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 _____	05/25/2016

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

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R 000	Initial Comments An annual survey and onsite investigation was conducted from April 25, 2016 through May 25, 2016, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. The Assisted Living Residence (ALR) provides care for one hundred forty-four(144) residents and employs one hundred ninety-three (193) staff members. The findings of the survey were based on observation, record review and interview. During the on-site annual survey process, the Intermediate Care Facilities Division received complaints on April 28, 2016, April 30, 2016, May 2, 2016, May 9, 2016, and May 10, 2016 by residents and/or family members that alleged the following: Please Note: Listed below are abbreviations used in the body report. ADON ---Assistant Director of Nursing ALA --- Assisted Living Administrator ALR --- Assisted Living Residence Apt. --- apartment cm - centimeters DON --- Director of Nursing ED --- Executive Director ER--- Emergency Room H&P --- history and physical ICU --- Intensive Care Unit ISP --- Individualized Service Plan LPN --- Licensed Practical Nurse OT------Occupational Therapy PDA --- Private Duty Aide POC ---Plan of Care prn --- as needed PT---Physical Therapy mg --- milligrams Allegation 1: The ALR failed to ensure a meal	R 000	Received 8/2/16	

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[lunch] was served in a sanitary manner.
Conclusion: The allegation was substantiated and is cited in the body of this report as a deficient practice. [See Tag #R 0981]
Allegation 2: The facility failed to ensure the maintenance of a clean and sanitary environment.
Conclusion: The allegation was substantiated and is cited in the body of this report as a deficient practice. [See Tags #R 0981 and #R 0953]
Allegation 3: The facility failed to ensure cleaning supplies were effective to address and maintain a sanitary environment.
Conclusion: This allegation could not be substantiated.
Allegation 4: The facility failed to provide residents with operational policies utilized by Grand Oaks.
Conclusion: Although this allegation was substantiated, it was not a violation of the ALR law.
Allegation 5: The facility' s management failed to ensure questions and concerns raised by residents and/or family members were addressed in a timely manner.
Conclusion: This allegation could not be substantiated.
Allegation 6: The facility is providing services to residents that are inappropriately placed.
Conclusion: This allegation could not be substantiated.
Allegation 7: The facility failed to ensure adequate nursing staff to ensure medications are administered correctly and on time.
Conclusion: The allegation was substantiated and is cited in the body of this report as a deficient practice. [See Tag #R 0292]
Allegation 8: The facility failed to ensure maintenance is provided timely to ensure heat, air conditioning, hot water and elevator services are

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available and functioning appropriately.
Conclusion: This allegation could not be substantiated.
Allegation 9: The facility failed to ensure that specific vegetables [asparagus, broccoli or sweet potatoes] were prepared and available daily for residents.
Conclusion: Although this allegation was substantiated, it was not a deficient practice.
Allegation 10: The facility has under their employ, overworked, angry, demoralized employees.
Conclusion: This allegation could not be substantiated.
Allegation 11: The facility failed to address ISP compliance issues and ongoing falls.
Conclusion: This allegation was substantiated and is cited in the body of this report as a deficient practice. [See Tag #R 0481 & #R 0483]
Allegation 12: The facility failed to ensure assistance is available timely when the life line system is activated.
Conclusion: Although this allegation was partially substantiated, there were no deficient practices.
Allegation 13: The facility failed to ensure the promotion of a safe and secure environment where complaints or concerns will be addressed without fear of retaliation from facility staff.
Conclusion: This allegation could not be substantiated.
Allegation 14: The facility failed to ensure residents belongings and personal environment are safe and free from unwanted individuals.
Conclusion: Although this allegation was substantiate, there were no deficient practices.
Allegation 15: The facility failed to ensure aides are trained and competent to perform their duties.
Conclusion: The allegation could not be substantiated.
Allegation 16: The facility failed to make certain staff performed their duties in a manner that

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R 000	Continued From page 3 prevented abuse and neglect. Conclusion: The referenced incident (2014) was substantiated and address accordingly. Additionally, at the time of the survey all other incidents [one (1) noted] have been resolved/addressed. Allegation 17: The facility failed to provide appropriate supervision and discipline to aides, especially during the night shift. Conclusion: This allegation could not be substantiated. Allegation 18: The facility failed to implement the individual support plan (ISP) in a timely manner after it has been updated and/or failed to follow the ISP as written. Conclusion: This allegation was partially substantiated and is cited in the body of this report as a deficient practice. [See Tag #R 0292]. Allegation 19: The facility failed to ensure the development of written procedures for aides on how to handle emergencies. The procedures failed to be publicly available. Conclusion: Although this allegation was partially substantiated, there were no deficient practices. Allegation 20: The facility failed to ensure furniture is cleaned, unstained, and free from urine/excrement. Conclusion: This allegation was partially substantiated and is cited in the body of this report as a deficient practice. [See Tag #R 0981]. Allegation 21: The facility failed to ensure food from the buffet is served hot (appropriate temperature). Conclusion: Although this allegation was substantiated, there were no deficient practices.	R 000	*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 between April 25, 2016 and May 25, 2016. 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 need and preferences consistent with their health and physical and mental capabilities and their health or safety of other residents I. Corrective Action In response to Resident #2, the weekly medical evaluation was discontinued by the primary physician.	
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services	R 292		

