Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0002	A. BUILDING _____ B. WING _____	10/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF D	316 F STREET, NE WASHINGTON, DC 20002

(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 on September 28, 2009 through October 2, 2009, to determine compliance with Title 22 DCMR, Chapter 39 Home Care Agencies Regulations. The following deficiencies were based on record reviews, staff interviews, and a patient interview. The sample sizes were ten (10) patients based on a census of thirty (30) and ten (10) employees based on a census of sixty-seven (67).	H 000	Received 11/23/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
H 053	3903.2(c)(1) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: (1) The evaluation shall include feedback from a representative sample consisting of either ten percent (10%) of total District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patients. This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to include feedback from a representative sample consisting of either ten percent (10%) of the total District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patient's in its annual evaluation.	H 053	**Provider's Plan of Correction** **H 053** **The Board of Director's will meet annually to review the agencies policies and procedures to determine the extent to which services promote patient care that is appropriate , adequate, effective, and efficient . This will include a review of 10% of patient service evaluation forms which will be completed on a bi-annual basis and monitored by the Quality Assurance (QA) Program on an annual basis.**	12/09

Health Regulation Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 053	Continued From page 1 The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed that there was no documented evidence of the feedback from a representative sample consisting of either ten percent (10%) of the total District of Columbia patients or forty (40) District of Columbia patients, whichever is less, regarding services provided to those patient's in the agency's annual evacuation dated February 3, 2009. A face to face interview with the Director on September 28, 2009 at approximately 11:00 a.m. confirmed findings.	H 053			
H 054	3903.2(c)(2) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: (2) The evaluation shall include a review of all complaints made or referred to the agency, including the nature of each complaint and the agency's response thereto. This Statute is not met as evidenced by: Based on a record review and interview it was determined that the agency failed to include a review of all complaints made or referred to the agency, including the nature of each compliant and the agency's response thereto in its annual evaluation.	H 054	**H 054**	**1.Complaint Policy and procedure written 2.Complaints will be responded to within 14 days by Nursing Administrator with documentation of intervention and resolution 3. Complaint Hotline Number (202)442-4779 will be provided to clients with CCNS-DC Complaint Policy given to clients/caregivers upon admission and denials 4. Complaints will be recorded with nature of complaint and resolution , Complaints will be reviewed by QA on a quarterly basis**	**11/09**

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H 054	Continued From page 2 The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed that there was no documented evidence of all complaints made or referred to the agency, including the nature of each compliant and the agency's response thereto in its annual evaluation dated February 3, 2009. A face to face interview with the Director on September 28, 2009 at approximately 11:00 a.m. confirmed findings.	H 054		
H 120	3906.1(a) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (a) A description of the services to be provided; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to include the description of services in its contract agreements. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a document entitled "Independent Contractor Agreement" under section Task, Duties and Scope of Work section #2 stated, "Independent Contractor agrees to devote as much time, attention and	H 120	**H 120** **Contractor Agreement Will be revised accordingly to meet DOH Regulations, to include the following information; If a Home Care Agency offers a service that is provided by a third party or contractor, agreements between the Home Care Agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum (a) A description of the services to be provided**	**12/09**

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H 120	Continued From page 3 energy as necessary to complete or achieve the following: RN/LPN/HHA- Scope of Work." The Scope of Work shall be completed by----------. section #3 stated "Independent Contractor shall additionally perform any task and duties associated with the Scope of Work set forth above, including but not limited to, work already being performed or related changes orders. Independent Contractor shall not be entitled to engage in any activities, which are not expressly set forth by this Agreement. Further review of the record revealed that there was no documented evidence of the description of services to be provided to the patient in the agents ' contractor agreement. A face to face to interview with the Director on September 28, 2009 at approximately 2:00 p.m. revealed that all employees except administrative staff are contract employees. And all contracted employees are required to sign the document entitled "Independent Contractor Agreement" which is used as the agency's contractor agreement. The Director also acknowledged the finding at the time of this face to face interview.	H 120	**Contractor Agreement Will be revised accordingly to meet DOH Regulations, to include the following information; If a Home Care Agency offers a service that is provided by a third party or contractor, agreements between the Home Care Agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum** **(a) A description of the services to be provided**	12/09
H 121	3906.1(b) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (b) The location where services are to be provided;	H 121	**H 121** **(b) The location where services are to be provided**	12/09

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H 121	Continued From page 4 This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to include the location of where services are to be provided in its contractor agreements. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a document entitled "Independent Contractor Agreement " under section Recitals it was stated "Independent Contractor is engaging in providing professional nursing RN, LPN, HHA services with their principle place of business at (address- 316 F St., NE Wash., DC 20002) Further review of the document revealed that there was no documented evidence of the location of where services are to be provided in contractor agreement. The only documented address was the above listed address which is the agency's office address. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., it was revealed that the agency only documents the office address on all contractor agreements and not the patient's address were services are provided Director also acknowledged the findings at the time of this interview.	H 121		
H 122	3906.1(c) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a	H 122	H 122 **(c) The manner in which services will be controlled, coordinated and evaluated by the primary home care agency**	12/09

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H 122	Continued From page 5 minimum, the following: (c) The manner in which services will be controlled, coordinated and evaluated by the primary home care agency; This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to include the manner in which services will be controlled, coordinated and evaluated by the primary home care agency. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence of the manner in which services will be controlled, coordinated and evaluated by the primary home care agency in the contractor agreement. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 122		
H 123	3906.1(d) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (d) The procedure for submitting clinical and progress notes, periodic patient evaluation, scheduling of visits, and other designated reports;	H 123	H 123 **(d)The procedure for submitting clinical and progress notes, periodic patient, evaluation, scheduling of visits, and other designated reports**	12/09

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H 123	Continued From page 6 This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to include the procedure for submitting clinical and progress notes, periodic patient evaluation, scheduling of visits, and other designated reports in contractor agreements. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence of the procedure for submitting clinical and progress notes, periodic patient evaluation, scheduling of visits, and other designated reports in the agency's contractor agreement. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 123		
H 124	3906.1(e) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (e) The procedure for payment for services and payment terms for services furnished; This Statute is not met as evidenced by: Based on record review and interview it was	H 124	**H 124** **(e) The procedure for payment for services and payment terms for services furnished**	**12/09**

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H 124	Continued From page 7 determined that the agency failed to include the procedure for payment for services and payment terms for services furnished in its contractor agreements. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence of the procedure for payment for services and payment terms for services furnished in the agency's contractor agreement. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 124		
H 125	3906.1(f) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (f) The procedures used for managing and monitoring the work of personnel employed on a contractual basis; This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to include the procedures used for managing and monitoring the work of personnel employed on a contractual basis in its contractor agreements.	H 125	H 125 **(f)The procedures used for managing and monitoring the work of personnel employed on a contractual basis**	12/09

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H 125	Continued From page 8 The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence of the procedures used for managing and monitoring the work of personnel employed on a contractual basis in the agency's contractor agreement. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 125		
H 126	3906.1(g) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (g) The duration of the agreement, including provisions for renewal, if applicable; and... This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to include the duration of the agreement, including provisions for renewal, if applicable in its contractor agreements. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence of the duration of the	H 126	**H 126** **(g) The duration of the agreement, including provisions for renewal, if applicable, and**	**12/09**

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H 126	Continued From page 9 agreement, including provisions for renewal in the agency's contractor agreement. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 126		
H 127	3906.1(h)(1) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (h) Assurance that the contractor will comply with: (1) All applicable agency policies, including the assurance that contract personnel meet the qualifications and fulfill the responsibilities of agency employees as set out in these rules; This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to include that the contractor will comply with all applicable agency policies, including the assurance that contract personnel meet the qualifications and fulfill the responsibilities of agency employees as set out in these rules in its contractor agreements. The finding includes: A record review on September 28, 2009 at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence that the contractor will	H 127	**H 127** **(h) Assurance that the contractor will comply with** **(1) All applicable agency policies, including the assurance that contract personnel meet the qualifications and fulfill the responsibilities of agency employees as set out in these rules**	**12/09**

