Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING: ______ B. WING ______	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND OAKS ASSISTED LIVING	5901 MACARTHUR BLVD NW WASHINGTON, DC 20016

(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
R 000	Initial Comments	R 000		

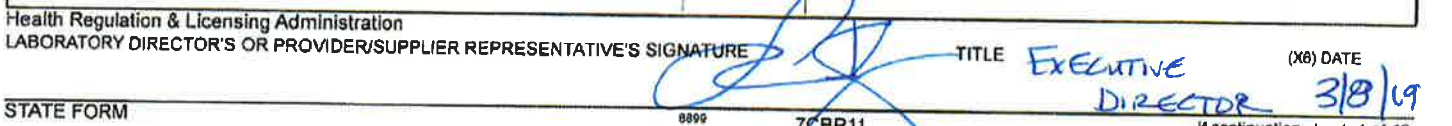
On Sunday 01/13/19, the Intermediate Care Facilities Division (ICFD) received an incident report from the ALR alleging abuse. Based on the nature of the incident, an onsite investigation was initiated on 01/16/19 to evaluate if the facility provided adequate supervision and oversight to ensure Resident #1's safety, as required by the "Assisted Living Law."

The findings were based on observations, interviews with direct care staff, nursing personnel, and administrative staff. Medical, clinical, and administrative records were reviewed. The results of the investigation revealed that the Assisted Living Residence staff acted appropriately in response to the abuse allegation, however, incidental findings were identified during the investigation and deficiencies are cited in this report.

Listed below are abbreviations used throughout the body of this report:

ALA - Assisted Living Administrator
ALR - Assisted Living Residence
CNA - Certified Nursing Assistant
DON - Director of Nursing
EC - Enteric-Coated
HHA - Home Health Aide
ICFD - Intermediate Care Facilities Division
IDT - Interdisciplinary Team
ADON - Assistant Director of Nursing
ISP - Individualized Service Plan
PDA - Private Duty Aide
POS - Physician Order Sheet
RN - Registered Nurse
mg - milligram
mcg - microgram
% - percent

Health Regulation & Licensing Administration



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE Executive Director   (X6) DATE 3/8/19

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R 292 Sec. 504.1 Accommodation Of Needs.

(1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents;
Based on interview and record review, the ALR failed to ensure that adequate services and treatments were provided to residents which included a reasonable accommodation of individuals' needs consistent with their physical and mental capabilities for one of one resident in the sample (Resident #1).

Findings included:

On 01/17/19 at 3:35 PM, a review of Resident #1's ISP, dated 10/04/18, showed that the resident used a rollator walker and a manual wheelchair. The resident had limited control of the right hand, required a one-person assist with mobility and transfers, and utilized a wrist pendant life alert for safety.

During a teleconference on 01/17/19 at 10:08 AM, Resident #1's CNA stated that on the date of the alleged abuse, the CNA had entered Resident #1's room at 6:00 AM in response to an activated safety pendant alert light. After arriving in Resident #1's apartment, the CNA alerted the resident by identifying herself and the purpose of her entry to respond to the alert light. The CNA indicated that the resident informed her that the wrist pendant was too tight on her arm. The CNA said that she asked if the resident wanted the wrist pendant removed and Resident #1 said yes. The CNA then said she placed the pendant on the resident's nightstand.

R 292

Grand Oaks is filing this response for the sole purpose of confirming compliance with requests of Department of Health in receipt of the survey report related to the survey conducted on January 13-16, 2019. This response is not an admission of liability or statement of agreement with respect to issues identified in discussions with the agency but is submitted to demonstrate regulatory compliance.

504.1 Accommodation of Needs
To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents.

I. Corrective Action

In response to the CNA placement of the pendant, the CNA received disciplinary action.

