FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 000 INITIAL COMMENTS H 000 H166 An annual licensure survey was conducted on 01/04/2023, and 01/05/2023 to determine The following corrective actions will be accomplished to address the identified deficient practice: compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Effective 1/27/2023, Employee #3 has been removed from all Agency provided home care services to three patient assignments. Employee #3 has been placed an patients and employs 22 staff. The findings of the inactive in our computer system. survey were based on the review of administrative records, three active patient records, seven The following measures/systemic changes will be made discharged patient records, 14 personnel records, to ensure the deficient practice doesn't recur: and a review of the agency's response to Effective 2/1/23, upon hiring an aide, the HR director will verify complaints and incidents received. The survey the aide's credentials. The aide will not be activated in our findings were also based on the completion of three computer system until the appropriate credentials (Active HHA patient telephone interviews. Certification) are in place. An aide, in an unactive status within our computer system, is not visible to the staffing team, thus Listed below are abbreviations used throughout this eliminating the possibility of the employee being placed on a report: patient assignment. The corrective action will be monitored/QA program will ADL - Activities of Daily Living be implemented to ensure the deficient practice does HHA- Home Health Aides not recur: **HCA-Home Care Agency** IADL - Instrumental Activities of Daily Living Beginning 2/1/23, the Director of HR will run an ongoing SN - Skilled Nurse monthly report on the first of every month to ensure that all SASH - intravenous administration employees proving direct patient care have active license technique - saline-administration-saline-heparin and certification in their file. Employees without an active QD - every day license will be removed from their assignment(s). IV - intravenous gms - grams H 166 3907.9 PERSONNEL H 166 Each employee who is required to be licensed, certified or registered to provide services shall be licensed, certified or registered under the laws and rules of the District of Columbia.

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Statute is not met as evidenced by: Based on record review and interview, it was determined the home care agency failed to

> (X6) DATE TITLE

FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 166 H 166 Continued From page 1 ensure that each employee providing direct care services in the homecare setting was certified in the H166 District of Columbia for two of eight home health The following corrective actions will be accomplished to aides included in the sample. (Employees #3 and address the identified deficient practice: #4). Effective 1/27/2023, Employee #4 has been removed from all Findings included: patient assignments. Employee #4 has been placed an inactive in our computer system. A review of personnel records conducted 01/04/2023 at 11:15 AM and 01/05/2023 at 10:00 The following measures/systemic changes will be made to ensure the deficient practice doesn't recur: AM revealed the following: Effective 2/1/23, upon hiring an aide, the HR director will verify Employee #3 was identified as a home health aide the aide's credentials. The aide will not be activated in our per agency staff. However, review of the personnel computer system until the appropriate credentials (Active HHA file showed that Employee #3 was hired on Certification) are in place. An aide, in an unactive status within 08/31/2022 and credentialed as a certified nursing our computer system, is not visible to the staffing team, thus assistant in Maryland. The record lacked evidence eliminating the possibility of the employee being placed on a that she was certified as a healthcare worker in the patient assignment. District of Columbia. There was no evidence the The corrective action will be monitored/QA program will employee or the agency, initiated notice to the be implemented to ensure the deficient practice does District's Board of Nursing, during the window of not recur: opportunity, to exercise waiver rights for endorsement. Beginning 2/1/23, the Director of HR will run an ongoing monthly report on the first of every month to ensure that all 2. A review of the personnel file for Employee #4 employees proving direct patient care have active license showed that her date of hire as a home health aide and certification in their file. Employees without an active was 12/04/17. Further review of the file showed that license will be removed from their assignment(s). the employee's home health aide certification in the District of Columbia expired 10/30/2019. The record lacked evidence of subsequent renewal of the employee's Home Health Aide certification. On 01/05/2023 at 4:00 PM, an interview with the Director of Nursing confirmed the findings. The agency failed to ensure that two employees who were required to be licensed, certified, or registered to provide healthcare services, were

