Received 7/23/09

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Capital City Nurses Healthcare Services	4910 Mass., Ave NW Wash., DC	05/15 & 05/19, 2009 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
Title 22 Chapter 39	An initial licensure survey was conducted from May 15, 2009 through May 19, 2009. The sample size selected for the clinical record review was ten (10) based on a census of forty –five (45) patients and ten (10) staff records based on a census of approximately one hundred (100) employees.		3908.1(d) Policy governing refunds: Policies and Procedure Manual was revised to include in Billing and Financial Procedures: Client Billing #8: Overpayment or Balances on Client accounts will be refunded within 30 days of receipt.	7/10/09
	3908 **ADMISSION**		3908.1 (f) Do Not Resuscitate. Policies and Procedure Manual was revised to include in Start of Care policy: Section Start of Care Documentation; Do Not Resuscitate the following: *Do Not Resuscitate* *If a client has a Do Not Resuscitate (DNR) directive, a copy will be placed in the client's clinical file as well as the client's Capital City Nurses Healthcare Services home folder. A notation will also be entered in the client's electronic database file under Special Instructions.* *In the event that a client, living outside of institution and not a HOSPICE client, has a Do Not Resuscitate (DNR) directive, and the client stops breathing, the caregiver will call 911.* *In the District of Columbia and Maryland, the ambulance/ rescue squad and police will respond to the 911 call. The caregiver should be prepared to present the officials with a copy of the clients DNR and Advance Directives. The Police, upon consultation with the Medical Examiner, will release the body to the funeral home or medical examiner. A physician will sign the death certificate.* *Family and the office will be notified by the caregiver after calling 911.*	7/10/09
3908.1	**Each home care agency shall have written policies on admission, which shall include, at a minimum, the following:**			
3908.1 (d)	**(d) Policies governing refunds;**			
3908.1 (f)	**(f) Do Not Resuscitate Orders;**			
	Based on a record review on May 15, 2009 at approximately			

Name of Inspector — Date Issued: 6/22/09

Facility Director/Designee — Date: 7/13/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	1:00 pm, that the agency's Admission Policy failed to address Refunds or Do Not Resuscitate Orders. The finding includes: During a face to face interview on May 18, 2009 with the President and Director of Operations the above listed findings were acknowledged.		
3908.4	**The home care agency shall notify each entity referring a potential patient to the agency, and each individual requesting services from the agency, of the availability or unavailability of services, and the reason(s) therefor, within 48 hours after the referral or request for services.** Based on a record review on May 15, 2009 at approximately 1:00 PM, the agency's Admission Policy failed to address that the agency shall notify each entity referring a potential patient to the agency, and each individual requesting services from the agency, of the availability of services, and the reason(s) therefor, within 48 hours after the referral or request for services. The findings include: During a face to face interview on May 18, 2009 at approximately 1:10 PM with the President and Director of Operations the above listed findings were acknowledged.	3908.4 Admission Policy Notification of availability of service and the reasons. Policies and Procedure Manual was revised to include in Section: Initiation of Services: Other Information, Pages 48,-49 *a. Helpers' name called to do case and accept case will be entered. Note will be made of inability to staff case.* *b. Contact/caller/client notified of helpers name will be entered to confirm notification.* *c. Name of Contact/caller/client that CCNHS will be unavailable to provide service. Notification of availability or unavailability will be made to the client or client's representative within 48 hours. The reason why CCNHS was unable to provide service will also be entered into the database.* *Page 52:* *Should CCNHS be unable to fulfill a request for services, CCNHS will notify the client or client representative within 48 hours so that an alternative arrangement may be made.*	7/10/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

