Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/08/2021

NAME OF PROVIDER OR SUPPLIER: **COMMUNITY CARE NURSING SERVICES OF DC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **6031 KANSAS AVE NW, WASHINGTON, DC 20002**

REVISED

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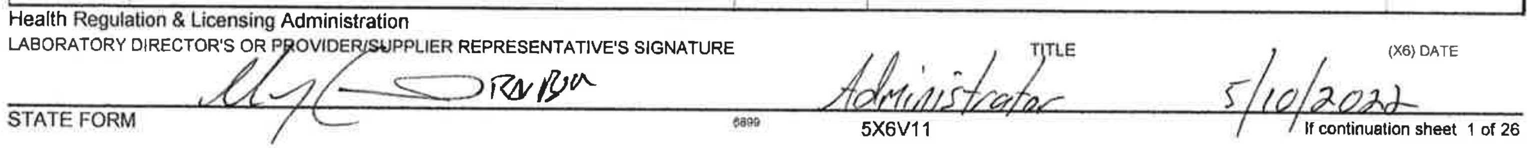
H 000	INITIAL COMMENTS An annual survey was conducted on 11/29/2021, 11/30/2021, 12/01/2021, 12/02/2021, 12/03/2021, 12/06/2021, 12/07/2021, and 12/08/2021 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 12 patients and employed 14 staff. The findings of the survey were based on the review of administrative records, 10 active patient records, three discharged patient records, 13 personnel records, and a review of the agency's response to complaints and incidents received. The survey findings were also based on the completion of five patient telephone interviews. Listed below are abbreviations used throughout this report: ADL - Activities of Daily Living CHF - Congestive Heart Failure DON- Director of Nursing HHA - Home Health Aide HCA - Home Care Agency IADL- Instrumental Activities of Daily Living mg/dl - milligrams per deciliter OT - Occupational Therapist PCA - Personal Care Aide POC - Plan of Care PT - Physical Therapist RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care	H 000		
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	H 126		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/10/2022

REVISED

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H 126	Continued From page 1 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, the home care agency (HCA) failed to ensure the agency ' s contractual agreements were renewed after the duration of the agreement for the agency ' s Medical Director and a licensed practical nurse (LPN) #3 included in the sample. Findings included: A review of the facility's personnel records was conducted on 12/03/2021 beginning at 11:15 AM revealed the following: The personnel file for the agency ' s Medical Director showed a contractual agreement that was signed on 04/02/2014. Further review of the agreement revealed that the agreement would be renewed by the execution of another "agreement and or addendum with the duration, commencement date, and the termination date included in said agreement and or addendum." The personnel file for licensed practical nurse (LPN) #3 showed a contractual agreement that was signed on 11/11/2014. During an interview on 12/03/2021 at 1:00 PM, the Administrator verified that the duration agreements for personnel employed on a contractual basis was for one year and stated that she would be sure to update the agreements for all persons applicable.	H 126	Missing contractual agreements will be obtained and placed in the corresponding files. The Human Resources Coordinator shall audit 100% of active personnel files to ensure the presence of a current contractual agreement. Additionally, the Human Resources Coordinator shall ensure Contractual agreements are renewed annually by tracking them in a database. The Human Resources Coordinator shall submit the list of expiring contractual agreements to the Quality Assurance Nurse monthly.	Jan. 7, 2022

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H 162	3907.6 PERSONNEL At the time of initial employment of each employee, the home care agency shall verify that the employee, within the six months immediately preceding the date of hire, has been screened for and is free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that each employee was free of communicable diseases within the six months immediately preceding the employee's date of hire for one of 12 employee's personnel files included in the sample (Human Resources Director). Findings included: A review of the facility's personnel records was conducted on 12/03/2021 beginning at 11:15 AM revealed the following: The personnel file for the agency's Human Resources Director included a hire date of 03/07/2018. Further review of his personnel file showed no documented evidence that he had ever been screened for and verified free of communicable disease. During an interview on 12/03/2021 at 1:46 PM, the Human Resources Director stated that because he had no contact with the patients, he was under the impression that he was not required to be screened. Review of the Home Care Agency's policy entitled "Employee Health Requirements Policy" on 12/08/2021 at 2:54 PM, showed "a basic health screening on initial application and additional	H 162	The Human Resources Director shall audit 100% of the employee personnel files to verify that each individual has documentation showing that they have been screened for communicable diseases within the last twelve months. Ongoing, all employees and contractors shall show documentation that they were screened for communicable diseases within the six months immediately preceding their date of hire. Also, the agency shall update its "Employee Health Requirements Policy" to include that all individuals, employees and contractors, regardless of the amount of time the individual is expected to interact with clients directly, shall provide documentation that they were screened for communicable diseases within the six months immediately preceding their date of hire or contract agreement and annually thereafter. (See Attachment A)	Jan 7, 2022