II. How to Identify Other

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R 292	Continued From page 2 During an interview on 01/17/19 at 11:13 AM, Resident #1's PDA stated that when she came on duty on 01/11/19 between 7:12 AM and 7:15 AM, she noticed that the resident was not wearing the wrist pendant. The PDA further stated that she asked the CNA about the location of Resident #1's wrist pendant and initially was told that the pendant was on the resident's arm. Continued interview with the PDA revealed that approximately 15 minutes later, the CNA returned to the apartment to say that she took the wrist pendant off of the resident's arm because of the resident complained that it was too tight. The CNA then apologized and offered to place the pendant back on Resident #1's arm. The PDA replaced the pendant on Resident #1's arm. On 01/17/19 at 11:53 AM, review of the Care Manager job description showed the CNA's essential duties and responsibilities. The duties included, "responds to security system and resident call bells promptly and immediately, takes appropriate action, including resetting call bells." At the time of the investigation, there was no evidence that the CNA had placed Resident #1's safety pendant back on her arm to enable her to activate the the service light if needed.	R 292	The Associate Director of Nursing, ADON, conducted an immediate staff training regarding the availability of pendants to residents. III. Systemic Changes The ADON, and/or designee, will conduct standing monthly trainings for the next 6 months regarding the availability of pendants to residents. IV. Monitoring Process The DON, and/or designee, will conduct random monthly audits of residents receiving assistance from Grand Oaks to ensure the availability of their pendant for the next 60 days. V. Date of Completion March 11, 2019 and ongoing	03/11/2019 & ongoing
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 observation, interview and record review, the ALR failed to ensure that the ISP specified how self-medication services would be	R 481	**604b Individualized Service Plans** The ISP shall include the services to be provided, when and how often the services will be provided, and how	

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R 481 Continued From page 3

provided and accessed for one of one resident in the sample (Resident #1).

Findings included:

On 01/17/19 at 2:00 PM, interview with the DON revealed that Resident #1 received services from a PDA, who was certified as an HHA, for six hours a day, five days a week (Monday through Friday). The DON stated that the resident's current ISP allowed the resident to self-administer medications. Further discussion with the DON showed that the family prepared the resident's medications and the resident was able to take the medications when mixed with applesauce by the PDA. During an interview conducted on 01/17/19 at 11:13 AM, the PDA stated that Resident #1 was able to self-administer medications once prepared.

On 01/17/19 at 1:15 PM, observation of Resident #1's medication supply maintained within the living unit showed that there were no medication containers. The PDA showed the surveyors small, clear plastic bags of crushed medications and also a separate small, clear plastic bag containing a pink pill. The bags were identified by the days of the week and the time to be administered. However, the bags did not include the names of the medications. Further observation showed that all of Resident's #1's medications to be administered at 9:00 AM were crushed together in one bag. The PDA stated that the original medication containers were kept by the family and were not kept onsite at the ALR.

On 01/17/19 at 2:35 PM, Resident #1's ISP, dated 10/04/18, was reviewed to determine the resident's capability for medication self-administration. The ISP documented that the

R 481

and by whom all services will be provided and accessed.

I. Corrective Action

In response to resident #1s ISP, the ISP has been rewritten to reflect current medication administration status with Grand Oaks.

II. How to Identify Other

The Director of Nursing (DON), and/or designee, will review all self-medication ISPs for verification of medication administration services provided by the resident if appropriate.

III. Systemic Changes

The DON, and/or designee, will review all self-medication assessments and their corresponding 45 day medication reviews prior to updating ISPs. (Every 6 months or due to significant change)

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R 481	Continued From page 4 resident had limited use of the right hand and received assistance from a PDA. The ISP also included the following provisions related to Medications/Treatments: "Resident is completely independent with self-medication administration with accompanying physician's orders and demonstrated competency. Resident successfully recognizes medications, can state its purpose, can state the correct dosage, frequency, and potential side effects." A review of the self-medication assessments and ISPs from admission to current showed contradicting evaluations by the ALR of Resident #1's capabilities to self-administer medications. On 01/17/19 at 2:15 PM, review of Resident #1's initial medical assessment and self-medication assessment, dated 05/19/15, showed that Resident #1 was evaluated as not able to self-administer medications. A subsequent ISP, dated 03/27/17, indicated that the resident "self-medicates, family refills." The resident's ISPs dated 10/09/17 and 04/03/18, however, failed to document whether the ALR was responsible for administering medications or whether Resident #1 was assessed as able to self-administer medications. At the time of the investigation, the ALR failed to define in the ISP how medication self-administration services were to be provided, accessed, and supervised for Resident #1	R 481	IV. Monitoring Process The DON, and/or designee, will monitor the ISP accuracy through the process of completion during the systemic change noted above. V. Date of Completion March 31, 2019 and ongoing **701b Staffing Standards** The ALA shall ensure that each resident has access to appropriate medical, rehabilitation, and psychosocial services as established in the ISP and that there is appropriate oversight, monitoring, and coordination of all components of the ISP, including necessary transportation and the delivery of needed supplies. I. Corrective Action In response to the inaccurate physician orders, Resident #1s physician came to see her and submitted new physician orders on February 7, 2019.	03/31/2019 & ongoing
R 563	Sec. 701b Staffing Standards. (b) The ALA shall ensure that each resident has access to appropriate medical, rehabilitation, and psychosocial services as established in the ISP and that there is appropriate oversight,	R 563		