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R 292	Continued From page 4 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 observation, interview and record review, the ALR failed to (1) ensure physician orders were followed as prescribed; and (2) ensure necessary monitoring for alterations in skin integrity and/or safety had been addressed in accordance with the resident's needs, as indicated in their ISP for four (4) of twenty-two (22) patients in the sample. (Resident #2, #5, #7 and #10) The findings include: I. The ALR failed to ensure weekly medical evaluations had been conducted and/or medications were administered as prescribed. a. On May 2, 2016, starting at 10:00 a.m., review of Resident #2's clinical record revealed a H&P dated September 14, 2015, that documented the resident had primary diagnoses of health care associated pneumonia and debility: and the resident's secondary diagnosis of dementia. The resident's aforementioned H&P required that the resident have a medical evaluation done weekly. Further review of the record lacked documented evidence that the weekly medical evaluations had been conducted. During an interview with the DON on May 2, 2016, at 3:30 p.m., the DON indicated that the weekly medical evaluation had not been conducted. At the time of the survey, the ALR failed to ensure Resident #2's weekly medical evaluations had been conducted, as required. b. On May 2, 2016, at 1:00 p.m., review of the incident log revealed that Resident #10 had experienced a medication error whereby two (2) Exelon patches were found on the client's chest	R 292	In response to Resident # 10, the second patch was immediately removed, the primary physician was notified, and nurse education was completed at the time of the incident. In response to Resident #7, Executive Director, ED, Director of Nursing, DON, and Associate Director of Nursing, ADON immediately began an investigation after being notified on May 2, 2016. Staff education was held on May 23, 2016 on the Grand Oaks un-witnessed injury process. In response to Resident #5: This is an elderly, intermittently ambulatory resident who suffers from exacerbations of child-hood Polio virus. When she feels well she becomes impulsive and tests her physical limitations. Until this past year, this has typically resulted in falls with non-serious injuries. The identified root cause is attempts to ambulate	

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R 292	Continued From page 5 on February 16, 2016. Review of the physician order in the clinical record revealed an order for "Exelon 4.6 MG/24, apply one patch topically once a day at 9:00 a.m., for memory impairment. Rotate site." dated January 16, 2015. Interview was conducted with the DON to discuss the medication error. The DON indicated that the nurse [LPN #26] who made the error was counseled. The DON also revealed that an in-service training was held for all nurses regarding accuracy in administering medications. II. The ALR failed to ensure that the staff monitored the resident for bruises as recommended on the ISP: a. On April 27, 2016 [Wednesday], at 12:52 p.m., Resident #7 was observed eating lunch in the dining room with a family member. When greeted by the surveyor, the resident complained that there were bruises on his/her arms. The resident showed the surveyor the bruises by pushing up the sleeves of the long sleeved shirt that he/she was wearing. At that time, dark red areas were observed on both arms several inches above the resident's wrists. Several small dark reddened bruised areas were also observed on the resident's right hand. When asked by both the surveyor and the family member, the resident was unable to state how the bruises occurred. On May 3, 2016 [Tuesday], starting at 10:45 a.m., review of Resident #7's ISPs under the title "Skin Integrity" dated August 10, 2015 and December 11, 2015, revealed that the staff was to report to the nurse "rashes, bruises, reddened areas, wounds, swelling, odor or drainage". Further review of the ISPs section "Bathing" revealed that the staff was to assist the resident with a shower once a week [every Thursday morning].	R 292	without calling her private duty aide for assistance. Grand Oaks has discussed the frequency of her falls with her power of attorney who is her lawyer. In the presence of all of the evident risk, the resident and the POA continue to forego the recommendation that the PDA remain present in the same room with the resident at all times. Both the resident and the POA understand the potential consequences of declination. Grand Oaks will initiate a shared responsibility agreement with the resident and POA to document the declination of PDA presence in the same room. II. How to Identify Other Residents/Staff DON, ADON or designee will complete an audit of initial resident D.C. DOH History and Physical forms to review the medical evaluation section. Grand Oaks will continue to provide regular	

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R 292	Continued From page 6 On May 3, 2016, at 2:25 p.m., interview with the DON regarding the bruises on Resident #7's arms revealed that the bruises had not been reported to the administration by the resident or by the staff. Further interview revealed that an unusual incident report would be submitted to DOH. In addition, an investigation would be conducted to try to ascertain how the resident sustained the aforementioned bruises. On May 3, 2016, at 3:25 p.m., review of an administrative file entitled, "File Summary Report" dated May 3, 2016, indicated that the DON assessed the aforementioned bruises and noted that there were two (2) cm by 2 cm on the left forearm. Further review revealed that the resident's physician and son were notified of the unwitnessed injury. Review of the "Unwitnessed Injury Policy" dated June 1, 2015, on May 5, 2016, at approximately 2:20 p.m., indicated that once identified an unwitnessed injury was to be investigated. At the time of the survey, the ALR failed to provide evidence that Resident #7's skin integrity was monitored consistently as recommended by the ISP. Additionally, there was no evidence an investigation had been conducted to determine the the origin of the bruises, as indicated by the facilities policy. b. On April 29, 2016, starting at 10:30 a.m., review of Resident #5's clinical record revealed that the resident experienced a total of three (3) falls with injuries from July 9, 2015 through April 2, 2016, as evidenced below: 1. On July 9, 2015, resident sustained a laceration to the back of head following a witnessed fall. The resident was transferred to the	R 292	medication management updates to nursing personnel. Staff education was held on May 23, 2016 to review the Grand Oaks un-witnessed injury process. Grand Oaks will continue to utilize the weekly interdisciplinary meeting to review resident falls and trends. Typical attendance includes the ED, DON, ADON, Nurse Practitioner and Therapy department. III. <u>Systemic Changes</u> Prior to admission, the DON, ADON, or designee will review the H&P for interventions that we cannot accommodate, such as weekly medical evaluations. Grand Oaks will continue to provide regular medication management	