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H 162	Continued From page 3 screenings if there is a change in the independent contractor/employee's condition." It should be noted that the personnel policy did not address that the agency would verify each employee would be screened for and certified free of communicable diseases within six months prior to the employee's hire dates.	H 162		
H 163	3907.7 PERSONNEL Each employee shall be screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that one of three licensed practical nurses (LPN) included in the sample underwent annual screening for communicable disease. (LPN #3). Findings included: The personnel file for LPN #3 showed that she was last screened and certified free of communicable disease on 11/06/2019. Review of the agency's policy entitled "Categories/Qualifications" on 12/08/2021 at 2:08 PM, showed "new hires must undergo a health screening with negative results before they are hired or rehired in accordance with federal, state, and local requirements." Continued review of the policy revealed that the health screening included but was not limited to all communicable diseases	H 163	The Human Resources Director shall audit 100% of its employee and contractor personnel files to verify that each individual has documentation showing that they have been screened for communicable diseases annually via a “TB Surveillance Form.” (See Attachment B) Those whose files do not have the proper documentation shall be required to furnish proof that they were screened for communicable diseases within the past twelve months. The Human Resources Coordinator shall track annual TB Surveillance Forms in the human resources database and shall submit his findings monthly to the Director of Clinical Services to ensure this statute is being met.	Jan 7, 2022

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H 163	Continued From page 4 such as Hepatitis B, tuberculosis, and Covid-19. The policy also showed that the "organization retains the option to require annual physical screening of all staff as required by state or local law or as deemed appropriate by the organization." At the time of survey, there was no documented evidence to show that LPN #3 was screened and verified free of communicable disease since 11/06/2019. This is a Repeat Deficiency (Previous survey 10/30/2020)	H 163		
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 record review and interview, the home care agency's (HCA ' s) skilled nurses failed to accurately and consistently document medication administration for one of the ten patients in the sample (Patient #1). Findings included: 1. On 12/02/2021 at 12:05 PM, review of Patient #1's clinical record revealed the patient had diagnoses that included Prune Belly Syndrome, Asthma, Seizures, Liver Transplant, Colostomy, and Gastrostomy. The plan of care showed a physician's order for skilled nursing services 15 hours daily for 60 days for medication	H 267	The Director of Clinical Services and Quality Assurance Nurse shall conduct an audit of 100% of current patient charts. A three-way check shall be performed between the physicians, medication administration records, and the prescription bottles (by way of the RN Supervisor). The Plan of Care and medication administration records for patient #1 were clarified and staff was educated. The Director of Clinical Services at the time of the survey was removed and replaced by a qualified individual. The Quality Assurance Nurse shall audit 25% of all patient charts monthly to ensure congruency between the Plan of Care and Medication Administration Record.	Dec 15, 2021

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H 267	Continued From page 5 administration and treatment to promote optimal level of wellness. Further review of the record showed that the patient had been prescribed Multivitamin (MVI) chewable, 1 tab via G-tube daily. A review of the patient's medication administration record (MAR) for June 2021 showed that the order was inaccurately transcribed. The MAR showed an order for the MVI to be administered two times a day and was initialed as administered at 8 AM and 8 PM. Also, the MAR for September 2021 showed that the Multivitamin chewable was transcribed and initialed as administered two times a day from 9/1/2021 to 9/12/2021 and then crossed out, while the October 2021 MAR showed that the Multivitamin chewable was, again, administered twice a day from 10/01/2021 to 10/24/2021. The MARs were unclear as to whether the Multivitamin chewable was being given once a day as ordered for the months of June 2021, September 2021, and October 2021. On 12/08/2021 at 3:30 PM, during interview, the Director of nursing was informed of the findings. At the time of the survey, the home care agency 's nurses failed to accurately transcribe Patient #1's MVI order. This is a Repeat Deficiency. (Previous survey 10/30/2020)	H 267		
H 335	3913.5 COMPLAINT PROCESS	H 335		

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H 335	Continued From page 6 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 record review and interview the home care agency (HCA) failed to respond to a complaint within 14 calendar days of its receipt and provide evidence of documentation for one of ten patients included in the sample (Patient #8). The findings included... Review of the home care agency's complaint log on 12/02/2021 at 3:20 PM, showed a complaint was made regarding Patient #8. Further review of the complaint showed nursing notes dated 10/15/2021 that revealed the agency's Quality Assurance personnel received a phone call from Patient #8's mother who complained regarding services provided by the night nurse. During an interview on 11/30/2021, at 3:54 PM the director of nursing (DON) was questioned regarding the complaint for Patient #8. The DON stated that she believed that LPN #6 was re-educated and was removed from providing care for Patient #8. Review of the agency's policy entitled "Complaint/Grievance Policy Handout to Patients" reviewed on 12/08/2021 at 3:22 PM showed that a summary report will be created for each reported grievance regardless of complaint withdrawal or completed investigation. At the time of the survey, there was no documented evidence that the home care agency	H 335	The complaint policy was reviewed among the Administrative Staff. Additionally, the complaint form was emailed to all administrative staff. The Management Team was able to express understanding of the complaint process. Moving forward, complaints will be addressed appropriately according to the policy within fourteen days, and the complainant will be notified of the results accordingly.	Dec. 9, 2021

