



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility: Grand Oaks Assisted Living		Street Address, City, State, ZIP Code: 5901 Mac Arthur Blvd NW Washington DC 20008 20016		Survey Date: May 26-27, 2009 Follow-up Dates(s):	
Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date	
Assisted Living Residence Law 13-127 Act 13-297 602(a)	An Annual licensure survey was conducted on May 26-27, 2009, to determine compliance with Assisted Living Residence Law 13-127 and Act 13-297. The following deficiencies were based on record reviews, observations and interviews. The sample sizes were (16) resident records based on a census of one hundred –sixty (160) residents and twenty (20) employee records based on a census of two hundred (200) employees. <p style="text-align: center;">602 <u>RESIDENT AGREEMENTS</u></p> A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. Based on interview and record review, it was determined	602A	<ul style="list-style-type: none"> A written + signed agreement of Res. #2 has been completed + placed in file The Move-In coordinator will confirm that each new Resident has a complete + signed agreement prior to admission The community will perform audits of residents files to confirm completion of all documentation. <p style="text-align: center;"><i>Received 7/20/09</i> GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	July 20, 2009	

Name of Inspector

6/25/09

Date Issued

Facility Director/Designee

7-17-09

Date



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that the facility failed to provide a written contract to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR for one of sixteen resident's in the sample. (Resident #2)

The findings include:

Review of Resident #2's administrative record on May 26, 2009 at approximately 1:20 PM revealed the facility failed to provide a written contract to Resident #2 prior to admission and signed by the resident or surrogate, and a representative of the ALR.

In an interview with the Director of Nursing on May 27, 2009 at approximately 1:05 PM it was acknowledged Resident #2's written contract that was provided to the resident prior to admission and signed by the resident or surrogate and a representative of the ALR, could not be located at the time of the survey.

There was no documented evidence the resident was provided a written contract prior to admission and signed by the resident or surrogate, and a representative of the ALR.

604

INDIVIDUALIZED SERVICE PLANS



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604 (b)

(b) The ISP shall include the services to be provided, when and how often the services will be provided and accessed.

Based on interview and record review, the agency failed to ensure the Individual Service Plan's (ISP) included the services to be provided; when and how often the services will be provided and accessed for four (4) out of sixteen (16) residents in the sample. (Resident #1, Resident #6, Resident #10 and Resident #11)

The findings include:

1. Review of Resident #1's medical assessment entitled "Health Care Practitioner Physical Assessment" dated November 17, 2006 on May 26, 2009 at approximately 1:10 PM Resident #1 was assessed to have depression at the severe level and was a danger to self.

Review of Resident #1's ISP dated May 25, 2009 on May 26, 2009 at approximately 1:11 AM, revealed Resident #1 was combative during care. Further review revealed Resident #1 was taking Cymbalta daily for depression and Seroquel twice a day for delusions.

In an interview with the Director of Nursing on May 27,

604 (b)

- An amendment to the ISP of Residents #1, 6, 10, 11, was completed + documented
- The Reminiscence + Assisted Living Coordinators will complete a more accurate and detailed ISP, in addition to updating the information as necessary.
- The community will perform audits of residents ISPs to confirm complete accuracy

#1
May 26, 2009
#6
May 27, 2009
#10
July 2, 2009
#11
May 27, 2009



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2009 at approximately 1:15 PM it was acknowledged the agency had not documented whether or not Resident #1 was a danger to herself or others on the ISP.

There was no documented evidence the safety services to be provided was documented on the ISP.

2. Review of Resident #6's ISP dated May 20, 2009 on May 26, 2009 at approximately 2:30 PM revealed Resident #6's wound care treatment was not documented on the ISP.

Review of Resident #6's physician's order (POS) dated May 15, 2009, on May 26, 2009 at approximately 2:32 PM, revealed Resident #6's right shin wound was to be cleansed with normal saline and triple antibiotic ointment was to be applied. Further review revealed the wound was to be covered with Mepidex Border and changed every Tuesday and Friday.

In an interview with the Director of Nursing on May 26, 2009 at approximately 2:34 PM it was acknowledged the agency had not documented Resident #1's wound care treatment on the ISP.

There was no documented evidence the wound care services to be provided was documented on the ISP.

3. Observation of Resident #10's apartment, revealed the



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presence of a portable oxygen canister and several oxygen tanks.

Review of Resident #10's ISP dated April 21, 2009 dated, on May 27, 2009 at approximately 11:06 AM revealed Resident #10's oxygen therapy was not documented on the ISP.

