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-0039	A. BUILDING: ______ B. WING ______	R 05/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A CHE	5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015

(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 A monitoring survey was conducted from 05/06/19 to 05/13/19 to assess the Assisted Living Residence's (ALR) compliance with deficiencies cited during their licensure survey on 06/26/18 through 07/13/18. At the time of the survey, the ALR provided care for 73 residents and employed 81 staff, which included professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. It should be noted that prior to the survey, the surveying team received an anonymous compliant that was incorporated as part of the monitoring survey. The complainant alleged the following: Allegation #1: Resident #1 had not been bathed in over six months from June, 2018 until December 2018. Conclusion: The allegation could not be substantiated. Allegation #2: Resident #1 had not been made aware timely that a rate increase was to occur on March 1, 2019, in accordance with ALR Law. Conclusion: The allegation could not be substantiated. Allegation #3: Resident #1 did not have an Individual Service Plan completed 30 days after admission. Conclusion: The allegation was substantiated, and cited in the body of this report. See [R 483]	R 000	The following is the Plan of Correction for Chevy Chase House as a response to the Statement of Deficiencies, dated 5/13/19. This Plan of Correction is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality services and we will continue to make changes and improvement to satisfy that objective. R292 Accommodation of needs 1. Resident ID # 1 was discharged from the community on 5/9/19. Nursing staff are currently undergoing re-education on the change of condition policy, in addition to being re-educated on the practice of notifying the medical director when a PCP is not available for consultation; completion date for this re-education is 6/12/19. The Director of Nursing or designee will review the communication log daily to ensure compliance.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki Beekman ALA 6/10/19		

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R 000	Continued From page 1 Allegation #4: Resident #1 had diarrhea for four consecutive days and the Primary Care Physician was not notified. Conclusion: The allegation was partially substantiated, and cited in the body of this report. See[R 292] On 05/13/19, the survey team identified systemic failures that posed a potential risk to the health and safety of all residents. The facility was notified and, effective on 05/13/19, was issued a 90 day restricted license for no new admissions. Listed below are abbreviations used throughout the body of this report. ALA-Assisted Living Administrator ALR - Assisted Living Residence ADON- Assistant Director of Nursing DON - Director of Nursing ER - Emergency Room ISP- Individualized Service Plan MPD -Metropolitan Police Department PCP - Primary Care Physician PT - Physical Therapy QA- Quality Assurance	R 000	2. The Director of Nursing/designee will audit ten percent of residents with change of condition, on a monthly basis, to verify that the PCP/Medical Director notification was completed properly. This audit will continue monthly for six months. Findings will be reported to the Quality Assurance Committee for follow up as needed. 3. Resident ID # 2 was discharged from the community on 4/4/19. Resident ID # 5's ISP was updated on 6/5/19 to include fall interventions. Appropriate staff will be re-educated on the falls policy by no later than 6/12/19. Falls, and, other incidents are now being discussed each morning in the daily wellness review; interventions are to be added or adjusted as needed. The Director of Nursing/designee will audit ten percent of resident	
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 record review and interview, the ALR nursing staff failed: (1) to notify the resident's PCP when there was a change in the resident's health status (Resident #1); (2) to follow the fall	R 292		

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policy for two of two residents in the sample who fell (Resident #2 and 5) and (3) to ensure that the results of the mini-mental screening and elopement risk assessment were evaluated by the ED and Wellness Director for one of one resident in the sample (Resident #4).

Findings included:

1. The ALR nursing staff failed to notify the resident's PCP when there was a change in the resident's health status as evidenced below:

On 05/06/19, review of Resident #1's Resident Care Notes dated 01/03/19, 01/04/19 and 01/12/19, showed that the resident complained of having diarrhea and telephone messages were left for the resident's PCP on each of the aforementioned days. However, there was no documented evidence that the PCP received or responded to the voice messages.

During an interview the ALR medical director on 05/07/19, at 11:05 AM, he stated that when the nursing staff cannot reach the resident's PCP by telephone, the nursing staff can always call the ALR medical director for medical assistance.

