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 _____	10/12/2016

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

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H 000	INITIAL COMMENTS An annual survey was conducted from September 28, 2016 through October 12, 2016, to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22 B DCMR Chapter 39). The home care agency provides home care services for eighteen (18) patients and employs thirty (30) staff to include professional and administrative staff. The findings of the survey were based on a review of administrative records, eight (8) active patient records, three (3) discharged patient records, ten (10) employee records, five(5) complaints, two (2) home visits and interviews with patients/family and staff. Please note listed below are abbreviations used throughout the body of this report. B/P -- blood pressure BSN --- Bachelor of Science of Nursing HCA --- home care agency HHA--- home health aide HOB --- head of bed HR--- human resources h2o --- water G tube --- gastrostomy tube GJ tube --- gastrostomy-jejunostomy tube MARs --- medication administration records mg --- milligrams POC --- Plan of Care SOC --- start of care SN --- skilled nurse TPR-- temperature, pulse and respiration v/s --- vital signs	H 000	Received 11/3/16 CM	
H 070	3904.1 DIRECTOR The governing body shall appoint a Director who shall be responsible for managing and directing	H 070	The Administrator shall ensure personnel are qualified and adequately trained. The Quality Assurance Nurse shall audit 100% of client charts to identify those diagnoses and	January 1, 2017

Government of the District of Columbia
Department of Health

Health Regulation and Licensing Administration

October 26, 2016

Margaret Collins, RN BSN
Community Care Nursing Services
6031 Kansas Avenue, N.W.
Suite 201
Washington, DC 20011

Re: Home Care Agency (HCA-0002)

Dear Ms. Collins:

On October 12, 2016, a licensure survey was completed at your facility identified above. Deficiencies were identified that requires your submission of a Plan of Correction (PoC) to respond to each deficiency. While a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan be signed with a specific date for anticipated completion and returned to this office prior to **November 5, 2016**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the original forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. The plan MUST also include the following.

- **What corrective action(s) will be accomplished to address the identified deficient practice;**
- **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and**
- **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.**

PLEASE NOTE: Plans of Correction not adhering to the above requirements will not be considered acceptable. Surveyors from our office may visit your facility at a future date to determine progress made towards the correction of deficiencies as provided for in your plan. As a result of continued non-compliance, civil monetary penalties may be issued.

If you have any questions, contact me or Laura Hunte, Supervisory Health Services Program Specialist, Intermediate Care Facilities Division, on (202) 442-4736 or laura.hunte@dc.gov.

Sincerely,

Sharon H. Mebane
Program Manager

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H 070	3904.1 DIRECTOR The governing body shall appoint a Director who shall be responsible for managing and directing	H 070	The Administrator shall ensure personnel are qualified and adequately trained. The Quality Assurance Nurse shall audit 100% of client charts to identify those diagnoses and	January 1, 2017

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H 070	Continued From page 1 the agency's operations, serving as liaison between the governing [*2880] body and staff, employing qualified personnel, and ensuring that staff members are adequately and appropriately trained. This Statute is not met as evidenced by: Based on record review and interview, the HCA's director failed to ensure that staff was adequately and appropriately trained to provide care for one (1) of two (2) patient's with Autism and self-injurious behavior. (Patient #10) The finding includes: On September 29, 2016, at 3:43 p.m., record review of patient #10's clinical record revealed a POC with a SOC date of June 27, 2015 and a certification period of June 22, 2016 to August 20, 2016. The patient had a primary diagnosis of Autism. The patient's diagnoses included: self injurious behavior and Pica. The attending physician ordered the following RN/HHA services: - RN monthly visits for comprehensive assessments to include pain and monitor HHA care and treatment plan. - HHA maintain safety precautions including close monitoring for Pica, head banging, pinching self, and non-purposeful running. Close monitoring and supervision at all times. On September 30, 2016 beginning at 1:50 p.m. RN # 3, HHA # 1, # 2 and # 3's personnel records were reviewed. The	H 070	treatments requiring additional training. A list shall be comprised, additional trainings implemented, and documented within the personnel files. The Quality Assurance Nurse shall continue to audit personnel files at a rate of 25% monthly and cross reference the personnel files to ensure the standard is maintained.	