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H 335	Continued From page 7 followed its policy to provide a summary report for the complaint involving Patient #8, nor was there evidence of a response to the complainant within 14 days of the receipt of the complaint.	H 335		
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, 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 record review and interview, the home care agency failed to ensure that each patient's plan of care included a description of the services to be provided, including frequency, amount, and duration of services, for two of the ten sampled patients receiving skilled nursing services. (Patients #3 and #8). The findings included: 1. On 12/07/2021 at 09:15 AM, review of Patient #3's plan of care (POC) showed a duration period of 12/03/2021 through 01/31/2022. The plan of care reflected skilled nursing services 16 hours per day seven days a week. The plan of care did not, however, provide a description of duties or the frequency, amount, or duration of the Registered Nurse's (RN's) services. Further review of Patient #3's clinical record revealed that the RN visited Patient #3 on 09/21/2021 and 10/19/2021 when the plan of care did not contain	H 355	All current patient Plans of Care will be reviewed and updated to include an accurate description of services to include monthly RN Supervisory visits. The Director of Clinical Services shall audit each Plan of Care to ensure accuracy in frequency, amount, expected duration, medication administration, including dosage, equipment, and supplies. Once corrected, the Director of Clinical Services or Designee shall update patient Plans of Care at least every 60 days and as needed.	Jan. 7, 2022

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H 355	Continued From page 8 orders for the RN visits. 2.On 12/7/2021 at 2:10 PM, review of Patient #8's plans of care showed duration periods of 9/7/2021 through 11/05/2021, 11/06/2021 through 01/04/2022. The plans of care reflected skilled nursing services 16 hours per day seven days a week. The plan of care did not, however, provide a description of duties or the frequency, amount, or duration of the Registered Nurse's (RN's) services. Further review of Patient #8's clinical record revealed that the registered nurse (RN) provided telephone visits for patient #8 on 10/07/2021 and 11/05/2021 when the plan of care did not contain orders for the RN's visits. On 12/08/2021 at 3:30 PM, the director of nursing was informed of the findings. At the time of the survey, the home care agency failed to ensure that the plans of care for Patients #3 and #8 included orders for Registered Nurse visits.	H 355		
H 366	3914.4 PATIENT PLAN OF CARE Each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care; provided, however, that a plan of care for personal care aide services only may be approved and signed by an advanced practice registered nurse. If a plan of care is initiated or revised by a telephone order, the telephone order shall be immediately reduced to writing, and it shall be signed by the physician within thirty (30) days. This Statute is not met as evidenced by:	H 366	The Plans of Care for patients #2, 6, 7, 8, and 9 were followed-up for the physician for signature. 100% of patients' Plans of Care shall be reviewed to ensure physician signature within thirty days. All patient Plans of Care shall be tracked in a spreadsheet with due dates and signature dates. Plans of Care shall be updated up to 30 days prior to their expiration and faxed to physicians for signature.	Jan. 7, 2022

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H 366	Continued From page 9 Based on record review and interview, the home care agency failed to ensure that each patient's plan of care was signed by their physician within 30 days, for five of the ten active patients included the sample (Patients #2, 6, 7, 8, and #9). Findings included: 1. On 12/6/2021 at 11:33 AM, review of Patient #2's record showed plans of care (POCs) with duration periods beginning on 05/05/2021 through 07/03/2021 and 11/01/2021 through 12/30/2021. Each plan of care contained a physician's order for skilled nursing services 119 hours per week, to perform comprehensive neurological, multi-system assessment and pain assessment with temperature, pulse, respiration each shift daily. The order, also, required the skilled nurse to document the presence and character of any seizure activity, aura, type, duration, frequency, time of onset, and postictal phase. Further review of the patient's record showed that the plans of care were not signed by the patient's physician within 30 days of the start of care. 2. On 12/7/2021 at 09:21 AM, review of Patient #6's record showed plans of care with duration periods beginning on 01/04/2021 through 03/04/2021, 03/05/2021 through 05/03/2021, and 10/31/2021 through 12/29/2021. Each plan of care contained a physician's order for personal care aide services 72 hours per week, to assist the patient with activities of daily living. The order, also, required the aide to always monitor and supervise the client and assist with toileting every two hours as needed. Further review of the patient's record showed that the plans of care were not signed by the patient's physician within 30 days of the start of care.	H 366	*(Continue from page 9)* The Director of Clinical Services shall follow up within 14 days to ensure the physician has received and is reviewing the Plan of Care. The following week the Director of Clinical Services or Designee shall reach out to the physician again to ensure the Plan of Care has been reviewed and signed. Additionally, the patient's family or representative shall be made aware if the orders are not signed timely; the agency shall ask for the family's assistance in contacting the physician. When all efforts have been made to ensure the Plan of Care is signed timely but to no avail, the patient's insurance company will be contacted for further assistance and a discharge letter will be generated. The "Plan of Care Signature" policy was reviewed and updated. (See Attachment C) The QA nurse shall monitor the Plans of Care for timely physician signature.	Jan. 7, 2022