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R 563 Continued From page 5

monitoring, and coordination of all components of the ISP, including necessary transportation and the delivery of needed supplies.
Based on observation, interview and record review, the ALA failed to ensure appropriate oversight, monitoring, and coordination with the ISP recommendation for self-administration of medications for one of one resident in the sample (Resident #1).

Findings included:

The facility failed to ensure current physicians orders for Resident #1 were available, as evidenced below:

On 01/17/19 at 1:12 PM, unidentified medications were observed in Resident #1's apartment. The medications were contained in clear plastic bags and had handwritten labels on each bag indicating the day of the week and time of day each was to be given. There were no original pill containers located in the resident's apartment with which to compare with the unidentified bagged medications.

On 01/17/19 at 2:20 PM, interview with the DON revealed that Resident #1's ISP included approval for medication self-administration, with assistance from the family and the PDA. A monthly POS was received by the ALR from the pharmacy. The DON stated that the family purchases the resident's medications and should promptly report any prescribed medication changes to the ALR. The DON stated that she would follow-up with the family to verify if there had been any recent changes.

On 01/17/19 at 4:33 PM, review of the facility's policy titled, "Medication Administration &

R 563

II. How to Identify Other

The DON, and/or designee, will complete a physician order review with each self-medication assessment and 45 day medication review.

III. Systemic Changes

The DON, and/or designee, will complete a physician order review with each self-medication assessment and 45 day medication review.

IV. Monitoring Process

The Executive Director (ED), and/or designee will conduct random monthly audits of 10% of our self-medicating residents for the self-medication assessment, 45 day medication review and physician orders to ensure accuracy for the next 90 days.

V. Date of Completion

March 31, 2019 and ongoing — 03/31/2019 & ongoing

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R 563 Continued From page 6 R 563

Management Policy," revised 11/27/18, indicated that "every 45 days, an RN will assess and document the resident's response to medication." The current POS for January 2019 showed that Resident #1 was prescribed the following ten routine medications daily: Aspirin 81 mg EC tablet, Atorvastatin 40 mg, Ferrous Sulfate 325 mg, Fluoxetine 10 mg, Irbesartan 150 mg, Isopto Tears .05% eye drops, Levothyroxine 112 mcg tablet, Omeprazole 20 mg capsule, Polyethylene Glycol, and Senna-Docusate 8.6 mg. At 4:33 PM, the DON presented a list of medications provided by the family. The list included five medications: Omeprazole 20 mg capsule, Irbesartan 150 mg tablet, Fluoxetine 10 mg, Levothyroxine 112 mcg tablet, and Atorvastatin 40 mg. When asked about the other medications identified on the January 2019 POS, the DON stated that the family member just reported that the other medications were discontinued or only prescribed to be administered as needed.

At the time of the investigation, there was no evidence that the ALR implemented an effective system to ensure that Resident #1's POS were current and accurate.

R 803 Sec. 903 3 On-Site Review. R 803

(3) Assess the resident's ability to continue to self-administer his or her medications.
Based on interview and record review, the facility failed to ensure that a resident's ability to continue to self-administer medications was reassessed for one of one resident in the sample (Resident #1).

Findings included:

903 3 On-Site Review
Assess the resident's ability to continue to self-administer his or her medications.

I. Corrective Action

In response to the assessment of the resident's ability to continue to self-administer medications, the DON conducted an assessment on January 22, 2019.

II. How to Identify Other

The DON, and/or designee, will complete self-medication assessments on all self-medicating residents.

III. Systemic Changes

The DON and/or designee will conduct a retraining of all RNs on the self-administration assessment process.