appropriately credentialed under the laws and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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HCA-0103			B. WING		01/0	01/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA SACHUSETT	S AVENUE, NW, SUITE 330			
CAPITAL	CITY HEALTH CARE	ASSOC DBA	TON, DC 20				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
H 166	Continued From pag	ge 2	H 166				
	rules of the District of	of Columbia.					
H 169	3907.10 PERSONN	EL	H 169				
	professional qualification provider to ensure the	ency shall document the ations of each employee or nat the applicable licenses, ditations or registrations are					
	This Statute is not	met as evidenced by:					
	Based on record revidetermined that the document the profesemployee to ensure	view and interview, it was home care agency failed to ssional qualifications of each that certifications were valid for ealth aides sampled.					
	Cross reference 390	7.9					
H 355	3914.3(d) PATIENT	PLAN OF CARE	H 355				
	The plan of care sha	all include the following:					
	including: the freque duration; dietary req	the services to be provided, ency, amount, and expected uirements; medication ding dosage; equipment; and					

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FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX TAG **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) H 355 H 355 Continued From page 3 This Statute is not met as evidenced by: Based on record review and interview, the home H 355 care agency (HCA) failed to ensure that each patient's plan of care (POC) included a description The following corrective actions will be accomplished to of the services to be provided, including frequency, address the identified deficient practice: amount, and duration of services, for three of three By 2/7/2023, the RN will visit the patient (identified as Patient sampled patients receiving skilled nursing services #1) to assess the patient's medication regimen, including (Patients #1, #2, and #3). dosage, frequency, route and time The nurse will document the patient medication regimen, including dosage, frequency, Findings included: route and time onto the POC and fax the POC to the PCP for review/approval/signature. 1. On 01/04/2023 at 11:00 AM, a review of Patient #1's plan of care (POC) showed a duration period of The following measures/systemic changes will be made 11/12/2022 through 01/12/2023. The POC to ensure the deficient practice doesn't recur: contained physician orders for skilled nursing (SN) Effective 1/27/2023 all care plans have a section to include services to perform a comprehensive Start of Care assessment, supervision of personal care services the list of medications, dosage, frequency, route and time so that the nurse can include this in all Plan of Care. (See provided by home health aides, and the aide to attachment, Care Plan). By 2/15/2023 all nurses will be provide personal care services daily for 12 hours trained on documenting medications, dosage, frequency per day or as requested. route and time onto the POC. Further review of the POC showed a Section titled The corrective action will be monitored/QA program will "(10) Medication Strength/Dose/Frequency/Route be implemented to ensure the deficient practice does ...Client representative manages client's not recur: medications". The agency failed to ensure the POC included a description of the patient's Beginning 2/15/2023, the DON will run an ongoing monthly medication regimen, including dosage. report of 20% of active clients to ensure that all care plans include the medication list, dosage, frequency, route and 2. On 01/04/2023 at 2:30 PM, a review of Patient time. This report will be ongoing on the first of each month. #2's plan of care (POC) showed a duration period of 12/09/2022 through 02/09/2023. The POC contained physician orders for Skilled nursing services through 01/12/2023, "Administer Ceftraxone 2 gms IV [intravenous] push daily SASH [saline-administration-saline-heparin] technique before and after IV medication administration ..."