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H 366	Continued From page 10 3. On 11/30/2021 at 3:30 PM, review of Patient #7's record showed the plans of care with duration periods beginning on 10/21/2020 through 12/19/2020, 12/20/2020 through 02/18/2021, 02/19/2021 through 04/19/2021, 06/19/2021 through 08/17/2021, 0/8/18/2021 through 10/16/2021, and 10/17/2021 through 12/15/2021. Each plan of care contained physician's orders for personal care aide services four hours seven days a week to assist the patient with activities of daily living. The order, also, required the aide to monitor and supervise the client at all times and assist with toileting every two hours as needed. Further review of the patient's record showed that the plans of care were not signed by the patient's physician within 30 days of the start of care. 4. On 12/6/2021 at 09:30 AM, review of Patient #8's record showed the plans of care with duration periods beginning on 9/7/2021 through 11/05/2021 and 11/06/2021 through 01/04/2022. Each plan of care contained physician orders for skilled nursing services 16 hours per day seven days a week, to perform comprehensive neurological, multi-system assessment and pain assessment with temperature, pulse, respiration each shift daily. The order, also, required the skilled nurse to engage in skill level appropriate activities that allows for maximum participation, motor function, and sensory input by client. Further review of the patient's record showed that the plans of care were not signed by the patient's physician within 30 days of the start of care. 5. On 12/6/2021 at 10:30 AM, review of Patient #9's record showed a plan of care with a duration period beginning on 12/23/2020 through 2/21/2021. The plan of care contained physician orders for skilled nursing services 16 hours per day seven days a week, to perform	H 366		

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H 366	Continued From page 11 comprehensive neurological, multi-system assessment and pain assessment with temperature, pulse, respiration each shift daily. The order, also, required the skilled nurse to administer all medications, feedings, and flushes via J-port of G-tube. Further review of the patient's record showed that the plan of care was signed by the patient's physician, 55 days later, on 02/16/2021. During interview on 12/08/2021 at 3:30 PM, the Director of nursing was informed of the findings. At the time of survey, the home care agency failed to ensure that plans of care for Patient's #2, 6, 7, 8, and #9 were signed by the patient's physician within 30 days of the start of care.	H 366		
H 391	3915.7 HOME HEALTH & PERSONAL CARE AIDE SERVICE Each home health or personal care aide shall be supervised by a registered nurse or other health professional for performing tasks specific to that profession. On-site supervision of skilled services shall take place at least once every two (2) weeks. On-site supervision of all other services shall take place at least once every sixty-two (62) calendar days. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each home health aide (HHA) providing services was supervised onsite by a registered nurse (RN) for three of the 10 patients receiving personal care aide services (Patients #5, 6, and #7).	H 391	Each home health or personal care aide shall be supervised by a registered nurse for performing tasks specific to their profession. On site supervision of skilled services shall take place at least once every two (2) weeks.	Jan. 7, 2022

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 ___	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 391	Continued From page 12 Findings included: 1. On 11/30/2021 at 03:14 PM, review of Patient #5's record showed a plan of care (POC) with a duration period of 10/31/2021 through 12/29/2021. The POC showed a physician's order for personal care aide (PCA) services 72 hours every week. It required the registered nurse (RN) to visit the patient two times a month to conduct assessment and evaluations of all body systems. Also, the POC required the nurse to instruct and supervise the home health aide at least every 60 days to assist the client with personal care and activities of daily living, review patient medications each visit, teach disease process, medication side effects, adverse reactions, and compliance. Further review of the record showed that the nurse conducted telephone visits with the patient during the months of August 2021, September 2021, October 2021, and November 2021. There was no evidence that the registered nurse conducted onsite supervision of services provided by the home health aides during the months noted above. 2. On 12/07/2021 at 09:08 AM, a review of Patient #6's record showed a plan of care (POC) with a duration period from 10/31/2021 through 12/29/2021. The POC showed a physician's order for personal care aide (PCA) services 72 hours every week. It required the registered nurse to visit the patient two times a month to conduct assessment and evaluations of all body systems. Also, the POC required the nurse to instruct and supervise the home health aide at least every 60 days to assist the client with personal care and activities of daily living, review patient medications each visit, teach disease process, medication side effects, adverse reactions, and	H 391	*(Continued from page 12)* On site supervision of all other services shall take place at least once every sixty two (62) calendar days. The Nurse Supervisor shall conduct assessments of the patients, review the medications for compliance, inspect the environment, and staff member. Furthermore, the Nurse Supervisor shall have another individual (e.g. parent/guardian, family, aide, or nurse), at the time of the visit, sign the RN Supervisory Visit Form to indicate the visit was conducted in-person. The QA Nurse shall review 100% of all supervisor visits monthly until 100% accuracy is achieved, then reduce audits to 25% monthly.	