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R 292	Continued From page 7 ER and the laceration was repaired with three (3) stitches; 2. On August 2, 2015, resident sustained two (2) skin tears to both arms following an unwitnessed fall; and 3. On April 2, 2016, resident sustained a laceration to right eye lid and skin tears to both thighs following an unwitnessed fall. The resident was transferred to the ER for evaluation and was admitted to ICU for close monitoring of a subdural hematoma. Further review of the record revealed ISPs dated November 23, 2015 and February 2, 2016, that documented under the "falls" section the resident was to have a PDA at his/her side twenty- four hours a day in an effort to avoid falls, however, the resident had two (2) unwitnessed fall as described above. Continued review of the record revealed a physical therapy POC with a recertification period from March 26, 2016 through June 15, 2016. The POC documented that the resident was impulsive and had decreased safety awareness. Additionally, the POC indicated that the resident continued to require twenty-four hour supervision for safety and a one person assist for all functional mobility to prevent falls. It should be noted that resident sustained an unwitnessed fall on April 2, 2016 [nine days after the aforementioned POC was developed] and sustained a subdural hematoma. Further review of the record revealed an occupational therapy POC with a certification period of January 15, 2016 through April 7, 2016, which documented in the "Therapy Necessity" section " therapy necessary for increase independence in self-care	R 292	updates to nursing personnel. Grand Oaks will continue to complete a skin check as part of the monthly wellness visit for all residents. Changes in resident status are discussed twice daily in staff huddles. IV. Monitoring Process ED, or designee, will randomly audit admission packets for completion/content prior to resident arrival for the next 6 months. DON, or designee, will randomly audit medication patch application and removal for the next 90 days. Grand Oaks will continue to hold a weekly interdisciplinary meeting to review resident falls and trends. Un-witnessed injuries will be investigated per our policy.	

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R 292	Continued From page 8 tasks and decreased risk of falls without therapy patient at risk for falls". The DON and ADON on April 29, 2016, at 3:40 p.m., revealed that the resident had two unwitnessed falls . When questioned as the reason for the falls the DON and ADON indicated that the resident sometimes refuses to have the PDA in the same area as him/her. Additionally, the DON revealed that the resident had always had a PDA since his/her admission [October 14, 2011] to the facility. Interview with the rehab director on May 2, 2016, at 11:00 a.m., revealed that the resident was a fall risk and required twenty-four hour supervision of the PDA for safety.	R 292	V. Date of Completion August 1, 2016 **504.2 Accommodation of Needs** To have access to appropriate health and social services, including social work, home health, nursing rehabilitative, hospice, medical, dental, dietary, counseling and psychiatric services in order to maintain the highest practicable physical, mental and psychosocial well-being I. Corrective Action In response to Resident #6, the wound has healed. In response to Resident #12, resident has since expired. In response to Resident #14, physician order received to discontinue recording of output every shift. II. How to Identify Other Residents/Staff DON, ADON or designee will complete an audit to review residents currently	08/01/2016
R 293	Sec. 504.2 Accommodation Of Needs. (2) To have access to appropriate health and social services, including social work, home health, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being; Based on record review and interview, it was determined that the ALR nurses failed to directly provide appropriate nursing services for three (3) of three (3) residents in the sample with wounds and/or Foley catheters. (Residents #6, #12, and #14) The findings include: I. The ALR failed to develop a system to identify residents at risk for the development of altered skin-integrity and implement a system to ensure	R 293		

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R 293	Continued From page 9 effective wound care management for residents with pressure ulcers; for example: On April 26, 2016, at 10:30 a.m., review of Resident #6's clinical record revealed a nursing note dated January 18, 2016 that documented, "cleanse intergluteal cleft with normal saline, apply argleas powder and cover with duoderm dressing every 72 hours." Additionally, review of the H&P dated February 8, 2016, indicated that the resident had an open area at the intergluteal area. The record, however, lacked documented evidence that the ALR nursing staff had provided weekly measurements and reassessment of wound, in an effort to effectively monitor the resident's wound. Interview with the DON and ADON, on April 26, 2016, at 3:00 p.m., revealed that the ALR did not have a "Wound Care Management " policy but would develop and implement a policy. At the time of the survey, the ALR failed to effectively monitor Resident #6's wound. II. The ALR failed to develop a system to ensure appropriate and effective Foley catheter care was implemented. 1. On April 26, 2016, starting at 10:52 a.m., review of Resident #12's record revealed that he/she was receiving hospice care, and had an indwelling Foley catheter. Further review of Resident #12's record revealed an ISP, dated April 20, 2016, documented that staff will assist in managing his/her catheter and emptying the drainage bag. Staff and hospice nurses' notes failed to document any Foley care to including	R 293	treated for wounds or Foley to ensure appropriate follow through. III. Systemic Changes Weekly interdisciplinary meeting will be held to review residents with recent care changes to include wounds and catheter care. This meeting will include at a minimum Director of Nursing, Oasis Coordinator, and Rehabilitative representative, or designees. IV. Monitoring Process DON, ADON or designee will audit nursing notes concurrently with the 45 day medication reviews to ensure appropriate documentation and follow through. V. Date of Completion August 1, 2016	08/01/2016