During interviews with the ADON and ALA on 05/06/19, it was confirmed that the nursing staff should have called the ALR medical director when the resident's PCP could not be reached. Further interview revealed that all nursing staff would be re-trained on notifying the ALR medical director when the resident's PCP was not available for consultation.

At the time of the monitoring visit, the ALR nursing staff failed to obtain medical services for

R 292

charts monthly, for six months, to assist with falls policy compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed. As an additional measure, falls are now being tracked and discussed weekly, at our new collaborative care meeting, which reviews hot topics, including resident falls. Interventions are reviewed and updated at these weekly meetings.

4. Resident ID # 4's mini mental screening and elopement risk assessment was completed by the RN and reviewed by the ALA on 6/5/19. The ALA and RN will sign the assessments no later than 6/11/19. The Director of Nursing/designee will audit ten percent of resident records, monthly, for six months, to assist with compliance.

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the resident when there was an alteration in health status.

2. The ALR nursing staff failed to follow the fall policy, as evidenced below:

a. Review of Resident #2's Resident Care Notes on 05/06/19 at 2:05 PM revealed that the resident fell on 09/20/18 and 03/29/19, sustained injuries and was transported to the ER for evaluation and treatment.

b. Review of Resident #5's Accident/Injury Report incident reports on 05/08/19 beginning at 4:55 PM, showed that the resident fell 18 times from 12/20/18 through 04/06/19, sustaining nine with injuries which included five head injuries.

Review of the ALR's policy titled, "Falls," revised 09/25/18, showed that after a fall, the DON was to ensure a fall investigation was completed if the resident sustained an injury within 24 hours, the resident's ISP was updated with interventions, a QA of the fall was reviewed, and a fall tracking was completed.

During an interview on 05/08/19 at 6:00 PM, the ADON confirmed that the ALR's fall policy was not followed for Residents #2 and 5. Further interview revealed that the ADON would re-train all of the nursing staff to ensure compliance with the fall policy when a resident sustains a fall with injury.

At the time of the monitoring visit, the DON/designee failed to implement the ALR's fall policy.

3. The ALR's nursing staff failed to ensure that the results of the mini-mental screening and

Findings will be reported to the Quality Assurance Committee for follow up as needed.

R481 Sec 604b Individualized Service Plans

1. Resident ID #5's ISP was reviewed and updated on 6/6/19 to include current therapy orders.
2. Resident ID #5's ISP was reviewed and updated on 6/6/19 to include details of PDA services being provided.
Nurses were re-educated on documentation of third-party providers and PDA services on the ISP's.
Completion date: 6/12/19.
The Director of Nursing/designee will audit ten percent of resident records monthly for six months to assist with compliance. Findings will be reports to the Quality

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elopement risk assessment were evaluated by the ALA and Wellness Director evidenced below:

Review of Resident #4's current clinical record on 05/07/19 at 11:57 AM, showed that resident was admitted on 04/28/18, with a diagnosis of dementia. Further review of the record revealed an ISP dated 08/24/18, which showed that the resident attempted to exit the ALR on 10/12/18 and 10/24/18. Further review revealed that on 10/23/18, the resident eloped through the back door of the ALR and was returned to the facility by a staff member.

On 05/07/19, at 11:57 AM, review of Resident #4's Elopement Risk Assessments, dated 10/15/18, 10/30/18, 11/12/18 and 12/07/19, showed that the resident was considered an elopement risk.

On 05/07/19, at 1:00 PM, review of Resident #4's Mini Mental Screening dated 10/30/18, with a score of 19 (indicating dementia) and contained a notation which stated "This demented patient's wandering outside and history of falls dictates placement in a nursing facility/dementia unit".

On 05/07/19, at 1:25 PM, review of the ALR's Elopement-Missing Person policy revised on January 2018, that the ALA and Wellness Director will meet with the resident /authorized responsible party if a resident has a diagnosis of early stage dementia to discuss the need for potential placement in a secure unit.