IV. Monitoring Process

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R 803 Continued From page 7

The ALR failed to implement its Self-Administration of Medications Policy by completing an accurate assessment of Resident #1 ' s capabilities to self-administer medications, as evidenced below:

1. On 01/17/19 at 4:33 PM, review of the ALR's Policy, entitled "Self-Administration of Medications" and revised 12/12/18, showed that "Self-Administration of Resident's Own medication" means "self-administration of all medications." The policy further stated that "residents are permitted to self-administer medications if this practice has been determined safe. The IDT will determine if self-administration of medication is safe through an initial medication assessment that identifies whether the resident is (a) Capable of self-administering his or her own medication, or (b) Is capable of self-administering his or her own medication, but requires a reminder to take medications or requires physical assistance with opening and removing medications from the container." The policy further stated that residents may self-administer medications, with or without assistance. However, all residents' self-medication skills would be assessed every 45 days by the following criteria to determine their capabilities, and if they are recommended to continue self-administration of medications:

(a) The resident will be able to state the name, strength, dose, and frequency of medication taken.
(b) The resident will demonstrate how to correctly administer, inject or apply the medication.
(c) The resident will be able to state if medication requires blood pressure or pulse monitoring.

R 803

The ED, and/or designee, will conduct a random monthly audit of self-administration assessments for the next 90 days.

V. Date of Completion

March 31, 2019 and ongoing — 03/31/2019 & ongoing

904e8 Medication Storage
Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep then secured from other residents.

I. Corrective Action

In response to the medications stored in the resident's room, we communicated with the family requesting properly labeled containers for medication administration on January 21, 2019. On February 8, 2019 Grand Oaks removed all medications and began assisting with medication administration.

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R 803	Continued From page 8	R 803		

(d) The resident will be able to state how and where to store medications.
(e) The resident will be able to state the common side effects of the medication.

Review of Resident #1's clinical record on 01/17/19 at 1:18 PM showed that the resident was admitted on 03/12/15. Further review of the record showed a History and Physical, dated 05/21/15, which documented that the resident could not independently administer medications.

Interview with the DON on 01/17/19 at 2:20 PM showed that a resident's ability to self-administer medications was determined by the 45-day medications assessment conducted by an RN.

On 02/07/19 at 2:57 PM, review of Resident #1's progress notes documented that the ongoing ability to self-administer medications was evaluated by the RN on the dates below and revealed the following:

(a) 45-day medication reviews completed on 05/07/16, 06/14/16, 12/17/16,01/24/17, 03/17/17, 05/09/17, 06/18/17 and 07/29/17; no evaluation criteria were identified and no resident competency level was documented.
(b) 45-day medication reviews completed on 08/06/16, 09/20/16, and 10/31/16; stated, "Resident is self-med." No evaluation criteria were identified.
(c) 45-day medication review completed on 09/29/17; stated, "successfully passed self-medication test." No evaluation criteria were identified.
(d) 45-day medication review completed on 12/17/17; stated, "resident self-medicates." No evaluation criteria were identified.
(e) 45-day medication review dated 02/13/18 did

II. How to Identify Other

The DON, and/or designee, will conduct room check of all self-medicating residents to ensure proper storage of medications and immediate education of the regulation to the resident as necessary.

III. Systemic Changes

The DON, and/or designee, will conduct room checks for proper medication storage as part of the 45 day self-administration assessment.

IV. Monitoring Process

The ED and/or designee will conduct a random monthly audit of proper medication storage in self-medicating resident rooms for the next 90 days.

V. Date of Completion

March 31, 2019 and ongoing

(X5) 03/31/2019 & ongoing

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R 803	Continued From page 9	R 803		

not document any assessment criteria. It stated that all medications were administered by the family.

2. On 01/17/19 at 2:20 PM, interview with the DON revealed that Resident #1's current ISP included approval for self-medication, with assistance from the family and the PDA. Further discussion with the DON indicated that the family prepared the resident's medications and the resident was able to take the medications when mixed with applesauce by the PDA. During an interview conducted on 01/17/19 at 11:13 AM, the PDA stated that Resident #1 was able to self-administer medications once prepared.