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 ____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW WASHINGTON, DC 20002

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H 391	Continued From page 13	H 391		

compliance.
Further review of the records showed that the nurse conducted telephone visits with the patient during the months of February, March, April, May, June, August, September, October, and November 2021. There was no evidence that the registered nurse conducted an onsite supervision of services provided by the home health aides during the months noted above.

3. On 12/3/2021 at 3:10 PM, review of Patient #7's record showed a plan of care (POC) with a duration period of 10/17/2021 through 12/15/2021. The POC showed a physician's order for personal care aide (PCA) services four hours a day seven days a week. It required the registered nurse (RN) to visit the patient two times a month to conduct assessment and evaluations of all body systems. Also, the POC required the nurse to instruct and supervise the home health aide at least every 60 days to assist the client with personal care and activities of daily living, review patient medications each visit, teach disease process, medication side effects, adverse reactions, and compliance.
Further review of the record showed that the nurse conducted telephone visits on 11/28/2020, 12/28/2020, 1/26/2021, 2/26/2021, 3/25/2021, 4/23/202, 5/21/2021, 6/20/2021, 8/20/2021, 9/9/2021, and 10/19/20211. There was no evidence that the registered nurse conducted onsite supervision of services provided by the home health aides during the months noted above.

On 12/08/2021 at 3:30 PM, during interview the Director of nursing was informed of the findings.

At the time of the survey, the home care agency

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 ______	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 391	Continued From page 14 failed to ensure that home health aides providing services to Patients #5, 6, and #7 were supervised onsite by the Registered Nurses.	H 391		
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 record review and interview, the home care agency (HCA) failed to ensure skilled nursing services were provided in accordance with the patient's plan of care (POC) for six of the ten patients in the sample (Patients #1, 2, 3, 8, 9, and #10). Findings included: 1. On 12/02/2021 at 12:05 PM, review of Patient #1's clinical record revealed the patient had diagnoses that included Prune Belly Syndrome, Asthma, Seizures, Liver Transplant, Colostomy, and Gastrostomy. The plan of care showed a physician's order for skilled nursing services 15 hours daily for 60 days for medication administration and treatment to promote optimal level of wellness. A. Further review of the record showed that the patient was prescribed Magnesium Citrate 750 mg (= 1.5 scoop) in 800 ml of ½ normal saline via G-tube at 115 ml/hour x 7 hours from 9 PM to 4 AM on May 5th, 2021. A review of the	H 453	The charts of patients #1, 2, 3, 8, 9, and 10 have been reviewed and the medications have been reconciled using 3-way check for proper transcription on MARs. The orders for all patients have been clarified and updated. No harm or adverse effects happened to patients. The Director of Clinical Services and QA Nurse shall audit 100% of all current patient charts. All clinical staff shall be in-serviced on Safe Practices to include medication administration and the correct protocol for verbal orders; transcription should be done word for word, verbal orders should be read back to the doctor (see Attachment D). The Quality Assurance Coordinator shall ensure all licensed clinical staff complete the in-service training. The Director of Clinical Services or Designee shall audit 100% of active	Jan. 7, 2022

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 ______	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 453	Continued From page 15 patient's medication administration record (MAR) for the months of June 2021, August 2021, September 2021, and October 2021 showed that the nurses were administering Magnesium Citrate 500 mg (= 1 scoop) in 800 ml of ½ normal saline via g-tube at 115 ml/hour x 7 hours from 9:00 PM to 4:00 AM. B. Continued review of the record showed that the patient was prescribed the following medications: Ferrous Sulfate 15mg/ml, 4ml via g-tube twice daily; Fluticasone Propionate, 50mcg/spray.1 spray each in nostril twice daily; Levetiracetam 100mg/ml, 5ml via g-tube in the mornings and 7ml via g-tube nightly; and Nystatin 500 000U/tab, 1 tab via g-tube twice daily, crush and dissolve in 5ml of water. Review of May 2021 MAR lacked evidence that the above medications were administered as prescribed on 5/16/2021 as evidenced by the lack of administration documentation on the medication administration records. During interview on 12/2/2021 at 3 PM, the Director of Nursing (DON) was made aware of the findings. The DON acknowledged the errors and stated she was confident "they were not giving it and will follow up." 2. On 12/06/2021 at 12:31 PM, review of Patient #2's clinical record revealed the patient had diagnoses that included Cerebral palsy, Acute Respiratory Distress, and Bilateral Hip Surgery. The plan of care (POC) showed a physician's order for skilled nursing services 119 hours per week for medication administration and treatment to promote optimal level of wellness. Also, the POC required the skilled nurse to "check g-tube placement and residual prior to feeds, and to hold feed and residual if residual is greater than 60ml	H 453	*(Continue from page 15)* clinical records to ensure accuracy. Once accuracy is achieved, the Director of Clinical Services or Designee shall continue to audit 25% of active patient charts monthly.	

