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9/13/17
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/27/2017
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NAME OF PROVIDER OR SUPPLIER BV/MSTAR CHEVY CHASE TENANT D/B/A CHE	STREET ADDRESS, CITY, STATE, ZIP CODE 5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015
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R 000 Initial Comments

R 000

An annual survey was conducted from July 20, 2017 to July 27, 2017, to determine compliance with the Assisted Living Law "DC Code § 44-101.01." The Assisted Living Residence (ALR) is licensed for a capacity of one hundred thirty-one (131) residents, and provides care for seventy-eight (78) residents and employs ninety-five (95) employees including professional and administrative staff. The sample size included eight (8) resident records and nine (9) employee records. The findings of the survey were based on observations, record reviews, and interviews with residents, resident's families and employees.

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

- ALA -- Assisted Living Administrator
- ALR -- Assisted Living Residence
- DCMR -- District of Columbia Municipal Regulations
- DON -- Director of Nursing
- ED -- Executive Director
- ISP -- Individual Service Plan
- LPN -- Licensed Practical Nurse
- POS -- Physician's Order Sheet
- PPD -- Purified Protein Derivative
- RN -- registered nurse
- F -- Fahrenheit

R 481 Sec. 604b Individualized Service Plans

R 481

(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 interview and record review, the ALR

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Melissa Stewart, Executive Director

9-12-17

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R 481	<p>Continued From page 1</p> <p>failed to ensure all ISPs included when, how often and by whom services will be provided, for one (1) of eight (8) residents in the sample. (Resident #5)</p> <p>The finding includes:</p> <p>On July 26, 2017, at 12:15 p.m., review of Resident #5's POS dated July 13, 2017, revealed a physician's order for the nursing staff to wash the puncture wound on the resident's lower right leg with soap and water, apply Bactroban ointment, cover with a Telfa two (2) by 2 dressing and secure with paper tape, twice a day for ten (10) days.</p> <p>On July 26, 2017, at 12:45 p.m., review of Resident #5's ISP dated July 14, 2017, revealed no documented evidence of the aforementioned physician's order for wound care services to be provided to the resident.</p> <p>On July 26, 2017, at 1:15 p.m., review of the ALR's "Skin Assessment, Wound Management Policy and Procedure", dated June 23, 2016, revealed the ISP would be modified at the time of the identification of changes in skin status for the purpose of documenting assessment findings, changes in status, interventions and outcomes.</p> <p>On July 27, at 11:00 a.m., interview with the DON confirmed Resident #5 had received wound care to the lower right leg according to the POS from July 13, 2017, through July 23, 2017. Further interview with the DON revealed the nursing staff would be re-trained on the "Skin Assessment, Wound Management Policy and Procedure" and specifically documenting when, how often, and by whom, wound care services were to be provided for Resident #5 on the ISP.</p>	R 481	<p>R 481-Sec.604b Individualized Service Plan Resident #5:</p> <p>1-DON/Designee has completed an audit of ISP's to identify any recent change of conditions/hospitalizations in our current resident population. completed</p> <p>2-DON/Designee has created an ISP Addendum which will track the residents change in conditions to include wounds and residents any other change in condition. The ISP Addendum includes a description of problem, intervention, frequency, responsibility of whom and a discontinue date. completed</p> <p>Nursing staff will continue to utilize Skin Assessment per Wound Management Policy and Procedure. ongoing</p> <p>3-DON/Designee will ensure change of condition is placed on ISP Addendum. Addendum includes all change of condition of residents. 10/10/17</p> <p>4-Educate/In-Service Licensed Nursing Staff on Skin Assessment/Wound Management P&P's. Educate/In-Service Licensed Nursing Staff on ISP Process & Addendum Procedures. 10/10/17</p> <p>5-DON/Designee will conduct monthly audit of ISP Process & Addendum Binder and Procedures to ensure compliance of new process. 10/6/17 monthly & ongoing</p> <p>6-DON/Designee will report findings of monthly audit to Executive Director. 10/6/17 monthly & ongoing</p>	
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R 481 Continued From page 2

R 481

At the time of the survey, there was no documented evidence on the ISP when, how often, and by whom wound care services were provided to the resident.

R 483 Sec. 604d Individualized Service Plans

R 483

(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 interview and record review, the RN failed to assess the resident's ability to safely continue to self-administer medications every forty-five days, for one (1) of one (1) resident's in the sample that self-medicated. (Resident #2)

The finding includes:

On July 26, 2017, at 2:00 p.m., review of Resident #2's clinical record revealed that the resident administered his/her medications. Further review of the record lacked documented evidence a 45-medication assessments had been conducted from February 23, 2017 through July 6, 2017. It should be noted that the facility discovered Resident #2 administered Atvian incorrectly to Resident #3 on July 3, 2017, which resulted in Resident #3 being admitted to the hospital.