On 01/17/19 at 2:35 PM, Resident #1's current ISP, dated 10/04/18, was reviewed to determine the resident's capability for medication self-administration. The ISP documented that the resident had limited use of the right hand and received assistance from a PDA. The ISP also included the following provisions related to Medications/Treatments: "Resident is completely independent with self-medication administration with accompanying physician's orders and demonstrated competency. Resident successfully recognizes medications, can state its purpose, can state the correct dosage, frequency, and potential side effects."

On 01/29/19 at 10:36 AM, a teleconference with the RN revealed that on 01/06/19 a 45-day medication review was conducted for Resident #1. The RN stated that conducting the review was difficult because only Tylenol and Iron Sulfate were observed in the resident's apartment. Continued discussion with the RN revealed that Resident #1 was not able to remove the top from the medication bottle. The RN further reported

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R 803 Continued From page 10 — R 803

that the resident said the family took the medications home to crush them. The RN also stated that she emailed these concerns to the supervisor (ADON) immediately for follow-up.

It should be noted that the 45-day medication review completed on 01/06/19 showed that Resident #1 was administered medications by the family and the PDA. The review stated that the "resident is self-medicating currently and based on the 45-day self-medication assessment, this resident can continue self-medicating."

A revised self-administration of medication assessment, dated 01/22/19, was reviewed on 01/24/19 at 3:15 PM. The assessment showed that Resident #1 was unable to name the medications, could not demonstrate the ability to open the Tylenol and Iron Sulfate. Additionally, the resident's ability to self-administer any other "family reported" prescribed medications could not be evaluated because the original medication containers were not stored in Resident #1's apartment. During a teleconference on 01/24/19 at 3:30 PM, the facility's Administrator, DON, and ADON verified that it was not appropriate for Resident #1 to self-administer any medications.

At the time of the investigation, the ALR's nurses failed to perform a thorough and complete assessment of the resident's ability to continue to self-administer medications.

R 821 Sec. 904e8 Medication Storage — R 821

(8) Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep them secured from other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING: ___ B. WING ___	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND OAKS ASSISTED LIVING	5901 MACARTHUR BLVD NW WASHINGTON, DC 20016

(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

R 821 Continued From page 11 R 821

Based on observation and interview, the facility failed to ensure that medications were maintained and secured in the resident's living unit for one of one residents in the sample who self-administered medications (Resident #1).

Findings included:

[Cross refer to 0563.1]. On 01/17/19 at 1:15 PM, observation of Resident #1's medication supply showed that there were no original medication containers maintained within the living unit. The PDA showed the surveyors small, clear plastic bags of crushed medications and also small, clear plastic bags containing a pink pill. The bags were identified by the days of the week and the time to be administered (8:00 AM and 9:00 AM), however, the bags contained no names of the medications.

Interviews with Resident #1 at 10:57 AM and the PDA at 11:13 AM, respectively, confirmed that the family crushes the resident's medications and brings the medications to the ALR in the plastic bags. The PDA stated that the original medication containers were kept by the family and were not located onsite at the ALR.

On 01/17/19 at 2:20 PM, interview with the DON showed that Resident #1's current ISP, dated 10/04/18, included approval for medication self-administration, with assistance from the family and the PDA.

On 01/17/19 at 2:53 PM, review of the ALR's policy titled, "Medication Administration & Management," revised 11/27/18, showed the following requirements for medication storage:

(1) All medications shall be kept in their original

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R 821	Continued From page 12 packaging and shall be properly labeled and identified. (2) Residents who self-administer may keep and use prescription and nonprescription medications in their apartments. At the time of the investigation, there was no evidence that the ALR ensured Resident #1's medications were kept in their original packaging, properly labeled and identified, and remained in the living unit.	R 821		

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
899 North Capitol St., NE
Washington DC 20002
2nd Floor (2224)
202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Grand Oaks Assisted Living ALR -0006	Grand Oaks Assisted Living ALR -0006	01/16/19 through 02/07/19 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	On Sunday 01/13/19, the Intermediate Care Facilities Division (ICFD) received an incident report from the ALR alleging abuse. Based on the nature of the incident, an onsite investigation was initiated on 01/16/19 to evaluate if the facility provided adequate supervision and oversight to ensure Resident #1's safety, as required by the "Assisted Living Law." The findings were based on observations, interviews with direct care staff, nursing personnel, and administrative staff. Medical, clinical, and administrative records were reviewed. The results of the investigation revealed that the Assisted Living Residence staff acted appropriately in response to the abuse allegation, however, incidental findings were identified during the investigation and deficiencies are cited in this report. Listed below are abbreviations used throughout the body of this report: ALA - Assisted Living Administrator			

