Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HCA-0083		06/13/2017

NAME OF PROVIDER OR SUPPLIER: MAXIM HEALTHCARE SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE: 1100 NEW JERSEY AVENUE, SE SUITE 845 WASHINGTON, DC 20003

Received 9/15/17

(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
H 000	INITIAL COMMENTS An annual survey was conducted from May 17, 2017 through June 13, 2017, 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 35 patients and employs 150 staff including professional and administrative staff. The findings of the survey were based on a review of administrative records, four (4) incident reports, seven (7) active patient records, three (3) discharged patient records, twenty (20) employee records, two (2) home visits and ten (10) interviews with patients/family and staff. Listed below are abbreviations used throughout the body of this report. EMT-- emergency medical technician HHA -- home health aide LPN -- licensed practical nurse POC -- plan of care RN --registered nurse SOB -- shortness of breath	H 000	***By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.***	
H 455	3917.2(e) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (e) For registered nurses, supervision of nursing services delivered by licensed practical nurses, including on-site supervision at least once every sixty-two (62) calendar days; This Statute is not met as evidenced by: Based on record review and interview, the	H 455		

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H 455	Continued From page 1 supervisory RN failed to supervise the services for one (1) of one (1) LPN's in the sample. (supervisory RN) The finding includes: On May 17, 2017 at 12:15 p.m., Patient #2's POC was reviewed and revealed an order for skilled nursing services for 13-18 hours, 5-7days a week. The skilled nursing services included complete skilled nursing head to toe assessment every shift, monitor intake and output every shift, adminster medications, change tracheostomy tube weekly, provide tracheosotomy care every shift, suction tracheostomy catheter as needed, monitor oxygen saturation for oxygen level equal or greater than 92%, monitor pilse ox while sleep, and apply ventilator at night and during nap time... On May 17, 2017, at 1:30 p.m., telephone interview with LPN #1 revealed she worked for Patient #2 from June 11, 2016 to May 11, 2017 on the 9 p.m. to 6 a.m. shift. When queried if the RN supervised the services she provided for Patient #2, she indicated that the RN supervisor had not visited Patient's #2's home to provide on site supervision. On June 13, 2017, at 10:00 a.m., review of the RN's supervisory visit notes dated August 4, 2016 though April 27, 2017, lacked evidence of supervised nursing services provided by LPN #1. At the the time of the survey, the RN failed to supervise the services provided by LPN #1.	H 455	***By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.*** ***The Clinical Supervisors were re-educated on policy for supervisory visits.*** ***The Accounts Manager (AO), Recruiters and Director of Clinical Services (DOCS) will meet weekly to discuss and generate the overnight home visit staff listing. Supervisory visits will be scheduled by DOCS at least every sixty-two (62) calendar days.*** ***Moving forward, the DOCS will meet with the Clinical Supervisors weekly to review the staff schedules for upcoming visits.***	6/21/2017 10/1/2017 Ongoing 10/1/2017 Ongoing

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H 456	Continued From page 2	H 456		
H 456	3917.2(f) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (f) Supervision of services delivered by home health and personal care aides and household support staff, as appropriate; This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse failed to provide supervision for (1) home home health aide's in the sample. (HHA #1) The finding includes: On May 18, 2017, at 2:00 p.m., review of Patient #4's clinical record revealed a POC with a start of care date from March 30, 2015, and a certification period of March 20, 2017 to May 17, 2017. Further review of the POC revealed that the physician ordered home health aide services to be provided 3-5 hours per day for 5-7 days a week. Continued review revealed supervisory visits notes, dated March 16, 2017 and April 14, 2017, failed to evidence that the skilled nurse supervised the services provided by HHA #1. On May 18, 2017, at 2:15 p.m., interview with the clinical director revealed that the skilled nurse had supervised HHA #1; however, the supervisory visit form had recently been changed and supervision of services provided by the HHA had been omitted from the new form. The clinical director indicated that the form was being updated to include supervision of services provided by home health aides.	H 456	***By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.*** ***The Clinical Supervisor was re-educated on Supervisory and Documentation Policy. <u>The electronic Medical Supervisory Visit was updated.</u>*** ***The Clinical Supervisor visits the HHA every 30 days per the insurance company guidelines. Per Maxim policies, the HHA must be present at least every 60 days for onsite visit. HHA #1 was supervised on March 7, 2017 on the electronic system (Vision) with an electronic signature of the HHA# 1 (attached). The Supervisory visit on April 10th was completed without the HHA#1 present so patient Supervisory visits were completed per guidelines.*** ***The Electronic Supervisory visit note (Vision) has been updated to reflect the skilled staff's name and date of visit completion.***	6/21/2017 10/1/2017 6/21/2017