3908.5	**A home care agency shall maintain records on each person requesting services whose request is not accepted. The records shall be maintained one (1) year from the date of non-acceptance and shall include he nature of the request for services and the reason for not accepting the patient.** Based on observation and interview, the agency failed to maintain records on each person requesting services whose request is not accepted. The records shall be maintained one (1) year from the date of non-acceptance and shall include the nature of the request for services and the reason for not accepting the patient. The finding includes: Review of policies on May 15th and 19th 2009, revealed that the agency did not keep records for non-accepted patients. This finding was acknowledged by the President and Director of Operation on May 19, 2009 at approximately 11:30 am. **3910** **RECORDS RETENTION AND DISPOSAL** **Each home care agency shall maintain a clinical record system that shall include the following:**	3908.5 Maintaining records for those not taken under care: Policies and Procedure Manual was revised to include in Section Initiation of Services: Other Information, Page 53: *8. A request for service that was not taken under care will be stored in the electronic data base for a one year period. The record will indicate why the case was not taken under care.*	7/10/09

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

3910.1 (a)	**Written policies that provide for the protection, confidentiality, retention, storage, and maintenance of clinical records:** Based on a record review and interview the agency failed to include protection, confidentiality and retention of clinical records in their written policies. The findings include: A record review of policies on May 19, 2009 at approximately 11:30 am revealed that the agencies written policies that provide for the protection, confidentiality, retention, storage, and maintenance of clinical records failed to include protection, confidentiality, and retention of clinical records. A face to face interview with the President and Director of Operations on May 19, 2009 at approximately 12 noon, it was revealed that the protection, confidentiality and retention of clinical record would be added to agencies policy.	3910.1(a) Written Policies that provide protection, confidentiality, retention, storage & maintenance of clinical records: Policies and Procedure Manual was revised to include in Section Initiation of Services: Client Records: page 83: *Policy* *CCNHS will maintain client records in accordance with appropriate regulations governing the CCNHS case. All active CCNHS patients will have a client file that will be maintained at the CCNHS office. The type of records maintained and the ownership of such records will be determined on a case-by-case basis.* *Client records will be stored in a secure location to ensure privacy and confidentiality. Client files will be accessed by appropriate CCNHS personnel only. Active files will be stored in secure and locked cabinets.* *Clients have the right to access their clinical record.* *Page 84:* *1. All District of Columbia client records will be maintained for five years after the date of client discharge within 100 miles of the District of Columbia.* *Client records will be retained in the CCNHS office at least until the end of the calendar year in which the case terminates. Client record may then be moved off site to a secure storage area.* *2. CCNHS will maintain records on each person requesting care services whose request is not accepted or care is declined for at least one year from the time of intake. The nature of the request for services and the reason for non acceptance of services shall be documented whenever possible.*	7/10/09
3910.3	**Each home care agency shall inform the Department of Health and each patient in writing, within thirty (30) days of dissolution of the agency, of the location of the clinical records and how each patient may obtain his or her clinical record.**		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Based on a record review and interview the agency failed to include in their written policies informing the Department of Health and each patient in writing, within thirty (30) days of dissolution of the agency, of the location of the clinical records and how each patient may obtain his or her clinical record.

The findings include:

A record review of policies on May 19, 2009 at approximately 11:30 am revealed that the agencies written procedures that address the transfer or disposition of clinical records in the event of dissolution of the home care agency failed to include informing the Department of Health and each patient in writing, within thirty (30) days of dissolution of the agency, of the location of the clinical records and how each patient may obtain his or her clinical record.

A face to face interview with the President and Director of Operations on May 19, 2009 at approximately 12 noon, revealed that the agency will include in their written procedures informing the Department of Health and each patient in writing, within thirty (30) days of dissolution of the agency, of the location of the clinical records and how each patient may obtain his or her clinical record.