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 355 H 355 Continued From page 4 H 355 The POC failed to include a description of the RN (skilled) services to include daily assessments of The following corrective actions will be accomplished to the patient before and after treatment, and address the identified deficient practice: assessment, and monitoring of the intravenous site before and after medication administration. By 2/7/2023, the RN will contact the Additionally, the clinical record showed that the physician to obtain an order for the IV that patient was receiving personal care services four includes: (a) Type, amount, flow rate, hours per day, seven days per week from duration, and mode of administration of 12/09/2022 through 12/31/2022 which was not nutritional formula or intravenous included in the POC. solution; (b) Type, dosage, frequency, duration, and mode of administration of 3. On 01/05/2023 at 1:00 PM, a review of Patient medication; (c) Type and frequency of #3's plan of care (POC) showed a duration period of 11/06/2022 through 01/06/2023. The POC laboratory tests to be monitored; (d) contained physician orders for "RN to perform a Information on use of an anticoagulant in comprehensive Start of Care (SOC) assessment, connection with intermittent intravenous and supervise care being provided every 14 therapy; (e) Specific laboratory test limits; calendar days." The POC failed to describe the care (f) Assessment and monitoring of the IV to be supervised. Further review of the clinical site before and after medication record showed time sheets evidencing that the administration. patient was receiving services by the LPN [licensed] practical nurse] 12 hours per day, seven days per The following measures/systemic changes will be made week to provide wound care, activities of daily living to ensure the deficient practice doesn't recur: (ADL), and instrumental activities of daily living (IADL). The POC failed to provide a description of Effective 1/27/2023 the care plan has a section specific to IV such services. Therapy that prompts the nurse to document the following: (a) Type, amount, flow rate, duration, and mode of At the time of the survey, the Home Care Agency administration of nutritional formula or intravenous Plans of Care (POCs) failed to include a description solution; (b) Type, dosage, frequency, duration, and of services to be provided, including the frequency, mode of administration of medication; (c) Type and amount, and expected duration; and/or medication frequency of laboratory tests to be monitored; (d) information. Information on use of an anticoagulant in connection with intermittent intravenous therapy; (e) Specific During an interview with the Director of Nursing on 01/05/2023 at 4:00 PM, the findings were laboratory test limits; (f) Assessment and monitoring of acknowledged. the IV site before and after medication administration. By 2/15/23 all nurses will be trained on how to appropriately complete a care plan for clients getting IV therapy. H 356 H 356 3914.3(e) PATIENT PLAN OF CARE

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# be implemented to ensure the deficient practice does not recur:

The corrective action will be monitored/QA program will

Beginning 2/15/2023, the DON will run an ongoing monthly report of 20% of the active clients getting IV therapy to ensure clients have appropriate orders in place. The DON will also run a report of 20% of field nurse documentation to ensure the nurses are documenting on the site status of the

IV both before and after treatment. Non-compliant nurses wi	il
be required to get training.	

#### H 355

### The following corrective actions will be accomplished to address the identified deficient practice:

By 2/7/2023, the RN will visit the patient (#3) and update the care plan to include the type of care being provided, the frequency of the care, the type of care (HHA, LPN, RN) and the supervision requirements for the care. The care plan will be faxed to the PCP for review and signature.

## The following measures/systemic changes will be made to ensure the deficient practice doesn't recur:

Effective 1/27/2023 all care plans will have a section that details the type and frequency of the care the client is getting. The care plan will then generate the level of supervision required based up the care needs. See attachment = Care Plan/POC. By 2/12/2023, all nurses will be trained on how to fill out this section of the care plan.

# The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does not recur:

Beginning 2/15/2023, the DON will run an ongoing monthly report of 20% of the active clients getting to ensure the care plans include the supervision of care, the service provided including the service provider (licensed nurse vs HHA), the amount of service, the frequency and the type. Nurses who are deficient in documenting this will be provided education to ensure compliance.

