STATEMEN	Regulation & Licensing	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION (X3)	DATE CLIEVE
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:		(7.6)	DATE SURVEY COMPLETED
		HSA-0011	B. WING		08/27/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	UUIZIIZUZI
ASHCNC	ENTERPRISES, LLC			VENUE, NW, SUITE 214	
		WASHING	GTON, DC 2	0013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
R 000	9900 General Provis	sions	R 000		
	9900 General Provi	sions			
	conducted virtually, 08/26/2021 and 08/2 compliance with Title Home Support Agen and employed 20 sta administrative staff. based on the review active patient records records, 13 personner response to complair survey findings were of five patient telephological part of the survey findings were of five patient telephological part of the survey findings were of five patient telephological part of the survey findings were of five patient telephological part of the survey findings were of five patient telephological part of the survey findings were of the surve	e 22B DCMR, Chapter 99. The cy provided care to eight clients aff to include professional and The findings of the survey were of administrative records, eight s, three discharged patient el records and the agency's nats and incidents received. The also based on the completion one interviews. The agency of the survey were of administrative records, eight so the records and the agency's nats and incidents received. The also based on the completion one interviews. The agency of the survey were of administrative records and the agency of the survey were survey and the agency of the survey were of administrative records, eight so the survey were administrative records, eight so the survey were expected to the survey were administrative records and eight so the survey were expected to the survey were e		Please begin typing your responses he	re:
(checklist, and prior en attendance at orientat	ation, training certificates, skills nployment, and evidence of tion and in-service training,	R 135	R135	
	vorkshops or seminar Based on record revie support agency (HSA) personnel records to in participation in orienta	s or seminars; record review and interview, the home gency (HSA) failed to maintain accurate records to include employee's on in orientation for four of six certified ssistants (CNAs), four of four home health As), and three of three Staffing ors included in the sample (CNAs #1, #2, 4, and HHAs #1, #2, and #3, and		As of 10/3/2021 all CNAs and HHAs records have been updated to reflect the completion of orientation. Moving forward all CNA and HHA personnel records will contain documentation reflecting completion of orientation, as	10/3/202

Health R	Regulation & Licensing	a Administration			. 01	MAFFICOVED
STATEMEN'	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE S	
		HSA-0011	B. WING		08/	27/2021
NAME OF P	PROVIDER OR SUPPLIER		DRESS, CITY, ST		00,2	11/2021
ASHCNC	ENTERPRISES, LLC		MEXICO AV STON, DC 20	VENUE, NW, SUITE 214 0013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
R 135	Continued From pag	je 1	R 135			
	Staffing Coordinators	s #1, #2, and #3).	1		1	
	Findings included:					
	conducted on 08/24/	ncy's personnel records /2021 at 11:08 AM, and 6 AM, revealed the following:				
	07/27/2021 with an o 08/22/2019. During a 10:04 AM, the Direct acknowledged that in	oviding services for the HSA on orientation packet dated an interview on 08/25/2021 at tor of Human Resources n 2019, the facility had a home license in which CNA #1 was an				
	08/14/2021 with an o 10/05/2017. During a 10:04 AM, the Directo acknowledged that in	roviding services for the HSA on orientation packet dated an interview on 08/25/2021 at tor of Human Resources in 2017, the facility had a HCA A #2 was an employee.				
7	08/01/2021 with an or 04/11/2019. During a 10:04 AM, the Director acknowledged that in	roviding services for the HSA on orientation packet dated an interview on 08/25/2021 at or of Human Resources on 2019, the facility had a HCA A #3 was an employee.				
	08/23/2021 with an or 10/13/2019. During a 10:04 AM, the Director acknowledged that in	oviding services for the HSA on orientation packet dated an interview on 08/25/2021 at or of Human Resources a 2019, the facility had a HCA & #4 was an employee.				
1	08/05/2021 with an or	oviding services for the HSA on rientation packet dated an interview on 08/25/2021				