3910.3 Notification of DOH & patient in writing of dissolution, location of clinical records and how patient may obtain his/her record: Policies and Procedure Manual was revised to include in Section Initiation of Services: Client Records: Page 87: *14. If CCNHS dissolves, and there is no new owner, client records or client clinical records shall be stored in a public warehouse within 100 miles of the District of Columbia or with the approval of the client, in the offices of the physician. District of Columbia client records will be shredded and destroyed in an appropriate confidential and secure manner at the end of five years.*	7/10/09
15.If CCNHS dissolves, and there is no new owner, the agency will notify the Department of Health and each patient in writing, within 30 days of dissolution, to inform them of the location of the records and how each patient may obtain their clinical record.	7/10/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	3912 **PATIENT RIGHTS AND RESPONSIBILITIES**		
3912.2	**Each home care agency shall develop a written statement of the patient rights and responsibilities that shall be given, upon admission, to each patient who receives home care services:**	3912.2 (c) (7) Written Statement of patient rights and responsibilities...to be informed orally and in writing of the telephone number of the Home Health Hotline. Pages 64, 65 *Client Bill of Rights and Responsibilities and Consent for Treatment* * *The nurse will review with the client, family or client representative that the Client/Family has the right to be: assured the right to voice grievances and complaints related to agency services in confidence without fear of reprisal from agency or agency personnel* *The client will be informed of the agency number to call if a problem is not satisfactory addressed and the number and address of the appropriate jurisdictional governmental agency will be provided to the client.* CCNHS form "Client Bill of Rights & Responsibilities & Consent for Treatment" was revised to include DC Home Health Hotline information. Revised copy is included in this response. A District of Columbia Department of Health Home Hotline was created and is included with all Start of Care packages given to clients. Copy is included in this response.	7/31/09
3912.2 (c) 3912.2 (c) (7)	**To be informed orally and in writing of the following:** **The telephone number of the Home Health Hotline maintained by the Department of Health;** Based on a record review, that the agencies patient Bill of Rights and Responsibilities failed to include The telephone number of the Home Health Hotline maintained by the Department of Health. The finding includes: A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and Responsibilities and Consent for Treatment" failed to include the telephone number of the Home Health Hotline maintained by the Department of Health. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.		
3913.2 (d)	**To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care;**	* Attachment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	Based on a record review, the agencies patient's "Bill of Rights and Responsibilities" failed to include that the patient will receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care. The finding includes: A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and Responsibilities and Consent for Treatment" which failed to include that the patient will receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.	3912.2 (d) Agency's "Client Bill of Rights & Responsibilities & Consent for Treatment"...failed to include pt will receive treatment, care & services consistent with agency/patient's agreement and plan of care. The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: *The Client/Family has the right to be:* • *receive treatment, care and services consistent with agency-patient agreement and plan of care*	7/31/09
3912.2 (f)	**To receive services by competent personnel who can communicate with the patient;** Based on a record review, the agencies patient's Bill of Rights and Responsibilities failed to include that the patient will receive services from personnel who can communicate with the patient. The finding includes:	3912.2 (f) Agency's "Client Bill of Rights & Responsibilities & Consent for Treatment"...failed to include pt will receive services from personnel who can communicate with the patient. The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: The Client/Family has the right to be: • served by individuals who can communicate with patient	7/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and Responsibilities and Consent for Treatment" failed to include that the patient will receive services from personnel who can communicate with the patient. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.			
3912.2 (g)	**To be informed of his or her condition by the health care provider in accordance with generally accepted professional standard;** Based on a record review, that the agencies patient's "Bill of Rights and Responsibilities" failed to include that the patient will be informed of his or her condition by the health care provider in accordance with generally accepted professional standard. The findings include: The findings includes: A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and Responsibilities and Consent for Treatment" failed to include that the patient will be informed of his or her condition by the health care provider in accordance with generally accepted professional standard.		3912.2 (g)) Agency's "Client Bill of Rights & Responsibilities & Consent for Treatment"...failed to include pt will be informed of his/her condition. The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: *The Client/Family has the right to be:* • .be informed of his/her condition by the health care provider in accordance with generally accepted professional standards	7/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.		
