PRINTED: 12/08/2017 FORM APPROVED

| INME OF PROVIDER OR SUPPLIER STREET ADDRESS, SCITY, STATE, ZIP CODE ### SAHIM HEALTH CARE SERVICES CALL DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CALL DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG An annual survey was conducted from 12/4/17, tinrough 12/5/17, 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 kwnty-eight (28) patients and employs one hundred kwenty-eight (128) staff including professional and administrative staff. The findings of the survey were based on a review of administrative records, fourteen (14) inciden/docomplaint reports, eight (8) active patient records, two (2) discharged patient records and ten (10) employee records. The findings were also based on one (1) home visit and thriteen (13) telephone interviews with patients/family and staff. Listed below are abbreviations used throughout the body of this report. ADHD -Attention Deficit Hyperactivity Disorder ADL/IADL - Activities of Daily Living/Instrumental Activities of Daily Living DME- Durable Medical Equipment G-tube - Gastrostomy tube HCA - Home Care Agency HHA - Home Health Aide POC - Plan of Care RN - Registered Nurse ROM - Range of Motton SN - Skilled Nurse SOC - Start of Care H 279 Each clinical record shall include the following information related to the patient: | | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: | CONSTRUCTION | (X3) DATE COMP | LETED |
|--|----------|--|--|--------------|---|---|--|
| AXIM HEALTHCARE SERVICES 1100 NEW JERSEY AVEAUE, SE SUITE 845 WASHINGTON, DC 20003 AXIM HEALTHCARE SERVICES SUMMARY STATEMENT OF DEFICIENCISES (EACH DEFICIENCY MUST BE PRECEDED BY HULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) H 000 INITIAL COMMENTS An annual survey was conducted from 12/4/17, through 12/5/17, 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 twenty-eight (28) patients and employs one hundred twenty-eight (28) active patient records, kno (2) discharged patient records and ten (10) employee records. The findings were also based on one (1) home visit and thirteen (13) telephone interviews with patients/family and staff. Listed below are abbreviations used throughout the body of this report. ADHD - Attention Deficit Hyperactivity Disprder ADL/IADL - Activities of Daily Living DME- Durable Medical Equipment G-tube - Gastrostomy tube HCA - Home Care Agency HHA - Home Health Aide POC - Plan of Care RN - Registered Nurse ROM - Range of Motion SN - Skilled Nurse SOC - Start of Care H 279 Each Clinical record shall include the following TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (CROS-REPERICRE) OF CORRECTION (EACH ORN CORRECTION (EACH ORN CORRECTION SILVED CROSS-REPERICRED OF CROSS-REP | | | HCA-0083 | B, WING | | 12/0 | 5/2017 |
| AMM HEALTH-CARE SERVICES WASHINGTON, DC 20003 PREFIX CARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATIONY OR LISC INCENTIFYING INFORMATION) H 000 INITIAL COMMENTS An annual survey was conducted from 12/4/17, through 12/5/17, to determine compliance with the District of Columbiar's Home Care Agency Regulations (Title 22 B DCMR Chapter 39). The home care agency provides home care services for twenty-eight (128) staff including professional and administrative records, fourteen (14) incident/complaint reports, eight (8) active patient records, two (2) discharged patient records and ten (10) employee records. The findings were also based on one (1) home visit and thirteen (13) telephone interviews with patients/family and staff. Listed below are abbreviations used throughout the body of this report. ADHD -Attention Deficit Hyperactivity Disorder ADL/IADL - Activities of Daily Living/Instrumental Activities of Daily Living DME- Durable Medical Equipment G-tube - Castrostomy tube HCA - Home Care Agency HHA - Home Health Aide POC - Plan of Care RN - Registered Nurse ROM - Range of Motion SN - Skilled Nurse SOC - Start of Care H 279 3911.2(s) CLINICAL RECORDS Each clinical record shall include the following | AME OF F | PROVIDER OR SUPPLIER | | | | 13/18 | |