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H 456	Continued From page 3 There was no evidence prior to the exit of the survey that HHA#1 had been provided nurse supervision.	H 456	*By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.*	
H 458	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse failed to inform the physician of a change in a patient's status for two (2) of seven patients in the sample. (Patient #1) The findings include: 1. On May 17, 2017, at 11:00 a.m., review of Patient #1's clinical record revealed a POC with a start of care date of March 19, 2017, and a certification period from March 19, 2016 to May 17, 2017. Further review of the aforementioned POC revealed that the patient had multiple diagnoses including chronic respiratory failure unspecified as to whether hypoxia or hypercapnia. Continued review of the record revealed a "Nursing Flow Sheet", dated April 1, 2017. The nursing flow sheet revealed that the Patient received emergency services on April 1, 2017. The EMT report revealed that assistance was provided to the patient for "SOB, low saturation level, and a heart rate greater than 140." The record lacked	H 458	*LPN# 1 was dismissed from Maxim Healthcare.* *DOCS AND Clinical Supervisor will re-educate the Clinical staff on following POC stating to contact the MD for any changes. Memo sent out to all Homecare staff's homes as well as one on one in service when staff comes into the office as well as telephone logins when speaking with staff over the phone.* *DOCS teach and discusses POC adherence during orientation of all new staff.* *Chart audit to be done quarterly by Quality Improvement Nurse and DOCS of 75% - 100% of charts with threshold of 90-100% of compliance.*	6/23/2017 9/1/2017 9/1/2017 Ongoing 10/1/2017 Ongoing

PRINTED: 08/02/2017
FORM APPROVED

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H 458	Continued From page 4 evidence that the nurse informed the physician about the patient's change in status. On May 17, 2017, at 2:00 p.m., interview with the clinical director revealed that the nurse had not made the physician aware of Patient #1's change in status. 2 a. On May 17, 2017, at 12:00 p.m., review of the agency's complaint log revealed a complaint dated March 29, 2017, which indicated Patient #2's mother complained that the patient's tracheostomy tube became dislodged, and the nurse "didn't trouble shoot as fast as she would like." The mother also indicated that she submitted a video of the incident to the agency. On May 17, 2017, at 12:15 p.m., review of Patient #2's clinical record revealed a POC with a start of care date of June 6, 2016, and a certification period from February 1, 2017 to April 1, 2017. Further review of the aforementioned POC revealed that the patient had multiple diagnoses including acute and chronic respiratory failure with hypoxia, acute tracheitis with obstruction, and tracheostomy. On May 17, 2017, at 12:30 p.m., interview with the Director of Clinical Services revealed that she had spoken with LPN #1, who informed her that the patient was "wiggling a lot and the tracheostomy tube came out a little, but not completely out." On May 17, 2017, at 1:00 p.m., telephone interview with the complainant revealed that on March 25, 2017, she heard the patient "struggling to breath". Upon entering the patient's room, she observed the nurse attempting to administer a nebulizer treatment in the dark. She	H 458	*By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.*	
			LPN# 1 was dismissed from Maxim Healthcare.	6/23 /2017
			LPN #1 was re-educated by one on one in service with the DOCS and return demonstration was completed in the clinical laboratory setting and documented in employee file.	3/31/2017
			All active employees assigned to patient #2 were re-educated with trach, Gtube and vent training and did return demonstration in clinical laboratory.	5/19/2017
			All active clinical staff has annual competencies completed per policy.	6/1/2017 Ongoing