Interview with the Director of Nursing on May 27, 2009 at approximately 2:00 PM revealed Resident #10 only uses oxygen whenever necessary. In a further interview it was acknowledged the agency had not documented Resident #10's oxygen therapy on the ISP.

There was no documented evidence the oxygen therapy services to be provided was documented on the ISP.

4. Review of Resident #11's ISP dated May 20, 2009 on May 27, 2009 at approximately 12:00 PM revealed Resident #11's physician's order (POS) dated April 21, 2009, on May 26, 2009 at approximately 12:02 PM revealed Resident #11 was to have physical therapy for continued gait training and muscle strengthening.

In an interview with the DON on May 26, 2009 at approximately 2:34 PM, it was acknowledged the agency had not documented Resident #11's physical therapy schedule on the ISP.



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There was no evidence the physical therapy services to be provided was documented on the ISP.

604 (d)

(d) The ISP shall be reviewed at least every six (6) months.

Based on interview and record review, the agency failed to ensure the Individual Service Plan's (ISP) was reviewed at least every six (6) months for one (1) out of sixteen (16) residents in the sample. (Resident #4)

The finding includes:

Review of Resident #4's ISP dated April 22, 2009 on May 26, 2009 at approximately 12:27 PM, revealed Resident #4's ISP was not reviewed every six months.

In an interview with the DON on May 27, 2009 at approximately 2:10 PM it was acknowledged the agency had not documented Resident #4's ISP was not reviewed every six months.

There was no documented evidence the ISP was reviewed every six months.

701 Staffing Standards

604 (d) →

- The residents #4 ISP was reviewed in April 2009.
- A system has been put in place to review the ISPs with the families every Tuesday of the month with the exception of the 1st Tuesday of the month, based on a prepared schedule.
- The schedule will be prepared based on the residents move-in date + confirmation from the residents family to attend the meeting.

June 16, 2009



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701 (E6)

Assure that there is at least one staff member within the ARL at all times who is certified in first aid and CPR.

701 (E6)

Assure that there is at least one staff member within the ARL at all times who is certified in first aid and CPR.

Based on record review, it was determined that the ARL failed to ensure that 11 of 20 staff were certified in first aid and CPR.

The finding includes:

Review of the ALR personnel files on May 27, 2009 revealed staff # 1, #4,#8,#10,#12,#13, #14,#15,#17,#18, and #19 did not have current CPR in their personnel records.

701 (E 11)

Maintain personnel records for each employee that include document of criminal background checks, statements of health status, and documentation of the employee's communicable disease status.

701 (E6) →

- Team Members # 1, 4, 8, 10, 12, 13, 14, 15, 17, 18, 19 have been scheduled to attend a CPR class by August 31, 2009.
- The Team Members who are in direct contact with the residents will renew their CPR certification and/or attend a CPR course in order to be certified.
- The community will require a current CPR certification from Team Members

August 31
2009



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Based on record review, it was determined that the ARL failed to provide documentation of current health certificates for 5 of 20 staff records and criminal background checks for 1 of 20 staff records reviewed.

The findings include:

Review of the ARL personnel records on May 27, 2009 revealed no current health certificates for staff # 5, #9 #10 #17, #18. Further review of the personnel files failed to evidence criminal background checks for staff #1.

Other findings included the following: Staff #2 (LPN) and Staff #11 (CNA) did not have a current license on file.

802

MEDICAL, REHABILITATION, AND
PSYCHOSOCIAL ASSESSMENT

802 (b)

(b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor.

Based on interview and record review, it was determined that the facility failed to have a medical, rehabilitation

701
(E11) →

Health certificates for staff are currently in their files. Health certificate for staff #5 is dated January 7, 2009. Health certificate for staff #9 is dated October 8, 2008. Health certificate for staff #10 is dated April 2, 2009. Health certificate for staff #17 is dated June 19, 2009. Health certificate for staff #18 is dated June 2, 2009 (Enclosure). Criminal background checks for staff #1 are currently in his file. They are dated March 2 + 3, 2006 (Enclosure). A copy of the current license for staff #2 + #11 is currently in their file. The expiration date of Staff #2 license is June 30, 2011. The license of staff #11 is dated July 14, 2008 (Enclosure).



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and psychosocial assessment on standardized forms approved by the Mayor for ten (10) of sixteen (16) resident's in the sample.