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 ___	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H 453	Continued From page 16 and call MD." A. Continued review of the patient's clinical record showed a physician's order for Diazepam 5 mg/ml. Give 2 ml via g-tube two times daily. Further review of the patient's August 2021 medication administration record (MAR) showed that the Diazepam was administered once daily from 08/03/2021 through 08/31/2021 as evidenced by the lack of signature documentation on the MAR. Based on record reviews, there was no evidence that Patient #2 sustained untoward effects as a result of this practice. B. Further review of the clinical records showed that there was no tube feeding placement and or residual check documented by nurses on 06/28/2021, 06/29/2021, and 08/17/2021. 3. On 12/02/2021 at 03:15 PM, a review of Patient #3's clinical record revealed the patient had diagnoses that included encounters for Gastrostomy Tube, Tracheostomy, and Chronic Lung Disease. The plan of care showed a physician's order for skilled nursing (SN) services 16 hours daily for 60 days, for medication administration and treatment to promote optimal level of wellness. A review of Patient #3's clinical record showed a physician's order for Simethicone 40 mg/0.6 ml. Give 0.3 ml q6hrs via G-Tube. The patient's medication administration record (MAR) for September showed the order transcribed as " Simethicone 0.6 ml QID PRN (four times a day as needed). The MARs for October 2021 and November 2021 were transcribed as Simethicone 40 mg/0.6 ml.	H 453		

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 ______	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 453	Continued From page 17 Give 0.3 ml every 6hrs via G-Tube (4 times/day) but was administered 3 times daily and signed by the nurses from 10/11/2021 to 10/31/2021, and 11/18/2021 through 11/30/2021. A clarification order on 10/28/2021 had the Simethicone order as "Simethicone 40 mg/0.6 ml. Give 0.3 ml every 6hrs via G-Tube as needed." There was no evidence that the Simethicone was administered as ordered during the month of September 2021. 4. On 12/02/2021 at 9:31 AM, review of Patient #8's clinical record revealed the patient had diagnoses that included Cerebral Palsy, Asthma, Acid Reflux, Neuromuscular Scoliosis, Gastrojejunostomy, Spastic Quadriparesis, and Chronic Lung Disease. The plan of care (POC) showed a physician's order for skilled nursing services 16 hours a day seven days a week. The plan of care required the skilled nurse to check the Gastrostomy tube for correct placement prior to medication administration, maintain patency, and to check gastric residual for gastrointestinal distress. Further review of the patient's clinical record showed that, there was no tube feeding placement and or residual check documented by nurses on 9/10/2021, 9/12/2021, 9/13/2021, 9/14/2021, 9/15/2021, 9/16/2021, 9/17/2021, 9/19/2021, 9/21/2021, 9/22/2021, 9/23/2021, 10/11/2021, 10/12/2021, 10/13/2021, 10/14/2021, 10/25/2021, 10/26/2021, 10/27/2021, 10/28/2021, 10/29/2021, 10/30/2021, 10/31/2021, 11/01/2021, 11/02/2021, 11/03/2021, 11/04/2021, 11/05/2021, 11/06/2021, and 11/07/2021. 5. On 12/02/2021 at 12:05 PM, a review of Patient #9's clinical record revealed the patient had diagnoses that included Chronic Respiratory	H 453		

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 ______	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 453	Continued From page 18 Failure, Gastrostomy/ Gastrojejunostomy Tube, Tracheostomy, Huntington's Disease, and Ventilator Dependent. The plan of care (POC) showed a physician's order for skilled nursing (SN) services 16 hours daily seven days a week for medication administration and treatment to promote optimal level of wellness. A). Continued review of the clinical records showed that Patient #9 was prescribed Amoxicillin Clavulanate 200 mg-28.5 mg/5ml, 20 ml every 12 hours via g-tube for seven days on 02/04/2021." Review of the February medication administration record (MAR) showed the medication was administered once at 10 PM on 02/4/2021 (as first dose), and the last dose was administered on 2/10/2021 at 10 PM. The patient missed one dose of the Amoxicillin Clavulanate 200 mg-28.5 mg/5ml to complete the full 14 doses of the antibiotic. B). Patient #9 was also prescribed Vancomycin 50 mg/ml, 2.5 ml every six hours for eight days on February 5, 2021. Further review of the patient's February MAR showed that the medication was administered from 02/05/2021 to 2/11/2021 for a total of seven days instead of the ordered eight days. The patient missed four doses of the Vancomycin as evidenced by the lack of documentation of administration on the MAR. C). On 11/17/2021 Patient #9 was prescribed Amoxicillin 500 mg, one tab via g-tube three times daily for 10 days for infection. The Amoxicillin was administered on 11/17/2021 at 2 PM and at 11 PM. The medication was then stopped on 11/26/2021 after administering the 11 pm dose. The patient missed one dose of the Amoxicillin 500 mg, which should have been administered on 11/27/2021.	H 453		

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 ______	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW WASHINGTON, DC 20002

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H 453	Continued From page 19	H 453		

Continued From page 19

6. On 12/07/2021 at 2:09 PM, review of Patient #10's clinical record revealed the patient had diagnoses that included Chronic Respiratory Failure, Tracheostomy, Ventilator, Gastrostomy Tube Dependent, Pulmonary Hypertension, Spastic Quadriplegia, and Acid Reflux. The plan of care (POC) showed a physician's order for skilled nursing services 16 hours a day seven days a week for medication administration and treatment to promote optimal level of wellness. Also, the POC required the skilled nurse to check the gastrostomy tube for correct placement prior to medication administration and to check gastric residual for gastrointestinal distress.