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R 293	Continued From page 10 emptying of the drainage bag until April 25, 2016. On April 26, 2016, at 12:13 p.m., an interview with the DON and ADON was conducted. The DON stated that the facility does not have a Foley policy, however the facility's nurses should perform daily assessment and clean the site as needed. The ADON stated that the doctor ordered that Resident #12 keep the Foley due to urinary retention. The DON further stated that hospice nurses had taken over Resident #12's care and were responsible for all Foley care and should have documenting care received in the resident's chart. 2. On April 29, 2016, starting at 1:54 p.m., review of Resident #14's record revealed that he/she had an indwelling Foley catheter. Further review of the record revealed a standing physician order dated February 20, 2015 to record output on every shift. Review of Resident #14's treatment record on April 29, 2016 lacked evidence that the facility's nursing staff consistently emptied and recorded the resident's Foley catheter every shift as ordered. On April 29, 2016 at 3:50 p.m., during interview with the DON and ED, the ED stated that the resident's family hired a private PCA. The DON stated that the PCA may have performed some tasks without documenting. The DON further stated that facility's nursing staff are trained to empty the Foley bag and document the care.	R 293	**604b Individualized Service Plan** 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. I. Corrective Action In response to Resident #6, the wound has healed and the ISP has been updated. In response to Resident #12, the resident has expired. In response to resident #15, the resident's ISP has been updated to include physical and occupational therapy details. In response to resident #13, the resident's ISP has been updated to include physical and	
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be	R 481		

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R 481	Continued From page 11 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, the ALR failed to ensure ISPs included when, how often, and by whom services will be provided for seven (7) of 22 residents in the sample. (Residents #6, #12, #13, #15, #18, #19 and #20) The findings include: 1. On April 26, 2016, at 10:30 a.m., review of Resident #6's clinical record revealed a physician order for wound care to the intergluteal cleft area every 72 hours and prn. Further review of the record revealed an ISP dated August 7, 2015 that lacked documented evidence when and how often wound services were to be provided. Interview with the ADON on April 26, 2016, at 1:00 p.m., revealed the frequency of the wound care was documented on the nursing treatment record and going forward will also be added to ISPs. 2. On April 26, 2016, starting at 10:52 a.m., review of Resident #12's clinical record revealed an ISP dated March 18, 2016. The ISP indicated that the resident was receiving physical therapy and occupational services. The ISP, however, lacked documented evidence of when and how often the physical and occupational therapy services would be provided. 3. On April 27, 2016, starting at 11:17 a.m. review of Resident #15's clinical record revealed ISPs dated October 24, 2015 and February 15, 2016. Each of the ISPs indicated that the resident was receiving physical therapy and occupational services. The ISPs, however, lacked documented	R 481	occupational therapy details. In response to resident #18, the resident's ISP has been updated to include physical and occupational therapy details. In response to resident #19, the resident's ISP has been updated to include physical and occupational therapy details. In response to resident #20, the resident's ISP has been updated to include physical and occupational therapy details. II. How to Identify Other Residents/Staff DON, ADON, or designee will audit current therapy caseload and update all ISPs with	

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R 481	Continued From page 12 evidence of when and how often the physical and occupational therapy services would be provided. 4. On May 4, 2016, starting at 10:34 a.m. review of Resident #13's clinical record revealed ISPs dated August 11, 2015 and February 8, 2016. Each of the ISPs indicated that the resident was receiving physical therapy and occupational services. The ISPs, however, lacked documented evidence of when and how often the physical and occupational therapy services would be provided. On April 27, 2016 at 1:17 p.m., during an interview, the DON stated that the frequency would be noted on each resident's ISP going forward. 5. On May 5, 2016 at 10:30 a.m., review of Resident #18's clinical record revealed ISPs dated May 21, 2015, and November 21, 2015. Review of the ISPs revealed that the resident fell on August 12, 2015, August 28, 2015, November 15, 2015, December 2, 2015, December 3, 2015, December 6, 2015 and December 9, 2015. Review of the Occupational and Physical therapists "Progress and Discharge Summary" notes revealed that the resident received ten (10) occupational therapist treatments and two (2) physical therapist treatments from September 24, 2015, through November 3, 2015. There was no documented evidence on the ISPs that the resident received physical or occupational therapy services as a result of these falls. 6. On April 26, 2016 at 1:30 p.m., review of Resident #19's clinical record revealed two (2) ISPs dated April 15, 2015, and December 17, 2015. Further review of the ISP dated April 15,	R 481	current services being received. III. Systemic Changes DON, ADON, or designee will update all ISPs with current PT/OT/ST caseload based on discussions at our weekly interdisciplinary meeting. IV. Monitoring Process ED or designee, will conduct random monthly audits for the next 6 months of ISPs to ensure appropriate services are documented. V. Date of Completion August 1, 2016	08/01/2016

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R 481	Continued From page 13 2015, revealed that the ISP was updated on May 11, 2015. The ISP contained documented evidence that the resident fell : on May 7, 2015, without injury; May 26, 2015, without injury; August 1, 2015, sustained a bruise to the lower back, and on August 17, 2015, without injury. Further review of the ISP under the title "Professional Support Services" revealed the following documentation " PT 1/27/15 to current. OT 4/29/15 to current." The ISP failed to specify how often the services were provided. Review of the ISP dated December 17, 2015, revealed that the client fell on April 19, 2016, without injury. Further review of the ISP under the title "Professional Support Services" revealed the following documentation " PT 12/30/15 to current. OT 1/15/16 to current." The ISP failed to specify how often the PT and OT services were provided. 7. On April 27, 2016, at 11:30 a.m., review of Resident #20's clinical record revealed ISPs dated July 12, 2015, and January 13, 2016. Review of the ISP dated July 12, 2015, revealed that the resident fell on October 7, 2015. Further review of the ISP under the title "Professional Support Services" revealed the following documentation " PT 10/14/14, OT 11/18/15." The ISP failed to specify how often the PT and OT services were provided. Review of the ISP dated January 13, 2016, revealed that the Resident #20 fell on January 12, 2016 at 12:15 p.m., without evidence of injury. Continued review of the ISP revealed that the client had an X-ray on January 15, 2016, that showed the resident had a fracture of the right fibula and a cast was applied by the orthopedist	R 481	**604d** **Individualized Service Plans** 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. I. <u>Corrective Action</u> In response to Resident #1,	