(Resident #1, Resident #2, Resident #4, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #12 and Resident #13)

The findings include:

1. Review of Resident #1's medical assessment dated November 17, 2006 on May 26, 2009 at approximately 1:10 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 26, 2009 at approximately 1:12 PM it was acknowledged Resident #1 did not have a medical, rehabilitation and psychosocial assessment on standardized form's approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

2. Review of Resident #2's medical assessment dated March 14, 2006 on May 21, 2009 at approximately 1:15

Cont. 701 (E11)

The community will continue requiring a health certificate from new Team Members + running a background check during the hiring process. In addition the community will continue requiring a valid license from Team Members who are required to have one.

July 20, 2009

802 (b)

An appointment w/Residents #1, 2, 4, 6, 7, 8, 9, 10, 12 + 13 physician will be made to complete an approved assessment form. New residents assessments will be done on the new approved assessment form. Monthly reviews of charts will be conducted to confirm that a completed new approved assessment form is in the chart.

November 30, 2009



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PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 26, 2009 at approximately 1:25 PM it was acknowledged Resident #2 did not a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

3. Review of Resident #4's medical assessment dated October 18, 2007 on May 26, 2009 at approximately 1:30 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 26, 2009 at approximately 1:40 PM it was acknowledged Resident #4 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been



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documented on the standardized form approved by the Mayor for Assisted Living Facilities.

4. Review of Resident #6's medical assessment dated October 23, 2000 on May 26, 2009 at approximately 1:50 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 26, 2009 at approximately 2:05 PM it was acknowledged Resident #6 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

5. Review of Resident # 7's medical assessment dated May 6, 2002 on May 27, 2009 at approximately 11:00 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 27, 2009 at approximately 12:25 PM it was acknowledged Resident



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7 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

6. Review of Resident # 8's medical assessment dated April 16, 2007 on May 27, 2009 at approximately 1:00 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 27, 2009 at approximately 1:45 PM it was acknowledged Resident # 8 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

7. Review of Resident #9's medical assessment dated January 17, 2002 on May 27, 2009 at approximately 11:20 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a



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standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 27, 2009 at approximately 12:26 PM it was acknowledged Resident # 9 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

8. Review of Resident #10's medical assessment dated August 20, 2001 on May 27, 2009 at approximately 11:05 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 27, 2009 at approximately 1:25 PM it was acknowledged Resident # 10 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.



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9. Review of Resident #12's medical assessment dated August 8, 2007 on May 27, 2009 at approximately 10:15 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 27, 2009 at approximately 10:25 AM it was acknowledged Resident # 12 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

10. Review of Resident #13's medical assessment dated July 12, 2007 on May 27, 2009 at approximately 10:35 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the DON on May 27, 2009 at approximately 1:40 PM it was acknowledged Resident #13 did not have a medical, rehabilitation and psychosocial assessment on standardized forms



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

803

FUNCTIONAL ASSESSMENT

Within 30 days prior to admission, the facility shall collect, on a standardized form approved by the Mayor, the following information regarding each applicant:

803 (1)

(1) Level of functioning in activities of daily living including bathing, dressing, grooming, eating, toileting, and mobility;

803 (2)

(2) Level of support and intervention, including any special equipment and supplies, required to compensate for the individual's deficit in activities of



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	daily living;		
803 (3)	(3) Current physical or psychosocial symptoms of the individual requiring monitoring, support, or other intervention by the ALR;		
803 (4)	(4) Capacity of the individual for making personal and healthcare related decisions;		
803 (5)	(5) Presence of disruptive behavior or behavior which presents a risk to the physical or emotional health and safety of self or others;		
803 (6)	(6) Social factors, including:		
803 (6) (A)	(A) Significant problems with family circumstances and personal relationships;		
803 (6) (B)	(B) Spiritual status and needs; and		
803 (6) (C)	(C) Ability to participate in structured and group activities and the resident's current involvement in		



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such activities.

Based on interview and record review, it was determined that the facility failed to collect a functional assessment on a standardized form approved by the Mayor for ten (10) of sixteen (16) resident's in the

sample. (Resident #1, Resident #2, Resident #4, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #12 and Resident #13)

The findings include:

1. Review of Resident #1's medical assessment entitled "Health Care Practitioner Physical Assessment" dated November 17, 2006 on May 26, 2009 at approximately 1:10 PM failed to include a functional assessment. Further review revealed Resident #1 was assessed to have depression at the severe level and was a danger to self.

