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-0004	A. BUILDING: _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEVY CHASE HOUSE	5420 CONNECTICUT AVENUE, NW WASHINGTON, DC 20015

(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)	(X5) COMPLETE
R 000	Initial Comments An annual survey was conducted from July 9, 2014, through July 15, 2014, to determine compliance with Assisted Living Law " DC Code § 44-101.01. " The Assisted Living Residence (ALR) provides care for one hundred- eleven (111) residents and employees eighty-four (84) employees to include professional and administrative staff. The findings of the survey were based on observation, record reviews, and interviews. Please Note:Listed below are abbreviations used in this report. Assisted Living Administrator (ALA) Assisted Living Residence (ALR) Director of Nursing (DON) Registered Nurse (RN)	R 000	*R008 102b2* ***To date we have witnessed no deficient practice. However, we appreciate the potential for a deficient practice to occur.*** ***To that end we have begun investigating businesses and options that could be obtained allowing surveillance of the 31 ingress/egress stairwell doors that wound centrally alarm staff of a penetration. Current residents who have aged-in-place will be identified (as a wanderer or potential wanderer) and along with their responsible parties offered the option of securing 24 hour supervision as well as committing to a shared responsibility agreement addressing the potential safety concerns of the facility or assistance in finding alternate placement. Additionally, increased scrutiny of potential admissions for severe dementia and/or wandering , will be assessed and will factor in the decision to admit or deny admission.*** ***The quarterly quality assurance committee meeting will review the number of identified current residents and examine steps taken to insure their safety. Additionally, an audit of potential residents denied admissions based on assessments indicating a high probability of cognitive issues and/or wandering behavior.***	9/7/14 on-going
R 008	Sec. 102b2 Philosophy of Care (2) The design of services and environment should acknowledge that a significant number of residents may have some form of cognitive impairment. Services and environment should offer a balance between choice and safety in the least restrictive setting. Based on observation and interview, the ALR failed to ensure sufficient safeguards were in place to prevent potential harm. The finding includes: On July 9, 2014, at approximately 10:30 a.m., a tour of the facility revealed the following: -All stairwells were unlocked and all exit doors did not have an alarm system; and	R 008		

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

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R 008	Continued From page 1 -All windows in residents rooms, common areas, as well as balconies in residents rooms, did not have safety locks. During an interview with the ALA on July 9, 2014, at approximately 10:55 a.m., the ALA was asked if a resident was to go in the stairwell, how would the staff be made aware? The ALA stated, we would not know.	R 008		
R 064	Sec. 302e2m Initial ALR Licensure (M) Other reasonably relevant information required by the Mayor. Based on record review and interview , the ALR failed to develop a written policy regarding resident falls. The finding includes: On July 9, 2014, at approximately 2:00 p.m., review of the incident report book revealed that the facility had a total of one hundred seventy-nine (179) falls from December 1, 2013 through June 30, 2014. A review of the facility's Policy and Procedures failed to evidence a written policy addressing resident falls. During an interview with the DON on July 9, 2014, the DON indicated that during orientation staff is shown a fall video which instructs staff what to do when a resident falls. The DON also indicated that the facility is working on developing a written fall policy.	R 064	***R064 Sec.302e2m*** ***Effective immediately, CCH adopted the CDC's STEADI tool kit for Health Care Providers and have begun assessing all residents identified with multiple falls over the past several months.*** ***A fall policy has been developed and has been adopted with the necessary protocols to cover such an events.*** ***All current and new nursing staff will be in-serviced on the fall policy as well as the contents of the STEADI tool kit and its utilization.*** ***The quarterly quality assurance committee meeting will trend and review the implementation of the new policy and assessment kit. The Directors of Nursing and Social Services will report on trends, interventions, shared responsibility agreements and transition options related to the issue of falls. The admission/marketing team will present to the committee the number of admissions and the numbers of admissions denied as a result the assessment protocols adopted.***	8/14/14 ongoing
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to	R 802		

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R 802	Continued From page 2 medication; and Based on record review and interview, it was determined that the ALR's RN failed to assess the resident's response to medications every forty-five days for (11) of eleven (11) residents in the sample. (Residents' #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11) The findings include: Record review of Residents' #1-#11's clinical records, on July 9, 2014, through July 15, 2014, at approximately 10:00 a.m. failed to evidence that the RN assessed the resident to determine the effectiveness of his/her medications. During an interview with the DON on July 15, 2014, at approximately 2:00 p.m., the DON indicated that the facility's RN does not assess the resident's response to medications every forty-five days but they will start.	R 802	8/7/14 ongoing *R 802 Sec, 903.2* ***All licensed staff have been in-serviced on the new policy and process and will be held accountable for follow-through.*** ***The Director of Nurses (RN) will assess all resident Medication responses every 45 days.*** ***The Director of Health Services (DON) shall be responsible for reporting compliance or lack thereof to the quarterly quality assurance committee, providing analysis, drug to drug interaction and adverse reactions. Licensed staff in-services focused specifically on medication administration and common signs of adverse reactions, will also be conducted as indicated.***	