3912.2 (l)	**To voice a complaint or other feedback in confidence and without fear of reprisal from the agency or any agency personnel, in writing or orally, including an in-person conference if desired, and to receive a timely response to a compliant as provided in these rules;** Based on a record review the agencies patient's "Bill of Rights and Responsibilities" form failed to include that a patient can file a compliant in writing or request an in-person conference if desired. The finding includes: A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and Responsibilities and Consent for Treatment". The form failed to include that a patient can file a compliant in writing or request an in-person conference if desired. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.	3912.2 (l)) Agency's "Client Bill of Rights & Responsibilities & Consent for Treatment"...failed to include pt will be informed to voice a complaint in writing or orally, including an in-person conference if desired and to receive a timely response to a complaint. The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: • Assured the right to voice grievances and complaints related to agency services in confidence without fear of reprisal from the agency or agency personnel. • It is your right to let the agency know if you have a problem or concern so that the agency can hopefully achieve a satisfactory outcome. You may call, write or visit In-person the following people for an in-person conference if you have a problem or concern: Your client care coordinator at 1-866-NURSE-07. If the problem is not resolved, the Director of Nursing at 1-866-NURSE-07. If still not resolved, call the Director of Operations at 1-866-NURSE-07. If the agency fails to resolve your concern or problem, you have the right to visit or contact the state hotline by phone or in writing to voice your complaint, problem, or concern. **DC Hotline: 202-442-4779** Home Health Hotline Ms. Sharon H. Mebane, Program Manager Government of the District of Columbia Department of Health Intermediate Care Facilities Division 825 North Capital Street, NE Washington, DC 20002	7/31/09 7/31/09
3912.2 (m)	**To have access to his or her own clinical records.** Based on a record review the agencies patient's "Bill of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	Rights and Responsibilities" The form failed to include that the patient will have access to his or her own clinical records. The finding includes: A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and Responsibilities and Consent for Treatment". The form failed to include that the patient will have access to his or her own clinical records. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm	3912.2 (m) Patient access to his/her own records: The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: • to have access to his/her own clinical records	7/31/09
3912.3	**Each home care agency shall inform all patients that they have the right to make complaints and /or to provide feedback concerning the services rendered by the agency to the Department of Health, in confidence and without fear of reprisal from the agency or any personnel, in writing or orally, including an in-person conference if desired** Based on a record review the agency failed to inform patient's that they have the right to make complaints and /or to provide feedback concerning the services rendered by the agency to the Department of Health, in confidence and without fear of reprisal from the agency or any personnel, in writing or orally, including an in-person conference if desired.	3912.3 Inform patients of the right to make complaints / to agency and DOH The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: • assured the right to voice grievances and complaints related to agency services in confidence without fear of reprisal from the agency or agency personnel. • It is your right to let the agency know if you have a problem or concern so that the agency can hopefully achieve a satisfactory outcome. You may call, write or visit in person the following people for an in person conference if you have a problem or concern: Your client care coordinator at 1-866-NURSE-07. If the problem is not resolved, the Director of Nursing At 1-866-NURSE-07. If still not resolved, call the Director of Operations at 1-866-NURSE-07. If the agency fails to resolve your concern or problem, you have the right to visit or contact the state hotline by phone or in writing to voice your complaint, problem, or concern. **DC Hotline: 202-442-4779** Home Health Hotline Ms. Sharon H. Mebane, Program Manager Government of the District of Columbia Department of Health Intermediate Care Facilities Division 825 North Capital Street, NE Washington, DC 20002	7/31/09 7/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	The findings include: A record review on May 19, 2009 at approximately 12:30 pm revealed there was no documented evidence that patient's had been informed by the agency that they have the right to make complaints and /or to provide feedback concerning the services rendered by the agency to the Department of Health, in confidence and without fear of reprisal from the agency or any personnel, in writing or orally, including an in-person conference if desired. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.		
3912.4 3912.4 (a)	**Each home care agency shall develop a statement of patient responsibilities regarding the following:** **Treating agency personnel with respect and dignity;** Based on a record review that the agencies patient's "Bill of Rights and Responsibilities" failed to include that the patient has the responsibility to treat agency personnel with respect and dignity. The finding includes: A record review on May 19, 2009 at approximately 12:30 pm revealed a form entitled "Client Bill of Rights and	3912.4 (a) Develop a statement of patient responsibility regarding "treating agency personnel with respect and dignity. The Client Bill of Rights & Responsibilities & Consent for Treatment"...was revised to include: **Patient's Responsibility:** • to treat agency personnel with respect and dignity	7/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	Responsibilities and Consent for Treatment" failed to include that the patient has the responsibility to treat agency personnel with respect and dignity. The above finding was acknowledged by the President and Director of Operations on May 19, 2009 at approximately 12:45 pm.		
	3914 **PATIENT PLAN OF CARE**		
3914.2	**The plan of care shall be approved by the patient's physician.** Based on interview and record review, the agency failed to ensure the plan of care was approved by the patient's physician for one out of ten patients in the sample. (Patient # 1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the plan of care was not approved by the patient's physician. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:21 PM acknowledged the POC was	3914.2 Plan of care not approved by the physician for patient #1. Physician has signed orders approving "private duty homecare services as patient/family request." See copy of signed orders as attached.	7/10/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	not approved by the patient's physician. There was no evidence that the POC was approved by the patient's physician.		
3914.3	**The plan of care shall include the following:**		