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H 070	Continued From page 2 records failed to provide evidence that the employees had been trained on Autism, pica and Patient's 10's self-injurious behavior. At the time of this survey, the director failed to ensure RN #3, HHA #1, HHA #2 and HHA #3 had been trained on Autism, pica, and self-injurious behavior.	H 070		
H 152	3907.2(h) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (h) Copies of completed annual evaluations; This Statute is not met as evidenced by: Based on review of personnel records and interview, the HCA failed to ensure that each employee personnel record included completed annual evaluations, for five (5) of twelve employees in the sample. (RN #3, LPN #2, LPN #3, HHA #2 and HHA #4) The finding includes: On September 30, 2016, starting at 1:50 p.m., review of RN #3, LPN #2, LPN #3, HHA #2 and HHA #4 personnel records failed to evidence a current annual evaluation. On September 30, 2016, at 2:30 p.m., interview with HR staff revealed he would look for the missing employee evaluations and email them to the surveyor by 10:00 a.m., on October 3, 2016.	H 152	CCNS of DC will conduct individual performance evaluations on every active homecare provider on an annual basis. A human resource database will be used to track when performance evaluations are due. Two weeks before the due date, a letter will be sent out along with a blank evaluation and a self-addressed envelope. The letter will include instructions for the homecare provider to complete their portion and return the evaluation to our office. Once received, the supervisor will complete the evaluation. Completed evaluations will be reviewed by both parties and a copy will be returned to the individual. An audit of 100% of our personnel files will be conducted to ensure all staff have a performance evaluation within the last 12 months from November 2016; then 25% of our actively personnel files will be randomly chosen to audit monthly ongoing to ensure the files are complete and accurate.	January 1, 2017

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H 152	Continued From page 3 It should be noted that the surveyor returned to the HCA's office on October 3, 2016, and the missing evaluations were not provided for review. At the time of the survey, the HCA failed to ensure that annual evaluations were conducted for RN #3, LPN #2, LPN #3, HHA #2 and HHA #4.	H 152		
H 227	3909.2 DISCHARGES TRANSFERS & REFERRALS 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: This Statute is not met as evidenced by: Based on record reviews and interviews, the HCA failed to provide seven (7) day written notice prior to discharging one (1) of two (2) discharged patients in the sample. (Patient #6) The finding includes: On September 30, 2016, starting at 10:30 a.m., review of Patient #6's clinical record revealed a "Client Discharge Form" dated June 2, 2016, which documented Patient #6 was discharged on June 2, 2016. According to the form, the discharge was due to no insurance. The record lacked documented evidence that a seven (7) day written notice was provided prior to discharge on	H 227	All clients being discharged by the agency regardless of the reason for discharge will be issued an official discharge letter giving a 7-day notice of discontinuation of services. The 7-day notice will be given from the date of the letter; services will end after the 7th day. The Director of Nursing will be solely responsible for issuing all Discharge Letters once the decision is made to end services for a client, regardless of the reason for discharge. A copy of the discharge letter will be maintained in the client's chart, copied to the client's case manager if applicable, and forwarded to the client's physician. The QA nurse all discharged client's charts, including the inclusion of a discharge summary and to ensure at least 7 days' prior notice was given.	Dec 1, 2017