| (EACH DEFICIENCY WIJST as PRECEDED BY HULL REGULATORY OR LSO DENTIFYING INFORMATION) H 000 INITIAL COMMENTS An annual survey was conducted from 12/4/17, through 12/5/17, to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22 B DCMR Chapter 39). The home care agency professional and administrative records, fourteen (14) incident/compliant reports, eight (8) active patient records, two (2) discharged patient records and ten (10) employee records. The findings were also based on one (1) home visit and thirteen (13) telephone interviews with patients/family and staff. Listed below are abbreviations used throughout the body of this report. ADHD -Attention Deficit Hyperactivity Disorder ADL/IADL - Activities of Daily Living/Instrumental Activities of Daily Living/Instrumental Activities of Daily Living/Instrumental Activities of Daily Living/Instrumental Activities of Daily Living Ponce Ponce RN - Registered Nurse ROM - Range of Motion SN - Skilled Nurse SOC - Start of Care H 279 Each Clincial record shall include the following PREFIX TAO TAO TAO CROSS-REFERENCED TO THE APPROPRIATE DEFICION. H 000 H 000 INITIAL COMMENTS H 000 H 000 An annual survey was conducted from 12/4/17, through 12/4/17, | AXIM H | EALTHCARE SERVIO | | | 003 | 1 | 1 |
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| Each clinical record shall include the following | | the body of this rep ADHD -Attention D ADL/IADL - Activitie Activities of Daily L DME- Durable Med G-tube - Gastrosto HCA - Home Care HHA - Home Healtl POC - Plan of Care RN - Registered No ROM - Range of M SN - Skilled Nurse | port. reficit Hyperactivity Disorder res of Daily Living/Instrumental riving dical Equipment reficiency refici | | | | |
| | H 279 | | | H 279 | | | and the second s |
| h Regulation & Licensing Administration Regulation & Licensing Administration Regulation & Licensing Administration (X6) DATE (X6) DATE | | information related | to the patient: | | | | |

| Health F | Regulation & Licensin | ng Administration | | and the second s | (X3) DATE SURVEY |
|-----------|-------------------------------------|--|-----------------------------|--|--|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A, BUILDING | LE CONSTRUCTION | COMPLETED |
| | | HCA-0083 | B. WING | | 12/05/2017 |
| | | etgeet Ani | DESS CITY | STATE, ZIP CODE | |
| NAME OF I | PROVIDER OR SUPPLIER | | | VENUE, SE SUITE 845 | |
| MAXIM F | IEALTHCARE SERVI | 720 | TON, DC 2 | 0003 | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL | ON (X5) D BE COMPLETE |
| PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX | CROSS-REFERENCED TO THE APPROP | |
| TAG | KEGODATOKT ON E | SO IDENTIFICATION OF THE PROPERTY OF THE PROPE | ,,,,, | DEFICIENCY) | |
| H 279 | Continued From pa | ae 1 | H 279 | By submitting this Plan of | |
| 1,2,0 | | _ | | Correction the agency does not | |
| | (s) Documentation | of training and education | | admit the allegations in the surve | ev |
| | given to the patient | and the patient's caregivers. | | report or that it violated any | 7 |
| | | | | regulations. The agency is | - [|
| | | | | submitting this Plan of Correction | 15 |
| | This Statute is not | met as evidenced by: | | in response to its regulatory | 13 |
| | Based on interview | and record review, the HCA | | obligations and commitment to | |
| | failed to ensure the | nursing staff provided | | compliance. The agency further | |
| | documented evider | nce of specific training and | | reserves the right to contrast any | , |
| | educational instruc | tions to the patient and the | | alleged findings, conclusions and | 91.5 26 |
| | patient's caregivers | s for four (4) of ten (10) | | deficiencies. The agency intends | 7.8 |
| | patients in the sam | ple (Patients #1, 2, 3,10). | | request that this Plan of Correction | |
| | | | | service as its Credible Allegation | |
| | Findings included: | | | | oj |
| | The HCA failed to 4 | ensure its SNs documented | - | Compliance. | . 4 |
| | the specific training | and educational instructions | ĺ | All active staff were re-educated | on |
| | given to the patient | /caregiver as ordered by the | | policy for educational | 12/22/201 |
| | POC as evidenced | below: | | documentation. Field Support te | um |
| | | | | mailed out reminder letters for t | the |
| | 1. On 12/04/17, at | 11:30 AM, review of Patient | | DOCS to active staff's homes ab | out |
| | #1's POC showed | a SOC date of 5/05/16, and a | | education documentation. | 4 |
| | certification period | of 10/27/17, through 12/25/17. | | | |