During an interview on 05/07/19 at 5:30 PM, the ADON stated that she was not aware of Resident #4's Mini-Mental Screening dated 10/30/18 or the Elopement Risk Assessment dated 10/30/19, that was in the resident's clinical record. The ADON

Assurance Committee for follow up as needed.

R483 Sec 604d Individualized Service Plans

1. Resident ID# 1 was discharged from the community on 5/9/19.
2. Resident ID #2 was discharged from the community on 4/4/19.
3. Resident ID # 3's ISP was reviewed and updated on 5/15/19 to include fall interventions.
4. Resident ID #4's ISP was reviewed and updated on 6/5/19 to include elopement interventions as indicated. The ISP will be reviewed by the healthcare practitioner and resident/surrogate by 6/12/19.
5. Resident ID #5's ISP was reviewed and updated to include fall interventions on 6/5/19. The ISP will be reviewed by the practitioner and resident/surrogate by 6/12/19.

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R 292	Continued From page 5 stated that she was not aware if the ED and Wellness Director were aware of the Mini-Mental Screening and the Elopement Risk Assessment. At the time of the monitoring visit, the ALR nursing staff failed to ensure that the results of the mini-mental screening and elopement risk assessments was evaluated by the ALA and Wellness Director.	R 292		
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 ISPs included when, how often, and by whom services will be provided for one of five residents in the sample (Resident #5). Findings included: 1. On 05/08/19, at 12:25 PM, review of Resident #5's clinical record revealed a physician's order dated 01/11/19, for the resident to have PT three times a week for the next 60 days for strength, balance and coordination training after the resident had repeated falls. The ISP dated 03/12/19, lacked documented evidence of when, how often and by whom PT services were to be provided to the resident. During an interview on 05/08/19 at 2:10 PM, the ADON confirmed that the resident was receiving PT services as ordered. Further interview revealed that the ADON would re-train all the nursing staff on documenting when, how often,	R 481	An audit of all resident ISP's will be completed by 6/14/19. Changes are being made, as needed, to reflect care needs. The ISP's will be reviewed by the healthcare practitioner and resident/surrogate, by no later than 6/21. Going forward, to ensure compliance, scheduled and change of condition ISP updates will be discussed at the daily wellness meetings. The Director of Nursing/designee will audit ten percent of resident records monthly, for six months, to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed.	

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R 481	Continued From page 6 and by whom PT services would be provided in all residents' ISPs. On 05/09/19 at 10:00 AM, review of Resident #5's "PT Daily Treatment Note" dated 02/04/19, showed that PT services started on 01/30/19. At the time of the monitoring visit, the ALR failed to provide documented evidence that all ISPs included when, how often, and by whom PT services would be provided. 2. Observations on 05/08/19, at 11:25 AM showed PDA #1 pushing Resident #5 in a manual wheelchair down the hallway toward apartment 313. During an interview on 05/08/19 at 12:54 PM, PDA #1 stated that she was hired by Resident #5's family and assisted the resident for 13 hours on Mondays, Wednesdays, and Fridays from 7:00 AM until 8:00 PM. Review of Resident #5's ISP dated 03/12/19, lacked documented evidence of when, how often and by whom PDA services were to be provided to the resident. During an interview on 05/08/19 at 2:30 PM, the ADON confirmed that the resident was receiving PDA services as stated by PDA #1. Further interview revealed that the ADON would re-train all the nursing staff on documenting when, how often, and by whom PDA services would be provided in the resident's ISP. At the time of the monitoring visit, the ALR failed to include who, when, and how often the PDA services were to be provided for the resident.	R 481		