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H 227	Continued From page 4 June 3, 2016, which was the last day the HCA staff provided service. On September 30, 2016, starting at 3:00 p.m., interview with the administrator revealed that a seven (7) day notice prior to discharge was not provided for Patient #6. The administrator also indicated that going forward they would provide patients with a seven (7) day notice prior to discharge. At the time of this survey, there was no documented evidence that Patient #6 was provided a seven (7) day written notice prior to discharge.	H 227		
H 260	3911.1 CLINICAL RECORDS Each home care agency shall establish and maintain a complete, accurate, and permanent clinical record of the services provided to each patient in accordance with this section and accepted professional standards and practices. This ELEMENT is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to maintain accurate clinical records for one (1) of eleven (11) patients in the sample. (Patient #9) The finding includes: On September 30, 2016, at approximately 11:00 a.m., review of Patient #9's clinical record revealed that the agency's staff conducted the following home visits: [LPN visits] On July 6, 2016, July 7, 2016 and	H 260	CCNS of DC shall maintain a complete and accurate clinical record of the services provided by this agency for each of its clients. The record shall represent an up-to-date "snapshot" of the clients' current condition, treatment and nursing interventions. The Quality Assurance Nurse will conduct audits to ensure that all clinical documentation is consistent and that any discrepancies are investigated for clarification. The Quality Assurance Nurse will audit 100% of current active client charts within 60 days and audit 25% of active charts monthly moving forward.	Dec. 1, 2017

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H 260	Continued From page 5 July 8, 2016, the LPN documented that the patient's skin was clear, intact and had no signs/symptoms of infection. [RN visit] On July 7, 2016, the RN documented that the patient had a "red rash on face, left leg, and neck area." During an interview with RN #2 on September 30, 2016, at 12:00 p.m., RN #2 stated, " The nursing notes don't match and they should have been called into the office to explain [the difference]." At the time of this survey, the HCA failed to have accurate documentation about Patient #9's skin assessment in his/her record.	H 260		
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 record review and interview, it was determined that the HCA failed to provide training for the patient/family for one (1) of eleven (11) patients in the sample. (Patient #3) The findings include: On September 28, 2016, at 2:10 p.m., review of Patient #3's clinical record revealed a POC with a SOC date of November 5, 2015 and a	H 279	The patient/family of Client #3 has been assessed and provided training as needed by a licensed nurse related to GJ tube care, ostomy care, infection control, and medication administration. Assessment and training has been documented and placed in Client #3's record. The Nursing Supervisor and all licensed nurses shall receive in-service education related to the assessment and documentation of patient education needs and training provided by the nurse. Additionally, all RN Supervisors have been instructed to provide education during each home visit related to clients' diagnosis and treatments. The Quality Assurance Nurse shall review of 100% of active client charts to assure that they contain documentation of ongoing assessment of patient/family knowledge and the provision of education as needed. Upon completion of the 100% chart audit, clinical charts will be audited at a rate of 25% monthly via random selection. The RN Supervisor shall be responsible for the corrective action. The Quality Assurance Nurse will be responsible for monitoring the corrective action.	January 1, 2017

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H 279	Continued From page 6 certification period of July 9, 2016 to September 6, 2016. Further review of the clinical record and POC revealed the patient had a primary diagnosis of Hirschsprung's Disease. Additionally, the patient's pertinent diagnoses included: gastrojejunal, severe dysmotility, colectomy and ileostomy. The attending physician orders included the following skilled nursing services: [SN] to assess and provide family/patient education related to the following: - GJ tube care; - ostomy care; - infection control; and - medication administration. The record lacked documented evidence that the patient/family had been assessed and/or educated on the aforementioned areas within the certification period of July 9, 2016 to September 6, 2016. On September 29, 2016, at 10:00 a.m., interview with LPN #1 revealed that she had provided the ordered training to the patient's father but did not document it. At the time of the survey, the record lacked documented evidence that the family's level of understanding with the patient's treatment/diagnoses had been assessed, as ordered by the physician.	H 279		
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following:	H 358	A clarification order was sent to Patient #1's physician for review and signature adding the diagnoses of Spina Bifida and Muscle Spasticity to the Plan of Care. The Quality Assurance Nurse shall review 100% of client	January 1, 2017