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H 127	Continued From page 10 comply with all applicable agency policies, including the assurance that contract personnel meet the qualifications and fulfill the responsibilities of agency employees as set out in these rules in its contractor agreements. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 127		12/09
H 129	3906.2(h)(3) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (h) Assurance that the contractor will comply with: (3) All applicable federal and District laws and regulations. This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to include the assurance that the contractor will comply with all applicable federal and District laws and regulations in its contractor agreements. The finding includes: A record review on September 28, 2009, at approximately 1:00 p.m. revealed a form entitled "Independent Contractor Agreement". There was no documented evidence that the contractor will	H 129	**H 129** **h) Assurance that the contractor will comply with** **(3) All applicable federal and District laws and regulations**	

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H 129	Continued From page 11 comply with all applicable federal and District laws and regulations in the agency's contractor agreements. During a face to face interview with the Director on September 28, 2009 at approximately 2:00 p.m., she acknowledged the finding.	H 129		
H 170	3907.11 PERSONNEL Each home care agency shall ensure that each employee or contract worker shall present a valid agency identification prior to entering the home of a patient. This Statute is not met as evidenced by: Based on an observation and interview it was determined that the failed to ensure that one (1)of the two (2) contract workers presented a valid agency identification prior to entering the home of a patient. (Employee #2) The finding includes: During an observation at the home of patient #4 on October 1, 2009 at approximately 2:00 p.m., it was revealed that employee #2 did not a form of identification from the agency. During a face to face interview on October 1, 2009 at approximately 2:10 p.m. with employee #2, she admitted that she was never issued a form of identification from the agency.	H 170	**H 170** **Contractor's will receive Employee ID Upon Date of Hire** **Employee Tracking Sheet in Human Resources Dept will include Employee ID Issued** **Employee will sign form receipt of Employee ID** **QA will monitor compliance of HR Files monthly with a goal of 100% compliance** **RN Supervisor will check for compliance with Employees at monthly visit**	**11/09**
H 221	3909.2(a) DISCHARGES TRANSFERS & REFERRALS	H 221		

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H 221	Continued From page 12 Each patient shall receive written notice of discharge or referral no less than seven (7) calendar days prior to the action. The seven (7) day written notice shall not be required, and oral notice may be given at any time, if the transfer, referral or discharge is the result of: (a) A medical or social emergency; This Statute is not met as evidenced by: Based on interview and record verification, the Home Care Agency (HCA) failed to ensure each patient received a written notice of discharge no less than seven (7) calendar days prior to the action for one (1) of ten (10) patients in the sample. (Patient #10) The finding includes: Review of Patient #10's Physician's Order Form dated July 23, 2009, on September 28, 2009, at approximately 1:30 p.m. revealed "discharge client from home health nursing services. Client does not meet criteria for home health services per case manager @ HSCSN". (Health Services for Children with Special Needs) Review of Patient #10 ' s CCNS (Community Care Nursing Services) Client Discharge Form dated July 23, 2009 on September 28, 2009, at approximately 1:35 p.m. revealed "client no longer meets criteria for services". Further review revealed Patient #10's physician was notified of her discharge on July 23, 2009, by mail. In an interview with the Director of Nursing (DON) on September 28, 2009 at approximately 1:50 p.m. it was acknowledged all services were	H 221	**H 221** **A written notice of intent to discharge will be mailed and or faxed to client, care manager, and primary care physician, 7 days prior to discharge.** **Letters were mailed out to clients/care managers/primary care physicians who were discharged prior to 10/09– in recognition of discharge from services** **QA will monitor monthly for 100% compliance**	**11/09**

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H 221	Continued From page 13 discontinued immediately for Patient #10 on July 23, 2009 and that Patient #10 did not receive a written notice of discharge no less than seven (7) calendar days prior to the action. There was no documented evidence the HCA ensured the patient received a written notice of discharge no less than seven (7) calendar days prior to the action.	H 221		
H 261	3911.2(a) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (a) Admission data, including name, address, date of application, date of birth, sex, agency case number, next of kin or responsible party, date accepted by the agency to receive services, and source of payment, if applicable; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to have admission data, including name, address, date of application, date of birth, sex, agency case number, next of kin or responsible party, date accepted by the agency to receive services, an source of payment, if applicable for seven (7) of ten (10) patient records. (Patient's #1, #2, #3, #4, #5, #6, and #7) The findings include: 1. A record review of patient #1's clinical record on September 28, 2009 at approximately 10:30 a.m. revealed that there was no documented evidence of the above llsted admission data from the agency.	H 261	**H 261** **Community Care Nursing Services of DC (CCNS-DC) Developed and Implemented Admission Intake form to capture admission data for patient information.** **Medical Records of current clients, new admissions, have Intake form included.** **QA will monitor for 100% monthly**	**10/09**

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H 261	Continued From page 14 A face to face interview with the Director on September 28, 2009 at approximately 12:55 p.m. confirmed findings. 2. A record review of patient #2's clinical record on September 28, 2009 at approximately 1:50 p.m. revealed that there was no documented evidence of the above listed admission data from the agency. A face to face interview with the Director on September 28, 2009 at approximately 2:30 p.m. confirmed findings. 3. A record review of patient #3's clinical record on September 29, 2009 at approximately 10:00 a.m. revealed that there was no documented evidence of the above listed admission data from the agency. A face to face interview with the Director on September 29, 2009 at approximately 10:30 a.m. confirmed findings. 4. A record review of patient #4's clinical record on September 29, 2009 at approximately 11:00 a.m. revealed that there was no documented evidence of the above listed admission data from the agency. A face to face interview with the Director on September 29, 2009 at approximately 11:30 a.m. confirmed findings. 5. A record review of patient #5's clinical record on September 29, 2009 at approximately 12:00 p.m. revealed that there was no documented evidence of the above listed admission data from the agency.	H 261	**H 261** **Community Care Nursing Services of DC (CCNS-DC) Developed and Implemented Admission Intake form to capture admission data for patient information.** **Medical Records of current clients, new admissions, have Intake form included.** **QA will monitor for 100% monthly**	**11/09**

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H 261	Continued From page 15 A face to face interview with the Director on September 29, 2009 at approximately 12:30 p.m. confirmed findings. 6. A record review of patient #6's clinical record on September 29, 2009 at approximately 1:00 p.m. revealed that there was no documented evidence of the above listed admission data from the agency. A face to face interview with the Director on September 29, 2009 at approximately 1:30 p.m. confirmed findings. 7. A record review of patient #7's clinical record on September 29, 2009 at approximately 2:00 p.m. revealed that there was no documented evidence of the above listed admission data from the agency. A face to face interview with the Director on September 29, 2009 at approximately 2:30 p.m. confirmed findings.	H 261		
H 262	3911.2(b) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (b) Source of referral, including date of discharge if from a hospital or extended care facility; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to have the source of referral, including a date of discharge if from a hospital or extended care facility in the clinical records of nine (9) out of ten (10) patients.	H 262	**H 262** **Admission Intake Form developed to include referral source, Date of discharge from hospital or extended care facility** **Clients admitted prior to survey have Admission Intake Forms included** **QA will monitor monthly for 100% compliance**	**10/09**

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H 262	Continued From page 16 (Patient #1, #2, #3, #4, #5, #6, #7, #8 and #9) The findings include: 1. A record review on patient #1's clinical record on September 28, 2009 at approximately at 10:30 a.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 28, 2009 at approximately 12:55 p.m. confirmed findings. 2. A record review on patient #2's clinical record on September 28, 2009 at approximately at 1:50 p.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 28, 2009 at approximately 2:30 p.m. confirmed findings. 3. A record review on patient #3's clinical record on September 29, 2009 at approximately at 10:00 a.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 29, 2009 at approximately 10:30 a.m. confirmed findings. 4. A record review on patient #4's clinical record on September 29, 2009 at approximately at 11:00 a.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 29, 2009 at approximately 11:30 a.m. confirmed findings.	H 262	**H 262** **Admission Intake Form developed to include referral source, Date of discharge from hospital or extended care facility** **Clients admitted prior to survey have Admission Intake Forms included** **QA will monitor monthly for 100% compliance**	10/09