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R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on observation, interview and record review, the ALR failed to ensure residents ISPs were reviewed 30 days after admission, every six months thereafter, or updated with significant changes for five of five residents in the sample (Residents #1, 2, 3, 4 and 5). Findings included: 1. Observation and interview of Resident #1 self-administering her medications on 05/06/19 at 12:56 PM, showed that the resident was knowledgeable about the administration times, names, dosage and side effects of the medications that she removed from her pill box. In addition, the resident stated that she always kept her apartment door locked to secure her medications. On 05/06/19 at 1:40 PM, review of Resident #1's current clinical record showed that the resident was admitted on 05/29/18. Further review of the record revealed that an ISP dated 07/17/18, was not completed 30 days after the resident was admitted to the ALR. The record also lacked documented evidence that an ISP review was	R 483		

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R 483	Continued From page 8 conducted six months after 05/29/18. Continued review of Resident #1's clinical record revealed that the resident had a physician's order dated 04/16/19, for the resident to self medicate. Prior to 04/16/19, the ALR nursing staff was administering the resident's medications. However, there was no documented evidence that the ALR staff updated the ISP to reflect the significant change in the resident's medication management. 2. Review of Resident #2's current clinical record on 05/06/19 at 1:55 PM showed that the resident was admitted on 04/28/18. Further review of the record revealed that an ISP, dated 06/26/18, was not completed 30 days after the resident was admitted to the ALR. The record also lacked documented evidence that an ISP review was conducted six months after 04/28/18. Review of the record revealed a nursing note dated 03/01/19, which documented that the resident was discovered outside the building on the corner of a busy street at 3:00 PM and was returned to the ALR by the MPD. Additionally, review of a nursing note dated 03/05/19, documented that the resident was discovered outside the building at 6:00 PM and was returned to the facility by a staff member. Review of an Elopement Risk Assessment, dated 03/07/19, showed a score of 14 which indicated that the resident was a high risk for elopement. Further review of the record revealed an ISP dated 1/30/19 and revised on 03/11/19, however there was no documented evidence that interventions addressing the resident's elopement risk were initiated until 03/11/19 (six days later). The ISP also lacked documented evidence that it had been reviewed by the resident's health care	R 483		

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R 483	Continued From page 9 practitioner, the resident, or the resident's surrogate. 3. Review of Resident #3's current clinical record on 05/06/19 at 2:10 PM showed that the resident's current ISP was dated 07/10/18. Further review showed that the next six month review was scheduled for January 2019, however there was no documented evidence that an ISP review was conducted after 07/10/18. Further review of the ISP dated 07/10/18, showed documented evidence that the resident fell on 09/20/18 and was taken to the ER after sustaining an abrasion to the right elbow and discoloration to the fourth toe on her left foot. Review of a fall assessment dated 09/12/18, showed a score of 11, which indicated that the resident was a high risk for falls. However, there was no documented evidence of any fall interventions on the ISP. Continued review of the record revealed a nursing note dated 03/29/19, which documented that the resident returned to the facility in a taxi at 10:15 PM and was observed with a laceration to the lip. The resident was unable to recall what had happened to her while she was outside the ALR when the incident occurred. Review of an incident report dated 04/02/19, showed that the resident fell at a theater and was transported via 911 to the ER where stitches were applied to her lip laceration. However, the record lacked documented evidence that the ALR staff had updated the ISP, dated 07/10/18, to address the change in the resident's health care status. 4. Review of Resident #4's current clinical record on 05/07/19 at 11:30 AM, showed that the resident was admitted on 04/28/18. Further	R 483		

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review of the record revealed an ISP dated 08/24/18, which showed that the resident attempted to exit the ALR on 10/12/18 and 10/24/18. Further review revealed that on 10/23/18, the resident eloped through the back door of the ALR and was returned to the facility by a staff member. However, the ISP lacked documented evidence that the resident or the resident's surrogate reviewed it. Continued review of the record showed an undated ISP that indicated that interventions were not initiated until 12/10/18 (48 days later), to address the residents elopement risk as evidenced by frequent attempts to exit the building. However, the ISP was not reviewed by the resident's health care practitioner, the resident, or the resident's surrogate.

