

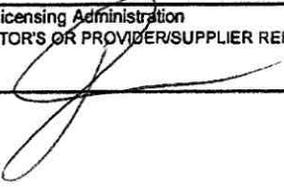
Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G239	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/26/2013
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NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA	STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 000	<p>INITIAL COMMENTS</p> <p>On July 12, 2013, the Office of Compliance and Quality Assurance and Investigation Division (OQAID) was notified of the death of Resident #1. Resident #1 passed away after an eight day stay in the hospital.</p> <p>An onsite investigation was initiated on December 3, 2013, to evaluate the health care rendered to Resident #1 prior to being hospitalized on July 4, 2013. The findings of the investigation were based on, interviews with direct care staff, nursing staff and the agency's management staff, the review of medical records, habilitation records and administrative records, as well as a review of the facility's incident management and reporting system.</p> <p>Note: The abbreviations listed below may appear throughout the body of this report.</p> <p>American Heart Association - AHA Direct Support Professional - DSP Registered Nurse - RN Occupational Therapy - OT Qualified Intellectual Disabilities Professional - QIDP Group Home for Individuals with Intellectual Disabilities - GHIID House Manager - HM Primary Care Physician - PCP Licensed Practical Nurse - LPN Cardiopulmonary Resuscitation - CPR Office of Compliance and Quality Assurance and Investigation Division - OQAID</p>	1 000		
1 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p>	1 227		

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



TITLE

Quality Assurance Coordinator

(X6) DATE

1/24/14

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I 227	<p>Continued From page 1</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review the facility's nursing staff failed to perform CPR in accordance with American Heart Association (AHA) standards, for one (1) of one (1) resident in the investigation. (Resident #1) The finding includes: The facility's nursing staff failed to perform emergency procedures [cardiopulmonary resuscitation (CPR)] in accordance with standards set forth by the American Heart Association (AHA) as evidenced below: A. Review of Resident #1's record, on December 4, 2013, between 10:00 a.m. and 4:30 p.m. revealed that on the morning of July 4, 2013, at approximately 7:20 a.m. Staff #1 discovered Resident #1 in her bed with clear thick saliva coming from her mouth. DSP #1 called LPN #1 to the resident's room. LPN #1 assessed Resident #1 and discovered that she had no pulse and was not breathing. B. LPN #1's written statement was reviewed on December 11, 2013, at 1:48 p.m. and verified in an interview conducted via telephone on January 13, 2014, at 3:31 p.m.. LPN #1 revealed that on July 4, 2013, he/she initiated CPR and instructed DSP #1 to dial 911. LPN #1 further revealed that she performed CPR on Resident #1 while the resident was in the bed. When asked why she performed CPR while the client was in bed, LPN #1 indicated that she was in "panic mode" and was not thinking. LPN #1 indicated that she could not find the CPR board and that she did not think</p>	I 227	<p>3510.5(d) VOAC will continue to train each staff hired on CPR and First aid and pay particular attention to the use of the orange board located in each home to be used during CPR. VOAC will continue to train staff to understand that the board is to be used providing a hard surface for the individuals during the CPR. Implemented August 2013 and continuing.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 331	Continued From page 2 Resuscitation (CPR)) in accordance with standards set forth by the American Heart Association (AHA) as evidenced below: A. Review of Client #1's record, on December 4, 2013, between 10:00 a.m. and 4:30 p.m. revealed that on the morning of July 4, 2013, at approximately 7:20 a.m. Staff #1 discovered Client #1 in her bed with clear thick saliva coming from her mouth. DSP #1 called LPN #1 to the client's room. LPN #1 assessed Client #1 and discovered that she had no pulse and was not breathing. B. LPN #1's written statement was reviewed on December 11, 2013, at 1:48 p.m. and verified in an interview conducted via telephone on January 13, 2014, at 3:31 p.m.. LPN #1 revealed that on July 4, 2013, he/she initiated CPR and instructed DSP #1 to dial 911. LPN #1 further revealed that she performed CPR on Client #1 while the client was in the bed. When asked why she performed CPR while the client was in bed, LPN #1 indicated that she was in "panic mode" and was not thinking. LPN #1 indicated that she could not find the CPR board and that she did not think to place the client on the floor prior to initiating CPR. C. Observations at the facility on December 26, 2013, at 9:49 a.m. revealed an orange board was located in the dining room area near the nursing station. The board was identified by Staff #1 as the CPR board. Staff #1 further stated that all of the staff know that the board is located there and to get it when needed. D. According to the AHA, CPR is most effective when performed on a hard surface to ensure the target depth of compressions is achieved to ensure the heart is completely emptied when the chest wall is compressed.	W 331	Training begun on 7/24/13 and continues until all staff in all homes are trained. This training will repeat as new staff comes onboard. VOAC will ensure that the process of informing the PCP about seizures will be as follows 1. If a seizure occurs, the staff will send the seizure form to the PCP with fax confirmation. 2. The RN will be notified by phone and will follow-up with the PCP to ensure he received the seizure data sheet. 3. A copy of that data sheet will be forwarded to the DON with a copy of the fax confirmation	