| | The patient had dia | ignoses that included | | Clinical Supervisors and DOCS to | 12/27/201 |
| | postsurgical malab | sorption, gastrostomy status, | | review with staff at monthly | 10 9 |
| | The POC showed | naturity, and hemangioma. a documented order for the SN | | supervisory visits/recertification | s. |
| | to instruct the natio | ent/caregiver on the following: | İ | | |
| | to manucline pane | into a register of the lene wing. | | Clinical Supervisors/DOCS will in | The state of the s |
| | ADL/JADLs; | | | service staff during first quarter | of 1/21/2010 |
| | Bowel managemen | nt; | 1 | 2018 to documentation policy. | 1/31/2018 |
| | Dietary requiremen | its; | | | |
| | Emergency interve | ntions; | 1 | Chart audit to be done quarterly | |
| | Home exercise pro | grams; | | Quality Improvement Nurse and | 1/21/2010 |
| | Fall prevention; | | | DOCS of 75% - 100% of charts wi | th 1/31/2018 |
| | Fluid intake manag | | | threshold of 90-100% of | - 0 |
| | Medication regime | | | compliance. | 1 |
| | Skin integrity mana | igement. | | | |
| | On 12/04/17, begin | nning at 11:40 AM, review of | 1 | · · | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|---|---|--|
| | | HCA-0083 | B, WING | | 12/05/2017 | |
| | PROVIDER OR SUPPLIER | 1100 NE\ | DDRESS, CITY, S' N JERSEY AV GTON, DC 20 | ENUE, SE SUITE 845 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLETE | |
| H 279 | | | H 279 | By submitting this Plan of Correction the agency do admit the allegations in report or that it violated regulations. The agency submitting this Plan of Compliance in response to its regulations and commit compliance. The agency reserves the right to concalleged findings, conclude deficiencies. The agency request that this Plan of Service as its Credible Accompliance. | oes not the survey I any is Corrections tory ment to y further ntrast any sions and y intends to f Correction | |
| | Fluid intake manag Medication manag Pulse oximetry; ROM exercises; ar Routine G-tube car | I ambulation safety measures; gement; ement; nd re. | | • | | |
| | Patient #2's "Nursi and 11/11/17 throu documented evide patient/caregiver w Instructions related diagnosed health of 3. On 12/04/17, be Patient #3's POC s | nning at 1:05 PM, review of ng Flow Sheets" dated 11/9/17 gh 11/16/17, showed no nce that the SN provided the vith training and/or educational it to any of the patient's care conditions. Iginning at 1:30 PM, review of showed a SOC date of 4/15/14 period of 11/25/17, through | | e _q | | |

| STATEMEN | Regulation & Licensir IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | HCA-0083 | B. WING | | 12/05/2017 |
| | PROVIDER OR SUPPLIER | 1100 NEW | | STATE, ZIP CODE VENUE, SE SUITE 845 0003 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETE |
| | autistic disorder; ce convulsions, unspe encounter for attent showed a documer instruct the patient// ADL/IADLs; Bowel managemen Dietary requiremen Fall prevention stra Fluid intake manag Maintaince/Improve Medication regimer Progressive exercis Seizure precautions On 12/04/17, at 2:3 "Nursing Flow Sheed documented evider patient/caregiver wiinstructions related diagnosed health cate 4. On 12/04/17, at 3 #10's POC showed certification period of The patient had dia encephalopathy, qui respiratory failure with mental status. The order for the SN to on the following: ADL/IADLs; Bowel managemen Dietary requirement Fall prevention strate Fluid intake managemen processive services and status are serviced as a service of the SN to on the following: | th had diagnoses that included in the palsy, unspecified cified asthma, ADHD, and tion to gastrostomy. The POC ited order for the SN to caregiver on the following: t; ts; tegies; ement; ement of short term memory; in for high risk medications; se/ROM; and is. 5 PM, review of Patient #3's set" dated 11/25/17, showed notice that the SN provided the th training and/or educational to any of the patient's are conditions. 8:30 PM, review of Patient a SOC date of 5/01/14, and a of 10/19/17, through 12/17/17. In gnoses that included adriplegia, epilepsy, chronic in hypoxia, and altered POC showed a documented instruct the patient/caregiver it; its; tegies; ement; ement of short term memory; ement of short term memory; | H 279 | By submitting this Plan of Correction the agency does not admit the allegations in the streport or that it violated any regulations. The agency is submitting this Plan of Correction response to its regulatory obligations and commitment compliance. The agency furtives reves the right to contrast alleged findings, conclusions deficiencies. The agency interequest that this Plan of Correservice as its Credible Allegat Compliance. | urvey tions to ner any and nds to ection |
