

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2012
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NAME OF PROVIDER OR SUPPLIER WILLIAMS ASSISTED LIVING RESIDENTIAL FA	STREET ADDRESS, CITY, STATE, ZIP CODE 1437 POTOMAC AVENUE SE WASHINGTON, DC 20003
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R 000 Initial Comments

An annual licensure survey was conducted on February 3, 2012 to determine compliance with Assisted Living Law " DC Code § 44-101.01." The survey was based on clinical and administrative record reviews, staff and patient interviews. The sample size was five (5) resident records based on a census of seven (5) residents and six (6) employee records.

R 000

Renewal 2/23/12

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

R 481. Sec. 604b Individualized Service Plans

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

Based on record review and interview, it was determined that the facility failed to document services to be provided, and when and how often the services would be provided on the Individualized Service Plan (ISP) for two (2) of five (5) resident's . (Residents #3 and #4)

The findings include:

Interview with the facility's administrator on February 3, 2012, at approximately 10:20 a.m., revealed Residents #3 and #4 received Home Health Aide (HHA) Services eight hours a day for five days per week. Interview with the facility's general manager on February 3, 2012, at approximately 1:00 p.m. confirmed both residents received services from a local Home Health Care Agency (HHCA).

Review of resident #3's record at approximately 10:20 a.m. revealed an ISP dated July 1, 2011. Resident #4's record was also reviewed on February 3, 2012, at approximately 3:30 p.m. which revealed an ISP dated June 30, 2011. At

R 481

Sec. 604b

The ISP for Resident #3 and Resident #2 has been reviewed and The services provided by The HHA for each Resident #2 & #3 has been recorded and documented on each individuals Current ISP and will be continued on all future ISP as requested by Sec. 604B ISP's. The split hours are 7-10 and 3-8P

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vera Williams</i>	TITLE <i>Director</i>	(X6) DATE <i>2/20/12</i>
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R 481	Continued From page 1 the time of the survey, There was no indication on Residents #3 and #4's ISP's regarding when and how often HHA services were to be provided.	R 481		
R 820	<p>Sec. 904e7 Medication Storage</p> <p>(7) Discontinued or expired medications shall be destroyed within 30 days in the ALR, or, if unopened and properly labeled, returned to the pharmacy. All medication destroyed in the ALR shall be witnessed and documented by two persons, one of whom shall be the ALA or the ALA designee.</p> <p>Based on observation, interview and record review, the facility failed to ensure provision were made to dispose of expired medications for one of the residents residing in the facility. (Resident # 4)</p> <p>The finding includes:</p> <p>Interview with the general manager on February 3, 2012, at approximately 3:43 p.m. revealed Resident #4 was a diabetic and that he was able to monitor his glucose independently. Further interview and review of the resident's record revealed a physician's order dated January 1-31, 2012, which prescribed Humulin (insulin) Reg. 100/injection PRN for Resident #4.</p> <p>On February 3, 2012, at approximately 4:12 p.m. interview with the administrator and general manager revealed Resident #4 was no longer using the Humulin. The general manger indicated that the resident's had insulin in the refrigerator. Observation of the medication that was stored in the refrigerator revealed the following boxes of expired insulin :</p> <p>- Novolin NU -100 injection "discard after July 7,</p>	R 820	<p>According to Sec. 904e7, All expired and discontinued medications that was stored in the refrigerator, has been destroyed according to Regulations.</p> <p>The ALA Director and RN will monitor all medications, for expiration dates and dis continued dates in the future.</p> <p>Documentation will accompany all discontinued medication signed by physician orders and dated.</p> <p>The medications will be destroyed or returned to pharmacist according to the Regulations Sec. 904e7 Medication Storage.</p> <p>All Regulations will be complied with by the ALR.</p>	

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R 820	Continued From page 2 2011" - Novolin NU -100 injection "discard after August 3, 2011" - Novolin NU -100 injection "discard after September 7, 2011" - Novolin NU -100 injection "discard after October 1, 2011" - Novolin NU -100 injection "discard after December 31, 2011" - Novolin NU -100 injection "discard after January 31, 2012" Interview with the general manager on February 3, 2012 revealed that he had completed the medication training and was told that they used to throw the medication in the trash.	R 820	All expired Medication Listed has been Destroyed in the ALR witnessed to and documented by two persons one of whom was the ALR Director. ① According to Sec. 1004a General Building Interior The Carpeting in the living room area with dark brown stains has been cleaned and the brown are removed and the Regulations Complied with as stated. ② The second floor bathroom toilet seat has been replaced as of 2/14/12. The tiles to the wall left of the toilet has been replaced around the bottom of the wall in the bathroom.	
R 981	Sec. 1004a General Building Interior (a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair. Based on observation and staff interview, the ALR failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: During an environmental inspection of the facility on February 3, 2012, at approximately 10:40 a.m., the following observations were made. 1. The carpeting in the living room area had dark brown stains. 2. The second floor bathroom toilet seat was worn and appeared to have urine stains on it. The wall to the left of the toilet had missing tiles	R 981		

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R 981	Continued From page 3 around the bottom of the wall. 3. Some of the linen in the linen closet were faded and appeared in need of replacement. 4. In bedroom #2, occupied, the resident's top dresser drawer is missing. At approximately 11:15 a.m. these concerns were acknowledged by the facility's General Manager who indicated the deficiencies will be abated.	R 981	<p>③ The linen that is faded in the the closet is being replaced as of February 28, 2012</p> <p>④ The chest of drawers in Bedroom #2 has been replaced by a new chest with all drawers in place. no drawers missing.</p> <p>Corrective Action</p> <p>① All deficiencies identified will be completed by March 1, 2012</p> <p>② The ALR will put in place systemic changes to insure that these deficient practice does not recur on a daily basis.</p> <p>The ALR will monitor all activities to assure that all the rules and regulations of Health, Regulations and Licensing Administration are complied with at all times.</p>	