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1390	<p>Continued From page 3</p> <p>The findings include:</p> <p>I. The facility's nursing staff failed to perform emergency procedures [Cardiopulmonary Resuscitation (CPR)] in accordance with standards set forth by the American Heart Association (AHA) as evidenced below:</p> <p>A. Review of Resident #1's record, on December 4, 2013, between 10:00 a.m. and 4:30 p.m. revealed that on the morning of July 4, 2013, at approximately 7:20 a.m. Staff #1 discovered Resident #1 in her bed with clear thick saliva coming from her mouth. DSP #1 called LPN #1 to the client's room. LPN #1 assessed Resident #1 and discovered that she had no pulse and was not breathing.</p> <p>B. LPN #1's written statement was reviewed on December 11, 2013, at 1:48 p.m. and verified in an interview conducted via telephone on January 13, 2014, at 3:31 p.m.. LPN #1 revealed that on July 4, 2013, he/she initiated CPR and instructed DSP #1 to dial 911. LPN #1 further revealed that she performed CPR on Resident #1 while the client was in the bed. When asked why she performed CPR while the client was in bed, LPN #1 indicated that she was in "panic mode" and was not thinking. LPN #1 indicated that she could not find the CPR board and that she did not think to place the client on the floor prior to initiating CPR.</p> <p>C. Observations at the facility on December 26, 2013, at 9:49 a.m. revealed an orange board was located in the dining room area near the nursing station. The board was identified by Staff #1 as the CPR board. Staff #1 further stated that all of the staff know that the board is located there and to get it when needed.</p> <p>D. According to the AHA, CPR is most effective</p>	1390	<p>3520.1</p> <p>VOAC will continue to train each staff hired on CPR and First aid and pay particular attention to the use of the orange board located in each home to be used during CPR. VOAC will continue to train staff to understand that the board is to be used providing a hard surface for the individuals during the CPR.</p> <p>Implemented August 2013 and continuing.</p> <p>VOAC will continue to train staff on the procedures related to seizure protocols and ensure through its internal QA policies and procedures that all nursing staff follow the procedures as outlined in the individuals chart. Individualized trainings have begun and will continue for the month of august until all staff in all homes is trained on the individualized issues.</p>	

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I 390	<p>Continued From page 4</p> <p>when performed on a hard surface to ensure the target depth of compressions is achieved to ensure the heart is completely emptied when the chest wall is compressed.</p> <p>At the time of the incident, the facility's nurse failed to ensure CPR was performed on a hard surface in accordance with AHA standards.</p> <p>II. The nursing staff failed to implement Resident #1's seizure protocol as evidenced below:</p> <p>Review of the seizure protocol on December 11, 2013, at approximately 2:55 p.m., revealed the staff was directed to call 911 if the client had seizures that lasted three (3) minutes.</p> <p>1. Review of the Seizure Tracking Forms on December 11, 2013, at approximately 2:30 p.m. revealed that in the month of June 2013, Resident #1 had five seizures, two of which (June 5, 2013 and June 24, 2013) lasted three minutes. Review of the nursing notes from June 3, 2013 through June 26, 2013, on December 11, 2013, at approximately 3:15 p.m., revealed that there was no evidence that the staff called 911 as directed in the protocol.</p> <p>2. Further review of the protocol revealed that the designated nurse (RN) was to be notified of all seizures. Review of the Seizure tracking forms on December 11, 2013, at approximately 2:30 p.m. and corresponding nursing notes revealed on December 11, 2013, at approximately 3:15 p.m. revealed that the LPN documented the RN was notified of only two of the five seizures.</p> <p>3. LPN #2 was interviewed via telephone on December 19, 2013 at 3:32 p.m. When asked if the nursing staff had received training on Resident #1's seizure protocol, she indicated that the nursing staff had received training on the protocol. When asked if all seizures were to be reported to the RN, LPN #2 stated yes.</p>	I 390	<p>Training begun on 7/24/13 and continues until all staff in all homes are trained. This training will repeat as new staff comes onboard.</p>	