5. Review of Resident #5's current clinical record on 05/08/18 at 10:55 AM showed that the resident was admitted on 04/26/18. Further review of the record revealed that an ISP dated 07/16/18, was not completed 30 days after the resident was admitted to the ALR. The record also lacked documented evidence that an ISP review was conducted six months after 04/26/18. The ISP dated 03/12/19, also failed to document interventions for the residents frequent falls with sustained injuries dated 01/23/19, 02/12/19, 02/19/19 (head injury), 03/06/19 (head injury), 03/11/19, 03/21/19 (head injury), 03/22/19, and 04/06/19 (head injury). Further review of the record revealed that the ISP dated 03/12/19, lacked documented evidence that it had been reviewed by the resident's health care practitioner.

During an interview on 05/08/19 at 4:40 PM, the ADON stated that the facility would re-train all of the nursing staff on conducting and documenting

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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Washington DC 20002
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202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
BVMSTAR CHEVY CHASE TENANT d/b/a Chevy Chase House ALR -0039	CHEVY CHASE HOUSE 5420 Connecticut Avenue NW Washington, DC 20015	Follow-up Dates(s): 05/06/19 through 05/13/19

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
000	A monitoring survey was conducted from 05/06/19 to 05/13/19 to assess the Assisted Living Residence's (ALR) compliance with deficiencies cited during their licensure survey on 06/26/18 through 07/13/18. At the time of the survey, the ALR provided care for 73 residents and employed 81 staff, which included professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. It should be noted that prior to the survey, the surveying team received an anonymous compliant that was incorporated as part of the monitoring survey. The complainant alleged the following: Allegation #1: Resident #1 had not been bathed in over six months from June 2018 until December 2018.		10118.02 Private Duty Healthcare Professionals A comprehensive audit of all PDA's was completed on 6/7/19. Copies of all licenses/certifications were obtained as needed, by 6/9/19. The administrator/designee will be responsible for ensuring compliance moving forward. A random audit of ten percent of PDA files will be conducted monthly for six months. Findings will be reported to the Quality Assurance Committee for follow up as needed.	

Cathy Hall, RN for Sheila W. Mata — 05/31/19
Name of Inspector — Date Issued

Nick Beekman MA — 6/10/19
Facility Director/Designee — Date

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Conclusion: The allegation could not be substantiated.

Allegation #2: Resident #1 had not been made aware timely that a rate increase was to occur on March 1, 2019, in accordance with ALR Law.

Conclusion: The allegation could not be substantiated.

Allegation #3: Resident #1 did not have an Individual Service Plan completed 30 days after admission.

Conclusion: The allegation was substantiated, and cited in the body of this report. See [R 483]

Allegation #4: Resident #1 had diarrhea for four consecutive days and the Primary Care Physician was not notified.

Conclusion: The allegation was partially substantiated, and cited in the body of this report. See [R 292]

On 05/13/19, the survey team identified systemic failures that posed a potential risk to the health and safety of all residents. The facility was notified and, effective on 05/13/19, was issued a 90 day restricted license for no new admissions.

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

10118.02 Private Duty Healthcare Professionals

A comprehensive audit of all PDA files was completed on 6/7/19. Copies of all personnel records were obtained for PDA's providing personal care in the ALR, by 6/9/19, as needed. Going forward, the community relations director, under the direction of the ALA, will ensure all resident PDA/Companions are fully registered, including, health, contracts, and, licensing, as applicable. The ALA/designee will audit ten percent of PDA files monthly, for six months, to ensure compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed.

10118.03 Private Duty Healthcare Professionals

A comprehensive audit of all PDA personnel files was completed on 6/7/19, to ensure a written agreement was present.

Where needed, a written agreement was obtained from all caregivers. The front desk was also inserviced, by 6/12/19, that, going forward, no PDA's, (companion or hands-on caregivers), will be allowed to enter the community, without being fully registered, with all paperwork properly in place.