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R 481	Continued From page 14 on January 18, 2016. Further review of the ISP under the title "Professional Support Services" revealed the following documentation "OT 1/29/16-2/25/16." The ISP failed to specify how often PT and OT the services were provided.	R 481		
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 record review and interview, the ALR failed to ensure ISP's were reviewed by the resident, the residents surrogate 30 days after admission, at least every six (6) months and/ or updated with significant changes for four (4) of 22 residents in the sample. (Residents #1, #6, #9 and #11) The findings include: 1. On May 4, 2016, starting at 11:00 a.m., review of Resident #1's record lack documented evidence of a six-month completed ISP after July 28, 2015. During interview with the ALA and DON on May 4, 2016, at 3:00 p.m., it was revealed that the ISP had been reviewed by the resident and the interdisciplinary team after July 28, 2015. However, Resident #1 had not scheduled a	R 483	Grand Oaks has repeated documented requests for meetings with this resident and family. This matter is being actively resolved in conjunction with the D.C. Ombudsman office and local attorneys. In response to Resident #9, the resident's ISP was completed late based on scheduling concerns. In response to Resident #11, the resident has expired.	

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R 483	Continued From page 15 meeting to discuss his/her ISP although he/she had been emailed several times requesting a ISP meeting. 2. On April 26, 2016, starting at 1:00 p.m., review of Resident #9's clinical record revealed that the resident's pre-admission ISP was completed on December 8, 2015. Further review revealed that the thirty (30) day ISP review was not completed until February 18, 2016. On April 26, 2016, at 2:03 p.m., interview with the DON revealed that he/she did not know why the ISP was not done within 30 days and that perhaps it was a scheduling issue. At the time of the survey there was no documented evidence that the aforementioned ISP had been reviewed in 30 days according to the regulations. 3. On May 6, 2016 starting at 10:41 a.m., review of Resident #11's record revealed ISPs dated June 9, 2015 and November 13, 2015. Upon further review, it was noted that the services remained consistent throughout each ISP. The service level on the November ISP, however, had been upgraded, which indicated that the resident was receiving a higher level of care. On May 6, 2016 at 2:15 p.m., when asked about Resident #11's service level change, the ED stated that the Resident was currently receiving more services from the staff. The ED further stated that Resident #11's daughter provided most of the resident's care, however, she died last year, leading to the increase in services that needed to be provided by the ALR's staff. On May 6, 2016 at 3:00 p.m. the ADON agreed	R 483	II. How to Identify Other Residents/Staff DON, ADON, or designee will complete an audit of resident ISP spreadsheet to review dates. III. Systemic Changes DON, ADON, or designee with utilize ISP spreadsheet upon admission to create a calendar of upcoming ISP dates. Grand Oaks will be transitioning to an electronic medical record thus discontinuing the need for a manual ISP	

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R 483	Continued From page 16 that the ISP should have been updated. The ADON then took Resident #11's ISP and updated the document with the current services that the ALR staff provided for Resident #11.	R 483	spreadsheet and calendar. IV. Monitoring Process ED, or designee, will conduct random monthly audits for the next 6 months of ISPs to ensure timeliness of completion. V. Date of Completion August 1, 2016	08/01/2016
R 782	Sec. 901 1 Responsibilities Of The ALR Personnel (1) Is capable of self-administering his or her own medications; Based on record review and interview, the ALA failed to ensure an initial assessment had been conducted to determine if a resident was capable of self-medicating for one (1) of one (1) resident's in the sample who self-medicated. (Resident #2) The finding Includes: On May 3, 2016, starting at 11:00 a.m. review of Resident #2's clinical record revealed seven (7) nursing notes from December 23, 2015 through April 26, 2016, which documented that the resident was independent in administering his/her own medications. However, review of the record revealed a history and physical dated September 11, 2015, that indicated the resident was not to self-medicate. Additionally, there was no evidence that the facility's registered nurse conducted an assessment to determine his/her level of independence and safety with self-medicating. During an interview with the DON on May 3, 2016, at 2:30 p.m., the DON indicated that the resident started self-medicating in November of 2015 at the request of the his/her daughter. The	R 782	**901.1 Responsibilities of the ALR Personnel** Is capable of self-administering his or her own medications I. Corrective Action	

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R 782	Continued From page 17 DON was queried if the resident was capable to safely self-medicate and if she had a physician order for the resident to self-medicate. The DON indicated that the resident's daughter was administering the resident medication, and she did not have a physician order for the resident to self-medicate. Continued review of the resident's clinical record on the same day revealed that the record lacked documented evidence that the resident's daughter was administering the resident's medication. Also, the review revealed an ISP dated March 8, 2016, that documented, "the resident will medicate self". Additionally, the clinical record lacked documented evidence of a physician order for the resident to self-medicate. At the time of this survey, the ALR failed to assess if the resident was capable of administering his/her own medications.	R 782	In response to Resident #2, resident is currently out of the community. Upon return to the community, Resident #2 will not be a self-medication resident. II. How to Identify Other Residents/Staff DON, ADON, or designee will perform an audit to ensure that no self-medicating residents have orders that dictate otherwise on the initial H&P III. Systemic Changes	
R 810	Sec. 904a Medication Storage (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 observation and interview, the ALR failed to store a medication cart in a secure area, for one (1) of one (1) medication carts. The finding includes: Observation of the second floor on April 27, 2016, at approximately 11:00 a.m., revealed one (1) unattended locked medication cart in the country kitchen [common area].	R 810		