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I 390	<p>Continued From page 5</p> <p>4. Interview with RN#1 on December 26, 2013, at 11:00 a.m. disclosed that the nursing staff failed to call 911 for seizures that lasted three minutes and to notify the RN of all seizures as outlined in the seizure protocol.</p> <p>III. The nursing staff failed to have evidence that the PCP and Neurologist were notified of seizure activity as outlined on the Seizure Tracking Form as evidenced below: Review of Resident #1's Seizure Tracking Forms on December 11, 2013, at approximately 2:30 p.m., revealed instructions located at the bottom of the form that instructed the nurses to fax the form to the neurologist and PCP before the end of their shifts. Further interview with LPN #2 on December 19, 2013, at 3:22 p.m. revealed that all Seizure Tracking Forms were to be faxed to the neurologist and PCP. Interview with RN #1 on December 26, 2013, at 11:00 a.m. verified that the nurses were directed to fax the forms to the PCP and neurologist; however the facility had no tracking system in place to verify that the forms were being faxed.</p> <p>IV. RN #2 failed to conduct and document a comprehensive nursing assessment that reflected an accurate account of Resident #1's health status evidenced below:</p> <ol style="list-style-type: none"> 1. Review of the "Nursing Health and Safety Assessment" dated June 21, 2013, completed by RN #2, revealed that a review of all systems was completed. 2. The neurosensory assessment reflected that the client was on multiple seizure medications and had 1-3 seizures per month. 3. The summary of the findings of the assessment reflected that there was a "work up for tapering (tapering) down (seizure) medications in progress. Phenobarbital was (discontinued). There was no increase in seizures ..." 	I 390	<p>3520.1 continued</p> <p>VOAC will ensure that any recommended and or discovery of missed appointment receives 24hrs follow-up to re-schedule with a different physician as recommended by the PCP. PCP should have notes in the record regarding his/her review and recommendation follow-up to the appointment. Our refined internal quality assurance process and tools such as the quarterly health record review is already in place. This review will be done at our bi-weekly meeting this system will be closely monitored to ensure meetings are comprehensive that assist in resolving this.</p> <p>Current Nursing, Quality Assurance and Director level staff can and will initiate immediate second opinions, when issues are of an acute nature which may cause adverse effect to the person health and wellbeing if appointment is not kept. This should include consultation with DDS health and Wellness unit and any other resources available to VOAC.</p>	

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I 390	<p>Continued From page 6</p> <p>Review of Resident #1's Seizure Tracking Forms on December 11, 2013, at approximately 2:30 p.m. revealed that Resident #1 had experienced four seizures prior to this assessment.</p> <p>4. RN #2 was interviewed via telephone on January 13, 2014; at 2:20 p.m. RN #2 was queried about her knowledge of the multiple seizures experienced by Resident #1 in June 2013. RN #2 indicated that the LPN's might have informed her and that she just failed to document them in the assessment.</p> <p>V. There was no evidence that the nursing staff informed the PCP that Resident #1's EEG was cancelled to seek further instructions as evidenced below:</p> <p>1. The neurologist evaluated Resident #1 on May 24, 2013. The neurologist documented that the client had one seizure and was more awake since the Phenobarbital was discontinued. The neurologist recommended an EEG (electroencephalogram) to assist in characterizing the seizures and to help determine the appropriateness of the remaining medications</p> <p>2. An EEG was scheduled for June 26, 2013, however it could not be completed because the client had cornrows in her hair and her wheelchair would not fit in the room. In addition, the neurologist was on vacation and unavailable for consultation.</p> <p>3. Review of the physician notes on December 4, 2013, at 2:30 p.m. - 4:30 p.m. revealed that the PCP's last assessment of Resident #1 was documented on June 20, 2013. There was no further documentation in the record to indicate the PCP was informed of the missed EEG.</p>	I 390		

