Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0064	A. BUILDING: _____ B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL VIEW HOME HEALTH	1820 JEFFERSON PLACE, NW WASHINGTON, DC 20036

(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 initial survey was conducted from February 11, 2014, through February 12, 2014, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to one hundred and three (103) patients and employs one hundred and seventy three (173) staff. The findings of the survey were based on observations, record reviews and interviews with current patients and staff. Please Note: Listed below are abbreviations used in this report. Skilled Nurse (SN) Plan Of Care (POC) Director of Nursing (DON) Home Care Agency (HCA) As Needed (PRN)	H 000	*Capitol View HHA has reviewed the Licensure Survey Report dated February 24, 2014 and all records and results of the home visits conducted during the* ***Licensure Survey for February 12 – 13, 1014.*** Received 3/6/14 DOH/HRLA/ICRD	3/11/14
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 record review and interview, the Home Care Agency (HCA) failed to implement their policy to ensure treatment, care and services were consistent with the patient's plan of care (POC) for two (2) of ten (10) patients in the sample. (Patient #4 and #5)	H 300	***Plan of Correction*** ***H 300*** ***Licensure: 3912.2(d) Patient Rights and Responsibilities*** *Capitol View HHA and its staff are now compliant with the accepted Professional Standards and principles that apply to the Licensure of HHAs 3912.2(d)* **1. Compliance with standard: To receive treatment, care and services consistent with the agency/patient agreement and with the patient's plan of care.** a. **Corrections:** All active patients have documentation to support that treatment, care and services are consistent with the patient's Plan of Care. Policy and Procedure (P&P) for "Care Planning Process" (Policy No. 2-018) was reviewed and all clinicians will be in-serviced. "The care planning process will be documented on the plan of care, individualized discipline-	3/11/14

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0064	A. BUILDING: _____ B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL VIEW HOME HEALTH	1820 JEFFERSON PLACE, NW WASHINGTON, DC 20036

(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 300	Continued From page 1 The finding include: 1. On February 11, 2014, Patient #4's record was reviewed at approximately 10:15 a.m. The clinical record (#4) revealed a POC with certification period of December 8, 2013 through February 5, 2014, with the following diagnoses; Depressive Disorder, Lupus Erythematosus, Hypertension, Morbid Obesity and Generalized Pain. The POC also contained a physician order for skilled nurse visits one (1) to three (3) times a week for nine (9) weeks to teach the patient/caregiver disease process, medications action and side effect and diet and lifestyle changes. The skilled nursing notes in clinical record #4 were reviewed on February 11, 2014 at 10:15 a.m. Review of the nursing notes dated December 20, 2013, and February 4, 2014, in the section titled "skilled intervention/instruction" revealed that the skilled nurse checked the boxes indicating instructions on Diabetic Observation and Teach Diabetic Foot Care. There was no evidence in the clinical record that Patient #4 had a diagnosis of Diabetes Mellitus. A face to face interview with the DON on February 12, 2014, at 4:30 p.m. confirmed that Patient #4 had no diagnosis of Diabetes Mellitus in the clinical record and the documentation was done in error. 2. On February 11, 2014, Patient #5's record was reviewed at approximately 10:35 a.m. The clinical record (#5) revealed a POC with certification period November 29, 2013, through January 27, 2014. The POC contained the following diagnoses; Diabetes Type 2,	H 300	specific care plans (if applicable), clinical notes medication profiles, care conference/summary forms, and discharge/clinical summaries." "Services to be provided will be based on the prioritized needs of the patient. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to determine if goals have been achieved. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes." b. **Identifying similar deficiencies:** All active patient records have been reviewed to identify similar problems. Any records lacking documentation of consistency between the patient's plan of care and treatment, care and services have been noted. Clinicians have been education on consistent documentation and have received a copy of the patient's current plan of care. c. **Systemic Changes/Quality Assurance Program:** The process of correcting the deficiency includes annual in-service training for continued compliance with the standard. An agency wide in-service will be given on March 7 and March 11, 2014 to all clinicians on the elements of performance that address ***Licensure: 3912.2(d) Patient Rights and Responsibilities.*** The staff will be educated on the P&P "Care Planning Process" and will understand it completely. Regular chart audits will be made to monitor compliance.	3/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0064	A. BUILDING: _____ B. WING _____	02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL VIEW HOME HEALTH	1820 JEFFERSON PLACE, NW WASHINGTON, DC 20036

(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 300	Continued From page 2 Hypertension, Backache, Esophageal Reflux and Epilepsy Unspecified. The POC also contained a physician order for skilled nurse visits one (1) to three (3) times a week for nine (9) weeks for observation/assessment of all systems, diabetic teaching of patient/caregiver to include disease process, medications action and side effect and diet and lifestyle changes. The skilled nursing notes in clinical record #5 were reviewed on February 11, 2014 at 10:35 a.m. The nursing notes from January 2, 2014 to February 7, 2014 revealed that the skilled nurse visited the Patient #5 seventeen (17) times but only addressed the Patient's blood glucose level on three occasions, (January 2, 2014, the blood glucose was 134 mg/dl, January 6, 2014, the blood glucose was 111 mg/dl, February 3, 2014, the blood glucose was 156 mg/dl). There was no documented evidence in the clinical record that the skilled nurse monitored Patient #5's blood glucose levels adequately to ensure successful teaching of Diabetes management. A face to face interview with the DON on February 12, 2014, at 4:30 p.m. confirmed that Patient #5's blood glucose levels were not monitored to ensure successful teaching of Diabetes management.	H 300	d. **Ongoing Monitoring:** Bi-weekly chart audits will be conducted on 50% of active patient records by the QA Nurse for compliance with this policy. The chart audit tracking tool will be utilized to monitor the level of compliance. The results will be reported at monthly and quarterly meetings with the DON, QI officer and Senior Management Team. Should a clinician not comply with the requirements the DON and Administrator will be notified immediately and the individual will be subject to disciplinary action. **Patient #4** – An addendum note to clarify the error for Diabetic Observation and Teach Diabetic Foot Care on notes dated 12/20/13 and 2/4/14 on a patient that is not a diabetic has been written and placed in the patient's record. **Patient #5** – An addendum note has been written to include patient's record of blood sugars in the home.	3/11/14