Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0008	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERVICES	6856 EASTERN AVENUE, NW, SUITE 220 WASHINGTON, DC 20012

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H 000	INITIAL COMMENTS An annual survey was conducted at your agency from March 9, 2011, through March 210, 2011, to determine compliance with Title 22 DCMR, Chapter 39. The findings of the survey were based on a random sample of ten (10) clinical records based on a census of thirty (30) patients and ten (10) personnel files based on a census of eighty-six (86) employees and three (3) home visits. The findings of the survey were based on observations in the home, interviews with agency staff and patient interviews as well as a review of patient and administrative records.	H 000	Received 4/5/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
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 interview and record review, the Home Care Agency (HCA) failed to ensure documentation of training and education given to the patient's caregivers for two (2) of ten (10) patients in the sample. (Patient # #2 and #5) The findings include: 1. Review of Patient # 2's records including nursing notes on February 11, 2011, at approximately 11:35 a.m., revealed there was no evidence the skilled nurse provided training and education to Patient #2's caregiver. 2. Review of Patient # 5's records including	H 279	Action: Each clinical record will include documentation of training and education given to patient and their caregivers. Plan: 1. DOCS/Clinical Designee will re-educate all clinicians regarding the provision and documentation of patient/caregiver education at each encounter. Monitoring: 1. DOCS/Clinical Designee will conduct focused review of 25% of medical records monthly to ensure documentation of education provided. 2. The DOCS/RDOCS will further monitor during quarterly medical record reviews. Complete Date: At Orientation, during supervisory visits, during mandatory in-services which began 3/11/11 and ongoing.	At orientation during supervisory visits, during mandatory in services the first of which began 3/11/11 and Dngoing.

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H 279	Continued From page 1 nursing notes on March 3, 2011, at approximately 1:45 p.m., revealed there was no evidence the skilled nurse provided training and education to Patient #5's caregiver. During a face to face interview with the Director of Nursing (DON) on March 9, 2011, at approximately 1:50 p.m., it was acknowledged the skilled nurse had not provided evidence of training and education to Patient #2 and #5's caregivers.	H 279		
H 390	3915.6 HOME HEALTH & PERSONAL CARE AIDE SERVICE After the first year of service, each aide shall be required to obtain at least twelve (12) hours of continuing education or in-service training annually, which shall include information that will help maintain or improve his or her performance. This training shall include a component specifically related to the care of persons with disabilities. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure each aide obtained at least twelve (12) hours of continuing education or in-service training annually for two of ten home health aides (HHA). (HHA #7 and #9) The finding includes: On March 9, 2011, at 1:05 p.m., review of the HCA's personnel records revealed the agency failed to ensure HHA #7 and HHA #9 had obtained at least 12 hours of continuing education or in-service training annually. During face to face interviews with the Director of Nursing	H 390	Action: Maxim Healthcare Services Aides' Personnel files will contain evidence of at least 12 hours of continuing education annually. Plan: 1. AM/DOCS will educate staff regarding requirement for continuing education hours 2. All staff not meeting requirement will be restricted from duty until requirement is met. 3. Employees will receive reminder calls monthly. 4. Employess will be provided access to continuing education credits through MyMaximConnect. Monitoring: 1. AM will conduct focused review of 5 Personnel Files weekly for documentation of continuing education hours.	Ongoing.

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H 390	Continued From page 2 (DON) and the Office Manager on the same day at 1:56 p.m., they acknowledged that HHA #7 and HHA #9 did not have at least twelve (12) hours of continuing education or in-service training annually in their personnel records.	H 390		
H 411	3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Home health aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on a record review and interview, it was determined that the agency failed to ensure home health aides (HHA) recorded, and reported on the patient's physical condition, behavior or appearance for four (4) of four (4) patients receiving HHA services in the sample. (Patient #4, # 5,and #7 and #10) The findings include: Review of Patient #4, # 5, #7 and #10's medical records on March 9, 2011, approximately between 11:30 p.m. to 1:10 p.m., revealed the home health aide (HHA) had not recorded and reported the patient's physical condition, behavior, or appearance to the agency. During a face to face interview with the Director of Nursing (DON) on March 9, 2011, at approximately 2:00 p.m., it was revealed the HHA's had not been trained to document and	H 411	Action: Maxim Healthcare Services' practice is to include "Aide to report changes in status to RN" in Home Health Certification orders of Discipline and Treatment. Plan: 1. DOCS/Clinical Designee will re-educate direct care staff to above requirement as well as to include in Activity summary for every shift a statement regarding the patient's condition, appearance and/or behavior. Monitoring: 1. DOCS/Clinical Designee will review Activity summary/direct care staff documentation weekly.	At Orientations, during supervisory visits and Ongoing

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H 411	Continued From page 3 report on Patient #4, # 5, #7 and #10's physical condition, behavior and appearance on a daily basis.	H 411		
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on interview and record review, the facility's skilled nursing staff failed to ensure documentation of patient instruction, and evaluation of patient instruction for two (2) of two (10) patients in the sample. (Patient #1 and #8) The findings include: 1. Review of Patient # 1's Supervisory Visit Note dated February 11, 2011, at approximately 10:35 a.m., revealed in the section entitled Education, Caregiver Teaching Completed, there was no evidence the skilled nurse documented the evaluation of the instructions given to Patient #1's caregiver. 2. Review of Patient # 8's Supervisory Visit Note dated March 4, 2011, at approximately 1:11 a.m., revealed in the section entitled Education, Caregiver Teaching Completed, there was no evidence the skilled nurse documented the evaluation of the instructions given to Patient #8's caregiver.	H 459	Action: Each clinical record will include documentation of patient instruction and evaluation of patient instruction. Plan. 1. DDCS/Clinical Designee will re-educate all clinicians regarding documentation of patient/caregiver instruction and evaluation of patient instruction at each encounter. Monitoring. 3. DDCS/Clinical Designee will conduct focused review of 25% of medical records monthly to ensure documentation of instruction and evaluation of patient instruction. 4. The DOCS/RDOCS will further monitor during quarterly medical record reviews.	At Orientations, during supervisory visits and Ongoing

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H 459	Continued From page 4 During a face to face interview with the Director of Nursing (DON) on March 9, 2011, at approximately 3:15 p.m., it was acknowledged Patient #1 and # 8's Supervisory Visit Notes did not document the evaluation of the patient instructions.	H 459		