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H 458	Continued From page 5 asked the nurse several times if the tracheostomy tube had dislodged, but the nurse continued to try to administer a nebulizer treatment. When the complainant observed that the tracheotomy tube had been dislodged from the stoma, she handed the nurse an obturator and the nurse re-inserted the tracheostomy tube. On May 17, 2017, at 1:30 p.m., an observation of the complainant's video confirmed the complainant's account of the incident. On May 17, 2017, at 1:30 p.m., telephone interview with LPN #1 revealed at approximately 4:55 a.m., on March 25, 2017, she noted that Patient #2 was "wiggling vigorously and sounding differently." She admitted that the light was off in the room, but she could still see the patient. The nurse indicated she checked the patient's tracheostomy tube and it was "fine". When queried about why the light was off in the room, she indicated that the patient's mother requested that she turn the room light off and use the light from the hallway. She indicated that during her initial assessment the patient's tracheostomy tube was in place, but the patient was "breathing differently". She suctioned the patient; however, the patient still appeared to be in respiratory distress. The nurse explained that because the patient's breathing did not improve, she prepared a nebulizer treatment. During the preparation of the nebulizer treatment, she realized the patient's tracheostomy tube had become dislodged with the cuff inflated. When asked if Patient #2's tracheostomy tube had ever dislodged with the inflated cuff, she stated "no." Continued interview revealed that after Patient #2's mother handed her the obturator (used to insert a tracheostomy tube), she re-inserted the patient's tracheostomy tube.	H 458	***By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.*** ***LPN# 1 was dismissed from Maxim Healthcare.*** ***DOCS re-educated LPN #1 and parents about having appropriate lighting in the room for LPN to do assessment and care to monitor patient's condition. Documentation in employee file and patient record.*** ***Ongoing supervisory visit to include any patient issues or concerns per policy.***	6/23/2017 3/31/2017 10/1/2017

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H 458	Continued From page 6 The nurse stated that after the tracheostomy tube was re-inserted the patient's breathing improved. When questioned if the physician was made aware of the incident, LPN #1 stated that she did not inform the physician because the patient was "stable" after the tracheostomy tube had been re-inserted. On May 18, 2017, review of the Patient #2's clinical record, revealed a nursing note, dated May 24, 2017, confirmed LPN #1's interview. Continued review of the record lacked documented evidence the physician had been made aware of the patient's change in status. 2 b. On May 18, 2017, at 10:30 a.m., Patient #2's mother was interviewed. During the interview the mother alleged that LPN #1 failed to provide timely medical treatment. The mother recalled that on May 2, 2017, the patient "was working hard to breathe and had an elevated pulse." At that time, LPN #1 administered a nebulizer treatment. Several hours later, at 1:00 a.m., the Patient's condition had not improved. The LPN informed the mother that the patient had "spiked a fever and was administered Tylenol." Further interview with the mother revealed that because her Patient's condition had not improved, 911 was called at 5:00 a.m. and admitted to Children's Hospital for two (2) days with an upper respiratory infection. On May 17, 2017, at 12:15 p.m., review of Patient #2's clinical record revealed a POC with a start of care date of June 6, 2016, and a certification period from April 2, 2017 to May 1, 2017. Further review of the POC revealed that the patient had	H 458	**By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.** **LPN# 1 was dismissed from Maxim Healthcare.** **LPN #1 had one on one re-educated by DOCS about change in condition and documentation per policy.** **Ongoing supervisory visit to include any patient issues or concerns per policy.**	6/23/2017 5/19/2017 10/1/2017

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H 458	Continued From page 7 multiple diagnoses including acute and chronic respiratory failure with hypoxia, acute tracheitis, and tracheostomy. The POC required the nurse to "inform the physician if the patient had a sustained pulse greater than 160." The clinical record however lacked evidence the nurse informed the physician about the patient's sustained heart rate. On June 13, 2017, at 1:00 p.m., telephone interview with LPN #1 revealed that on May 2, 2017, the patient had increased secretions, increase heart rate that fluctuated from "180-200", and elevated temperature. Continued interview revealed that the patient's mother instructed the LPN to observe the patient and if he did not improve they would take him to the hospital " Further interview revealed that she had not informed the patient's doctor of the patient's significant change because she thought working his "sick plan" would improve the patient's condition. At the time of the survey, the skilled nurse failed to inform the physician about Patient's #1's change in status.	H 458	**By submitting this Plan of Correction the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this Plan of Corrections in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this Plan of Correction service as its Credible Allegation of Compliance.** **LPN# 1 was dismissed from Maxim Healthcare.** **LPN #1 had one on one re-educated by DOCS about change in condition and documentation per policy.** **Ongoing supervisory visit to include any patient issues or concerns per policy.**	 6/23/2017 5/19/2017 10/1/2017