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H 262	Continued From page 17 5. A record review on patient #5's clinical record on September 29, 2009 at approximately at 12:00 p.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 29, 2009 at approximately 12:30 p.m. confirmed findings. 6. A record review on patient #6's clinical record on September 29, 2009 at approximately at 1:00 p.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 29, 2009 at approximately 1:30 p.m. confirmed findings. 7. A record review on patient #7's clinical record on September 29, 2009 at approximately at 2:00 p.m. revealed that there was no documented evidence of a source of referral. A face to face interview with the Director on September 29, 2009 at approximately 2:30 p.m. confirmed findings. 8. Review of Patient #8's clinical record on September 28, 2009, at approximately 12:00 p.m., revealed the source of referral, including date of discharge if from a hospital or extended care facility was not documented in the record. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 12:35 p.m., it was acknowledged Patient #8's clinical record did not include the source of referral, including date of discharge if from a hospital or extended care facility.	H 262	**H 262** **Admission Intake Form developed to include referral source, Date of discharge from hospital or extended care facility** **Clients admitted prior to survey have Admission Intake Forms included** **QA will monitor monthly for 100% compliance**	**10/09**

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H 262	Continued From page 18 There was no documented evidence the HCA ensured the patient's clinical record included the source of referral, including date of discharge if from a hospital or extended care facility. 9. Review of Patient #9's clinical record on September 28, 2009, at approximately 12:45 p.m., revealed the source of referral, including date of discharge if from a hospital or extended care facility was not documented in the record. In an interview with the DON on September 28, 2009, at approximately 12:48 p.m. it was acknowledged Patient #9's clinical record did not include the source of referral, including date of discharge if from a hospital or extended care facility. There was no documented evidence the patient's clinical record included the source of referral, including date of discharge if from a hospital or extended care facility.	H 262	**H 262** **Admission Intake Form developed to include referral source, Date of discharge from hospital or extended care facility** **Clients admitted prior to survey have Admission Intake Forms included** **QA will monitor monthly for 100% compliance**	**10/09**
H 267	3911.2(g) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (g) Medication sheet; This Statute is not met as evidenced by: Based on interview and record verification the Home Care Agency (HCA) failed to ensure each clinical record included the medication sheet for one (1) of ten (10) patients in the sample. (Patient #9) The finding includes:	H 267	**H 267** **(g) RN Supervisor will complete Medication Review Sheet on all clients upon initial visit and monthly thereafter** **QA will monitor medical record monthly for 100% compliance**	**10/09**

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H 267	Continued From page 19 Review of Patient #9's clinical record on September 28, 2009, at approximately 12:20 p.m., revealed the medication sheet was not in the record. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 12:25 p.m., it was acknowledged Patient #9's clinical record did not include the medication sheet. There was no documented evidence the patient's clinical record included the medication sheet.	H 267		
H 270	3911.2(j) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (j) Documentation of discharge planning, if appropriate; This Statute is not met as evidenced by: Based on interview and record verification the Home Care Agency (HCA) failed to ensure each clinical record included documentation of discharge planning for two (2) of ten (10) patients in the sample. (Patient #8 and Patient #9) The findings include: 1. Review of Patient #8's clinical record on September 28, 2009 at approximately 12:18 p.m., revealed no documentation of discharge planning. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 12:50 p.m. it was acknowledged Patient #8's clinical	H 270	**H 270** **(j)Discharge Planning will begin at the point of admission ,** **Discharge goals will be written on initial 485 Plan of Care (POC) and will be and updated every 60 days on POC** **RN Supervisor will address Discharge Plan and Teaching on Monthly Visit** **QA will monitor medical record monthly for 100% compliance**	**10/09**

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H 270	Continued From page 20 record did not include discharge planning. There was no documented evidence the patient's clinical record included discharge planning. 2. Review of Patient #9's clinical record on September 28, 2009, at approximately 12:28 p.m., revealed no documentation of discharge planning. In an interview with the DON on September 28, 2009, at approximately 12:55 p.m., it was acknowledged Patient #9's clinical record did not include discharge planning. There was no documented evidence the patient's clinical record included discharge planning.	H 270		
H 279	3911.2(s) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (s) Documentation of training and education given to the patient and the patient's caregivers. This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure documentation of training and education given to the patient and the patient's caregivers for two (2) of ten (10) patients in the sample. (Patient #1 and Patient #8) The findings include: 1. A record review of patient #1's clinical record on September 28, 2009 at approximately at 10:30	H 279	**Nurses will be oriented upon hire on Documentation of training and education given to the patient and patient's caregivers on Flow Sheet and Nurse's Notes. RN Supervisor will monitor monthly the documentation on Nurse's Flow Sheet of training and education to the patient and caregiver's. RN Supervisor will provide education and training to patient and the caregiver's and assess and evaluate training provided during monthly visit. RN Supervisory Assessment form has been modified to capture documentation of RN training, education, assessment and evaluation. QA will monitor monthly for 100% compliance**	**11/09**

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H 279	Continued From page 21 a.m. revealed that there was no documented evidence of training and education given to patient and the patient's caregiver as evident by nurse notes dated July 10, 2009, August 18, 2009, September 4, 2009 and Supervisor Notes dated July 10, 2009 and August 18, 2009. A face to face interview with Director on September 28, 2009 at approximately 12:55 p.m. confirmed the findings. 2. Review of patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009, on September 28, 2009, at approximately 11:02 a.m., revealed safety measures that included universal, fall, environmental and seizure precautions. Review of the register nurse (RN) Supervisory Assessment Form dated August 27, 2009, on September 28, 2009, at approximately 1:46 p.m., revealed "provided teaching on safety". In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 1:53 p.m., it was acknowledged the skilled nursing staff did not document the specific training and education on safety management given to patient #8's caregiver in accordance with the POC. There was no evidence in the clinical record documenting the specific training and education given to the patient's caregiver on safety management.	H 279	**Nurses will be oriented upon hire on Documentation of training and education given to the patient and patient's caregivers on Flow Sheet and Nurse's Notes.** **RN Supervisor will monitor monthly the documentation on Nurse's Flow Sheet of training and education to the patient and caregiver's.** **RN Supervisor will provide education and training to patient and the caregiver's and assess and evaluate training provided during monthly visit. RN Supervisory Assessment form has been modified to capture documentation of RN training, education, assessment and evaluation.** **QA will monitor monthly for 100% compliance**	11/09
H 291	3912.2(a) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to	H 291	**Patient Bill of Rights have been revised to include the following :**	11/09

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H 291	Continued From page 22 ensure that each patient who receives home care services has the following rights: (a) To be treated with courtesy, dignity, and respect; This Statute is not met as evidenced by: Based on a record review and interview it was determined the agency failed to include that patients are to be treated with courtesy, dignity, and respect in its Patient Rights and Responsibilities Policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included patients are to be treated with courtesy, dignity, and respect in its Patient Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., it was revealed that the agency uses Patient Bill of Rights as its Patient Right and Responsibility policy. The Director also acknowledged the finding at the time of this interview.	H 291	**H 291** **(a) To be treated with courtesy, dignity, and respect:** **Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled QA will monitor monthly for 100% compliance**	11/09
H 292	3912.2(b) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights:	H 292	**H 292**	

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H 292	Continued From page 23 (b) To control his or her own household and life style; This Statute is not met as evidenced by: Based on a record review and interview it was determined that the agency failed to include that patients have the right to control his or her own household and lifestyle in its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patients have the right to control his or her own household and life in its Patient Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 292	**(b) (b) To control his or her own household and life style** **Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled** **QA will monitor monthly for 100% compliance**	**11/09**
H 293	3912.2(c)(1) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the following:	H 293	**H 293** **Patient Bill of Rights have been revised to include the following :** **(c) To be informed orally and in writing of the following:**	**11/09**

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H 293	Continued From page 24 (1) Services to be provided by the agency, including any limits on service availability; This Statute is not met as evidenced by: Based on a record review and interview it was determined the agency failed to include services to be provided by the agency including limits on service availability in its Patient Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights. " Further review of the record revealed that there was no documented evidence that the agency included services to be provided by the agency, including limits on service availability in its Patient Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 293	**Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and** **QA will monitor monthly for 100% compliance**	
		H 294	**Patient Bill of Rights Form has been revised to include the following :** **(c) To be informed Orally and in writing Of the following:** **2)Whether services Are covered by health Insurance, Medicaid, Medicare, or any Other sources , and The extent of un-Covered expenses for Which the patient May be liable.**	**11/09**
H 294	3912.2(c)(2) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the following: (2) Whether services are covered by health insurance, Medicaid, Medicare, or any other	H 294		