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H 358	Continued From page 7 (g) Physical assessment, including all pertinent diagnoses; This Statute is not met as evidenced by: Based record review and interview, the HCA failed to ensure all pertinent diagnoses were on the POC for one (1) of eleven (11) patients' in the sample. (Patient #1) The finding includes: On September 28, 2016, at 11:45 a.m., review of Patient #1's clinical record revealed a document from "The George Washington University" that documented Patient #1 had diagnoses of spinal bifida and muscle spasticity. Further review of the record revealed a POC with a certification period of June 26, 2016 to August 24, 2016, that lacked evidence of the aforementioned diagnoses. On September 28, 2016, interview with RN #1, starting at 1:00 p.m., revealed that the diagnoses should have been included on the POC. At the time of the survey, there was no documented evidence that all of Patient #1's pertinent diagnoses was included on his/her POC.	H 358	records to ensure the POC's accurately reflect each patient's major and pertinent diagnoses. Any modifications will be included on clarification forms and submitted to the patient's physician for review and signature. The Quality Assurance Nurse, Nursing Supervisors, and all licensed nurses will be provided with in-service training related to the inclusion of client diagnoses on the Plan of Care. The Quality Assurance Nurse will be responsible for implementing and monitoring the corrective action by auditing 100% of all client charts promptly and 25% of all client charts monthly ongoing; including the Plan of Care to ensure all major and pertinent diagnoses are listed and include the dates of onset or exacerbation until at least 90% accuracy is achieved.	
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	H 366	The Plan of Care for Patient's #5 and #8 have been hand delivered to the physician for signature. Plans of Care will be developed and verbal orders for recertification will be obtained from the physician at least 10 days prior to the recertification date to assure that they reach the physician in a timely manner. The RN	January 1, 2017

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H 366	Continued From page 8 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: Based on record review and interview, the HCA failed to ensure that each POC was approved and signed by a physician within thirty days of the SOC, for two (2) of eight (8) active patients in the sample (Patients #5 and #8) The findings include: 1. On September 29, 2016, at 12:00 p.m., review of Patient #5's clinical record revealed a POC with a SOC of July 17, 2016. The POC revealed that the patient had a primary diagnosis of Epilepsy. Additionally, the patient's other pertinent diagnoses included: obesity and hyperalimentation. Continued review of the POC revealed that SN services were to be provided "4 hours a day Tuesday and Wednesday." The POC lacked documented evidence it had been approved by a physician. On September 29, 2016, at 1:00 p.m., interview with RN #1 revealed that they had emailed the physician on July 5, 2016, in an effort to get the POC signed. Additionally, RN#1 indicated that she would contact the physician to get the POC signed. 2. On September 30, 2016, at 11:00 a.m., review of Patient #8's clinical record revealed a POC with a SOC of June 16, 2016. The POC revealed that the patient had a primary diagnosis of Epilepsy. Additionally, the patient's other pertinent diagnoses included: obesity, headache and	H 366	staff nurse shall monitor the flow of the POC for timely physician signatures each week. Any POC that remains unsigned after 2 weeks past the certification period start date will be personally delivered to the physician for signature. The RN staff shall track 100% of active patient records each week to ensure timeliness of physician signatures. As outstanding Plans of Care approach 30 days with no signature, they will be given to the Medical Director to have physician to physician conversations to increase compliance. We will involve the client families and alert the client's case managers of physicians who are not in compliance with returning the requested documentation within the specified time frame. The Quality Assurance Nurse shall review at least 25% of patient records monthly to ensure continuing compliance.	