PRINTED: 01/23/2023 FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 356 H 356 Continued From page 5 H356 The plan of care shall include the following: The following corrective actions will be accomplished to (e) Identification of agency personnel who are address the identified deficient practice: responsible for the provision of each service, By 2/15/2023, the Supervising RN will visit Patient #2 to including, if applicable, contract providers by job title assess and identify personnel who are responsible for the or discipline; provision of services. This care plan will include the title of the employee who is providing the care. The care plan will This Statute is not met as evidenced by: Based on record review and interview, it was determined that the agency failed to document in be faxed to the PCP for review and signature. the plan of care, the identification of agency The following measures/systemic changes will be made personnel who are responsible for the provision of to ensure the deficient practice doesn't recur: each service for two of three active patients in the sample (Patients #2 and #3). Effective 1/27/2023 the agency has added a section to all care plans that allows the RN creating the care plan to Findings included: document the personnel responsible for providing personal care services. See attached: Care plan/POC 1. On 01/04/2023 at 2:30 PM, a review of Patient #2's plan of care (POC) showed a duration period of The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does 12/09/2022 through 02/09/2023, and included not recur: physician orders for "RN QD through 1/12/2023. Administer Ceftraxone 2 gms IV PUSH Daily SASH Effective 2/1/2023, the Director of Nursing will run an Technique before and after IV medication ongoing monthly report on the first of each month to audit administration ... " Additionally, a continued review of 20% of the active client files to ensure that the care plans the clinical record showed that the patient was have orders that identify all agency personnel responsible for receiving personal care services four hours per day, the provision of services: HHA, LPN, RN. Nurse who are seven days per week from 12/09/2022 through non-compliant with documentation will be given education to 12/31/2022. The POC failed to identify the agency ensure compliance. personnel who was responsible for the provision of personal care services. 2. On 01/05/2023 at 1:00 PM, a review of Patient #3's plan of care (POC) showed a duration period of 11/06/2022 through 01/06/2023, and included

physician orders for "RN to perform a

to be supervised and who was responsible

comprehensive Start of Care (SOC) assessment. and supervise care being provided every 14

calendar days." The POC failed to describe the care

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 356 H 356 Continued From page 6 H356 for the provision of services being supervised. The following corrective actions will be accomplished to At the time of the survey, the home care agency address the identified deficient practice: failed to identify the personnel who was responsible By 2/15/2023, the RN will visit Patient #3 to assess and for the provision of each service. update the care plan to include the care being supervised and who is responsible the supervision of the services. This During an interview with the Director of Nursing on care plan will be faxed to the PCP for review and signature. 01/05/2023 at 4:00 PM, the findings were acknowledged. The following measures/systemic changes will be made to ensure the deficient practice doesn't recur: H 358 3914.3(g) PATIENT PLAN OF CARE H 358 Effective 1/27/2023 the agency has added a section to the care plan that includes orders for the specific personnel The plan of care shall include the following: responsible for the supervision of care, and what supervision entails. These orders will populate based upon the type of (g) Physical assessment, including all pertinent care client is getting. See attached: Care Plan/PO¢ diagnoses; The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does This Statute is not met as evidenced by: Based on record review and interview, the Home Care Agency failed to ensure the plan of care not recur: (POC) included all pertinent diagnoses for two of Effective 2/1/2023, the Director of Nursing will run an the three active patients sampled (Patient #2, and ongoing monthly report on the first of each month to audit #3). 20% of the active client files to ensure that the care plans have orders that identify the supervision of care, the care Findings included: being supervised and what the supervision entails. Nurse who are non-compliant with documentation will be given 1. On 01/04/2023 at 2:30 PM, a review of Patient education to ensure compliance. #2's plan of care (POC) showed a duration period of 12/09/2022 through 02/09/2023. A continued review of the POC showed physician's orders for "RN QD through 1/12/2023. Administer Ceftraxone 2 gms IV push daily ..." H358 Further review of Section 11 on the plan of care The following corrective actions will be accomplished to titled "Principal Diagnosis" was left blank. The address the identified deficient practice: agency failed ensure all pertinent diagnoses were included in the POC. By 2/7/23 the RN will update the POC for Patient #2 to

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ICWL11 If continuation sheet 7 of 17 care plan will be faxed to the PCP for review and signature.

include ALL diagnoses noted and reported. The updated

The following measures/systemic changes will be made to ensure the deficient practice doesn't recur:

Effective 1/27/2023 the POC includes a section for the RN to document all diagnoses. By 2/14/2023 all nurses will be

given education on how to complete this section of the care plan.

The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does not recur:

Beginning 2/1/2023 the Director of Nursing will run an ongoing monthly report of 20% of active clients to ensure that their care plans include all pertinent diagnoses. Nurse who are non-compliant with documentation will be given education to ensure compliance.