Health R	<u>tequiation & Licensing</u>	Administration					
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HSA-0011	B. WING		08/2	7/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
ASHCNC	ENTERPRISES, LLC	JIDIA	MEXICO AV	/ENUE, NW, SUITE 214 1013			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
R 135	at 10:04 AM, the Diracknowledged that in license in which HH// 6. HHA #2 began pro8/23/2021 with an of 02/14/2019. During 10:04 AM, the Direct acknowledged that in license in which CN// 7. HHA #3 began pro8/17/2021 with an of 03/23/2017. During 10:04 AM, the Direct acknowledged that in license in which CN// 8. Staffing Coordina showed that she was was no documented in orientation for the 9. Staffing Coordina showed that she was employee for the fact was no documented in orientation for the was licensed in 2020. During an interview of Director of Human R the facility had a HC/Staffing Coordinator 10. Staffing Coordinator 10. Staffing Coordinator showed that she was semployed that she was staffing Coordinator 10.	ector of Human Resources in 2017, the facility had a HCA A #1 was an employee. Toviding services for the HSA on orientation packet dated an interview on 08/25/2021 at tor of Human Resources in 2019, the facility had a HCA A #1 was an employee. Toviding services for the HSA on orientation packet dated an interview on 08/25/2021 at tor of Human Resources in 2017, the facility had a HCA A #1 was an employee. Itor #1's personnel record is hired on 03/08/2020. There evidence that she participated HSA program. Itor #2's personnel record is hired on 08/09/2016 as an ility's home care agency. There evidence that she participated home support agency, which is on 08/25/2021 at 10:04 AM, the esources acknowledged that A license in 2016 in which #2 was an employee. ator #3's personnel record is hired on 03/11/2019 as an employee.		DEFICIENCY)			
		ility's home care agency. There evidence that she participated home support					

Health R	Regulation & Licensing	Administration				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HSA-0011	B. WING		08/2	27/2021
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
ASHCNC	ENTERPRISES, LLC	J/D/A	/ MEXICO AV TON, DC 20	/ENUE, NW, SUITE 214 0013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
R 135	Continued From pag	je 3	R 135			
	agency.					
	Director of Human R the facility had a hor	on 08/25/2021 at 10:04 AM, the Resources acknowledged that me care agency (HCA) license affing Coordinator #3 was an				
	ensure CNAs #1, #2 #3, and Staffing Coo	rvey, the agency failed to 2, #3 and #4, HHA #1, #2, and ordinators #1, #2, and #3's vere maintained to include ation in orientation.				
R 143	9909.2k Personnel		R 143	R143		
	(k) A position descr	ription signed by the employee;		As of 10/3/2021 all personnel reco		10/3/2021
	support agency (HS/ records to include cu five of six certified nu three of four home ha	riew and interview, the home A) failed to maintain personnel urrent position descriptions for ursing assistants (CNAs) and realth aides (HHAs) included in \$1, #3, and #6, and HHAs #2,		been updated to include acknowledgement of updated job description. Moving forward all CN HHAs personnel records will conta current job descriptions, as reflected policies and procedures. The Direct HR will oversee and maintain this total time.	in ed in our ctor of	
	Findings included:			real time.		
	conducted on 08/24/	ncy's personnel records /2021 at 11:08 AM, and AM, revealed the following:				
	review of CNA #1's p signed a position des an interview on 08/2! Director of Human R	d on 08/22/2019. Continued personnel record showed she scription on 08/22/2019. During 5/2021 at 10:04 AM, the tesources acknowledged that in a licensed as a home care nich CNA #1 was an				