Name of Inspector: Shee West Morton (signature)

Date Issued: 2/28/19

Facility Director/Designee: (signature)

Date: 3/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ALR - Assisted Living Residence
CNA - Certified Nursing Assistant
DON - Director of Nursing
EC - Enteric-Coated
HHA - Home Health Aide
ICFD - Intermediate Care Facilities Division
IDT - Interdisciplinary Team
ADON - Assistant Director of Nursing
ISP - Individualized Service Plan
PDA - Private Duty Aide
POS - Physician Order Sheet
RN - Registered Nurse
PRN – as needed
mg - milligram
mcg - microgram
% - percent

Grand Oaks is filing this response for the sole purpose of confirming compliance with requests of Department of Health in receipt of the survey report related to the survey conducted on January 13-16, 2019. This response is not an admission of liability or statement of agreement with respect to issues identified in discussions with the agency but is submitted to demonstrate regulatory compliance.

10118.02 Private Duty Healthcare Professionals
An ALR shall require that private duty healthcare professionals arranged by a resident surrogate, or party other than the ALR to provide healthcare related services to the resident on the ALR's premises on a recurring basis: (a) Be certified or otherwise

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10118 Private Duty Healthcare Professionals	**10118.02** **An ALR shall require that private duty healthcare professionals arranged by a resident surrogate, or party other than the ALR to provide healthcare related services to the resident on the ALR's premises on a recurring basis: (a) Be certified registered or otherwise authorized by the District of Columbia to healthcare related services they will provide to the resident.** Based on interview and record review, the ALR failed to ensure that the PDA hired to provide healthcare services was certified to administer medication for one of one resident included in the investigation (Resident #1). Findings included: Interviews with Resident #1 and the PDA on 01/17/19 at 10:57 AM and 11:13 AM, respectively, confirmed that the resident's family crushes the resident's medications and brings the medications to the ALR in small, clear plastic bags. The PDA stated that the original medication containers were kept by the family and were not located onsite at the ALR. The PDA also stated that the family prepared the medications, but she did not know the names of the medications. Continued interview with the PDA revealed that		authorized by the District of Columbia to healthcare related services they will provide to the resident. I. Corrective Action In response to the PDA not having certification to administer medications, the PDA ceased assisting with medication administration by February 8, 2019 as Grand Oaks began administering medication. II. How to Identify Other The Director of Nursing (DON), and/or designee, will communicate with all self-medicating residents who have retained PDA services to educate them on the regulations regarding medication administration assistance. III. Systemic Changes The DON, and/or designee, will communicate with self-medicating residents during the 45 day medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	she was pouring unidentified medications (crushed and one single pill) from a small plastic bag onto the resident's applesauce and allowing the resident to independently eat the mixture. The PDA verbalized that she was not certified to administer medications, and the PDA did not consider the pouring of the medications from the plastic bags onto the applesauce as medication administration. Review of the ALR's "Role and Responsibilities of Private Duty Aide/Companion" policy on 01/17/19 at 12:03 PM showed that the PDA was not permitted to administer medications or treatment to the resident. Additionally, the policy showed that if the PDA was not certain, she should speak to the resident's nurse for clarification. At the time of the investigation, the ALR failed to ensure that Resident #1's PDA was certified to administer medications.	review regarding medication administration regulations. Grand Oaks will also provide all self-medicating residents with written documentation regarding self-medication policies. IV. Monitoring Process The Executive Director (ED), and/or designee will randomly audit 45 day medication review to ensure resident education regarding regulation requirements related to medication administration regarding PDA exclusion from the process for the next 90 days. V. Date of Completion March 31, 2019 and ongoing	
10122 On-Site Medication Review	**10122.01** **The on-site medication review arranged to occur every forty-five (45) days, pursuant to Section 903 of the Act (D.C. Official Code 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued.** Based on interview and record review, the ALR failed to ensure accurate documentation of changes in medications that	**10122.01 On-Site Medication Review** The on-site medication review arranged to occur every 45 days, pursuant to Section 903 of the Act (D.C. Official Code 44-109.03), shall include documentation of any changes to the resident's medication profile, including	3/31/19 ongoing

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had been discontinued or prescribed PRN for one of one resident in the sample (Resident #1).