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 358 H 358 Continued From page 7 H358 2. On 01/05/2023 at 1:00 PM, a review of Patient #3's plan of care (POC) showed a duration period of The following corrective actions will be accomplished to 11/06/2022 through 01/06/2023. The POC address the identified deficient practice: contained physician orders for the registered nurse By 2/7/23 the RN will update the POC for Patient #3 to to perform a comprehensive Start of Care (SOC) include ALL diagnoses noted and reported. The updated assessment, and supervise care being provided care plan will be faxed to the PCP for review and signature. every 14 calendar days. The following measures/systemic changes will be made Further review of Section 13 of the POC titled to ensure the deficient practice doesn't recur: "Other Pertinent Diagnoses" was left blank. It must be noted that the patient was diagnosed with Type 1 Effective 1/27/2023 the POC includes a section for the RN to Diabetes Mellitus and was receiving wound care document all diagnoses. By 2/14/2023 all nurses will be that was not mentioned as diagnoses on the POC. given education on how to complete this section of the care plan. The agency failed to ensure all pertinent diagnoses The corrective action will be monitored/QA program will were included on the plan of care. be implemented to ensure the deficient practice does not recur: During an interview with the Director of Nursing on 01/05/2023 at 4:00 PM, the findings were Beginning 2/1/2023 the Director of Nursing will run an acknowledged. ongoing monthly report of 20% of active clients to ensure that their care plans include all pertinent diagnoses. Nurses At the time of this survey, the agency failed to who are non-compliant with documentation will be given ensure all the patient's pertinent diagnoses were education to ensure compliance. included on the plan of care. H 364 3914.3(m) PATIENT PLAN OF CARE H 364 The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined the home care agency (HCA) failed to include emergency protocols in the Plan of Care (POC) for three of three patients in the sample

(Patient #1, #2, and #3).

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
HCA-0103			B. WING		01/0	01/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE			
CAPITAL	CITY HEALTH CARE	ASSOCIOBA	SACHUSETT	S AVENUE, NW, SUITE 330 0016			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	JLD BE COMPLETE		
H 364	Findings included:  1. On 01/04/2023 at #1's plan of care (P0 11/12/2022 through contained physician services to perform assessment, superv 62 calendar days, at services daily for 12 Further review of the was diagnosed with suffers from urinary an indwelling urinary.  Continued review of evidence of emerge patient's hypertensic infections, and indwelling transport of the was no evidence of emerge patient's tolerance/reantibiotics e.g., elevitation of the care of evidence of emerge patient's tolerance/reantibiotics e.g., elevitations.	ge 8  11:00 AM, a review of Patient OC) showed a duration period of 01/12/2023. The POC orders for skilled nursing (SN) a comprehensive Start of Care rise care being provided every nd aide to provide personal care hours per day or as requested. The POC showed that the patient essential primary hypertension, tract infections (UTIs), and has	H 364	H364  The following corrective actions will be address the identified deficient practice. By 2/7/2023 the RN will update Pt #1 POC protocols related to the patient's diagnoses sent to the client's PCP for review and sign. The following measures/systemic changensure the deficient practice doesn't reserve the deficient practice doesn't respecifies emergency protocols. Furtherm specific prompts to support common diagn. Care Plan/POC)  The corrective action will be monitored implemented to ensure the deficient practice is documentation/orders for emergency protocols are non-compliant will be given education appropriate documentation.  H364  The following corrective actions will be address the identified deficient practice. By 2/7/2023 the RN will update Pt #2 POC protocols related to the admin or iv antibiot tolerance to IV treatment and how to respond and signature.  The following measures/systemic changensure the deficient practice doesn't reserve the deficient practice doesn't re	accomplise:  a to include of s. This PO nature.  ges will be cur:  a section the care of the polynomial of t	made to  made to  mat e plan has e attached  m will be not recur:  going that there urses who to ensure  hed to  emergency g patient's vent of an for review  made to  made to	
				specific prompts to support emergency pro a patient with an IV. (See attached Care will be trained by 2/14/2023 on how to pro	Plan/POC)	All RNS	