| rate FORM | | | 0899 | VIOJ11 | If continuation sheet 4 |

| STATEMEN | Regulation & Licensin IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE COMPI | |
|--------------------------|---|--|---------------------|--|--|------------------|
| | | HCA-0083 | | TATE, ZIP CODE | 1 1210 | 5/2011 |
| | PROVIDER OR SUPPLIER HEALTHCARE SERVIO | 1100 NEW | JERSEY AV | ENUE, SE SUITE 845 | | |
| IVIAXIIVI F | | WASHING | TON, DC 20 | 903 PROVIDER'S PLAN OF CORRE | CTION | (X5) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | COMPLETE DATE |
| H 279 | Medication regimer Progressive exercis Seizure precautions On 12/04/17, at 4:0 "Nursing Flow Sheet 11/25/17, showed in the SN provided the and/or educational the patient's diagnot on 12/04/17, 4:45 I supervisor said that ensure all patients/ training and education by the POC. At the time of the sensure all SNs doce educational instructions. | of for high risk medications; se/ROM; and so. OPM, review of Patient #10's sets" dated 10/20/17, through o documented evidence that e patient/caregiver with training instructions related to any of seed health care conditions. PM, interview with the clinical trail sold all SNs will be re-trained to caregivers are given specific ional instructions as ordered survey, the HCA failed to umented specific training and | H 279 | By submitting this Plan of Correction the agency does admit the allegations in the report or that it violated an regulations. The agency is submitting this Plan of Corr in response to its regulator, obligations and commitme compliance. The agency fureserves the right to contra alleged findings, conclusion deficiencies. The agency in request that this Plan of Coservice as its Credible Alleg Compliance. | rections y nt to rether ust any nt and utends to prrection | |
| H 411 | AIDE SERVICE Home health aide of following: (f) Observing, recopatient's physical cappearance; This Statute is not Based on a record failed to ensure that recorded and report | MEALTH & PERSONAL CARE duties may include the rding, and reporting the ondition, behavior, or met as evidenced by: review and interview, the HCA at each HHA observed, ted on the patient's physical or appearance, for one (1) of | H411 | DOCS AND Clinical Supervire-educate the Clinical state documentation policy to in the ABC's (appearance, be and condition) of each pate during orientation, before case is discuss on PSO (pates specific orientation sheet) during monthly supervisor visits/recertification visits. DOCS teach and discusses adherence during orientation orientations and discusses adherence during orientations. | ff on nclude havior lent new lient and ly | 12/20/2017 |

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| STATEMEN | Regulation & Licensing of DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | HCA-0083 | B, WING | | 12/05/2017 |
| | PROVIDER OR SUPPLIER | 1100 NEV | | TATE, ZIP CODE 'ENUE, SE SUITE 845 1003 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI | JLD BE COMPLET |
| | Continued From page 5 the three (3) patients who had an HHA in the sample. (Patient #7) Findings included: On 12/4/17, at 2:25 PM, review of Patient #7's, "Aide Weekly Notes" dated 10/16/17, through 11/19/17, showed that the HHA failed to observe and document the aforementioned patients' physical condition, behavior or appearance in the clinical record. On 12/4/17, at 3:30 PM, interview with the clinical supervisor said that the agency would conduct an in-service with all of the HHAs on how to document the patients' physical condition, behavior or appearance in the clinical record. At the time of the survey, there was no evidence the HHA documented the patients' physical condition, behavior or appearance in the clinical record. | | H 411 | Chart audit to be done quarter Quality improvement Nurse ar DOCS of 75% - 100% of charts of threshold of 90-100% of compliance. | nd 1/31/20 |
| | | | | | |