A). Further review of Patient #10's clinical record showed that on 08/10/2021, Patient #10 was prescribed Famotidine 40 mg/5ml oral liquid, 0.5ml via g-tube two times a day. A review of the medication administration records (MARs) for the month of August 2021, September 2021, and October 2021 showed that the medication was transcribed and administered as Famotidine 40 mg/5ml, 0.3ml two times daily via G-tube.
The home care agency nurses failed to accurately administer the correct dose of the medication as ordered by the physician.

B). Continued review of Patient #10's record also showed that on 9/7/2021 the physician gave an order to "Start increasing time off the vent to a goal of 12 hours a day. Increase every two hours every other day." A review of the September 2021 medication administration record (MAR) showed that the order was not initiated until 09/12/2021, five days after the order was written.

C). Also, Patient #10's record showed an order

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 ____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 453	Continued From page 20 to discontinue Cetirizine 1 mg/ml. Give 2. 5ml via G-tube every day on 06/14/2021. Continued review of the August, September, and October 2021 MARs showed that the nurses continued to administer the medication as evidenced by the signed MAR's during these months. During interview with the Director of nursing on 12/3/2021 at 11:00 AM, she confirmed that the order was supposed to have been discontinued on June 14, 2021. D). Patient #10's clinical record showed that there was no tube feeding placement and or residual check documented by nurses on 07/14/2021, 07/19/2021, 07/20/2021, 07/21/2021, 07/26/2021, 07/27/2021, 07/28/2021, 08/2/2021, 08/3/2021, 08/04/2021, 09/7/2021, 09/08/2021, and 10/12/2021. During interview on 12/08/2021 at 3:30 PM, the Director of nursing was informed of the findings. At the time of the survey, the home care agency failed to ensure that skilled nursing services were provided in accordance with the Patient's plans of care. There was no evidence that Patients #1, 2, 3, 8, 9, and #10 sustained any untoward effect(s) by this practice. This is a Repeat Deficiency (Previous survey 10/30/2020)	H 453		
H 455	3917.2(e) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (e) For registered nurses, supervision of nursing services delivered by licensed practical nurses,	H 455	Patient receiving skilled nursing services via LPN receive two RN Supervisory Visit monthly. The Plan of Care is for sixty days and therefore the Plan of Care indicates four visits.	Dec 10, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 455	Continued From page 21 including on-site supervision at least once every sixty-two (62) calendar days; This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to provide evidence that the Registered Nurses (RNs) provided onsite supervision every 62 days to Licensed Practical Nurses (LPNs) that provided skilled services for six of ten patients in the sample (Patient #1, 3, 4, 8, 9, and #10). Findings included: 1. On 12/2/2021 at 12:05 PM, review of Patient #1's clinical record showed a plan of care (POC) that contained a physician's order that required nursing supervisory visits two times a month for assessments and clinical management. Also, the POC required skilled nursing services 15 hours per day seven days a week. The patient had diagnoses that included Prune Belly Syndrome, Asthma, Seizures, Liver Transplant, Colostomy, and Gastrostomy tube. Further review of the patient's clinical record failed to show that the skilled nurse provided onsite supervision every 62 days to the LPN's that provided skilled nursing services during the months of April 2021, June 2021, and August 2021. 2. On 12/02/2021 at 09:08 AM, review of Patient #3's clinical record showed a plan of care (POC) that contained a physician's order that required nursing supervisory visits two times a month for assessments and clinical management. Also, the POC required skilled nursing services 16 hours per day seven days a week. The patient had diagnoses that included Gastrostomy Tube,	H 455	*(Continue from page 22)* All RN Supervisors were informed that all supervisory visits must be conducted in person. The Director of Clinical Services shall track bi-weekly supervisory visits to ensure completion within the correct allotted time frame. RN Supervisors will first be given written warnings and then removed from their position if they are unable to comply.	