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The corrective action will be monitored/QA program will be

section of the POC.

implemented to ensure the deficient practice does not recur:

Effective 2/15/23 the Director of Nursing will run an ongoing monthly report of 20% of active patient files to ensure that there is documentation/orders for emergency protocols in each client's

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) H 364 Continued From page 9 H 364 H364 3. On 01/05/2023 at 1:00 PM, a review of Patient #3's plan of care (POC) showed a duration period of The following corrective actions will be accomplished to 11/06/2022 through 01/06/2023. The POC included address the identified deficient practice: physician orders for the registered nurse to perform By 2/7/2023 the RN will update Pt #3 POC to include emergency a comprehensive Start of Care (SOC) assessment, protocols related to the patient's diagnoses and will send the and supervision of care being provided. POC to the PCP for review and signature. The POC further showed that the patient's The following measures/systemic changes will be made to diagnoses included Type I Diabetes Mellitus and ensure the deficient practice doesn't recur: was receiving Novolog insulin six units after Effective 1/27/2023 the care plan includes a section that breakfast seven units after lunch, and eight units specifies emergency protocols. Furthermore, the care plan has after dinner. Additionally, the patient was receiving specific prompts to support common diagnoses. (See attached Lisinopril 10 milligrams daily for blood pressure Care Plan/POC) management and Levothyroxine for Autoimmune Thyroiditis. The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does not recur: The plan of care failed to include evidence of Effective 2/15/23 the Director of Nursing will run an orgoing emergency protocols that may warrant emergency monthly report of 20% of active patient files to ensure that there interventions as it relates to the patient's blood is documentation/orders for emergency protocols. Nurses who pressure management and potential for glycemic are non-compliant with documentation will be given reaction related to diabetes mellitus. education to ensure compliance. At the time of the survey, the home care agency failed to ensure that patient's plans of care (POC) included emergency protocols to properly manage diagnoses. During an interview with the Director of Nursing on 01/05/2023 at 4:00 PM, the findings were acknowledged. H 366 3914.4 PATIENT PLAN OF CARE H 366 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

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 366 H 366 Continued From page 10 H366 approved and signed by an advanced practice registered nurse. If a plan of care is initiated or The following corrective actions will be accomplished to revised by a telephone order, the telephone order address the identified deficient practice: shall be immediately reduced to writing, and it shall By 2/7/2023 the Supervising RN will obtain the required be signed by the physician within thirty (30) days. signature on the POC of Pt #1 by refaxing and following up with the PCP to ensure compliance. This Statute is not met as evidenced by: The following measures/systemic changes will be made to Based on record review and interview, the home care agency (HCA) failed to ensure that each ensure the deficient practice doesn't recur: patient's plan of care (POC) was approved and Effective 2/15/2022 all supervising nurses will complete a file signed by a physician and/or medical team within 30 audit and flag unsigned care plans. The Director of Client days of the start of care (SOC) for one of three Services will fax the unsigned care plans to the PCP and follow active patients in the sample (Patient #1). up via phone call to ensure they are returned with the PCP signature. Findings included: The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does not recur: On 01/04/2023 at 11:00 AM, a review of Patient #1's plan of care (POC) showed a duration period of Effective 2/15/23 the Director of Nursing will run an orgoing 11/12/2022 through 01/12/2023. The POC monthly report of 20% of active patient files to ensure that there contained physician orders for skilled nursing is signature of the Physician on all care plans within the 30-day services and personal care services. Further time frame of completion. For MD who are not compliant the review showed that the POC was not signed by the DON will request a conference call to request prompt returning of physician and/or designee at the time of the record the care plans. review on 01/04/2023. At the time of the survey, the home care agency failed to ensure that the plan of care for Patient #1 was signed by the physician and/or medical team within 30 days of the start of the care. During an interview with the Director of Nursing on 01/05/2023 at 4:00 PM, the findings were acknowledged. H 451 3917.2(a) SKILLED NURSING SERVICES H 451