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W 000	INITIAL COMMENTS On July 12, 2013, the Office of Compliance and Quality Assurance and Investigation Division (OQAID) was notified of the death of Client #1. Client #1 passed away after an eight day stay in the hospital. An onsite investigation was initiated on December 3, 2013, to evaluate the health care rendered to Client #1 prior to being hospitalized on July 4, 2013. The findings of the investigation were based on, interviews with direct care staff, nursing staff and the agency's management staff, the review of medical records, habilitation records and administrative records, as well as a review of the facility's incident management and reporting system. Note: The abbreviations listed below may appear throughout the body of this report. American Heart Association - AHA Direct Support Professional - DSP Registered Nurse - RN Occupational Therapy - OT Qualified Intellectual Disabilities Professional - QIDP Group Home for Individuals with Intellectual Disabilities - GHIID House Manager - HM Primary Care Physician - PCP Licensed Practical Nurse - LPN Cardiopulmonary Resuscitation - CPR Office of Compliance and Quality Assurance and Investigation Division - OQAID	W 000			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties	W 189			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Quality Assurance Coordinator* (X6) DATE *1/24/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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W 189	Continued From page 1 effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the staff was effectively trained to implement the provisions outlined in each client's Seizure Protocol and Seizure Tracking Form for one (1) of one (1) client in the investigation. (Client #1) The findings include: Cross refer to W331. The nursing staff failed to dial 911(emergency medical Services) for Client #1 when the client had seizures that lasted three (3) minutes, and failed to notify the RN of all seizures. (See Section II) The nursing staff also failed to notify the PCP and Neurologist of all seizures by faxing the Seizure Tracking Forms to their offices. (See section III). Review of the training records on December 26, 2013, at 11:30 a.m. revealed that the nursing staff was trained on the Seizure Protocol on November 19, 2012, and on the Seizure Tracking Form on April 15, 2013.	W 189	VOAC will continue to train staff on the procedures related to seizure protocols and ensure through its internal QA policies and procedures that all nursing staff follow the procedures as outlined in the individuals chart. Individualized trainings have begun and will continue for the month of august until all staff in all homes is trained on the individualized issues.		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide nursing care in accordance with the client needs for one (1) of one (1) client in the investigation. (Client #1) The findings include: I. The facility's nursing staff failed to perform emergency procedures [Cardiopulmonary	W 331			

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W 331	<p>Continued From page 2</p> <p>Resuscitation (CPR) in accordance with standards set forth by the American Heart Association (AHA) as evidenced below:</p> <p>A. Review of Client #1's record, on December 4, 2013, between 10:00 a.m. and 4:30 p.m. revealed that on the morning of July 4, 2013, at approximately 7:20 a.m. Staff #1 discovered Client #1 in her bed with clear thick saliva coming from her mouth. DSP #1 called LPN #1 to the client's room. LPN #1 assessed Client #1 and discovered that she had no pulse and was not breathing.</p> <p>B. LPN #1's written statement was reviewed on December 11, 2013, at 1:48 p.m. and verified in an interview conducted via telephone on January 13, 2014, at 3:31 p.m.. LPN #1 revealed that on July 4, 2013, he/she initiated CPR and instructed DSP #1 to dial 911. LPN #1 further revealed that she performed CPR on Client #1 while the client was in the bed. When asked why she performed CPR while the client was in bed, LPN #1 indicated that she was in "panic mode" and was not thinking. LPN #1 indicated that she could not find the CPR board and that she did not think to place the client on the floor prior to initiating CPR.</p> <p>C. Observations at the facility on December 26, 2013, at 9:49 a.m. revealed an orange board was located in the dining room area near the nursing station. The board was identified by Staff #1 as the CPR board. Staff #1 further stated that all of the staff know that the board is located there and to get it when needed.</p> <p>D. According to the AHA, CPR is most effective when performed on a hard surface to ensure the target depth of compressions is achieved to ensure the heart is completely emptied when the chest wall is compressed.</p>	W 331	<p>Training begun on 7/24/13 and continues until all staff in all homes are trained. This training will repeat as new staff comes onboard.</p>		