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H 294	Continued From page 25 sources, and the extent of uncovered expenses for which the patient may be liable; This Statute is not met as evidenced by: Based on a record review and interview, it was determined the agency failed to include whether services are covered by health insurance, Medicaid, Medicare, or any other sources, and the extent of uncovered expenses for which the patient may be liable in its Patients Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included whether services are covered by health insurance, Medicaid, Medicare, or any other sources, and the extent of uncovered expenses for which the patient may be liable in its Patient Rights and Responsibilities policy. During an interview with the Director on September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 294	**Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled QA will monitor monthly for 100% compliance**	11/09
H 296	3912.2(c)(4) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the	H 296	**Patient Bill of Rights Form has been revised to include the following :** **(c) To be informed Orally and in writing Of the following:**	11/09

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COMMUNITY CARE NURSING SERVICES OF D	316 F STREET, NE WASHINGTON, DC 20002

(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 296	Continued From page 26 following: (4) Prompt notification of acceptance, denial or reduction of services; This Statute is not met as evidenced by: Based on a record review and interview, it was determined the agency failed to include prompt notification of acceptance, denial or reduction of services in its Patient ' s Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included prompt notification of acceptance, denial or reduction of services in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 296	**Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled** **QA will monitor monthly for 100% compliance**	**11/09**
H 297	3912.2(c)(5) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the following:	H 297	H 297 **Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and** **(c) To be informed Orally and in writing Of the following:**	**11/09**

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H 297	Continued From page 27 (5) Complaint and referral procedures; This Statute is not met as evidenced by: Based on an interview and a record review, it was determined the agency failed to include compliant and referral procedures its Patient ' s Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included compliant and referral in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding. During a face to face interview conducted on October 1, 2009 with patient #7 during a home visit, patient #7 denied that the agency made him aware verbally or in writing of the complaint process. There was no documented evidence in the patient's home of the compliant process. The patient was given the telephone number of the Home Health Hotline maintained by the Department of Health (202)442-4779 at the time of this interview by the inspector. During an interview with the Director October 2, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 297	**Patient Bill of Rights Form has been revised to include the following :** **(c) To be informed Orally and in writing Of the following:** **Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised** **Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 298	Continued From page 28	H 298		11/09
H 298	3912.2(c)(6) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the following: (6) The name, business address, and telephone number of the agency supervising the patient's care; and... This Statute is not met as evidenced by: Based on a record review and interview it was determined the agency failed to include the name, business address, and telephone number of the agency supervising the patient's care its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included include the name, business address, and telephone number of the agency supervising the patient's in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 298	**H 298** **Patient Bill of Rights Form has been revised to include the following :** **(c) To be informed Orally and in writing Of the following:** **(6) The name, business, address, and telephone number of the agency supervising the patient's care, and...** **Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	

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H 299	Continued From page 29	H 299		
H 299	3912.2(c)(7) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (c) To be informed orally and in writing of the following: (7) The telephone number of the Home Health Hotline maintained by the Department of Health; This Statute is not met as evidenced by: Based on an interview and record review, it was determined that the agency failed to include the telephone number of the Home Health Hotline maintained by the Department of Health its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included the telephone number of the Home Health Hotline maintained by the Department of Health in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 299	**H 299** **Patient Bill of Rights Form has been revised to include the following :** **c) To be informed Orally and in writing Of the following:** **(7) The telephone number of the Home Health 24 Hotline(202-442-4779) maintained by the Department of Health** **Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 300	Continued From page 30	H 300	**H 300**	
H 300	3912.2(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (d) To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care; This Statute is not met as evidenced by: Based on an interview and record review, it was determined the agency failed to include the patient has the right to receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient has the right to receive treatment, care , services consistent with the agency/patient agreement and patient ' s plan of care in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 300	**Patient Bill of Rights Form has been revised to include the following :** **d) To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care:** **Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 302	Continued From page 31	H 302		
H 302	3912.2(f) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (f) To receive services by competent personnel who can communicate with the patient; This Statute is not met as evidenced by: Based on an interview and record review, it was determined that the agency failed to include the patient is to receive services by competent personnel who can communicate with the patient's in its Patient ' s Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is to receive services by competent personnel who can communicate with the patient's in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 302	***H 302*** **Patient Bill of Rights Form has been revised to include the following :** **(f) To receive services by competent personnel who can communicate with the patient** **Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 303	3912.2(g) PATIENT RIGHTS & RESPONSIBILITIES	H 303		

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H 303	Continued From page 32 Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (g) To be informed of his or her condition by the health care provider in accordance with generally accepted professional standards; This Statute is not met as evidenced by: Based on an interview and record review, it was determined that the agency failed to include that the patient is to be informed of his or her condition by the health care provider in accordance with generally accepted professional standards in its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is to be informed of his or her condition by the health care provider in accordance with generally accepted professional standards in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 303	**H 303** **Patient Bill of Rights Form has been revised to include the following :** **(g) To be informed of his or her condition by the health care provider in accordance with generally accepted professional standards;** **Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 307	3912.2(k) PATIENT RIGHTS & RESPONSIBILITIES	H 307		

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H 307	Continued From page 33 Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (k) To be educated about and trained in matters related to the services to be provided; This Statute is not met as evidenced by: Based on an interview and record review, it was determined the agency failed to include the patient is to be educated about and trained in matters related to the services to be provided in its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is to be educated about and trained in matters related to the services to be provided in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 307	**H 307** **Revised Patient Rights Form has been revised to include the following :** **(k) To be educated about and trained in matters related to the services to be provided** **Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 310	3912.3 PATIENT RIGHTS & RESPONSIBILITIES 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	H 310		

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H 310	Continued From page 34 Department of Health, in confidence and without fear of reprisal from the agency or any agency personnel, in writing or orally, including an inperson conference if desired. This Statute is not met as evidenced by: Based on an interview and record review, it was determined the agency failed to include that the agency shall inform all patients that they have 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 agency personnel, in writing or orally, including an in-person conference if desired in its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the agency shall inform all patients that they have 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 agency personnel, in writing or orally, including an in-person conference if desired in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she	H 310	**H 310** **Patient Responsibilities Form has been revised to include the following :** **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 agency personnel , in writing, or orally, including an in person conference if desired.** **Revised Patient Responsibilities Form RN Supervisor will be informed of Revised Patient Responsibilities and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09, RN will review and have patient/caregiver sign form, and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 310	Continued From page 35 acknowledged the finding.	H 310		
H 311	3912.4(a) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop a statement of patient responsibilities regarding the following: (a) Treating agency personnel with respect and dignity; This Statute is not met as evidenced by: Based on an interview and a record review, it was determined that the agency failed to include that the patient is responsible for treating agency personnel with respect and dignity in its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is responsible for treating agency personnel with respect and dignity in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 311	**H 311** **Patient Responsibilities Form has been revised to include the following : (a) Treating agency personnel with respect and dignity:** **Revised Patient Responsibilities Form RN Supervisor will be informed of Revised Patient Responsibilities and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09, RN will review and have patient/caregiver sign form, and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 312	3912.4(b) PATIENT RIGHTS & RESPONSIBILITIES	H 312		

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H 312	Continued From page 36 Each home care agency shall develop a statement of patient responsibilities regarding the following: (b) Providing accurate information when requested; This Statute is not met as evidenced by: Based on an interview and a record review, it was determined that the agency failed to include that the patient is responsible for providing accurate information when requested in its Patient's Rights and Responsibilities. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is responsible for providing accurate information when requested in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 312	**H 312** **Patient Responsibilities Form has been revised to include the following :** **(b) Providing accurate information when requested** **Revised Patient Responsibilities Form RN Supervisor will be informed of Revised Patient Responsibilities and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09, RN will review and have patient/caregiver sign form, and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 313	3912.4(c) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop a statement of patient responsibilities regarding the following:	H 313		

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H 313	Continued From page 37 (c) Informing the agency when instructions are not understood or cannot be followed; and... This Statute is not met as evidenced by: Based on an interview and a record review, it was determined that the agency failed to include that the patient is responsible for informing the agency when instruction are not understood or cannot be followed in its Patient ' s Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is responsible for informing the agency when instruction are not understood or cannot be followed in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 313	**H 313** **Patient Responsibilities Form has been revised to include the following :** **c)Informing the agency when instructions are not understood or cannot be followed: and...** **Revised Patient Responsibilities Form RN Supervisor will be informed of Revised Patient Responsibilities** **Revised Patient Bill of Rights Form RN Supervisor will be informed of Revised Patient Bill of Rights and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09 , RN will review and have patient/caregiver sign form , and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 314	3912.4(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop a statement of patient responsibilities regarding the following: (d) Cooperating in making a safe environment for care within the home.	H 314		