In an interview with the Director of Nursing (DON) on May 26, 2009 at approximately 1:12 PM it was acknowledged Resident #1 did not have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

803

(1)
(2)
(3)
(4)
(5)
(6)
(6A)

→

(6B)

(6C)

- An appointment with Residents #1, 2, 4, 6, 7, 8, 9, 10, 12 + 13 physician will be made to complete an approved assessment form.
- Copies of the approved assessment form were given to the Sales Dept. to issue to new residents before they go to see their physician.
- Charts will be reviewed monthly to ensure that the new approved assessment form is being updated every year.

November
30, 2009



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2. Review of Resident #2's medical assessment dated March 14, 2005 on May 26, 2009 at approximately 1:45 PM failed to include a functional assessment.

In an interview with the DON on May 26, 2009 at approximately 1:15 PM it was acknowledged Resident #2 did not have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

3. Review of Resident #4's medical assessment dated October 18, 2007 on May 26, 2009 at approximately 1:30 PM failed to include a functional assessment.

In an interview with the DON on May 21, 2009 at approximately 1:40 PM it was acknowledged Resident #4 did not have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

4. Review of Resident #6's medical assessment dated October 23, 2000 on May 26, 2009 at approximately 1:50 failed to include a functional assessment.

In an interview with the DON on May 26, 2009 at approximately 2:05 PM it was acknowledged Resident



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#6 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

5. Review of Resident # 7's medical assessment dated May 6, 2002 on May 27, 2009 at approximately 11:00 AM failed to include a functional assessment.

In an interview with the DON on May 27, 2009 at approximately 12:25 PM it was acknowledged Resident # 7 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

6. Review of Resident # 8's medical assessment dated April 16, 2007 on May 27, 2009 at approximately 1:00 PM failed to include a functional assessment.

In an interview with the DON on May 27, 2009 at approximately 1:45 PM it was acknowledged Resident # 8 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed

7. Review of Resident # 9's medical assessment dated



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January 17, 2002 on May 27, 2009 at approximately 11:20 AM failed to include a functional assessment.

In an interview with the DON on May 27, 2009 at approximately 12:26 PM it was acknowledged Resident # 11 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

8. Review of Resident # 10's medical assessment dated August 20, 2001 on May 27, 2009 at approximately 11:05 AM failed to include a functional assessment.

In an interview with the DON on May 27, 2009 at approximately 1:25 PM it was acknowledged Resident #10 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

9. Review of Resident #12's medical assessment dated August 8, 2007 on May 27, 2009 at approximately 10:15 AM failed to include a functional assessment.

In an interview with the DON on May 27, 2009 at approximately 10:20 AM it was acknowledged Resident #12 did not to have a functional assessment.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

There was no documented evidence that a functional assessment had been completed.

10. Review of Resident #13's medical assessment dated July 12, 2007 on May 27, 2009 at approximately 10:35 AM failed to include a functional assessment.

In an interview with the DON on May 27, 2009 at approximately 1:40 PM it was acknowledged Resident #13 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

904

MEDICATION STORAGE

904 (a)

(a) The ALA shall provide a secured space for medication storage with access to a sink and cold storage in the same area. Space for necessary medical supplies and equipment shall be provided.

Based on an observation on May26, 2009 at approximately 11:00 am, it was determined that the facility failed to provide a secured space for medication



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storage with access to a sink and cold storage in the same area. Space for necessary medical supplies and equipment shall be provided.

The findings include:

During observation on May 26, 2009 at approximately 11:00 on the second floor, it was revealed that locked medication carts were stored in unsecure common area. The above finding was acknowledged by the DON on May 26, 2009 at approximately 11:15am.

904

MEDICATION STORAGE

904 (e) (2)

(e) (2) The label of each resident's prescription medication container shall be permanently affixed and contain the resident's full name, healthcare practitioner's name, prescription number, name and strength of drug, lot number, quantity, date of issue, expiration date, manufacture's name, if generic, direction for use, and cautionary or accessory information. Required information appearing on individually packaged drugs or within an alternate medication delivery system need not be repeated on the label.

Based on an observation on May 26, 2009 at

904
(a)

- A secured + locked area has been provided to keep the medication carts in such area.
- Staff has been properly trained to store the medication carts in provided locked area.
- Management staff will maintain an ongoing training for the Medication Care Managers to keep the medication carts in locked area.

July 20,
2009



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approximately 11:00 am, it was determined the facility failed to label a medication with a permanently affixed and contain the resident's full name, healthcare practitioner's name, prescription number, name and strength of drug, lot number, quantity, date of issue, expiration date, manufacture's name, if generic, direction for use, and cautionary or accessory information. Required information appearing on the individually packaged drugs or within an alternate medication delivery system need not be repeated on the label.

