with a coccyx pressure ulcer...doctor notified of client's</p>	H 450	<p>All nurses doing skilled nursing visits will be in-serviced to make sure that the frequency of nursing visits are as stated in the Plan of Care. The Director of Nurses and the Quality Assurance person will review 100% of the skilled records to ensure that nursing visit frequencies are as stated in the Plan of Care. This exercise will be done every month until compliance is achieved. At that point, the quality assurance person will continue to monitor this item during the quarterly clinical record reviews.</p>	10/30/13
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H 450	<p>Continued From page 2</p> <p>situation and visits reduced to 4 to 5 times a week".</p> <p>During a telephone interview with licensed practical nurse #3 (LPN #3) on October 3, 2013, at approximately 1:05 p.m., it was acknowledged that during the week of September 22, 2013, Patient #3 did not receive wound care management 4 to 5 times a week. Further interview revealed that LPN #3 provided wound care management to Patient #3 only on September 23 and September 28, 2013.</p> <p>During a face to face interview with the SNC on October 3, 2012, at approximately 1:25 p.m., it was confirmed that Patient #3's POC and the 60 Day Summary stated that the patient was to receive wound care management 4 to 5 times a week for 9 weeks. The SNC acknowledged that LPN #3 provided wound care to Patient #3 only on September 23 and September 28, 2013.</p> <p>During a telephone interview with Patient #3 on October 4, 2013, at approximately 4:05 p.m., it was confirmed that the patient had received wound care only twice during the week of September 22, 2013. Patient #3 stated that their left buttock pressure ulcer was healing well according to the wound specialist and that they were very satisfied with the services provided by LPN #3.</p>	H 450		
H 453	<p>3917.2(c) SKILLED NURSING SERVICES</p> <p>Duties of the nurse shall include, at a minimum, the following:</p> <p>(c) Ensuring that patient needs are met in accordance with the plan of care;</p>	H 453		

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H 453	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: Based on record review and interview, the home care agency's (HCA's) nurse failed to ensure that patient needs were met in accordance with the plan of care (POC), for two (2) of twenty-five (25) patients in the sample. (Patient #14 and #15)</p> <p>The findings include:</p> <p>1. On October 1, 2013, at approximately 11:25 a.m., review of Patient #14's plan of care (POC) for the certification period of July 30, 2013 to September 27, 2013, revealed that the registered nurse (RN) was ordered to measure the patient's wound weekly and document drainage, color, consistency, and the size of the wound. The nursing notes failed to include wound measurements for the week of August 26 th and the week of September 16 th 2013.</p> <p>Additionally, Interview with the skilled nurse coordinator (SNC) on October 1, 2013, at approximately 3:00 p.m., revealed that the RN attempted to visit the patient on August 27 th and September 17 th of 2013, to measure and assess the wound; however, the patient was not available at the time of the visits. Further interview with the SNC, revealed that the practice of the agency was that the RN does not make any additional visits to measure and assess the wounds, if the weekly scheduled RN visit is missed.</p> <p>2. On October 2, 2013, at approximately 10:00 a.m., review of Patient #15's POC, for the certification period of August 14, 2013 to September 27, 2013, the skilled nurse (SN) was</p>	H453	<p>1. The RN responsible for wound measurement was in-serviced to continue to do wound measurement every seven (7) day from the start of care date and to do it any other day of that week if the client is not at home on the 7<sup>th</sup> day. Also, the RN must complete a "missed visit" note on that 7<sup>th</sup> day to justify why wound measurement frequency was altered. The Director of Nurses and the Quality Assurance person will review 100% of the wound care records to ensure that wound measurements are done as stated in the Plan of Care. This exercise will be done every month until compliance is achieved. At that point, the quality assurance person will continue to monitor this item during the quarterly clinical record reviews.</p>	10/14/13
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H 453	<p>Continued From page 4</p> <p>ordered to visit one (1) to two (2) times per week for medication teaching.</p> <p>The record failed to evidence the SN provided medication teaching on the following dates: August 22, 2013, August 25, 2013, August 28, 2013, September 5, 2013, September 10, 2013, September 11, 2013, September 17, 2013 and September 20, 2013.</p> <p>During an interview with the agency's licensed practical nurse (LPN) on October 2, 2013, at approximately 10:49 a.m., the LPN, who has worked with the patient for approximately 2 weeks stated, "I have not started teaching medications yet but I will".</p> <p>Interview with the SNC on October 2, 2013, at approximately 10:00 a.m., revealed that the reason for not providing medication teaching was due to a additional orders received that ordered skill nurse visit to increase to twice a week for trach inner cannula care, cleaning and teaching until patient can demonstrate competency with good trach care. The SNC was informed that the order for medication teaching was still to be followed.</p>	H453	<p>2. All nurses doing skilled nursing visits will be in-serviced to make sure that all teaching orders are implemented during nursing visits as stated in the Plan of Care. The Director of Nurses and the Quality Assurance person will review 100% of the skilled records to ensure that teaching orders are done as stated in the Plan of Care. This exercise will be done every month until compliance is achieved. At that point, the quality assurance person will continue to monitor this item during the quarterly clinical record reviews.</p>	10/30/13
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