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H 314	Continued From page 38 This Statute is not met as evidenced by: Based on a record review and interview it was determined that the agency failed to include that the patient is responsible for cooperating in making a safe environment for care within the home in its Patient's Rights and Responsibilities policy. The finding includes: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence that the agency included that the patient is responsible for cooperating in making a safe environment for care within the home in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 314	**H 314** **Patient Responsibilities Form has been revised to include the following :** **d) Cooperating in making a safe environment for care within the home.** **Revised Patient Responsibilities Form RN Supervisor will be informed of Revised Patient Responsibilities and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09, RN will review and have patient/caregiver sign form, and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 316	3912.6 PATIENT RIGHTS & RESPONSIBILITIES The home care agency shall take appropriate steps to ensure that all information is conveyed, pursuant to these rules, to any patient who cannot read or who otherwise needs accommodations in an alternative language or communication method. The home care agency shall document in the patient's records the steps taken to ensure that the patient has been provided with all required information.	H 316	**H316** **Revised Patient Rights Form has been revised to include the following :** **The Home Care Agency shall take appropriate steps to ensure that all information is conveyed , pursuant, to these rules, to any patient who cannot read or who otherwise needs accommodations in a n alternative language or communication method.** **The Home Care Agency**	**11/09**

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	HCA-0002	A. BUILDING _____ B. WING _____	10/02/2009

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H 316	Continued From page 39 This Statute is not met as evidenced by: Based on interview and record review, it was determined that the agency failed to include that the agency shall take appropriate steps to ensure that all information is conveyed, pursuant to these rules, to any patient who cannot read or who otherwise needs accommodations in an alternative language or communication method. And that the agency shall document in patient's records the steps taken to ensure that the patient has been provided with all required information care within in its Patient's Rights and Responsibilities policy. The findings include: A record review on September 28, 2009 at approximately 10:00 a.m. revealed a form entitled "Community Care Nursing Services of DC Patient Bill of Rights." Further review of the record revealed that there was no documented evidence the that the agency shall take appropriate steps to ensure that all information is conveyed, pursuant to these rules, to any patient who cannot read or who otherwise needs accommodations in an alternative language or communication method. And that the agency shall document in patient's records the steps taken to ensure that the patient has been provided with all required information care within in its Patient's Rights and Responsibilities policy. During an interview with the Director September 28, 2009 at approximately 10:30 a.m., she acknowledged the finding.	H 316	**H316** **shall document in the patient's record the steps taken to ensure that the patient has been provided with all required information.** **Revised Patient Bill of Rights Form** **RN Supervisor will be informed of Revised Patient Responsibilities and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09, RN will review and have patient/caregiver sign form, and provide client/caregiver with a copy at next scheduled monthly visit.**	**11/09**
H 331	3913.2(a) COMPLAINT PROCESS A written summary of the complaint process shall	H 331		

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H 331	Continued From page 40 be disseminated as follows: (a) Given to the patient or his or her representative upon acceptance or denial of services; and... This Statute is not met as evidenced by: Based on interview and record verification the Home Care Agency (HCA) failed to ensure a written summary of the complaint process was given to the patient or his or her representative upon acceptance or denial of services. The finding includes: Review of the Compliant/Concern Resolution Policy on September 28, 2009, at approximately 10:40 a.m., revealed the HCA did not ensure a written summary of the complaint process was given to the patient or his or her representative upon acceptance or denial of services. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:20 a.m., it was acknowledged the HCA did not ensure a written summary of the complaint process was given to the patient or his or her representative upon acceptance or denial of services. There was no documented evidence the HCA ensured a written summary of the complaint process was given to the patient or his or her representative upon acceptance or denial of services.	H 331	**H331** **The Internal Complaint Process has been developed and included in the CCNS-DC Policy and Procedure book:** **A written summary of the complaint process shall be disseminated as follows:** **(a) Given to the patient or his or her representative upon acceptance or denial of services... by RN Supervisor** **Clients who have been admitted prior to survey date of 10/2/09 will be provided copies of complaint process by RN Supervisor** **QA will monitor monthly for 100% compliance**	**11/09**

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H 332	Continued From page 41	H 332		
H 332	3913.2(b) COMPLAINT PROCESS A written summary of the complaint process shall be disseminated as follows: (b) Given to all patients receiving service from a home care agency on the effective date of these rules. This Statute is not met as evidenced by: Based on interview and record verification the Home Care Agency (HCA) failed to ensure a written summary of the complaint process was given to all patients receiving service from a home care agency on the effective date of these rules. The finding includes: Review of the Compliant/Concern Resolution Policy on September 28, 2009, at approximately 10:45 a.m., revealed the HCA did not ensure a written summary of the complaint process was given to all patients receiving service from the home care agency on the effective date of these rules. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:21 a.m., it was acknowledged the HCA did not ensure a written summary of the complaint process was given to all patients receiving service from the home care agency on the effective date of these rules. There was no documented evidence the HCA ensured a written summary of the complaint	H 332	**H 332** **Clients who have been admitted prior to survey date of 10/2/09 will be provided copies of complaint process via mail and by RN Supervisor** **RN Supervisor will explain complaint process to client/care givers during home visit and its contents will implement revised Bill of Rights upon admission and for active client s admitted prior to survey 10/09, RN will review and have patient/caregiver sign form, and provide client/caregiver with a copy at next scheduled monthly visit.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 332	Continued From page 42 process was given to all patients receiving service from the home care agency on the effective date of these rules.	H 332		
H 335	3913.5 COMPLAINT PROCESS The home care agency shall respond to the complaint within fourteen (14) calendar days of its receipt, and shall document the response. This Statute is not met as evidenced by: Based on interview and record verification the Home Care Agency (HCA) failed to ensure the establishment of a written policy to respond to a compliant within fourteen (14) calendar days of its receipt, and shall document the response. The finding includes: Review of the Compliant/Concern Resolution Policy on September 28, 2009, at approximately 10:48 a.m., revealed the HCA did not establish a written policy to respond to a compliant within fourteen (14) calendar days of its receipt, and to document the response. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:25 a.m., it was acknowledged the HCA did not establish a written policy to respond to a compliant within fourteen (14) calendar days of its receipt, and to document the response. There was no documented evidence the HCA established a written policy to respond to a compliant within fourteen (14) calendar days of its receipt, and to document the response	H 335	**H335** **The Internal Complaint Process has been developed and included in the CCNS-DC Policy and Procedure book: The policy includes the following:** **The Home Care Agency shall respond to the complaint within 14 calendar days of receipt, and shall document the response.** **QA will monitor monthly for 100% compliance**	11/09

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H 336	Continued From page 43	H 336		
H 336	3913.6 COMPLAINT PROCESS If the patient indicates that he or she is not satisfied with the response, the agency shall respond in writing within thirty (30) calendar days from the date of the agency's initial response. The response shall include the telephone number and address of all District government agencies with which a complaint may be filed and the telephone number of the Home Health Hotline maintained by the Department of Health. This Statute is not met as evidenced by: Based on interview and record verification the Home Care Agency (HCA) failed to establish a written policy to ensure that if the patient indicates that he or she is not satisfied with the response, the agency shall respond in writing within thirty (30) calendar days from the date of the agency's initial response. The response shall include the telephone number and address of all District government agencies with which a complaint may be filed and the telephone number of the Home Health Hotline maintained by the Department of Health. The finding includes: Review of the Compliant/Concern Resolution Policy on September 28, 2009, at approximately 10:50 a.m., revealed the HCFA did not establish a written policy to ensure that if the patient indicates that he or she is not satisfied with the response, the agency shall respond in writing within thirty (30) calendar days from the date of the agency's initial response and that the response included the telephone number and address of all District government agencies with which a complaint may be filed and the telephone	H 336	**H336** **The Internal Complaint Process has been developed and included in the CCNS-DC Policy and Procedure book: The policy includes the following:** **If the patient indicates that he/she is not satisfied with the response, the agency shall respond in writing within 30 calendar days from the date of the agency's initial response. The response shall include the telephone number and address of all District government agencies with which a complaint may be filed and the telephone number of the Home Health Hotline maintained by the Department of** **A written summary of the complaint process shall be disseminated as follows: RN Supervisor will provide at the time of admission/denial .** **QA will monitor monthly for 100% compliance**	**11/09**