The findings include:

An observation on May 26, 2009 at approximately 11:00 am of the second floor medication refrigerator revealed a medication named "Sterile Dilute Live Virus Vaccine" did to have a label.

The finding was acknowledged by DON on May 26, 2009 at approximately 11:15 am

904

MEDICATION STORAGE

(8) Residents who self-administer may keep and use

904
(e)
(2)



- The medication "Sterile Dilute Live Virus Vaccine" found in the refrigerator of the 2nd floor with no label was discarded on May 26, 2009.
- The staff has been trained to properly label each + all medications kept in the refrigerator.
- Management staff will maintain an ongoing training for the Medication Care Managers to properly label each + all medications kept in the refrigerator. May 26, 2009



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904 (8)

prescription and nonprescription medications in their units as long as they keep them secured from other residents.

Based on observation and interview, it was determined that the facility failed to ensure that a one (1) of one (1) self-medicating resident's kept medication secure from other residents.

The findings include:

Observation of resident #14's apartment on May 27, 2009 at approximately 12 noon, revealed medications were left on a desk- top in the living room.

Interview with the resident #14 on May 27, 2009 at approximately 12 noon, revealed that he keeps his medication on the top of the desk in his living room.

Further interview revealed that resident #14 never locks his apartment door so medications remain unsecured on the desktop in his living room.

There was no evidence that self-medicating resident secured his medication from other residents.

904 (8)



- Resident # 14 has been informed of the regulations and the necessity of locking all medications in his apartment. Resident # 14 will continue locking his apartment door.
- Management will educate those residents who self-medicate to lock their medications.
- Management will continue an ongoing reminder to those residents who medicate themselves.

June 24, 2009



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1005

ACCESSIBILITY

1005 (1)

An ALR that provides services for wheelchair – bound residents, shall insure that

- (1) Doorways and hallways provide a clear opening.

Based on observation and interview on May 29, 2009, it was determined that the ALR failed to maintain clear passages for clients and staff.

The findings include:

1. The hallway that leads directly to the to the Alzheimer's unit, had (6) beds stored in the hallway.
2. On the second floor in the hallway, a cleaning cart was observed left in front of the patients library blocking the entrance way.
3. There was a wheelchair and a mattress left unattended in front of apartment #212.

These observations were acknowledged by maintenance staff.

1005
(1)



- The six (6) beds from Sibley Hospital located in the tunnel area were immediately removed. The cleaning cart blocking the library entrance way was immediately removed. The wheelchair + mattress left unattended by apartment 212 were immediately removed after resident who was returning from the hospital was situated comfortable in her apartment.
- Sibley Hospital was informed of the regulation + the need to maintain the tunnel area clear of any obstacle. The staff

→ 25
cont.



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1009 KITCHEN

An ALR shall provide a kitchen that has the following:

1009 (2)

(2) Food preparation areas with cleanable surfaces;

1009 (4)

(4) Sufficient equipment and staffing to be in compliance with section 1116 of Title 14 of the Districts of Columbia Municipal Regulations,

Based on observation and interview, the ARL failed to ensure that the kitchen areas were cleaned and maintained with sufficient equipment and staffing.

The findings include:

(1) Pots and flat cooking trays were covered with cooking grease on the outside and inside.

(2) It was observed that (6) six of the kitchen staff working at the time of the survey, were in the

cont. 1005 (1)

→ was properly trained to maintain all areas clear of any obstruction. Management will continue an ongoing training of the staff to maintain all areas clear of any obstruction.

May 26, 2009

1009 (2) (4) →

(1) The pots + flat cooking trays that were in bad condition were immediately replaced. (2) The kitchen staff has been issued hair nets on a daily basis + has been trained to properly wear them while in the kitchen. (3) The kitchen staff whose license had expired attended a class on May 27, 2009. Their new licenses have been issued. (enclosure)

cont. →



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kitchen without hair nets on.

(3) Five of the kitchen staff was working with expired food handler licenses.

These observations were acknowledged by the ALR'S Director of Food and Beverage at 1:30 pm on May 27, 2009.

cont. 1009 (2)(4)

(1) The Director of Dining Services will maintain an accurate inventory of pots & flat cooking trays in good condition. (2) The kitchen staff has been properly trained & is required to wear hair nets while in the kitchen. (3) The kitchen staff is required to maintain a valid license at all times. The Director of Dining Services will maintain an inventory of pots & flat cooking trays in good condition, will monitor the wear of the hair nets in the kitchen, & will require a valid license from his staff.

licenses- May 27, 2009 Pots & Flat cook. July 15, 2009