3914.3 (a)	**(a) Physician orders for skilled services;** Based on interview and record review, the agency failed to ensure the plan of care included was approved by physician's orders for skilled services for one out of ten patients in the sample. (Patient # 1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the plan of care did not include physician's orders for skilled services. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:21 PM it was acknowledged Patient #1's POC did not	3914.3 (a) Plan of care not approved by the physician for skilled services for patient #1. 1. Physician has signed orders approving "private duty homecare services as patient/family request." See copy of signed orders as attached. Attached are signed orders for medication and request from agency for physician's signature. * 2. As these are not Medicare/Medicaid patients the format for orders is different. CCN will develop a multi-purpose and service form for physician review. 3. Policies and Procedures under Section Initiation of Services indicate the following on page 58: 4. *The Director of Nursing or her delegate shall evaluate each client at the time of he initial visit for the following criteria:* *a. the ability of the agency to provide and coordinate services that the patient needs;* *b. the patient's general health and the patient's psychosocial condition or functioning status pertinent to the service being requested,* *c. the adaptability of the patient's place of residence to accommodate the services being requested; and* *d. the ability of the patient to participate in his or her own care, or the availability of an individual willing to assume the appropriate level of responsibility when the patient is unable to do so.* *e. The clients' goals, expected outcomes will be documented at the initial visit.* *f. Prognosis and rehabilitation potential will be documented.* *g. Admission paperwork such as Advance Directives, HIPAA, and Clients Rights and Responsibilities will be reviewed with the client at the time of the nurse's initial visit.* *h. Physician's orders will be obtained for any skilled needs the client may have.* *i. Physician's orders for medications or skilled services will be renewed every 90 days.* *j. Verbal physician orders will be signed within 30 days.* *k. A client residing in the District of Columbia may have physician orders for private duty personal care services and that physician will be forwarded a copy of the clients plan of care for his/her review.* * Attachment	7/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	include physician's orders for skilled services. There was no evidence the POC included physician's orders for skilled services.		
3914.3 (c)	**(c) The goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient;** Based on interview and record review, the agency failed to ensure the plan of care included the goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient for one out of ten patients in the sample. (Patient # 1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the plan of care did not include the goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:24 PM it was acknowledged Patient #1's POC did not include the goals of the services to be provided, including the expected outcome, based upon the	3914.3 (c) Plan of Care did not include goals of the services and expected outcomes. CCN will develop a multi-purpose and service form stating goals of service and expected outcomes based on immediate and long-term needs of the patient.	8/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	immediate and long-term needs of the patient. There was no evidence the POC included the goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient.			
3914.3 (d)	**(d) A description of the services to be provided, including: the frequency, amount, and expected duration and medication administration, including dosage;** Based on interview and record review, the agency failed to ensure the plan of care included a description of the services to be provided, including the frequency, amount, and expected duration and medication administration, including dosage for one out of ten patients in the sample. (Patient # 1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the plan of care did not include a description of the services to be provided, including the frequency, amount, and expected duration and medication administration, including dosage. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:26 PM acknowledged Patient #1's POC did not include a description of the services to be	3914.3 (d) Plan of Care did not include a description of services to be provided including frequency, amount, and expected duration and medication administration dosages. 1. CCN will develop a multi-purpose and service form for physician review specifying services, frequency and expected duration. 2. Signed physician orders indicated that services were as requested by patient/family 3. Medication list with dosage, frequency, and route was signed by physician. See attached.	8/30/09 7/10/09 7/10/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	provided, including the frequency, amount, and expected duration and medication administration, including dosage. There was no evidence the POC included a description of the services to be provided, including the frequency, amount, and expected duration and medication administration, including dosage.		
3914.3 (g)	**(g) Physical assessment, including all pertinent diagnoses;** Based on interview and record review, the agency failed to ensure the plan of care included a physical assessment, including all pertinent diagnoses for one out of ten patients in the sample. (Patient # 1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the POC did not include a physical assessment, including all pertinent diagnoses. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:28 PM acknowledged Patient #1's POC did not include the aforementioned assessment and diagnoses.	3914.3 (g) Physical Assessment including all pertinent diagnoses. Plan of Care did not include a Physical Assessment including all pertinent diagnoses. 1. CCN will develop a multi-purpose and service form with physical assessment to include all pertinent diagnoses.	8/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	There was no evidence the POC included a physical assessment.		
3914.3 (h)	**(h) Prognosis, including rehabilitation potential;** Based on interview and record review, the agency failed to ensure the plan of care (POC) included a prognosis, including rehabilitation potential for one out of ten patients in the sample. (Patient # 1) The finding includes: Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the plan of care did not include a prognosis, including rehabilitation potential. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:30 PM acknowledged Patient #1's POC did not include a prognosis, including rehabilitation potential. There was no evidence the POC included a prognosis.	3914.3 (h) Prognosis, including rehab potential was not included on the plan of care. 1. CCN will develop a multi-purpose and service form with prognosis and rehab potential.	8/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