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H 336	Continued From page 44 number of the Home Health Hotline (HHH) maintained by the Department of Health (DOH). In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:28 a.m., it was acknowledged the HCA did not establish a written policy to ensure compliance with the aforementioned regulation. There was no documented evidence the HCA established a written policy to ensure compliance with the aforementioned regulation.	H 336		
H 354	3914.3(c) PATIENT PLAN OF CARE The plan of care shall include the following: (c) The goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs of the patient; This Statute is not met as evidenced by: Based on interview and record review the Home Care Agency (HCA) failed to ensure the plan of care (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 for two (2) of ten (10) patients in the sample. (Patient #8 and Patient #9) The findings include: 1. Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009 on September 28, 2009, at approximately 11:00 a.m., did not reveal the goals of the services to be provided, including the expected outcome,	H 354	**H 354** **On the Plan of Care(485) Goals will be written to indicate Short Term and Long Term Goals upon start of care date.** **The RN Supervisor will review , evaluate, and if needed modify Short and Long Term Goals at the monthly RN Supervisor Visit as noted on the RN Supervisory Monthly Assessment Form.** **QA will monitor monthly for 100% compliance**	12/09

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H 354	Continued From page 45 based upon the immediate and long-term needs In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:15 a.m., it was acknowledged Patient #8's goals of the services to be provided; including the expected outcome, based upon the immediate and long-term needs was not documented on the POC. There was no documented evidence of the goals of the services to be provided; including the expected outcome used by the patient was on the POC. 2. Review of Patient # 9's Home Health Certification and Plan of Care (POC) dated August 29, 2009 to October 27, 2009 on September 28, 2009 at approximately 12:40 p.m. did not reveal the goals of the services to be provided, including the expected outcome, based upon the immediate and long-term needs In an interview with the DON on September 28, 2009, at approximately 12:52 p.m., it was acknowledged Patient #9's goals of the services to be provided; including the expected outcome, based upon the immediate and long-term needs was not documented on the POC. There was no documented evidence of the goals of the services to be provided, including the expected outcome used by the patient on the POC.	H 354	**H 354** **On the Plan of Care(485) Goals will be written to indicate Short Term and Long Term Goals upon start of care date.** **The RN Supervisor will review , evaluate, and if needed modify Short and Long Term Goals at the monthly RN Supervisor Visit as noted on the RN Supervisory Monthly Assessment Form.** **QA will monitor monthly for 100% compliance**	**12/09**
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,	H 355		

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H 355	Continued From page 46 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 Home Care Agency (HCA) failed to ensure the plan of care (POC) included a description of the services to be provided, including: the frequency, amount, and expected duration for five (5) of ten (10) patients in the sample. (Patient #1, Patient #2, Patient #3, Patient #8 and Patient #9) The findings include: 1. A record review for patient #1's care plan on September 28, 2009 at approximately 11:00 a.m. revealed that there was no documented evidence of the description of services to be provided including: the frequency, amount and expected duration as evident by a care plan dated July 14, 2009 to September 12, 2009 which had an order that stated " RN Assessment ". During a face to face interview with the Director on September 28, 2009 at approximately 11:30 a.m. she acknowledged the finding. 2. A record review of patient #2 at approximately 1:50 p.m. revealed a care plan date June 27, 2009 to August 25, 2009 which ordered " respite care services for skilled nursing from June 29, 2009 through July 3, 2009. Further review of the record revealed nursing documentation date July 9, 2009 through July 16, 2009 and an authorization form from Health	H 355	**H 355** **The Plan of Care will be modified to include the following** **1. Specific duties/tasks involved with the RN Assessment. This will be clearly defined to include a multisystem cardio-pulmonary assessment to include , vital signs , Temp, Pulse, Resp, BP- PRN, and the frequency of RN** **Assessment/Evaluations to be done in the current Certification period. For the duration of the Certification period, 8 weeks.** **Included in the Plan of Care will be any After-School Programs the client attends, the hours of attendance and the location of the program.** **2. For Respite Care Hours, it will be clearly defined the description of LPN services to be provided during this time on the Plan of Care(485)** **QA will monitor monthly for 100% compliance**	**12/09**

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H 355	Continued From page 47 Services for Children with Special Needs which authorized the agency to provide respite care LPN services from July 9, 2009 to July 16, 2009. There was no documented evidence of the description of services for LPN services from July 9, 2009 to July 16, 2009 on the care plan dated June 27, 2009 to August 25, 2009. During a face to face interview with the Director on September 28, 2009 at 2:30 p.m., she acknowledged findings. 3. A record review for patient #3's care plan on September 29, 2009 at approximately 10:00 a.m. revealed that there was no documented evidence of the description of services to be provided including: the frequency, amount and expected duration as evident by a care plan dated August 13, 2009 to October 11, 2009 which had an order that stated "RN Assessment". During a face to face interview with the Director on September 29, 2009 at approximately 10:30 a.m., she acknowledged findings. 4 (a) Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009 on September 28, 2009, at approximately 11:05 a.m., revealed one (1) RN assessment/Evaluation monthly. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:15 a.m., it was acknowledged Patient #8's POC did not provide a description of the services to be provided, including: the expected duration. There was no documented evidence of the	H 355	**3. Specific duties/tasks involved with the RN Assessment. This will be clearly defined to include a multisystem cardio-pulmonary assessment to include , vital signs , Temp, Pulse, Resp, BP-PRN, and the frequency of RN** **Assessment/Evaluations to be done in the current Certification period. For the duration of the Certification period, 8 weeks.** **4. (a)Specific duties/tasks involved with the RN Assessment. This will be clearly defined to include a multisystem cardio-pulmonary assessment to include , vital signs , Temp, Pulse, Resp, BP-PRN, and the frequency of RN** **QA will monitor monthly for 100% compliance**	**12/09**

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H 355	Continued From page 48 description of the services to be provided, including: the expected duration on the POC. 4 (b) Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009, on September 28, 2009 at approximately 11:06 a.m., revealed Personal Care Aide (PCA) services seven and one-half hours (7.5) on Monday and five (5) hours per day on Tuesday through Friday. Interview with the DON on September 28, 2009, at approximately 2:20 p.m., revealed Patient #8 received the PCA services at his afterschool program. Further interview revealed that the description of the services to be provided was not on the POC. There was no documented evidence of the description of the PCA services to be provided at the afterschool program on the POC. 5 .Review of Patient # 9's Home Health Certification and Plan of Care (POC) dated August 29, 2009, to October 27, 2009, on September 28, 2009, at approximately 2:31 p.m., revealed one (1) RN Assessment/Evaluation monthly. In an interview with the DON on September 28, 2009, at approximately 2:32 p.m., it was acknowledged Patient #9's POC did not provide a description of the services to be provided, including: the expected duration. There was no documented evidence of the description of the services to be provided, including: the expected duration on the POC.	H 355	**Assessment/Evaluations to be done in the current Certification period. For the duration of the Certification period, 8 weeks.** **QA will monitor monthly for 100% compliance** **4. (b) Included in the Plan of Care will be listed any After-School Programs , the contact person at the location, the specific duties to be done during After School Program, name and address of After Program client attends, and the hours of attendance, and information regarding transportation if applicable.** **QA will monitor monthly for 100% compliance** **5. Specific duties/tasks involved with the RN Assessment. This will be clearly defined to include a multisystem cardio-pulmonary assessment to include , vital signs , Temp, Pulse, Resp, BP- PRN, and the frequency of RN** **Assessment/Evaluations to be done in the current Certification period. For the duration of the Certification period, 8 weeks.** **QA will monitor monthly for 100% compliance**	12/09

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H 357	Continued From page 49 3914.3(f) PATIENT PLAN OF CARE The plan of care shall include the following: (f) Provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services; This Statute is not met as evidenced by: Based on record review and interview it was determined the agency failed to make provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services, for four (4) of ten (10) care plan reviewed. (Patients #1, #2, #3 and #4) The findings include: 1. A record review of patient #1's care plan on September 28, 2009 at approximately 11:00 a.m. revealed a care plan dated July 14, 2009 to September 12, 2009 which had no documented evidence of provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services. During a face to face interview with the Director on September 28, 2009 at approximately 11:30 a.m. she acknowledged the finding. 2. A record review of patient #2's care plan on September 28, 2009 at approximately 1:50 p.m. revealed a care plan dated June 27, 2009 to August 25, 2009 which had no documented evidence of provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services. During a face to face interview with the Director	H 357 H 357	**H 357** **The current Plan of Care (485) shall be revised to include the following information:** **(f) Provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services:** **The RN will include this information at the Start of Care upon initial development of plan of care and will update it every 60 days based on information provided from the monthly RN Supervisory Visit and Summary of Care Form.** **QA will monitor monthly for 100% compliance**	**12/09**