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H 366	Continued From page 9 intermittent nausea and vomiting. Continued review of the POC revealed that PCA services were to be provided "6 hours a day seven (7) a week." The POC lacked documented evidence it had been approved by a physician. On September 30, 2016, at 1:00 p.m., interview with RN #2 revealed that they had emailed the physician on June 10, 2016, in an effort to get the POC signed. RN #2 also indicated that he would contact the physician to get the POC signed. At the time of this survey, the HCA failed to ensure Patients #5 and #8 POCs had been approved by the physician within thirty days of the SOC.	H 366		
H 393	3915.9 HOME HEALTH & PERSONAL CARE AIDE SERVICE Each home care agency shall define the duties of home health aides and personal care aides. This Statute is not met as evidenced by: Based on record review and interview, it was determined that the HCA failed to define the duties of the HHA for one (1) of eleven 11 patients in the sample. (Patient #10) The finding includes: On September 30, 2016, at 3:00 p.m., review of Patient #10's clinical record revealed a POC with the SOC August 27, 2015, and a certification period of June 22, 2016 to August 20, 2016. Review of the record and the aforementioned POC revealed that the patient had a principal	H 393	CCNS of DC shall develop a thorough plan of care for all clients receiving services through this agency. Behavioral tendencies which may cause self-inflicted injuries will be identified on clients' plans of care with clearly stated interventions should injuries occur and to prevent injuries. Client documents shall be filed timely and properly. All clients will have an initial plan of care covering services from the beginning of care and renewed routinely and as needed. Plans of are shall be updated and sent to the client's physician for review and signature. The Quality Assurance Nurse shall audit 100% of client charts to ensure there is a current and signed plan of care for each client receiving services. Charts shall be monitored at a rate of 25% monthly thereafter. Those charts identified as not having a plan of care will be submitted to the Director of Nursing for follow up with the client's doctor. CCNS of	January 1, 2017

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H 393	Continued From page 10 diagnosis of Autism. The patient's pertinent diagnoses included: self-injurious behavior and pica. The attending physician orders included the following HHA services: HHA services eight (8) hours a day for seven (7) days a week to maintain safety precautions include "close monitoring for pica, head banging, pinching self ,non-purposeful running, and needs close supervision, at all times. Additionally, review of the record revealed a home health aide plan of care dated August 19, 2016 [about one year after HHA services initiated]. The record also failed to define the aide's duties if Patient #10 exhibited self-injurious behaviors. On October 3, 2016, interview with RN #2 revealed that the aforementioned home health aide POC dated August 19, 2016, was the only home health aide POC in the record. At the time of this survey, the HCA failed to ensure a home health aide POC had been developed from August 27, 2015 to August 18, 2016.	H 393	DC shall develop an educational tool to ensure a better understanding of the risk of injuries autistic clients may cause to themselves.	
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;	H 453	The management team shall ensure patient needs are met in accordance with the plan of care. The Quality Assurance Nurse shall audit all client chart to ensure the plan of care is followed and the plan of care, nurse's notes, and medication records match. Discrepancies shall be clarified with the client's physician to ensure optimal care is	January 1, 2017

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H 453	Continued From page 11 This Statute is not met as evidenced by: Based on record review and interview, it was determined that the skilled nurse failed to ensure that the patient's needs were met in accordance with their POC for five (5) of eleven (11) patients in the sample. [Patients #1, #2, #3, #8 and #10] The findings include: 1. On September 28, 2016, at 11:45 a.m., review of Patient #1's clinical record revealed a POC with a start of care date of March 14, 2014 and a certification period of June 26, 2016 to August 24, 2016. Review of the record and the aforementioned POC revealed that the patient had a principal diagnosis of Cerebral Palsy. The patient's pertinent diagnoses included diabetes and asthma. The attending physician orders included the following SN [RN] services: The "SN [RN] to visit monthly to obtain TRP and B/P every visit" Further review of the record lacked documented evidence that the SN [RN] obtained the patient's B/P during her visits for July 25, 2016 and August 24, 2016. On September 28, 2016, at 12:30 p.m., interview with RN #1 revealed that the nurse should have taken the patient's B/P every visit as ordered by the physician. 2. On September 28, 2016, at 1:00 p.m., review of Patient #2's clinical record revealed a POC with a SOC date of July 16, 2013 and a certification period of June 30, 2016 to August 28,	H 453	given. Clinical staff shall be brought in from the field for further teaching and clarification of the plan of care as needed. The aforementioned audits shall continue at a rate of 25% monthly to ensure plans of care continue being followed. The Director of Nursing shall review the audits monthly to ensure compliance.	

