

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HCA-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/13/2011
-----------------------------------------------------	-----------------------------------------------------------------------	------------------------------------------------------------------	-------------------------------------------------

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

DEFICIENCY 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
-----------------------------	------------------------------------------------------------------------------------------------------------------------------	---------------------	--------------------------------------------------------------------------------------------------------------------------	--------------------------

11000 INITIAL COMMENTS

H 000

An annual survey was conducted at your agency from December 12, 2011, through December 13, 2011, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of ten (10) clinical records based on a census of twenty-seven (27) patients, ten (10) personnel files based on a census of seventy-eight (78) employees and two (2) 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.

*Received 1-9-12*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

11111 3915.11(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE H 411

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 five (5) of ten (10) patients in the sample. (Patient #1, #5, #6, #7 and #10)

The findings include:

Review of Patient #1, #5, #6, #7 and #10's medical records on December 12, 2011, approximately between 12:50 p.m. to 3:50 p.m.,

Action:

Maxim Healthcare Services' direct care staff will be required to document the patient condition, behavior and appearance at least weekly.

Plan:

- (1) DOCS/Clinical Designee will re-educate direct care staff to above requirement and include a reminder in the patient home charts.
- (2) Also, 100% of direct care staff documentation will be reviewed within one month.

Monitoring:

DOCS/Clinical Designee will audit direct care staff documentation on a weekly basis.

- 1) At orientations during supervisory visits and ongoing.
- 2) February 7<sup>th</sup>, 2012.

Health Regulation & Licensing Administration

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DATE FORM

6899

YNFC11

If continuation sheet 1 of 2

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/13/2011</b>
-----------------------------------------------------	------------------------------------------------------------------------------	------------------------------------------------------------------	--------------------------------------------------------

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

DEFIC 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
------------------------	------------------------------------------------------------------------------------------------------------------------------	---------------------	--------------------------------------------------------------------------------------------------------------------------	--------------------------

H 411	Continued From page 1	H 411		
-------	-----------------------	-------	--	--

revealed the home health aides (HHA's) had not consistently recorded and reported the patient's physical condition, behavior, or appearance to the agency. Further review revealed the HHA only documented the activities of daily living (ADL) tasks performed for Patient #1, #5, #6, #7 and #10.

During a face to face interview with the Accounts Manager and Director of Clinical Services on December 12, 2011, at approximately 5:26 p.m., it was acknowledged the HHA's did not document consistently on the patient's physical condition, behavior or appearance.