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COMMUNITY CARE NURSING SERVICES OF D	316 F STREET, NE WASHINGTON, DC 20002

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H 357	Continued From page 50 on September 28, 2009 at approximately 2:30p.m.she acknowledged findings. 3. A record review of patient #3's care plan on September 29, 2009 at approximately 11:00 a.m. revealed a care plan dated August 13, 2009 to October 11, 2009 which had no documented evidence of provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services. During a face to face interview with the Director on September 29, 2009 at approximately 11:30 a.m., she acknowledged findings. 4. A record review of patient #4's care plan on September 29, 2009 at approximately 12 p.m. revealed a care plan dated September 15, 2009 to November 13, 2009 which had no documented evidence of provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services.	H 357	**H 357** **The current Plan of Care (485) shall be revised to include the following information:** **(f) Provisions relating to the reevaluation of services, discharge planning, referral of services and continuation or renewal of services:** **The RN will include this information at the Start of Care upon initial development of plan of care and will update it every 60 days based on information provided from the monthly RN Supervisory Visit and Summary of Care Form.** **QA will monitor monthly for 100% compliance**	**12/09**
H 360	3914.3(i) PATIENT PLAN OF CARE The plan of care shall include the following: (i) Activities permitted or precluded because of functional limitations; This Statute is not met as evidenced by: Based on interview and record review the Home Care Agency (HCA) failed to ensure the plan of care (POC) included the activities permitted or precluded because of functional limitations for two (2) of ten (10) patients in the sample. (Patient #8 and Patient #9) The findings include:	H 360	**H 360** **The current plan of care (485) includes the following information:** **(i) Activities permitted or precluded because of functional limitations:** **RN to insure section is completed upon development of Plan of care at Start Of Care Date and modified PRN based on RN monthly Assessment.** **QA will monitor monthly for 100% compliance**	**12/09**

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H 360	Continued From page 51 1. Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009 on September 28, 2009 at approximately 11:03 a.m., revealed the POC did not include the activities permitted or precluded because of functional limitations. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:04 a.m., it was acknowledged Patient #8's POC did not include the activities permitted or precluded because of functional limitations. There was no documented evidence of the activities permitted or precluded because of functional limitations on the POC. 2. Review of Patient # 9's Home Health Certification and Plan of Care (POC) dated August 29, 2009, to October 27, 2009 on September 28, 2009, at approximately 2:30 p.m., revealed the POC did not include the activities permitted or precluded because of functional limitations. In an interview with the DON on September 28, 2009, at approximately 2:34 p.m., it was acknowledged Patient #9 ' s POC did not include the activities permitted or precluded because of functional limitations. There was no documented evidence of the activities permitted or precluded because of functional limitations on the POC. During a face to face interview with the Director on September 29, 2009 at approximately 12:30 p.m., she acknowledged findings.	H 360	**The current plan of care (485) includes the following information:** **(i) Activities permitted or precluded because of functional limitations:** **RN to insure section is completed upon development of Plan of care at Start Of Care Date and modified PRN based on RN monthly Assessment.** **QA will monitor monthly for 100% compliance**	**12/09**

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H 361	3914.3(j) PATIENT PLAN OF CARE The plan of care shall include the following: (j) Psychosocial needs of the patient; This Statute is not met as evidenced by: Based on interview and record review, the Home Care Agency (HCA) failed to ensure the plan of care (POC) included the psychosocial needs of the patient for one (1) of ten (10) patients in the sample. (Patient #9) The finding includes: Review of Patient # 9's Home Health Certification and Plan of Care (POC) dated August 29, 2009, to October 27, 2009 on September 28, 2009, at approximately 2:20 p.m., revealed the POC did not include the psychosocial needs of the patient. In an interview with the DON on September 28, 2009, at approximately 2:33 p.m., it was acknowledged Patient #9's POC did not include the psychosocial needs of the patient. There was no documented evidence of the psychosocial needs of the patient on the POC.	H 361	**H 361** **The current plan of care (485) includes the following information:** **(j) Psychosocial needs of the patient, information is identified and listed on plan of care under support care caregivers.** **RN to insure section is completed upon development of Plan of care at Start Of Care Date and modified PRN based on RN monthly Assessment.** **QA will monitor monthly for 100% compliance**	**12/09**
H 362	3914.3(k) PATIENT PLAN OF CARE The plan of care shall include the following: (k) Safety measures required to protect the patient from injury; This Statute is not met as evidenced by: Based on interview and record review the Home	H 362	**H 362** **RN Supervisor will identify safety measures upon initial assessment and provide information to Nurse Administrator to include on the plan of care and RN Supervisor to monitor at monthly RN visit..** **QA will monitor monthly for 100% compliance**	**12/09**

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H 362	Continued From page 53 Care Agency (HCA) failed to ensure the plan of care (POC) included the safety measures required to protect the patient from injury for one (1) of ten (10) patients in the sample. (Patient #9) The finding includes: Review of Patient # 9's Home Health Certification and Plan of Care (POC) dated August 29, 2009 to October 27, 2009, on September 28, 2009, at approximately 2:26 p.m., revealed the safety measures only included universal precautions. Further review revealed Patient #9 needed close supervision at all times. Review of Patient # 9's Aide Service Sheets dated September 01, 2009, September 07-10, 2009, and September 12, 2009, on September 28, 2009, at approximately 2:27 p.m., revealed the Personal Care Aide (PCA) recorded fall safety precautions in the Patient #9's record. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 2:29 p.m., it was acknowledged Patient #9 ' s POC did not include fall safety precautions required to protect the patient from injury and the patient needed close supervision at all times. There was no documented evidence that all safety measures required to protect the patient from injury were on the POC.	H 362	**H 362** **RN Supervisor will identify safety measures upon initial assessment and provide information to Nurse Administrator to include on the plan of care and RN Supervisor to monitor at monthly RN visit..** **QA will monitor monthly for 100% compliance**	**12/09**
H 363	3914.3(l) PATIENT PLAN OF CARE The plan of care shall include the following: (l) Identification of employees in charge of managing emergency situations;	H 363		**12/09**

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H 363	Continued From page 54 This Statute is not met as evidenced by: Based on a record review and interview it was determined the agency failed to include identification of employees in charge of managing emergency situations for four (4) of ten (10) care plans reviewed. (Patients #1, #2, #3, #4) The findings include: 1. A record review of patient #1's record on September 28. 2009 at approximately 11:00 a.m. revealed a care plan dated July 14, 2009 to September 12, 2009 which had no documented evidence of identification of employees in charge of managing emergency situations. During a face to face interview with the Director on September 28, 2009 at approximately 11:30 a.m. she acknowledged findings. 2. A record review of patient #2's record on September 28. 2009 at approximately 1:50 p.m. revealed a care plan dated June 27, 2009 to August 25, 2009 which had no documented evidence of identification of employees in charge of managing emergency situations. During a face to face interview with the Director on September 2:30 she acknowledged findings. 3. A record review of patient #3's care plan on September 29, 2009, at approximately 11:00 a.m. revealed a care plan dated August 13, 2009 to October 11, 2009. The care plan had no documented evidence of identification of employees in charge of managing emergency situations. During a face to face interview with the Director	H 363	**H 363** **Upon Initial plan of care, it will identify in the Emergency Plan all staff who are responsible for *managing emergency situations* who provide care to the patient.** **Nurse Administrator to include on the plan of care and RN Supervisor to monitor at monthly RN** **QA will monitor monthly for 100% compliance**	**11/09**

