STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0040	A. BUILDING _____ B. WING _____	06/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL CITY NURSES HEALTH CARE SERVI	4910 MASSACHUSETTS AVE NW 323 WASHINGTON, DC 20016

(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
H 000	INITIAL COMMENTS An annual survey was conducted at your agency from June 27, 2011 through June 28, 2011, 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 from a census of forty- six (46) patients and ten (10) personnel files from a census of one hundred (100) employees. Three (3) home visits.	H 000	Received 8/11/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
H 350	3914.1 PATIENT PLAN OF CARE Each home care agency shall develop, with the participation of each patient or his or her representative, a written plan of care for that patient. This Statute is not met as evidenced by: Based on a record review and interview, the home care agency (HCA) failed to develop a written plan of care for seven (7) of ten (10) patients included in the sample. (Patient #1, #2, #5, #6, #7, #8 and #9) The findings include: Review of Patient #1, #2, #5, #6, #7, #8 and #9's clinical record on June 27, 2011, between 1:20 p.m. and 3:00 p.m., revealed no evidence of a current plan of care (POC) in the patient's clinical record. During a face to face interview with the Director of Operations (DOO)on June 27, 2011 at approximately 3:15 p.m., it was acknowledged the HCA whom the agency has a contract with did not forward Patient #1, #2, #5, #6, #7, #8 and #9's current POCs; therefore the patients plans of care were not available for review.	H 350	H 350 3914.1 Patient Plan of Care 1. Current Plan of Care (POC) will be found in all patient's clinical record by 8/20/11. Current plan of care have been obtained for 6 of 7 patients. The remaining POC will be obtained by 8/20/11. 2. Updated POCs will be sent to the physician 1 month prior to expiration for review and signature. 3. A staff person will be assigned to monitor the date of POC expiration and develop a list of clients whose POC is to expire. Agency staff nurses will be notified of expiration 6 weeks prior to the expiration to initiate the renewal process.	

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H 459	Continued From page 1	H 459		
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 facility's skilled nursing staff failed to ensure evaluation of patient instruction for two (2) of ten (10) patients in the sample. (Patient # 1 and #2) The finding includes: Review of #1 and #2's nursing notes on June 27, 2011 between 1:00 p.m. and 1:15 p.m. revealed the skilled nurse documented patient instruction however, there was no documented evidence the skilled nurse specifically evaluated the instructions given to Patient # 1 and #2. During a face to face interview with the Director of Nursing (DON) on June 27, 2011, at approximately 1:40 p.m., it was acknowledged there was no evidence the skilled nurse specifically evaluated the instructions given to Patient # 1 and #2. Further interview revealed the skilled nurses would be re-trained on how to document the evaluation of instructions given to patients in the medical record.	H 459	H459 3917.2(i) Skilled Nursing Services Patient instruction and evaluation 1. CCNHS held an in-service education/training on Nursing Documentation for all skilled nurses on 7/21/11. CCNHS reviewed that when a skilled nurse provided instruction to a patient/patient's representative the nurse must obtain feedback of understanding or return demonstration of technique when applicable and evaluate that understanding. The nurse must document the education/ instruction given and the patient/ patient's representative's understanding of such. 2. Routine Nursing in-services will be scheduled at least twice annually. 3. The management team will randomly monitor nursing documentation to ensure that staff is complying with corrective training. Susan Ladyga RN 8/11/11	