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W 331	Continued From page 3 At the time of the incident, the facility's nurse failed to ensure CPR was performed on a hard surface in accordance with AHA standards. II. The nursing staff failed to implement Client #1's seizure protocol as evidenced below: Review of the seizure protocol on December 11, 2013, at approximately 2:55 p.m., revealed the staff was directed to call 911 if the client had seizures that lasted three (3) minutes. 1. Review of the Seizure Tracking Forms on December 11, 2013, at approximately 2:30 p.m. revealed that in the month of June 2013, Client #1 had five seizures, two of which (June 5, 2013 and June 24, 2013) lasted three minutes. Review of the nursing notes from June 3, 2013 through June 26, 2013, on December 11, 2013, at approximately 3:15 p.m., revealed that there was no evidence that the staff called 911 as directed in the protocol. 2. Further review of the protocol revealed that the designated nurse (RN) was to be notified of all seizures. Review of the Seizure tracking forms on December 11, 2013, at approximately 2:30 p.m. and corresponding nursing notes revealed on December 11, 2013, at approximately 3:15 p.m. revealed that the LPN documented the RN was notified of only two of the five seizures. 3. LPN #2 was interviewed via telephone on December 19, 2013 at 3:32 p.m. When asked if the nursing staff had received training on Client #1's seizure protocol, she indicated that the nursing staff had received training on the protocol. When asked if all seizures were to be reported to the RN, LPN #2 stated yes. 4. Interview with RN#1 on December 26, 2013, at 11:00 a.m. disclosed that the nursing staff failed to call 911 for seizures that lasted three minutes	W 331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/26/2013
NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
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W 331	Continued From page 4 and to notify the RN of all seizures as outlined in the seizure protocol. III. The nursing staff failed to have evidence that the PCP and Neurologist were notified of seizure activity as outlined on the Seizure Tracking Form as evidenced below: Review of Client #1's Seizure Tracking Forms on December 11, 2013, at approximately 2:30 p.m., revealed instructions located at the bottom of the form that instructed the nurses to fax the form to the neurologist and PCP before the end of their shifts. Further interview with LPN #2 on December 19, 2013, at 3:22 p.m. revealed that all Seizure Tracking Forms were to be faxed to the neurologist and PCP. Interview with RN #1 on December 26, 2013, at 11:00 a.m. verified that the nurses were directed to fax the forms to the PCP and neurologist; however the facility had no tracking system in place to verify that the forms were being faxed. IV. RN #2 failed to conduct and document a comprehensive nursing assessment that reflected an accurate account of Client #1's health status evidenced below: 1. Review of the "Nursing Health and Safety Assessment" dated June 21, 2013, completed by RN #2, revealed that a review of all systems was completed. 2. The neurosensory assessment reflected that the client was on multiple seizure medications and had 1-3 seizures per month. 3. The summary of the findings of the assessment reflected that there was a "work up for tapering (tapering) down (seizure) medications in progress. Phenobarbital was (discontinued). There was no increase in seizures ..." Review of Client #1's Seizure Tracking Forms on December 11, 2013, at approximately 2:30 p.m.	W 331			

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W 331	Continued From page 5 revealed that Client #1 had experienced four seizures prior to this assessment 4. RN #2 was interviewed via telephone on January 13, 2014; at 2:20 p.m. RN #2 was queried about her knowledge of the multiple seizures experienced by Client #1 in June 2013. RN #2 indicated that the LPN's might have informed her and that she just failed to document them in the assessment. V. There was no evidence that the nursing staff informed the PCP that Client #1's EEG was cancelled to seek further instructions as evidenced below: 1. The neurologist evaluated Client #1 on May 24, 2013. The neurologist documented that the client had one seizure and was more awake since the Phenobarbital was discontinued. The neurologist recommended an EEG (electroencephalogram) to assist in characterizing the seizures and to help determine the appropriateness of the remaining medications 2. An EEG was scheduled for June 26, 2013, however it could not be completed because the client had cornrows in her hair and her wheelchair would not fit in the room. In addition, the neurologist was on vacation and unavailable for consultation. 3. Review of the physician notes on December 4, 2013, at 2:30 p.m. - 4:30 p.m. revealed that the PCP's last assessment of Client #1 was documented on June 20, 2013. There was no further documentation in the record to indicate the PCP was informed of the missed EEG.	W 331	VOAC will ensure that any recommended and or discovery of missed appointment receives 24hrs follow-up to re-schedule with a different physician as recommended by the PCP. PCP should have notes in the record regarding his/her review and recommendation follow-up to the appointment. Our refined internal quality assurance process and tools such as the quarterly health record review is already in place. This review will be done at our bi-weekly meeting this system will be closely monitored to ensure meetings are comprehensive that assist in resolving this. Current Nursing, Quality Assurance and Director level staff can and will initiate immediate second opinions, when issues are of an acute nature which may cause adverse effect to the person health and wellbeing if appointment is not kept. This should include consultation with DDS health and Wellness unit and any other resources available to VOAC.		