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H 364	Continued From page 56 p.m., she acknowledged findings. 2. A record review of patient #6's care plan on September 29, 2009 at approximately 2:00 p.m. revealed a care plan dated September 1, 2009 to October 30, 2009 which had no documented evidence of identification of employees in charge of managing emergency situations. During a face to face interview with the Director on September 29, 2009 at approximately 2:30 p.m., she acknowledged findings. 3. A record review of patient #7's care plan on September 29, 2009 at approximately 3:00 p.m. revealed a care plan dated August 29, 2009 to October 27, 2009 which had no documented evidence of identification of employees in charge of managing emergency situations. During a face to face interview with the Director on September 29, 2009 at approximately 3:30 p.m., she acknowledged findings. 4. Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009, on September 28, 2009 at approximately 11:05 a.m., revealed the POC did not include the identification of employees in charge of managing emergency situations. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 11:08 a.m., it was acknowledged Patient #8's POC did not include the identification of employees in charge of managing emergency situations.	H 364	**H 364** **Upon Initial plan of care, it will identify in the Emergency Plan all staff who are responsible for *emergency protocols* Nurse Administrator to include on the plan of care and RN Supervisor to monitor at monthly RN visit.** **QA will monitor monthly for 100% compliance**	**11/09**
H 399	3915.10(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE	H 399		

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H 399	Continued From page 57 Personal care aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on interview and record review the Home Care Agency (HCA) failed to ensure the Personal care aide (PCA) duties included observing, recording, and reporting the patient's physical condition, behavior, or appearance for two (2) of ten (10) patients in the sample. (Patient #8 and #9) The finding includes: Review of Patient # 8's Aide Service Sheets dated September 10-11, 2009 and September 16-18, 2009, on September 28, 2009, at approximately 2:00 p.m., revealed the Personal Care Aide (PCA) did not report on Patient #8's physical condition, behavior, or appearance in the record. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 2:08 p.m., it was acknowledged Patient #8's PCA did not report on the patient's physical condition, behavior, or appearance on the aforementioned dates. There was no documented evidence of the identification of employees in charge of managing emergency situations on the POC.	H 399	**H 399** **Personal Care Aide (PCA)Service Sheet has been revised to include the following, this will also be included in the HHA job description and aide duties:** **(f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance:** **New PCA's will be oriented to revised PCA Sheet in orientation and at the monthly RN Supervisory Visit.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 399	Continued From page 58 5. Review of Patient # 9's Home Health Certification and Plan of Care (POC) dated August 29, 2009, to October 27, 2009 on September 28, 2009 at approximately 2:40 p.m. revealed the POC did not include the identification of employees in charge of managing emergency situations. In an interview with the DON on September 28, 2009, at approximately 2:45 p.m., it was acknowledged Patient #9's POC did not include the identification of employees in charge of managing emergency situations. There was no documented evidence on the POC of the identification of employees in charge of managing emergency situations. There was no documented evidence of the PCA reporting on the physical condition, behavior, or appearance of the patient on the aforementioned dates.	H 399		
H 411	3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on a record review and interview it was determined that the agency failed to ensure that a	H 411	H 411 **Home Health Aide(HHA) Service Sheet has been revised to include the following, this will also be included in the HHA job description and aide duties:** **f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance...** **and reporting the patient's physical condition, behavior, or appearance...** **New HHA's will be oriented to revised HHA Sheet in orientation and at the monthly RN Supervisory Visit.** **QA will monitor monthly for 100% compliance**	11/09

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H 411	Continued From page 59 home health aide observe, record, and report patient's physical condition, behavior or appearance for two (2) of ten (10) patients. (Patients #1 and #5) The findings include: 1. A record review of patient #1's record on September 28, 2009 at approximately 11:00 a.m. revealed that there was no documented evidence of the home health aide observing, recording, and reporting the patient's physical condition, behavior, or appearance to the agency. During a face to face interview with the Director on September 28, 2009 at approximately 11:30 a.m. she acknowledged findings. 2. A record review of patient #5's record on September 29, 2009 at approximately 12:00 p.m. revealed that there was no documented evidence of the home health aide observing, recording, and reporting the patient's physical condition, behavior, or appearance to the agency. During a face to face interview with the Director on September 29, 2009 at approximately 12:30 p.m. she acknowledged findings.	H 411		
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on interview and record review the Home	H 453	**H 453** **RN Supervisor to consult with Nursing Administration and client, and care providers at monthly RN Supervisory visit medication regimen and review the plan of care on current 485 for recent medication orders by physician upon initial assessment and monthly .** **HHA's/PCA's to document on Service Sheet Medication Reminders.** **QA will monitor monthly for 100% compliance**	**11/09**

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H 453	Continued From page 60 Care Agency's (HCAs)nurse failed to ensure that patient needs are met in accordance with the plan of care (POC) for one (1) of ten (10) patients in the sample. (Patient #8) The finding includes: Review of Patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009, to October 16, 2009, on September 28, 2009 at approximately 10:05 a.m., revealed Patient #8 was prescribed Trileptal 300mg/5ml(300mg) by mouth twice a day and Ativan 2mg/tablet (2mg) by mouth whenever necessary for seizures. Further review revealed all medications were to be administered by the parent and medication reminders were to be provided. Review of Patient # 8's register nurse (RN(Supervisory Assessment Form dated August 27, 2009, on September 28, 2009, at approximately 10:06 a.m., indicated Patient #8 was not on medications. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 10:08 a.m., it was acknowledged Patient #8 was prescribed Trileptal 300mg/5ml (300mg) by mouth twice a day and Ativan 2mg/tablet (2mg) by mouth whenever necessary for seizures. There was no documented evidence the HCA's nurse ensured that the patient's medication needs were met in accordance with the POC.	H 453		
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following:	H 459		

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H 459	Continued From page 61 (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 (HCA) failed to ensure documentation of the evaluation of patient instruction given to the patient and the patient's caregivers for two (2) of ten (10) patients in the sample. (Patient #2 and Patient #8) The findings include: 1. A record review of patient #2's record on September 28, 2009 at approximately 1:50 p.m. revealed forms entitled "Community Care Nursing Services, Inc. Nursing Flow Sheet " dated July 13, 2009, July 15, 2009 and July 16, 2009. On all the dated forms the skilled nurse wrote in education section that she taught patient about aspiration precaution. There was no documented evidence of the patient's evaluation of the teaching. During a face to face interview with the Director on September 28, 2009 at approximately 2:30 p.m. she acknowledged findings 2. Review of patient # 8's Home Health Certification and Plan of Care (POC) dated August 19, 2009 to October 16, 2009, on September 28, 2009 at approximately 11:02 a.m., revealed safety measures that included universal, fall, environmental and seizure precautions. Review of the RN Supervisory Assessment Form dated August 27, 2009, on September 28, 2009, at approximately 1:47 p.m., revealed "provided	H 459	**H 459** **RN Supervisor to review Nursing Flow Sheet monthly during routine visit for documentation of evidence of the following:** **(i)Patient instruction, and evaluation of patient instruction: and..** **QA will monitor monthly for 100% compliance**	**11/09**

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H 459	Continued From page 62 teaching on safety". Further review revealed the skilled nurse did not document the evaluation of patient instruction on safety management. In an interview with the Director of Nursing (DON) on September 28, 2009, at approximately 1:54 p.m., it was acknowledged the skilled nursing staff did not document the evaluation of the patient instruction on safety management given to Patient #8's caregiver. There was no documented evidence in the record on the evaluation of the patient's instruction on safety management.	H 459		
H 460	3917.2(j) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (j) Discharge planning. This Statute is not met as evidenced by: Based on a record review and interview it was determined that the agency, failed to ensure discharge planning for one (1) out of ten (10) patients. (Patient #2) The findings include: A record review on September 28, 2009 at approximately 1:50 p.m. revealed that patient #2 received respite services from the agency on two different occasions June 29, 2009 to July 3, 2009 and July 9, 2009 to July 16, 2009 at which time the patient was discharge from the agency. Further review of the record revealed nursing notes dated June 29, 2009 through June 3, 2009	H 460	**H 460** **RN Supervisor will begin Discharge Plan at the time of initial intake /admission with client and or care giver and document on RN assessment/Intake Form.** **Discharge plan will be addressed monthly at RN Supervisory visit and documented on RN Supervisory Assessment Form.** **Discharge Plan will be noted on the initial plan of care(485) and updated every 60 days .** **QA will monitor monthly for 100% compliance**	**11/09**

FORM APPROVED

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H 460	Continued From page 63 and July 9, 2009 through July 16, 2009. On all the dated nursing notes, there was no documented evidence of discharge planning. During a face to face interview with the Director on September 28, 2009 at approximately 2:30 p.m. revealed that patient only received respite services form the agency, per family's request. The findings were acknowledged.	H 460		