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 ____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW 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 455	Continued From page 22 Tracheostomy, and Chronic Lung Disease. Further review of the patient's clinical record failed to show that the skilled nurse provided onsite supervision every 62 days to the LPN's that provided skilled nursing services during the months of September 2021 and October 2021. 3. On 12/2/2021 at 03:11 PM, review of Patient #4's clinical record showed a plan of care (POC) that contained a physician's order that required nursing supervisory visits two times a month for assessments and clinical management. Also, the POC required skilled nursing services ten hours per day seven days a week. The plan of care showed that the patient had diagnoses that included Chronic Lung Disease, Acid Reflux, and Developmental Delay. Further review of the patient's clinical record failed to show that the skilled nurse provided onsite supervision every 62 days to the LPN's that provided skilled nursing services during the months of August 2021, September 2021, and October 2021. 4. On 12/3/2021 at 11:05 AM, review of Patient #8's clinical record showed a plan of care (POC) that contained a physician's order that required nursing supervisory visits two times a month for assessments and clinical management. Also, the POC required skilled nursing services 16 hours per day seven days a week. The patient had diagnoses that included Cerebral Palsy, Asthma, Acid Reflux, Neuromuscular Scoliosis, Gastrojejunostomy, Spastic Quadriparesis, and Chronic Lung Disease. Further review of the patient's clinical record failed to show that the skilled nurse provided onsite supervision every 62 days to the LPN's that provided skilled nursing services during the	H 455		

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 ___	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF DC	**6031 KANSAS AVE NW 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 455	Continued From page 23 month of September 2021. 5. On 12/2/2021 at 12:05 PM, review of Patient #9's clinical record showed a plan of care (POC) that contained a physician's order that required nursing supervisory visits two times a month for assessments and clinical management. Also, the POC required skilled nursing services 16 hours per day seven days a week. The patient had diagnoses that included Prune Belly Syndrome, Asthma, Seizures, Liver Transplant, Colostomy, and Gastrostomy. Further review of the patient's clinical record failed to show that the skilled nurse provided onsite supervision every 62 days to the LPN's that provided skilled nursing services during the during the month of September 2021. 6. On 12/5/2021 at 3:35 PM, review of Patient #10's clinical record showed a plan of care (POC) that contained a physician's order that required nursing supervisory visits two times a month for assessments and clinical management. Also, the POC required skilled nursing services 16 hours per day seven days a week. The patient had diagnoses that included Chronic Respiratory Failure, Tracheostomy, Ventilator, Pulmonary Hypertension, Spastic Quadriplegia, Acid Reflux, and Gastrostomy Tube. Further review of the patient's clinical record failed to show that the skilled nurse provided onsite supervision every 62 days to the LPN's that provided skilled nursing services during the during the months of August 2021, September 2021, October 2021, and November 2021. During interview on 12/08/2021 at 3:30 PM, the Director of nursing was informed of the findings. At the time of the survey, the HCA failed to provide documented evidence that the Registered	H 455		

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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 ______	12/08/2021

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COMMUNITY CARE NURSING SERVICES OF DC	6031 KANSAS AVE NW WASHINGTON, DC 20002

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H 455	Continued From page 24 Nurses provided onsite supervision every 62 days to the LPNs who provided skilled nursing services for Patients #1, 3, 4, 8, 9, and #10.	H 455		
H 458	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse failed to report changes in patient's conditions to the physician for two of ten sampled patients. (Patients #4 and #8). Findings Included: 1. On 12/1//2021 at 9:00 AM, a review of Patient #4's plan of care showed that the patient had diagnoses that included Chronic Lung Disease, Acid Reflux, and Developmental Delay. The clinical record showed that the nurse was required to visit the patient twice a month for clinical management and supervision of nursing services delivered by licensed practical nurses. The plan of care further recommended that the skilled nurse would monitor the patient's heart rate each shift and "call the doctor for heart rate above 100 or below 60." Further review of patient #4's clinical record showed documented heart rate readings above 100 repeatedly on 09/03/2021, 09/06/2021, 09/07/2021, 09/27/2021, 09/29/2021, and 09/30/2021. There was no documented evidence that the nurse informed the	H 458	The nurses for patient's #4 and #8 were educated on the importance of reporting changes in the patients' conditions. An Emergency Protocol Inservice will go out to all clinical staff to ensure staff members are educated on following the emergency protocol. (See Attachment E) The Director of Clinical Services and Quality Assurance Coordinator shall audit 100% of patient charts to ensure emergency protocols are being followed. Those found out of compliance shall be educated and face disciplinary actions. The Quality Assurance Nurse shall continue to audit 25% of patient charts monthly to ensure nursing staff are reporting changes in patient's conditions.	Jan. 7, 2022

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H 458	Continued From page 25 physician when the patient's assessed heart rate exceeded the prescribed parameters. 2. On 12/1//2021 at 11:26 AM, a review of Patient #8's plan of care showed that the patient had diagnoses that included Cerebral Palsy, Asthma, Acid Reflux, Neuromuscular Scoliosis, Gastrojejunostomy, Spastic Quadriparesis, and Chronic lung disease. The plan of care included skilled nursing services 16 hours a day seven days a week. The clinical record showed that the nurse was required to visit the patient monthly for clinical management and supervision of nursing services delivered by licensed practical nurses. Further review of patient #8's clinical record showed the nurse documented "coffee ground emesis" twice at 1AM and 5AM on 11/02/2021. Continued review showed there was no documented evidence that the nurse informed th physician of the changes in patient's condition. During interview on 12/08/2021 at 3:30 PM, the Director of nursing was informed of the findings. At the time of survey, the home care agency's nurses failed to report changes in the patients' condition to the physician for Patients #4 and #8.	H 458		