3914.3 (l)	**(l) Identification of employees in charge of managing emergency situations;** Based on interview and record review, the agency failed to ensure the identification of employees in charge of managing emergency situations on the Plan of Care (POC) for four out of ten patients in the sample. (Patient # 1, Patient # 2, Patient # 7, and Patient # 10) The findings include: 1. Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the identification of employees in charge of managing emergency situations was not documented. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:20 PM acknowledged that the agency did not document the identification of employees in charge of managing emergency situations on the POC. There was no evidence that the agency documented the identification of employees in charge of managing emergency situations. 2. Review of Patient #2's Home Health Certification and Plan of Care (POC) dated November 4, 2008 through May 2, 2009 on May 15, 2009 at approximately 1:50 PM revealed the identification of employees in charge of managing emergency situations was not documented.	3914.3 (l) Plan of Care did not identify employees in charge of managing emergency situations. 1. Agency Plan of Care does not identify employees in charge of managing emergency situations. Clients receive an Initiation of Services letter which outlines what to do in a medical emergency. It reads as follows: "For the client's convenience, Capital City Nurses Healthcare Services provides a counselor on call 24 hours per day. That counselor is available to service both emergency and regular patient requests for care. However, if a client is experiencing a medical emergency, they are advised to call their physician or go to the nearest emergency room. " 2. Agency's Policies & Procedures include the following: Emergency Procedures: *A Client Care Coordinator is available on call 24 hours each day. The Coordinator is available for the receipt of emergency calls.* *Additionally, the Capital City Nurses Healthcare Services Director of Nursing or her delegate may be called at any time with concerns or problems. The company president may be called if the Director of Nursing is not available.* *The On-call Coordinator will relay medical emergency calls to the on-call registered nurse who will advise the client/ client representative.* *While Capital City Nurses Healthcare Services provides clients with assistance in daily living functions and occasional routine nursing services, it does not provide clients with emergency nursing services. Therefore, if a client is experiencing a medical emergency CCNHS caregivers or client or client's representatives should call 911 for immediate and urgent medical emergencies.* *All clients will be considered a "Do Resuscitate" unless they have a "Do Not Resuscitate" order.*	7/10/09 7/31/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