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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	ALR - Assisted Living Residence PDA – Private Duty Aide ADL – Activities of Daily Living NSA – Nurse Staffing Agency ALA – Assisted Living Administrator ER - Emergency Room DON – Director of Nursing LPN – Licensed Practical Nurse		A notice, on 6/7/19, was also sent to residents and families identifying our policy, requiring all private caregivers to be fully registered with the community before being allowed to begin practice in the community. 10125.02 Reporting Abuse, Neglect, Exploitation, and, Unusual Incidents Staff were re-educated on the reporting of abuse, neglect, exploitation, and, unusual events. All staff will be inserviced by 6/15/19.
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, licensed, or otherwise authorized by the District of Columbia to healthcare related services they will provide to the resident.** Based on observation, interview, and record review, the ALA failed to ensure that the PDAs working with ALR residents possessed a license or certification for the District of Columbia to provide ADL assistance for four PDAs in the sample (PDAs #1, #2, #3, and #4). Findings included:		The training for abuse/neglect/exploitation, and, unusual events, will be regularly scheduled annually, upon new hire, and, as needed. Incidents, and, the 24 hour log will be reviewed daily at the wellness review, to ensure compliance with our policy. Any issues identified as reportable to the Department of Health will be reviewed to ensure compliance. The ALA will be responsible for timely reporting. The ALA/designee will conduct a random audit of communication and incident logs monthly for six months, to monitor compliance with the reporting policy. Findings will be reported to the Quality Assurance Committee for follow up as needed.

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Observation on 05/08/19 at 12:52 PM showed Resident #5 in her apartment accompanied by an aide (PDA #1). During an interview on 05/08/19 at 12:54 PM, PDA #1 stated that she was hired by the resident's family and assisted the resident for 13 hours on Mondays, Wednesdays, and Fridays from 7:00 AM until 8:00 PM.

During a telephone interview on 05/08/19 at 12:19 PM, the ALR's Human Resources Director stated that the ALA handled all PDAs, including their personnel records.

During an interview on 05/08/19 at 4:46 PM, the ALA stated that the PDA services were being provided through a NSA. Further interview with the ALA revealed that he was not certain about the number of hours of PDA services that were provided for Resident #5, however the ALA provided a list of the names of the PDAs assigned to Resident #5. A review of the personnel list showed there was a total of four PDAs assigned (PDA #1, #2, #3, and #4) to assist Resident #5. No personnel records for these PDAs were made available for review.

At the time of the monitoring visit, there was no documented evidence that PDAs #1, #2, #3, and #4 were certified or registered by the District of Columbia.

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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: (b) Maintain an accurate and current personnel record with the ALR.** Based on interview and record review, the ALA failed to ensure that a current personnel record for PDAs was maintained by the ALR for four PDAs in the sample (PDA #1, #2, #3, and #4). Findings included: During an interview on 05/08/19 at 12:23 PM, the surveyor requested the personnel records for PDAs #1, #2, #3, and #4 for review. The ALA stated that because the records were not on the premises, he would have to obtain a copy of the PDAs' personnel records from the NSA, and would provide a copy on the next day [05/09/19] via email. At the time of the survey, the ALA failed to obtain and maintain complete personnel records for PDAs #1, #2, #3, and #4.			

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10118 Private Duty Healthcare Professionals	**10118.03 An ALR shall have a written agreement with each private duty healthcare professional described in this section, or the agency that employs him or her, if applicable, describing his or her obligation to report to the ALR: (a) Medication errors and adverse drug reactions; and (b) Abuse, neglect, exploitation, or unusual incidents, such as changes in the resident's condition.** Based on interview and record review, the ALA failed to ensure that a written agreement detailing the ALR's reporting requirements was obtained from the PDAs, or their employing NSA, for four PDAs in the sample (PDA #1, #2, #3, and #4). Findings included: During an interview on 05/08/19 at 12:23 PM, the surveyor requested the ALR's records for PDAs #1, #2, #3, and #4 for review. The ALA stated that the records were not on the ALR premise, but he would obtain a copy of the PDAs' personnel records from the NSA and forward a copy via email on the next day [05/09/19]. Review of the ALR's policy titled, "Private Caregiver/Companion Sitter," revised 09/17/18, showed that the ALA was responsible to implement the aforementioned policy and to ensure that the Private Caregiver/Companion Sitter Agreement was signed by			