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H 453	Continued From page 12 2016. Review of the record and the aforementioned POC revealed that the patient had a principal diagnosis of Rheumatoid Arthritis. The attending physician orders included the following SN [RN] services: The "SN [RN] to visit monthly to obtain TRP and B/P every visit." Further review of the record lacked documented evidence that the SN [RN] obtained the patient's B/P during her visits on July 27, 2016 and August 15, 2016. On September 28, 2016, at 1:00 p.m.,interview with RN #1 revealed that the nurse should have taken the patient's B/P every visit, as ordered by the physician. 3. On September 28, 2016, at 2:10 p.m., review of Patient #3's clinical record revealed a POC with a SOC date of November 5, 2015 and a certification period of July 9, 2016 to September 6, 2016. Further review of the clinical record and POC revealed that the patient had a primary diagnosis of Hirschsprung's Disease. The patient's pertinent diagnoses included: gastrojejunal, severe dysmotility, colectomy and ileostomy. The attending physician orders included the following skilled nursing [SN] services: - take v/s every eight (8) hours; - monitor for strict intake and output , document and report; - elevate HOB at 15-30 degrees as tolerated; - monitor for feeding intolerance (vomiting,	H 453		

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H 453	Continued From page 13 labored breathing, gaggling) each shift; - clamp gtube as tolerated for 5 hours and open gtube for 1 hour; and - assess peri-anal for redness, exudate, pain, or any signs of sign breakdown with each diaper change. Further review of the clinical record revealed that the RN failed to ensure that the aforementioned orders had been conducted, as evident below: - LPN nursing notes from July 9, 2016 to September 6, 2016, revealed v/s had been conducted every 12 hours and not every eight (8) hours, as ordered; - LPN nursing notes and MARs from July 9, 2016 to September 6, 2016, revealed that the total amount of h2o used to flush gtube had not been recorded; - LPN nursing notes from July 9, 2016 to September 6, 2016, lacked documented evidence that the patient's HOB was elevated [as ordered], the patient was monitored for feeding intolerance, the gtube was clamped and opened [as ordered], and the patient's peri-anal area had been assessed. During a face-to-face interview with LPN #1 on August 29, 2016, at 10:45 a.m., she indicated that she only took v/s at the beginning and end of her twelve hour shift. She also indicated that she did not document the total amount of h2o used to flush the gtube daily and did not clamp and open the g-tube as ordered. Additionally, she did monitor the patient for feeding intolerance and assessed the patient peri-anal area but did not document her assessments.	H 453		

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H 453	Continued From page 14	H 453		

LPN #1 was asked how did she ensure that the patient's HOB was elevated at a 15-30 degree angle. The LPN indicated that the patient did not have a hospital bed, but she used two pillows to elevate the patient's head when he/she was in bed. LPN #1 then indicated she would just observe the degree in which the patient's head was elevated.

4. On September 30, 2016, at 11:00 a.m., review of Patient #8's clinical record revealed a POC with a SOC date of August 21, 2015, and a certification period of June 16, 2016 to August 14, 2016. Review of the record and the aforementioned POC revealed that the patient had a principal diagnosis of Down Syndrome. The patient's pertinent diagnoses included: obesity, headache, and intermittent nausea and vomiting.

The attending physician orders included the following HHA/RN services:

[HHA] services six (6) hours/day for seven (7) days a week.

Continued review of the patient's record revealed HHA services were not provided seven (7) days a weeks, as ordered. The record lacked documented evidence that HHA services were provided on the following dates:

- June 18th, 19th, 25th, and 26th of 2016;
- July 2nd, 3rd, 9th, 10th, 16th, 17th, 23rd, 24th, 30th, and 31st of 2016; and
- August 6th, 7th, 13th, and 14th of 2016.