Findings included:

1.On 02/07/19 at 2:57 PM, review of Resident #1's progress notes documented that the ability to self-administer medications was evaluated by the RN on the dates below and revealed the following:

(a) 45-day medication reviews completed on 05/07/16, 06/14/16, 12/17/16, 01/24/17, 03/17/17, 05/09/17, 06/18/17 and 07/29/17; no evaluation criteria were identified and no resident competency level was documented.
(b) 45-day medication reviews were completed on 08/06/16, 09/20/16, and 10/31/16; stated, "resident is self-med." No evaluation criteria were identified.
(c) 45-day medication review completed on 09/29/17; stated, "successfully passed self-medication test." No evaluation criteria were identified.
(d) 45-day medication review completed on 12/17/17; stated, "resident self-medicates." No evaluation criteria were identified.
(e) 45-day medication review dated 02/13/18 did not document any assessment criteria. It stated that all medications were administered by the family.

2. Review of Resident #1's clinical record on 01/17/19 at 2:00 PM showed a current POS for January 2019 that the resident was prescribed the following ten routine medications daily: Aspirin 81 mg EC tablet, Atorvastatin 40 mg, Ferrous

changes in dosing and any medication that have been added or discontinued.

I. Corrective Action

In response to Resident #1s prescribed medication record, her primary physician came to see her on February 7, 2019 and provided the community with updated physician orders.

II. How to Identify Other

The DON, and/or designee, will complete a physician order review with each self-medication assessment and 45 day medication review.

III. Systemic Changes

The DON, and/or designee, will complete a physician order review with each self-medication assessment and 45 day medication review to ensure accuracy.

IV. Monitoring Process

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	Sulfate 325 mg, Fluoxetine 10 mg, Irbesartan 150 mg, Isopto Tears .05% eye drops, Levothyroxine 112 mcg tablet, Omeprazole 20 mg capsule, Polyethylene Glycol, and Senna-Docusate 8.6 mg. At 4:33 PM, the DON presented a list of medications provided by the family. The list included five medications: Omeprazole 20 mg capsule, Irbesartan 150 mg tablet, Fluoxetine 10 mg, Levothyroxine 112 mcg tablet, and Atorvastatin 40 mg. When asked about the other medications identified on the January 2019 POS, the DON stated that the family member just reported that the other medications were discontinued or only prescribed to be administered as needed. At the time of the investigation, the ALR failed to maintain an accurate record of Resident #1's prescribed medications.	The ED, and/or designee, will conduct random monthly audits of 10% of our self-medicating residents for the self-medication assessment, 45 day medication review and physician orders to ensure accuracy for the next 90 days. V. Date of Completion March 31, 2019 and ongoing	3/31/19 ongoing
10123 Medication Storage	**10123.02** **ALR shall keep a current record of each prescription and non-prescription medication and dietary supplements kept by a resident in his or her living unit. (Name of medication; strength of medication and quantity; lot number).** Based on observation, and interview, the ALR failed to ensure a current record was maintained for each prescription and non-prescription medication kept in the resident's living unit for one of one resident (Resident #1). Findings included:	**10123.02 Medication Storage** ALR shall keep a current record of each prescription and non-prescription medication and dietary supplements kept by a resident in his or her living unit. (Name of medication; strength of medication and quantity; lot number). I. Corrective Action In response to the unavailable medication information, Resident #1s physician came to see her and submitted new physician orders on February 7, 2019.	