Health R	equiation & Licensino	Administration			1 01114	ALLKOVED
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
		HSA-0011	B. WNG		08/:	27/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE. ZIP CODE	1 00/1	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ASHONO	ENTERPRISES, LLC	NR/Δ 3301 NEW	MEXICO AV	/ENUE, NW, SUITE 214		
Acricio	ENTERN MOLO, ELO E	WASHING	TON, DC 20	013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
R 143	Continued From pag	e 4	R 143			
	employee. Further in began providing sen agency on 07/27/20	nterview revealed that the CNA vices for the home support 21.				
	review of CNA #3's position description of During an interview of Director of Human R 2019, the facility was agency, in which CN	I on 04/11/2019. Continued personnel record showed the was signed on 04/11/2019. On 08/25/2021 at 10:04 AM, the resources acknowledged that in a licensed as a home care A #3 was an employee. Further lat the CNA began providing e support agency on				
	was hired on 06/14/2 #6's personnel recordescription signed or interview on 08/25/2 Human Resources a facility was licensed which CNA #1 was a revealed that the CN the home support ag 4. HHA #1's personnel was hired on 02/14/2 #2's personnel recordescription signed or interview on 08/25/20 Human Resources a facility was licensed which HHA #2 was a revealed that the aid the home support ag	nel record showed that the HHA 1019. Continued review of HHA d showed a copy of a position of 02/14/2019. During an 021 at 10:04 AM, the Director of cknowledged that in 2019, the as a home care agency, in n employee. Further interview e began providing services for ency on 08/23/2021.				
	5. HHA #3's personr	nel record showed that the				

PRINTED: 09/22/2021 **FORM APPROVED** 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 HSA-0011 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3301 NEW MEXICO AVENUE, NW, SUITE 214 ASHCNC ENTERPRISES, LLC D/B/A WASHINGTON, DC 20013 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 143 Continued From page 5 R 143 HHA was hired on 03/23/2017. Continued review of HHA #3's personnel record showed a copy of a position description signed on 03/23/2017. During an interview on 08/25/2021 at 10:04 AM, the Director of Human Resources acknowledged that in 2017, the facility was licensed as a home care agency, in which HHA #3 was an employee. Further interview revealed that the aide began providing services for the home support agency on 08/17/2021. 6. HHA #4's personnel record showed that the HHA was hired on 06/06/2017. Continued review of HHA #4's personnel record showed a copy of a position description signed on 02/14/2019. During an interview on 08/25/2021 at 10:04 AM, the Director of Human Resources acknowledged that in 2017, the facility was licensed as a home care agency, in which HHA #4 was an employee. Further interview revealed that the aide began providing services for the home support agency on 08/06/2021. R150 R 150 9909.6 Personnel R 150 As of 10/3/21 personnel records for 10/3/2021 staffing coordinators #1, #2, and #3 9909.6 At the time of initial employment, the home contain documentation verifying they are support agency shall verify that the employee, free of communicable disease. Moving within the six months immediately preceding the forward, we will require all new employees date of hire, has been screened for and is free of all communicable diseases. to provide such documentation, not only those with direct patient contact, as stated Based on record review and interview, the home in our policies and procedures. The support agency (HSA) failed to verify that each director of HR will oversee and maintain employee was free of all communicable diseases

Findings included:

within the six months immediately preceding the

employee's date of hire for three of three Staff Coordinators included in the sample (Staffing

Coordinators #1, #2, and #3).

EQOJ11

this task in real time.

Health R	Regulation & Licensing	Administration			FORIV	IAPPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
		HSA-0011	B. WING		08/2	27/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
ASHCNC	ENTERPRISES, LLC	IIDIA	MEXICO AV	/ENUE, NW, SUITE 214 1013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETE DATE
R 150	Continued From pag	ne 6	R 150			
	conducted on 08/03/at 11:28 AM revealed. 1. Staffing Coordinate before the home sup Staffing Coordinator'd documented evidence and certified free from within six months implied. 2. Staffing Coordination 08/09/2016, before the staffing record showed no do had been screened at 11:28 AM revealed.	for #1 was hired on 03/08/2020 aport agency was licensed. The spersonnel record showed no be that she had been screened in communicable diseases mediately preceding her date of the tor #2 was hired on the home support agency was goordinator's personnel ocumented evidence that she and certified free from ses within six months				
	before the home sup Staffing Coordinator's documented evidence and certified free from	tor #3 was hired on 03/11/2019 port agency was licensed. The s personnel record showed no the that she had been screened in communicable diseases mediately preceding her date of				
	11:15 AM, showed the that they have been scommunicable disease	cy's policy on 08/27/2021 at lat "all employees must verify screened and are free of se no more than six months for any employee that is in				
1	At the time of the sur ensure that Staffing (were screened and c	vey, the agency failed to Coordinators #1, #2, and #3 ertified free from				