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R 810	Continued From page 18 Interview with the DON on April 27, 2016, at approximately 11:10 a.m., revealed the medication cart was stored in the country kitchen because it could not fit in the storage closet. Observation on April 28, 2016, at 12:10 p.m., revealed one (1) unattended locked medication cart in the country kitchen. Observation on April 29, 2016, at 12:30 p.m., revealed one (1) unattended locked medication cart in the country kitchen. Interview with a resident on May 6, 2016, at 2:16 p.m., revealed medication carts are left unattended by staff frequently on the 2nd, 3rd and 4th floors. When queried if the unattended medications carts were locked, the resident stated, "I don't know". At the time of this survey, the ALR failed to store all medication carts in a secure area.	R 810	Prior to allowing someone to self-medicate, the DON, ADON, or designee will review the H&P and perform a self-medication assessment. IV. Monitoring Process ED or designee will perform random audits of residents who self-medicate for the next 90 days to ensure compliance. V. Date of Completion August 1, 2016	08/01/2016
R 953	Sec. 1001b General Conditions. (b) An ALR shall maintain all structures, installed equipment, grounds, and individual living units in good repair and operable. Based on observation and interview, the ALR failed to maintain the trash collection area in a sanitary manner. The finding includes: On April 28, 2016, at 2:23 p.m., the surveyor and the rodent control code enforcement inspector conducted an observation of the trash collection dumpster's located on the exterior of the facility.	R 953	**904a Medication Storage** 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. I. Corrective Action	

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R 953	Continued From page 19 Observation of two of the three dumpster's revealed trash piled high above the top, causing the lids to remain open. The third dumpster had a broken lid, which caused it to hang inside the dumpster. Trash was observed on the ground behind and around the dumpster's. On April 28, 2016, at 2:31 p.m., the ALR's director of facilities, indicated that the trash in the dumpster's should be covered. The director of facilities further stated that the broken dumpster would be replaced and that the trash on the ground behind and around the dumpster's would be removed. On May 5, 2016, at 2:56 p.m., further observation of the dumpster area revealed each dumpster was closed with a properly fitting lid, and no trash was observed on the ground or around the dumpster's. At the time of the survey, the ALR failed to ensure that equipment (dumpster's) for collecting trash outside were maintained at all times.	R 953	In response to the surveyor finding locked medication carts located in the community, we immediately relocated them behind another locked door. II. How to Identify Other Residents/Staff Education on medication cart storage was completed with nurses. III. Systemic Changes Medication carts will now be relocated to a locked closet when not attended. IV. Monitoring Process DON, or designee, will perform random site audits over the next 90 days to ensure compliance V. Date of Completion August 1, 2016	08/01/2016
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 observations and interviews, the ALR: (I) failed to ensure the carpets were maintained clean; (II) failed to ensure stairwells were maintained clean; (III) failed to ensure trash rooms were maintained clean; (IV) failed to ensure chairs in the common areas of the facility were free from stains; (V) failed to ensure the staff lounge/locker room area was maintained	R 981		

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R 981	Continued From page 20 clean and in good repair; and (VI) failed to maintain sanitary conditions in the food service area. The findings include: The annual re-licensure survey of the ALR was initiated on April 25, 2016. At various times during the environmental inspection(s), the following concerns were identified: I. Wall to wall carpet was soiled. On April 25, 2016, beginning at 10:40 a.m., observation revealed the carpet was soiled in apartments #108, #124, #216, and #474. At approximately 12:02 p.m., on the same day, the finding was discussed with the ALR's director of facilities, who explained that the ALR was in the process of shampooing the carpets in some of the residents' apartments. Re-inspection of the aforementioned carpets on May 9, 2016, beginning at 11:24 a.m., revealed the carpet in apartments #108, #124, #216, and #474 had been cleaned. Although some cleaning was evident, some stained and soiled areas remained. During the follow-up inspection, the director of facilities and the executive director stated that the carpets had been cleaned as much as possible and would need to be replaced. II. The facility failed to maintain the stairwells on the second floor of the ALR: On May 9, 2016, at beginning at 12:05 p.m., observation revealed the stairwell near apartment #297 appeared to have been swept; however, it had a dark area on the steps leading to the third	R 981	**1001b General Conditions** An ALR shall maintain all structures, installed equipment, grounds and individual living units in good repair and operable. I. Corrective Action The dumpster area was pressure washed and cleaned during the inspection. The dumpster that needed repairs was replaced during the inspection. II. How to Identify Other Residents/Staff Staff education was held on 05/23/16 and 06/21/2016 to review dumpster area and need for always closing the lid. Food and Beverage staff education was held on 06/24/16 to review cleanliness, pest control reporting, and proper disposal of trash.	

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R 981	Continued From page 21 floor. The director of facilities indicated that the observed dark area had been cleaned, and determined to be a stain. Continued observation on May 9, 2016, at 12:08 p.m., revealed the stairwell located by apartment #286 appeared to have been swept. The paint on the floor of the stairwell, however was worn. The excessive wear of the paint made it difficult to determine if the floor had been thoroughly cleaned. The director of facilities indicated that the floor had been cleaned and that the area with worn paint would be repainted. III. The facility failed to maintain the trash collection rooms located on each floor (second, third and fourth floors) in a sanitary condition: On April 29, 2016, at beginning at 7:16 p.m., 7:23 p.m., and 7:31 p.m., respectively, observation of the trash collection rooms located on the fourth, third, and second floors, revealed the exterior and the interior of the trash cans were dirty. This caused a foul odor in the adjacent hallways. A follow-up inspection of all trash collection rooms (fourth, third and second floors) on May 2, 2016, beginning at 12:26 p.m., revealed that all trash cans and trash collection rooms and had been cleaned. Interview with a resident on May 5, 2016, at 12:39 p.m., revealed the trash rooms "are not a problem now." Interview with the director of facilities on May 5, 2016, at 2:28 p.m., revealed the trash cans should be emptied twice daily and should be cleaned whenever necessary to maintain sanitary conditions. IV. The facility failed to maintain all chairs in the common areas of the facility clean and sanitary.	R 981	Additional staff education will be held with the Maintenance and Housekeeping staff. III. Systemic Changes Director of Facilities, or designee, will conduct daily rounds of exterior dumpster area to ensure compliance. IV. Monitoring Process ED or designee will perform random site inspections of the dumpster area for the next 90 days to ensure compliance. V. Date of Completion August 1, 2016 **1004a General Building Interior** An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment,	08/01/2016