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	During an interview on 01/17/19 at 2:20PM, the DON stated that the ALR was not recording the administration of medication for Resident #1. She also stated that if there was a change in the resident's medication regimen, the family was to notify the ALR immediately so that the POS could be kept current. The DON stated that she would follow-up with the family to verify the current list of medications prescribed for the resident. On 01/17/19 at 4:33 PM, the DON presented a list of medications dated (08/09/18) from Resident #1's family. The DON stated that the family member had explained that some of the medications previously prescribed were discontinued, and some were now only prescribed PRN. The list received from the family included the following five medications: Omeprazole 20 mg, Irbesartan 150 mg, Fluoxetine (Prozac) 10 mg, Levothyroxine (Synthroid) 112 mcg and Atorvastatin 40 mg. At the time of the investigation, the ALR was unable to verify the names, dosage of medications, and the times the medications were administered.		II. How to Identify Other The DON, and/or designee, will complete a POS review with each self-medication assessment and 45 day medication review. The DON, and/or designee, will conduct room checks of all self-medicating residents to ensure proper storage of medication. III. Systemic Changes The DON, and/or designee, will complete a physician order review with each self-medication assessment and 45 day medication review. The DON and/or designee will conduct room checks for proper medication storage as part of the 45 day self-administration assessment.
10124 Medication Administration	**10124.06** **An ALR shall ensure that all medications administered to a resident by licensed practical nurse, registered nurse, advanced practice registered nurse, physician, physician assistant, TME or certified medication aide on its**		IV. Monitoring Process The ED, and/or designee, will conduct random monthly audits of 10% of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	premises shall be recorded on a written or electronic medication administration record that is kept as part of the resident's medical record. Based on observation and interview, the ALR failed to ensure that medications were administered by a licensed nurse, physicians, physician assistant, TME or certified medication aide and documented on a written or electronic medication administration record for one of one resident included in the investigation (Resident #1). Findings included: On 01/17/19 at 4:37 PM, interview with the DON revealed that Resident #1 received services from a PDA, who was certified as an HHA, for six hours a day, five days a week (Monday through Friday). The DON stated that the resident's current ISP allowed the resident to self-administer medication. Further discussion with the DON indicated that the family prepared the resident's medications and that the resident was able to take the medication when mixed with applesauce by the PDA. During an interview on 01/17/19 at 11:13 AM, the PDA stated that Resident #1 was able to self-administer medications once prepared. On 01/17/19 at 1:15 PM, observation of Resident #1's medication supply maintained in the living unit showed that there were no original containers. The PDA showed the surveyors small, clear plastic bags of crushed medications and also a separate small, clear plastic bag containing a pink pill. The bags were identified by the days of the week and	self-medication assessment, 45 day medication and physician orders to ensure accuracy for the next 90 days. V. Date of Completion March 31, 2019 and ongoing **10124.06 Medication Administration** An ALR shall ensure that all medication administered to a resident by licensed practical nurse, registered nurse, advanced practice registered nurse, physician, physician assistant, TME or certified medication aide on its premises shall be recorded on a written or electronic medication administration record that is kept as part of the medical record. I. Corrective Action In response to medication administration by an appropriately licensed professional, Grand Oaks began administering medication on February 9, 2019. II. How to Identify Other	3/31/19 ongoing

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	the time to be administered, however the bags did not include the names of the medications. The PDA stated that the original medication containers were kept by the family and were not onsite at the ALR. On 01/17/19 at 2:30 PM, review of the ALR's "Role and Responsibilities of Private Duty Aide/Companion" policy showed that PDAs "[were] not permitted to administer medications or render any treatment to residents. If [the PDA was] not certain, please speak to the resident's assigned nurse for clarification." On 01/28/19 at 1:15 PM, review of the Home Care Agency's Plan of Care, effective 12/31/18 through 12/31/19, showed that their PDA staff "is not administering any medication" but that the PDA "provides medication reminders." An interview was conducted on 01/28/19 at 2:25 PM with the DON from the Home Care Agency that employed Resident #1's PDA. She stated that if the PDA was placing Resident #1's medication on the applesauce for the resident to take independently, she "[believed] that would be working outside of their scope of practice." At the time of the investigation, the ALR failed to ensure that Resident #1 was administered medications by an appropriately licensed professional or certified paraprofessional, and that an accurate medication administration record was maintained.	The DON, and/or designee, will communicate with all self-medicating residents who have retained PDA services to educate them on the regulations regarding medication administration assistance. III. Systemic Changes The DON, and/or designee, will communicate with self-medicating residents during the 45 day medication review regarding medication administration regulations. IV. Monitoring Process The ED, and/or designee, will randomly audit 45 day medication review to ensure resident education regarding regulation requirements related to medication administration regarding PDA exclusion from the process for the next 90 days. V. Date of Completion March 31, 2019 and ongoing	3/31/19 ongoing