Health Regulation & Licensing Administration

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING; _____

(X3) DATE SURVEY COMPLETED

HSA-0011

B. WNG ____

08/27/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASHCNC ENTERPRISES, LLC D/B/A

3301 NEW MEXICO AVENUE, NW, SUITE 214 WASHINGTON, DC 20013

	WASHINGTON, DC 20013				
(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	
R 150	Continued From page 7 communicable diseases.	R 150			
R 151	9909.7 Personnel 9909.7 Each employee shall be screened for communicable diseases according to the guidelines issued by the federal Centers for Disease Control and Prevention, and shall be certified free of communicable diseases. Based on record review and interview, the home support agency (HSA) failed to verify that each employee was free from all communicable diseases in accordance with guidelines issued by the federal Centers for Disease Control and Prevention (CDC) for three of the three Staffing Coordinators included in the sample (Staffing Coordinators #1, #2, and 3). Findings included Cross reference; Title 22B DCMR, Chapter 99, §9909.6	R 151	As of 10/3/21 personnel records for staffing coordinators #1, #2, and #3 contain documentation verifying they are free of communicable disease. Moving forward, we will require all employees to provide such documentation, not only those with direct patient contact, as stated in our policies and procedures. The director of HR will oversee and maintain this task in real time.	10/3/2021	
R 171	9910.4 Admissions 9910.4 Each home support agency shall conduct an initial assessment by a registered nurse to ensure that the client does not require services outside of the scope of personal care services. The assessment shall include a home visit and a review of information provided by the prospective client or the client representative and any other pertinent data and shall take place prior to the time that personal care services are initially provided to the client. The assessment must determine whether the home support agency has the ability to provide the necessary services in a safe and consistent manner. Based on record review and interview it was	R 171	Due to the public health emergency, on 3/12/2020 we received a letter from the DC Department of Health stating "we understand that your plans for care and services may require flexibility in state regulatory and licensure requirements while maintaining patient/resident safety." The letter also encourages us "to be innovative during your planning processes and to contact DC Health (specifically Sharon Mebane or Veronica Longstreth) if your plans may require the regulatory agency to review changes in your operations, modes delivery of services."	03/13/2020	

Health F	Regulation & Licensing	Administration			1 Oldivi	ALLIKOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION	(X3) DATE S COMPL	
		HSA-0011	B. WING		08/2	7/2021
NAME OF P	ROVIDER OR SUPPLIER			ATE, ZIP CODE		
ASHCNC	ENTERPRISES, LLC	// LI/A	MEXICO AV TON, DC 20	/ENUE, NW, SUITE 214 1013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
R 171	ensure the registered visits during initial as records reviewed (#2 Findings included: 1. On 08/24/2021 at record showed a state 06/14/2021. This assigned the care services required prepare a care plant follow while providing review of the assessigned documentation that the conducted virtually. The RN failed to condetermine if the client agency's ability to safely and care services required agency's ability to safely and care services required prepare a care plant follow while providing review of the assessigned as the care services required prepare a care plant follow while providing review of the assessigned coumentation that the conducted virtually. The RN failed to condetermine if the client conducted virtually.	Home Support Agency failed to d nurse conducted a home seessments in five of eight client 2, 3, 4, 6 and #8). 1:45 PM a review of Client #2's rt of care assessment dated sessment is required to rt's needs exceed the agency's consistently provide personal and by the patient, and to for the home health aides to g personal care. Continued ment form showed a he initial assessment was duct an initial in-home visit to t's needs exceeded the fely and consistently provide revices. 7:30 AM a review of Client #3's rt of care assessment dated essment is required to t's needs exceed the agency's consistently provide personal d by the patient, and to or the home health aides to g personal care. Continued ment form showed a ne initial assessment was	R 171	After receipt of this letter, we conta Sharon Mebane with an innovative solution of virtual nurse assessme reduce number of in person contact a vulnerable population. She acknowledged this and signed off plan on 3/13/2020. We have attact copies of both the letter and correspondence for viewing. For this reason, nurse assessment conducted virtually until the declarate end of the public health emergion 7/25/2021. Since 7/26/2021 we resumed in home nurse assessment will continue to conduct nurse assessments in this way. Our direct nursing will ensure this happens.	ents to cts with on this hed ts were ation of ency have ents and	7/26/2021