Duties of the nurse shall include, at a minimum,

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 451 H 451 Continued From page 11 H451 the following: The following corrective actions will be accomplished to (a) Initial assessment and evaluation; address the identified deficient practice: By 2/7/2023 the RN will visit Pt 1 to get a current set of vital signs and will follow up with PCP to obtain orders for This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the skilled parameters. nurse accurately assessed the patient to enable The following measures/systemic changes will be made to efficient and effective treatment for one of the three ensure the deficient practice doesn't recur: skilled patients included in the sample (Patient #1). By 2/15/2023 all RNs who preform assessments will be trained Findings included: on the proper way to fill out the assessment form which includes documenting vital signs in the correct location of the form and ensuring that parameters are in place. On 01/04/2023 at 11:00 AM, a review of Patient #1's plan of care (POC) showed a duration period of The corrective action will be monitored/QA program will be 11/12/2022 through 01/12/2023. The POC included implemented to ensure the deficient practice does not recur: physician orders for the skilled nurse to perform a comprehensive Start of Care assessment. Further Effective 2/15/23 the Director of Nursing will run a monthly report review of the clinical record showed a document of 20% of active patient files to ensure that the RNs are titled "Client Assessment Form." On page two of the documenting the VS in the correct location of the form. All nurses will be reeducated to ensure they are familiar with the assessment form is a section where vital signs location of where to document VS and where to write the should be entered. This section was left blank. parameters. At the time of the survey, the home care agency failed to ensure that the registered nurse completed an accurate initial assessment to include vital signs enabling the clinical staff to identify any variances in the patient's condition that would warrant attention. During an interview with the Director of Nursing on 01/05/2023 at 4:00 PM, the findings were acknowledged. H 491 H 491 3920.2(a) INTRAVENOUS THERAPY SERVICES

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and the mode of administration (peripheral line,

During an interview with the Director of Nursing

indwelling central line etc.).

Health Regulation & Licensing Administration								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
HCA-0103		B. WING		01/05/2023				
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE, ZIP CODE				
CAPITAL	CITY HEALTH CARE	ASSOC DBA		SACHUSETTS AVENUE, NW, SUITE 330 TON, DC 20016				
(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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	SHOULD BE COMPLETE			
H 491	Continued From page 13			H 491				
	on 01/05/2023 at 4:00 PM, the finding was acknowledged.							
H 492	3920.2(b) INTRAVENOUS THERAPY SERVICES			H 492	H492			
	The intravenous therapy service plan shall include, at a minimum, the following:				The following corrective actions will be accomplished to address the identified deficient practice:			
	(b) Type, dosage, frequency, duration, and mode of administration of medication;				The RN will CONTACT Pt #2 POC by 2/1/2023 for orders for the type, amount, flow rate, duration and mode of administration of IV solution. The nurse will document this order on the POC and then fax the POC to the PCP for review and signature.			
	This Statute is not met as evidenced by:			ne following measures/systemic changes will be made to				
	determined that the include the duration intravenous therapy one patient receiving #2).	on record review and interview it was ned that the Home Care Agency failed to the duration and mode of administration of lous therapy in the service plan for one of lient receiving intravenous therapy (Patient			ensure the deficient practice doesn't re  Effective 1/27/2023 the care plan includes receiving IV TX that prompts the nurse to amount, flow rate, duration and mode of a solution and ALLERGIES within the care part Care Plan/POC). All nurses will be trained	a section for obtain the ty dministration olan (see att	pe, n of IV ached	
	Cross Reference 3920.2(a)				correctly complete this section of the care plan.			
H 494	3920.2(d) INTRAVENOUS THERAPY SERVICES			H 494	The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does not recur:			
	The intravenous therapy service plan shall include, at a minimum, the following:  (d) Information on use of an anticoagulant in connection with intermittent intravenous therapy; and				Effective 2/15/23 the Director of Nursing will run an orgoing monthly report of 20% of active patient files getting IV therapy to ensure that the POC include the the type, amount, flow rate,			
					duration and mode of administration of IV solution, are non-compliant with this documentation will be complete training.			
	This Statute is not met as evidenced by:							
	Based on record rev determined that the include information of the intravenous there patient receiving intr	iew and intervie Home Care Age on the use of an apy service plar	ew it was ency failed to anticoagulant in n for one of one					

FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 494 H 494 Continued From page 14 H494 Findings Included: The following corrective actions will be accomplished to address the identified deficient practice: On 01/04/2023 at 2:30 PM, a review of Patient #2's The RN will obtain orders for PT #2 POC by 2/1/2023 to include intravenous therapy service plan showed a duration the Information on use of any anticoagulant in connection with period of 12/09/2022 through 02/09/2023 and intermittent intravenous therapy and the safety measures include physician's orders for "RN QD through necessary to protect the pt getting the anticoagulant tx. This will 1/12/2023, Administer Ceftraxone 2 gms IV push be added to the POC and faxed to the PCP for review and daily SASH [saline-administration-saline-heparin] signature. Technique before and after IV medication The following measures/systemic changes will be made to administration - 0.9% NSS Flushes with Heparin ensure the deficient practice doesn't recur: Flushes". Further review of the plan lacked evidence of information on the use of anticoagulant Effective 1/27/2023 the care plan includes a section for patient therapy, such as precautions for bleeding, potential receiving IV TX that populates Information on use of an for headaches, gastrointestinal disturbances etc. anticoagulant in connection with intermittent intravenous therapy – see attached care plan/poc During an interview with the Director of Nursing on 01/05/2023 at 4:00 PM, the finding was The corrective action will be monitored/QA program will be acknowledged implemented to ensure the deficient practice does not recur: Effective 2/15/23 the Director of Nursing will run an orgoing monthly report of 20% of active patient files getting IV therapy to ensure that the POC includes Information on use of an H 497 3920.3(b) INTRAVENOUS THERAPY SERVICES H 497 anticoagulant in connection with intermittent intravenous therapy. Nurses who are non compliant with the documentation will be Each clinical record shall include, at a minimum, the required to get training. following information related to intravenous therapy: (b) A copy of the consent form for intravenous therapy executed by the provider of the intravenous therapy product, or a copy of the consent form for intravenous therapy executed by the home care agency, including risks, benefits and alternatives; This Statute is not met as evidenced by:

Based on record review and interview it was determined that the agency failed to execute a consent form for the provision of intravenous

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Findings Included:

Based on record review and interview it was determined that the agency failed to include documentation of training related to intravenous therapy to the Patient, the patient's caregiver, or

another responsible person.

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING **HCA-0103** 01/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4900 MASSACHUSETTS AVENUE, NW, SUITE 330 CAPITAL CITY HEALTH CARE ASSOC DBA WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG **PREFIX** OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 498 Continued From page 16 H 498 H498 On 01/04/2023 at 2:30 PM, a review of Patient #2's intravenous therapy service plan showed The following corrective actions will be accomplished to physician's orders for "RN QD through 1/12/2023, address the identified deficient practice: administer Ceftraxone 2 gms IV PUSH ..." Further The RN will visit PT #2 to provide education and training and review of the clinical record lacked evidence that update file by 2/1/2023 to include training. training was provided to the patient and/or caregiver regarding the intravenous therapy. The following measures/systemic changes will be made to ensure the deficient practice doesn't recur: During an interview with the Director of Nursing on By 2/15/2023 all nurses will be trained on documenting 01/05/2023 at 4:00 PM, the finding was education and training that is necessary when providing care to acknowledged. patients with IVs. The corrective action will be monitored/QA program will be implemented to ensure the deficient practice does not recur: Effective 2/15/23 the Director of Nursing will run an orgoing monthly report of 20% of active patient files getting IV therapy to ensure that the clients have documented training/edu¢ation in their file related to IV therapy. Nurse who are non-compliant with providing education and documenting education will get required to get training to on this to ensure compliance.