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R 981	Continued From page 22 A. On May 3, 2016, beginning at 12:30 p.m., the executive director accompanied the surveyors to conduct observations of the common areas of the facility. 1. At 12:34 p.m., observation of the chairs located in the "Commons" located on the first floor of the building revealed none were soiled. 2. At 12:37 p.m., observation of a couch in the library located on the first floor revealed a large stained area on one of the seat cushions. The executive director indicated that staff would remove the stains from the couch and sanitize it. A follow-up observation of the couch in the library on May 4, 2016, at 12:38 p.m., revealed the stain had been removed from the cushion. 3. Beginning at 1:08 p.m., observation of the chairs in the country kitchens located on the second, third and fourth floors revealed no soiled areas. At 1:18 p.m., however, fraying dark colored threads were observed in the upholstery on the seats of two chairs in the third floor country kitchen. These frayed, dark areas caused the upholstery to appear to be stained. At the time of the observation, the executive director stated that the chairs would need be reupholstered or replaced. 4. At 1:27 p.m., observation of the burgundy colored arm chair located in the sitting area (near Apartments #472 and #474), revealed a large circular stained area on the seat cushion of the chair. During the observation, the executive director	R 981	and fixtures are maintained structurally sound, sanitary and in good repair. I. Corrective Action Resident in suite 108 expired, carpet will be replaced. Carpet in room 124 was cleaned during the inspection. Carpet in room 216 has been replaced. Carpet in room 474 was cleaned during the inspection. The stairwell near apt. 297 was cleaned again during the inspection and will be repainted. The stairwell near apt. 286 was cleaned again during the inspection and will be repainted. All trash rooms were cleaned during the inspection.	

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	ALR-0006	A. BUILDING: _____ B. WING _____	05/25/2016

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R 981	Continued From page 23 indicated that staff would remove the stain from the chair and sanitize it. Further observation of the burgundy colored armchair located in the sitting area (near apartments #472 and #474), on May 6, 2016, at 1:49 p.m., revealed the stain had been removed. B. On May 4, 2016, at 2:42 p.m., observation of all chairs in the dining room revealed the room contained approximately 200 chairs. A staff was observed washing the seats of the chairs and no soiled areas were seen. Interview with the dinning room supervisor indicated that the water being used contained a cleaning and sanitizing solution. Interview with the executive director on May 9, 2016, at 12:09 p.m., indicated that a plan has been implemented to regularly inspect the chairs of the facility to ensure they are maintained in a sanitary condition. At the time of the survey, the facility failed to ensure each chair was maintained in a sanitary condition for seating by residents. V. The facility failed to maintain the staff lounge/locker room area clean and in good repair. On April 29, 2016, beginning at 7:55 p.m., the director of facilities and the executive director accompanied the surveyors to the employee break room areas, including the restrooms and locker rooms. These areas were located on the first floor, across the hall from the kitchen, and were adjacent to each other. Dirt was observed in the corners, and the floor was in need of thorough sweeping and mopping. In the	R 981	The burgundy chair and the living room cushion were immediately cleaned during the inspection. The staff lounge and locker room were cleaned again during the inspection. The broken locker in the staff lounge has been repaired. Pest control treated the kitchen areas on April 28, 29 and 30th and May 1st and 2nd. Pest control has continued to inspect and treat the kitchen weekly. Infection control/serve safe education held on 04/29/16. Food Safety education led by Dept. of Health held on 050616. II. How to Identify Other Residents/Staff	

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R 981	Continued From page 24 lounge sitting area, the window blinds were dirty, and spillage was observed inside the refrigerator. Paper and trash were observed in a broken locker that was located in the corner of the locker room. A tile was missing from an area directly above one of the lockers. In the same area of the ceiling, there was a ceiling tile on which there was a large brown stain. A follow-up observation was conducted on May, 9, 2016, at 12:17 p.m., and revealed that the employee break room areas, including the refrigerator, restrooms and locker rooms had been cleaned. The stained and missing ceiling tiles had been replaced. The trash had been removed from the broken locker, however the door on the locker was still broken. On May 9, 2016, at 12:25 p.m., the director of facilities and the executive director indicated that a schedule would be developed and implemented for regular cleaning and maintenance of the aforementioned staff areas. Additionally, the director of facilities revealed that if the broken locker door could not be repaired, the locker would be replaced. VI. The ALR failed to maintain sanitary conditions in the food service area. On April 28, 2016, at 4:07 a.m., the DOH/HRLA received an anonymous complaint dated April 28, 2016. The complainant alleged that on April 20, 2016, a resident observed vermin in a salad received from the kitchen during the lunch meal. Due to the allegation of an unsanitary food handling practice, an investigation of the ALR's food service area and food handling practices was initiated on April 28, 2016, beginning at 3:05 p.m. An inspection of the facility's food service	R 981	The Director of Facilities (DOF), Director of Housekeeping (DOH), or designee will conduct a full community walkthrough to identify interior building areas that need additional attention. The Executive Chef, Front House Manager, or designee will conduct a full department walkthrough to identify areas needing attention. Staff education was conducted on 05/23/2016 and 06/21/2016 regarding trash rooms, furniture, and pest control. III. <u>Systemic Changes</u> DOF, DOH or designee will conduct daily environmental rounds to determine cleaning needs	