[RN] supervisory visits every month for comprehensive RN assessment...

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H 453	Continued From page 15 The record lacked documented evidence that the RN visited that patient in June, July, and August of 2016. On September 30, 2016, at 12:21 p.m., interview with RN#2 revealed that the HHA/RN services should have been provided as ordered. RN #2 also indicated that he would look for HHA timesheets and RN assessments for the aforementioned missing dates. 5a. On September 30, 2016, at 3:00 p.m., review of Patient #10's clinical record revealed a POC with the SOC August 27, 2015, and a certification period of June 22, 2016 to August 20, 2016. Review of the record and the aforementioned POC revealed that the patient had a principal diagnosis of "autism". The patient's pertinent diagnoses included: "self-injurious behavior and pica." The attending physician orders included the following HHA/RN services: - HHA services eight (8) hours a day for seven (7) days a week to maintain safety precautions include close monitoring for Pica, head banging, pinches self and non purposeful running, need close supervision at all times... Continued review of the record revealed "Home Health Aide Notes" from June 23, 2016 to August 22, 2016, that lacked documented evidence that the aides closely monitored the patient for Pica, head banging, pinching self and non purposeful running. The record also lacked documented evidence that the RN ensured that the HHA's closely monitored the patient for Pica, head banging, pinching self and non purposeful running.	H 453		

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On September 30, 2016, at 3:45 p.m., interview with RN #1 revealed that the supervisory RN who visits the patient monthly did monitor the HHA's for closely monitoring the patient. Additionally, RN #1 indicated that going forward the supervisory nurse will document the patients specific behaviors the HHAs are monitoring.

5 b. On October 5, 2016, at 11:00 a.m., telephone interview with Patient #10's mother revealed that patient was ordered HHA services eight (8) hours a day seven (7) days a week. Further interview revealed that Patient #10 had not been provided HHA services for about two months.

On October 7, 2016, at 1:00 p.m., telephone interview with the administrator revealed that the Patient #10 had not been provided HHA services for about two months. The administrator then indicated that the weekend HHA services had not been provided because the weekend HHA quit, and they had been trying to find a new HHA to provide weekend services. The administrator was asked to email the current POC and HHA timesheets to DOH.

On October 12, 2016, at 3:00 p.m., review of the emailed POC revealed a certification period date of August 21, 2016 to October 19, 2016. The attending physician ordered HHA services eight (8) hours a day seven (7) days a week.

On October 12, 2016, at 3:15 p.m., review of the emailed HHA timesheets dated August 29th to October 12th of 2016 revealed HHA services were not provided on weekends as ordered.

The emailed documents lacked documented evidence that the SN ensured services were

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H 453	Continued From page 17 provided in accordance to Patient #10's POC. At the time of this survey, the nurse failed to ensure Patients #1, #2, #3, #8 and #10 needs were met in accordance to their POC.	H 453		
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, it was determined that the skilled nurse failed to inform the physician of a change in a patient's condition for one (1) of eleven (11) patients in the sample. (Patient #9) The finding includes: On September 30, 2016, at approximately 2:00 p.m., review of Patient #9's clinical record revealed a POC with a start of care date of September 10, 2013. The POC had a certification period of July 3, 2016 to September 20, 2016. Further review of the record and the aforementioned POC revealed that the patient had a primary diagnosis of Cognitive Impairment. The patient's other pertinent diagnoses included : gastrostomy, visual impairment, hypotonia, and cleft palate.	H 458	Skilled nurses shall be in-serviced on their duty to report changes in the clients' condition to his or her physician. The Quality Assurance Nurse shall create and implement an in-service for all skilled and unskilled personnel to include reporting changes in the clients' skin, behaviors, neurological status, vital signs, etc. The in-service shall be graded and results filed in the personnel chart. All client charts shall be audited to ensure changes in conditions are reported to client physicians. Following the 100% audit of client charts, charts will continue to be audited at a rate of 25% monthly to ensure the standard remains met.	January 15, 2017