In an interview with the DOO on May 15, 2009 at approximately 1:55 PM acknowledged the agency had not documented the identification of employees in charge of managing emergency situations on the POC.

There was no evidence that the agency documented the identification of employees in charge of managing emergency situations.

3. Review of Patient # 7's Home Health Certification and POC dated October 10, 2008 through April 29, 2009 on May 19, 2009 at approximately 11:00 PM revealed the identification of employees in charge of managing emergency situations was not documented.

In an interview with the President on May 19, 2009 at approximately 11:15 PM it was acknowledged that the agency had not document the identification of employees in charge of managing emergency situations as indicated on the POC.

There was no evidence that the agency documented the identification of employees in charge of managing emergency situations.

4. Review of Patient # 10's Home Health Certification and POC dated December 24, 2008 through June 24, 2009 on May 19, 2009 at approximately 1:25 PM revealed the identification of employees in charge of managing emergency situations was not documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	In an interview with the President on May 19, 2009 at approximately 1:55 PM acknowledged that the agency did not document the identification of employees in charge of managing emergency situations as indicated on the POC. There was no evidence that the agency documented the identification of employees in charge of managing emergency situations.			
3914.3(m)	**(m) Emergency protocols;** Based on interview and record review, the agency failed to ensure emergency protocols were documented on the Home Health Certification and Plan of Care (POC) for four out of ten patients in the sample. (Patient # 1, Patient # 2, Patient # 7, and Patient # 10) The findings include: 1. Review of Patient #1's Plan of Care (POC) dated March 2, 2009 on May 15, 2009 at approximately 1:15 PM revealed the emergency protocols was not documented. Interview with the Director of Operations (DOO) on May 15, 2009 at approximately 1:20 PM acknowledged that the	3914.3 (m) Emergency Protocols were not documented on the Plan of Care 1. CCN will develop a multi-purpose and service form with goals and rehab potential which will include that the "patient is instructed in use of 911 in case of medical emergency."	8/30/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

agency had not documented the emergency protocols on the POC.

There was no evidence that the agency documented the emergency protocols on the POC.

2. Review of Patient #2's Home Health Certification and Plan of Care (POC) dated November 4, 2008 through May 2, 2009 on May 15, 2009 at approximately 1:50 PM revealed the emergency protocols were not documented.

In an interview with the DOO on May 15, 2009 at approximately 1:55 PM acknowledged that the agency had not documented the emergency protocols on the POC.

There was no evidence that the agency documented the emergency protocols on the POC.

3. Review of Patient # 7's Home Health Certification and POC dated

October 10, 2008 through April 29, 2009 on May 19, 2009 at approximately 11:00 PM revealed the emergency protocols were not documented.

In an interview with the President on May 19, 2009 at approximately 11:15 PM acknowledged that the agency had not documented the emergency protocols on the POC.

There was no evidence that the agency documented the emergency protocols on the POC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

4. Review of Patient # 10's Home Health Certification and POC dated December 24, 2008 through June 24, 2009 on May 19, 2009 at approximately 1:25 PM revealed the emergency protocols were not documented.

In an interview with the President on May 19, 2009 at approximately 1:55 PM acknowledged that the agency had not documented the emergency protocols were on the POC.

There was no evidence that the agency documented the emergency protocols on the POC.