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R 981	Continued From page 25 and dining areas was conducted by the Department of Health Food Safety & Hygiene Investigation Services Division. The ALR inspector accompanied the food service inspector to conduct the observations. Review of the "Observations and Corrective Actions", dated April 28, 2016, revealed that during the inspection, several live vermin were seen in the food service area (ceiling above dishwasher, in the seams of a support rack in the food preparation area, and at the beverage equipment in the kitchen.) There was also an accumulation of oil, food waste, and debris on the kitchen floors in the corners and the baseboards. An accumulation of grease was observed on the sides and the rear of the deep fat fryer, and grease accumulation was also observed on the oven door interior. On April 28, 2016, at 5:11 p.m., the DOH requested the ALR to discontinue food preparation and service from the kitchen until the live vermin were eradicated, until the food service area was thoroughly cleaned, and until the kitchen was reinspected by the DOH. On April 28, 2016, at 8:00 p.m., the ALR submitted a plan of correction to DOH, to address the identified deficient practices. Interview with the executive director on April 28, 2016, at 6:02 p.m., revealed that provisions were being made to obtain the residents' meals from the local hospital affiliated with the ALR, until the kitchen was thoroughly cleaned, reinspected and approved by the DOH for reopening. Additionally, the executive director stated that concurrently, services were scheduled to facilitate additional treatments by a professional pest control vendor until the roaches were completely eradicated.	R 981	throughout the community. Nursing and housekeeping staff will immediately report cleaning needs of resident apartments during routine care/services. Executive Chef, Front House Manager, or designee will conduct daily environmental rounds in the kitchen and dining room area. IV. Monitoring Process ED or designee will conduct weekly environmental rounds for the next 6 months. Senior Vice President, SVP, will conduct monthly rounds for the next 90 days. V. Date of Completion August 1, 2016 **1006c Bathrooms**	08/01/2016

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R 981	Continued From page 26 On April 29, 2016, at 10:30 a.m., repairs, and in-depth cleaning were observed in progress in the food service area. No food was observed being prepared or served from the kitchen. On April 29, 2016, the surveyors observed that all meals (breakfast, lunch, and dinner) were provided by the hospital affiliated with, and adjacent to the ALR. Similarly, on April 30, 2016, at 4:45 p.m. , the surveyors observed that the dinner meal was catered by an outside provider. On May 1, 2016, at 1:30 p.m. the surveyors also observed that the lunch meal was provided by the hospital affiliated with, and adjacent to the ALR. Interview with the executive director and the executive chef on April 29, 2016, at 3:37 p.m., revealed the food service operation in the kitchen would not be resumed until May 2, 2016 at breakfast. On May 2, 2016, at 12:47 p.m., review of the Food Establishment Inspection Report, "Observations and Corrective Actions" dated April 30, 2016, revealed heavy cleaning of the entire kitchen was observed in progress and that no active vermin activity was observed during the inspection. The facility was instructed to complete all cleaning and to clean and sanitize all food contact surfaces before resuming the kitchen operation. According to the corrective action plan, the ALR's executive director agreed to provide the written corrective action plan to the DOH inspectors. On May 3, 2016, at 2:37 p.m., the executive director presented invoices for pest control treatment for roaches on the following dates: April 22, 2016, April 28, April 29, April 30, May 1, 2016, and May 2, 2016. Additionally, the executive director presented two invoices for cleaning of the	R 981	An ALR shall insure that the temperature of the hot water at all taps to which the residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. I. Corrective Action DOF adjusted water temperatures in suites 386 and 474. II. How to Identify Other Residents/Staff DOF, or designee will conduct an audit of at least 25% of resident room water temperatures throughout the community. III. Systemic Changes DOF, or designee will conduct daily random checks of resident room	

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R 981	Continued From page 27 Kitchen dated April 29, 2016. At the time of the survey, the facility abated and satisfied all deficient practices in the kitchen area.	R 981	and common space water temperatures throughout the community. In the event that water temperatures exceed the regulatory requirements, the DOF will be immediately notified. IV. Monitoring Process ED, or designee will conduct random monthly audit of water temperatures throughout the community. V. Date of Completion August 1, 2016	08/01/2016
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation and interview, the ALR failed to ensure that the hot water temperature does not exceed 110 degrees Fahrenheit in two of the fourteen bathrooms inspected. (Apartments #386 and #474) The findings include: During the environmental walk-through/inspection on May 3, 2016, beginning at 12:26 p.m., the hot water temperature measured 120.2 degrees Fahrenheit at the hand sink in the bathroom of apartment #386. At 1:42 p.m., on the same day, the hot water temperature measured 112.4 degrees Fahrenheit at the hand sink in the bathroom of apartment #474. Follow-up observations on May 4, 2016, at 2:03 p.m., revealed the hot water temperature at the hand sink in apartment #386 was 110.7 degrees Fahrenheit. The water temperature at the hand sink in apartment #474 was 111.2 degrees on the same day at 3:25 p.m. On May 5, 2016, at 4:10 p.m., the hot water temperature at the hand sink in apartment #474 when checked again, and was	R1003		

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R1003	Continued From page 28 109.5 degrees Fahrenheit. At the time of the survey, the ALR failed to ensure that the water temperature did not exceed 110 degrees Fahrenheit in two of the apartment bathrooms inspected.	R1003		