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	all parties (resident, authorized responsible party, and private caregiver/companion sitter) prior to a PDA starting an assignment with a resident. The policy included provisions that PDAs "must immediately report any change in a resident's condition, medication errors, adverse drug reactions" and "any suspected abuse, neglect, exploitation or an unusual incident immediately to the Supervisor." At the time of the survey, the ALA failed to implement the ALR's Private Caregiver/Companion Sitter policy and failed to maintain complete records, including the Private Caregiver/Companion Sitter Agreement, for PDAs #1, #2, #3, and #4.				
10125 Reporting Abuse, Neglect, Exploitation, and Unusual Incidents	**10125.02 In addition to the requirements to report abuse neglect, and exploitation of a resident provided in Section 509 of the Act (D.C. Official Code§ 44-105.09), each ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone immediately, and shall be followed up by written notification to the same within twenty-four (24) or the next business day.**				

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Based on interview and the review of incident reports, the ALR failed to ensure that all incidents that presented a risk to residents' health and safety were reported to the Department of Health for Residents #2, #3, #4, and #5.

Findings included:

During an interview on 05/06/19 at 11:17 AM, the ALA stated that he received all incident reports. He further stated that he reviews all of the reports, and then returns them to the DON.

A review of unusual incident reports on 05/07/19 through 05/08/19 revealed the following incidents that were not reported to the Department of Health:

1. On 03/05/19, Resident #2 had absconded and was found several blocks from the facility.

2. On 09/20/18, Resident #3 fell outside of the facility and sustained an abrasion to the right elbow and discoloration to her left fourth toe. 911 was called and the resident was taken to the ER.

3. On 10/12/18 at 6:15 AM, Resident #4 attempted to elope through the ALR's fire exit door near the kitchen.

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On 10/23/18, one of the ALR's LPNs reported that Resident #4 left the facility through the back door. The resident then had attempted to leave the facility through the front door when the ALR's Receptionist tried to redirect Resident #4 back inside of the building.

On 10/24/18, Resident #4 attempted to elope from the ALR and was found by an employee in the back hallway of the facility.

4. Between 12/20/18 and 04/06/19, Resident #5 had 18 falls. Eight of the 18 falls resulted in injuries as listed below which were not reported to the Department:

On 12/20/18, Resident #5 fell when she was reaching for a glass, sustaining a skin tear to her right ear and bruising to her back.

On 01/18/19, Resident #5 fell and sustained an eyebrow laceration and swelling. The resident was transported to the ER.

On 02/12/19, Resident #5 reported that she was trying to check her mail and fell onto her buttocks. She was observed with discoloration on the left breast.

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On 02/19/19, Resident #5 fell with assistance while getting out of the shower. The resident hit the back of her head on the side rail. The resident refused to go to the ER for further evaluation/treatment.

On 03/06/19, Resident #5 reported that she was trying to get up from the toilet, lost her balance, and hit the back of her head. The resident refused to go to the ER for further evaluation/treatment.

On 03/11/19, Resident #5 stated that she fell while attempting to urgently use the bathroom. The resident was observed with bruising on the left and middle of her back and right buttocks.

On 03/21/19, Resident #5 fell in front of the bathroom. She sustained an abrasion to her right elbow and a parietal scalp hematoma.

On 03/22/19, staff observed Resident #5 with a skin tear to the right elbow. The resident was not able to identify what had caused the skin tear.

Review of the ALR's "Internal Incident Reporting," revised January 2018, showed that the ALA was "responsible to assure an incident is reported and sent to the State Agency on the appropriate form and within the required time required."

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At the time of the survey, there was no evidence that the ALA implemented a system to ensure that every incident which presented a risk to a resident's health, safety, or placement, was reported immediately to the Department of Health and in writing within 24 hours.