Health Regulation	n & Licensino	Administration			FORIV	IAFFROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1	E CONSTRUCTION	(X3) DATE : COMPL		
		HSA-0011	B. WING		08/2	27/2021
NAME OF PROVIDER O	R SUPPLIER	STREET ADD	DRESS, CITY, ST	ATÉ, ZIP CODE		
ASHONC ENTER	PRISES, LLC		MEXICO AV	/ENUE, NW, SUITE 214 0013		
(X4) ID PREFIX TAG	EFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
R 171 Continu	ued From pag	ge 9	R 171			
3. On 0 #4's redated 0 determ ability to care seprepare follow with the personal conductor of th	18/25/2021 at cord showed 18/18/2021. Tine if the clier o safely and ervices require a care plan while providing of the assess entation that it ted virtually. If failed to corine if the clier is ability to sail showed a standard require a care plan while providing of the assess entation that it ted virtually. If failed to conne if the clier is ability to sail th	11:00 AM a review of Client a start of care assessment this assessment is required to not's needs exceed the agency's consistently provide personal and by the patient, and to for the home health aides to g personal care. Continued ament form showed a the initial assessment was affect an initial in-home visit to not's needs exceeded the afely and consistently provide exceeds and a review of Client #6's art of care assessment dated assessment is required to not's needs exceed the agency's consistently provide personal and by the patient, and to for the home health aides to g personal care. Continued ment form showed a he initial assessment was duct an initial in-home visit to it's needs exceeded the fely and consistently provide				

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: HSA-0011 B. WING 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3301 NEW MEXICO AVENUE, NW. SUITE 214 ASHCNC ENTERPRISES, LLC D/B/A WASHINGTON, DC 20013 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) R 171 Continued From page 10 R 171 personal care services required by the patient, and to prepare a care plan for the home health aides to follow while providing personal care. Continued review of the assessment form showed a documentation that the initial assessment was conducted virtually. The RN failed to conduct an initial in-home visit to determine if the client's needs exceeded the agency's ability to safely and consistently provide the personal care services. During an interview on 08/27/2021 at 2:30 PM with the Clinical Services director (DON), she acknowledged the findings. At the time of survey, the Home Support Agency failed to ensure the registered nurse conducted in-home visits during initial assessments. R 204 9913.2 Client Service Plan R 204 R 204 9913.2 A registered nurse shall develop a service plan on admission based upon the initial As of 10/3/2021 the Client service 10/3/2021 assessment of the client and in accordance with document has been updated in include a Section 9917.4. specific question regarding dietary Based on record review and interview, the Home requirements. Moving forward the Client Support Agency failed to ensure that client service Service Plan will be completed thoroughly plans included dietary requirements, functional including the dietary requirements, limitations, and activities permitted, for five of the eight clients sampled (Clients #2, 3, 4, 6, and #8). functional limitations and activities permitted sections, by one of our RNs Findings included: directly following nurse assessments. This policy is reflected in our policies and 1. On 08/24/2021 at 1:45 PM a review of Client #2's procedures. Our Director of Nursing will record showed that the client's diagnoses included oversee and monitor this task. memory loss, and unsteady gait. Continued review of the service plan showed that