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H 458	Continued From page 18 Continued review of the clinical record revealed that RN #3 conducted a home visits on July 7, 2016. On that same day, RN #3 documented that the patient had a "red rash on face, left leg, and neck area." The clinical record lacked documented evidence that the physician was informed of the patient's change in conditions. On September 30, 2016, at 2:30 p.m., interview with RN #2 revealed that RN #3 should have informed the physician of the patient's change in condition. At the time of this survey, Patient #9's clinical record lacked documented evidence that RN#3 inform the physician of the change in condition of the patient.	H 458		
H 474	3918.2(c) PSYCHIATRIC NURSING SERVICES Psychiatric nursing services shall be provided by a registered nurse with: (d) American Nurses' Association certification in psychiatric or community health nursing. This Statute is not met as evidenced by: Based on record review and interview, the HCA failed to ensure a registered nurse met the required qualifications to provide care for one (1) two (2) patient's in the sample requiring psychiatric services. (Patient #10) The finding includes: On September 29, 2016, starting at approximately 2:30 p.m., review of Patient #10's	H 474	CCNS of DC shall actively recruit a minimum of one registered nurse who is certified by the American Nurses' Association as a psychiatric or community health nurse. Moving forward, clients requiring psychiatric services will only be admitted when there is a registered nurse with certification as a psychiatric or community health nurse by the American Nurses' Association available to provide the needed services. The QA Nurse will routinely audit client charts to ensure services are being provided as instructed by the plan of care; also, the audits will verify that the services being provided is by nursing professionals with the appropriate credentials and certifications as required by HCA regulations. The Quality Assurance Nurse shall audit 100% of all active client charts to identify those needing a psychiatric nurse and shall continue to	February 1, 2017

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H 474	Continued From page 19 clinical record revealed that the patient's primary diagnosis was Autism. The patient's pertinent diagnoses included self injurious behavior and *Pica. The patient was prescribed Clonazepam [used for panic attacks] 0.5 mg [two tablets] by mouth daily. The record revealed a POC with a SOC date of August 27, 2015, and a certification period of June 22, 2016 to August 20, 2016. The attending physician ordered the following RN services: RN supervisory visit monthly for comprehensive assessment and monitor the HHA care and treatment plan. [It should be noted that the HHA orders included safety precautions to monitor the patient closely for pica, head banging, pinching self and non purposeful running. The orders further indicated that the patient required close supervision.] On the same day, review of nursing notes dated: June 16th, July 8th and August 19th of 2016, lacked documented evidence that the nurse assessed the patient's level of self-injury, as indicated in the "goal" section of the aforementioned POC. On September 29, 2016, at 3:30 p.m., interview with RN #1 that the agency did not have a nurse on staff with the required psychiatric training. On September 30, 2016, starting at 2:00 p.m., review of RN #3's personnel file revealed that RN #3 was a BSN, however, the record failed to evidence that RN #3 had the required certification in psychiatric or community nursing from American Nurses' Association. Continued review of the record revealed that the only psychiatric	H 474	audit 25% of client charts monthly to ensure clients needing psychiatric nursing services needs are being met by a psychiatric or community health nurse.	

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H 474	Continued From page 20 experience RN #3 had was during her psychiatric rotation while in nursing school in 2007. At the time of this survey, the HCA failed to ensure RN #3 had the required certifications to provide psychiatric services for Patient #10. *Pica - an abnormal craving for and eating of substances (as chalk, ashes, or bones) not normally eaten that occurs in nutritional deficiency states (as aphosphorosis) in humans or animals or in some forms of mental illness-compare geophagy. [www.merriam-webster.com/dictionary]	H 474		