Health R	Regulation & Licensing	Administration				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE :	
			A. BOILDING,			
		HSA-0011	B. WNG		08/2	27/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
ASHCNC	ENTERPRISES, LLC			/ENUE, NW, SUITE 214		
		WASHING	TON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
	the client was at risk assistance with activ preparation and light of the service care p nurse failed to identi limitations and client direct the home heal achieve their highest 2. On 08/25/2021 at record showed that t knee replacement ar the service plan show endurance and requi and meal preparation care plan revealed the identify the client's diclient centered activithome health aide in a their highest practical. 3. On 08/25/2021 at #4's record showed to included impaired moservice plan showed non-ambulatory due assistance with all action food preparation/feed service care plan revealed to identify the climitations and client direct the home health achieve their highest 4. On 08/26/2021 at 94.	for falls and required rities of daily living, meal thousekeeping. Further review lan revealed that the registered fy the client's diet, functional centered activities permitted, to thaide in assisting the client to thaide in assisting the client to the practicable quality of life. 8:30 AM a review of Client #3's he client's diagnoses included and arthritis. Continued review of wed that the client had limited red assistance with transfers in. Further review of the service mat the registered nurse failed to let, functional limitations and ties permitted, to direct the assisting the client to achieve ble quality of life. 11:00 AM a review of Client hat the client's diagnoses obbility. Continued review of the that the client is to a recent fall and requires civities of daily leaving and ding. Further review of the ealed that the registered nurse client's diet, functional centered activities permitted, to thaide in assisting the client to practicable quality of life.	R 204			

PRINTED: 09/22/2021 **FORM APPROVED** 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 HSA-0011 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3301 NEW MEXICO AVENUE, NW, SUITE 214 ASHCNC ENTERPRISES, LLC D/B/A WASHINGTON, DC 20013 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID מו (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX COMPLETE PREFIX TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) R 204 R 204 Continued From page 12 Continued review of the service plan showed the client is non-ambulatory and requires total care. Further review of the service care plan revealed that the registered nurse failed to identify the client's diet, functional limitations and client centered activities permitted, to direct the home health aide in assisting the client to achieve their highest practicable quality of life. 5. On 08/26/2021 at 1:45 PM a review of Client #8's record showed that the client's diagnoses included ataxia and unsteady gait. Continued review of the service plan showed that the client is at risk for falls. ambulates with a wheelchair and requires assistance with housekeeping and meal preparation. Further review of the service care plan revealed that the registered nurse failed to identify the client's diet, functional limitations and client centered activities permitted, to direct the home health aide in assisting the client to achieve their highest practicable quality of life. During an interview on 08/27/2021, at 2 PM, the Clinical Services Director and the Chief Executive Officer were informed of the findings. At the time of survey, the home support agency failed to ensure that client service plans specified dietary requirements, functional limitations and activities to assist clients to achieve their highest practicable quality of life. R 226 As of 10/3/2021 all nursing staff has 10/3/2021 been notified and that a medication list is R 226 9914.2j Client Records R 226 required for all clients. Moving forward a

Health Regulation & Licensing Administration

(i) Medication list;

Based on record and policy review and interview,

contained a list of current medications, for five of

five clients receiving care from the agency

the agency failed to ensure that each client's record

medication list will be requested from the

client at the time of assessment. The

Director of Nursing will oversee and

maintain this task.

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 HSA-0011 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3301 NEW MEXICO AVENUE, NW, SUITE 214 ASHCNC ENTERPRISES, LLC D/B/A WASHINGTON, DC 20013 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) R 226 Continued From page 13 R 226 (Clients #, 3, 4, 6 and #8). Findings included: From 08/24/2021, through 08/27/2021, review of the records for Clients # 3, 4, 6 and #8 was conducted. The records lacked evidence of a list of the clients' medications. On 08/26/2021 at 4:47 PM, a review of the agency's policies was conducted. The policy for documentation in the health record showed that the record would contain all of the client's medications. It should be noted that the nurse's initial assessment form contained a designated area to list medications. Each client's assessment lacked documented evidence of their current medication(s). On 08/27/2021 at 2:00 PM during an interview, the Director and the Clinical Services Director acknowledged the findings. At the time of survey, the home support agency failed to ensure that each client's record contained a list of current medications.