R 483-Sec. 604d Individualized Service Plan Resident # 2:

1-DON/Designee has completed an Audit of the residents who currently Self Administer their own medications	completed 9/11/17
2-DON/Designee has created a Self Medication Administration schedule/tracking tool.	completed 9/11/17
3-DON/Designee will conduct monthly audit of Medication Administration Program to ensure compliance.	10/6/17
4-DON/Designee will report findings of monthly audit to Executive Director.	10/6/17 monthly & ongoing

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R 483 Continued From page 3 **R 483**

On July 26, 2017, at 2:30 p.m., interview with the DON revealed that she was unable to find 45-medication assessments that had been conducted from February 23, 2017 through July 6, 2017.

At the time of the survey, the RN failed to assess Resident #2's ability to continue to safely self-administer his/her own medications between February 23, 2017 through July 6, 2017.

R 598 Sec. 701d11 Staffing Standards. **R 598**

(11) Maintain personnel records for each employee that include documentation of criminal background checks, statements of health status, and documentation of the employee's communicable disease status; Based on record review and interview, the ALA failed to document each employee's communicable disease status, for two (2) of nine (9) employees. (Dietician and LPN #1)

The findings include:

1. On July 27, 2017, at 10:02 a.m., review of the dietician's personnel record revealed no documented evidence of her communicable disease status. Approximately two (2) minutes later, the surveyor informed the ED of the aforementioned finding. The ED indicated that she would call the office and have the office fax over the dietician's health status information. It should be noted that the surveyor did not receive the information prior to the survey exit.

2. On July 27, 2017, at 10:54 a.m., review of LPN #1's personnel record revealed her PPD expired

R 598 -Sec. 701d11 -Staffing Standards
Employee #1 & Dietician:

1-Audit in process of personnel records for each employee. for document of each employee's communicable disease status	10/6/17
2-Employee #1 & Dietician have completed/updated ppd & documentation for communicable disease status documentation.	8/31/17
3-Business Office Manager will maintain a schedule of documentation of personnel record which needs to be updated on initial & annual basis.	10/31/17 ongoing
4-Business Office Manager will audit schedule monthly basis to ensure continued compliance of personnel records.	10/31/17 monthly
5-Business Office Manager will report findings of audit to Executive Director monthly.	10/31/17 monthly

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R 598	<p>Continued From page 4</p> <p>on February 17, 2017. At 10:57 a.m., interview with the ED confirmed that LPN #1's PPD had expired and that she would contact LPN #1 to have her update her health status.</p> <p>At the time of the survey, the ALR failed to maintain personnel records for the dietician and LPN #1 that included their current communicable disease status.</p>	R 598		
R 803	<p>Sec. 903 3 On-Site Review.</p> <p>(3) Assess the resident's ability to continue to self-administer his or her medications. Based on interview and record review, the RN failed to assess the resident's ability to safely continue to self-administer medications every forty-five days, for one (1) of one (1) resident's in the sample that self-medicated. (Resident #2)</p> <p>The finding includes:</p> <p>On July 26, 2017, at 2:00 p.m., review of Resident #2's clinical record revealed that the resident administered his/her medications. Further review of the record lacked documented evidence 45 day-medication assessments had been conducted from February 23, 2017 through July 6, 2017. It should be noted the facility discovered that Resident #2 had incorrectly administered Ativan to Resident #3 on July 3, 2017, which resulted in Resident #3 being admitted to the hospital.</p> <p>On July 26, 2017, at 2:30 p.m., interview with the DON revealed she could not find evidence that the RN had conducted 45 day-medication assessments from February 23, 2017 through</p>	R 803	<p>R 803-Sec. 903 3-On-Site Review Resident #2 & Resident #3: 1-DON/Designee has conducted Audit of residents 9/11/17 currently on Medication Administration Program & residents who participate in the Self-Administration Program. Audit also completed of 45 Day Reviews. 2-DON/Designee has developed and completed 9/11/17 & a schedule which to stay in compliance with 45 update day reviews. ongoing 3-DON/Designee will conduct monthly audit of 10/6/17 45 day Review Schedule and report findings of monthly & the monthly audit to the Executive Director. ongoing</p>	

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R 803	Continued From page 5 July 6, 2017. At the time of follow-up visit, the RN failed to assess Resident #3's ability to continue to safely self-administer his/her own medication from February 23, 2017 through July 6, 2017.	R 803		
R 981	Sec. 1004a General Building Interior (a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair. Based on observation and interview, the ALR failed to ensure equipment, walls, and a ceiling were structurally sound and in good repair. The findings include: On July 20, 2017, at 2:00 p.m., observation of the kitchen revealed the following concerns: - Reach-in refrigeration unit located on cook line was not operational; - Dish machine pressure and temperature gauges not working; - Deteriorating wall tiles located behind the three compartment sink and behind cook line equipment; and - Missing ceiling tiles. During an exit conference on July 20, 2017, at 3:00 p.m., the ALA was made aware of the findings mentioned above.	R 981	R981-Sec. 1004a General Building Interior 1-Reach-in refrigeration unit located on cook line has been repaired and now operational. 8/20/17 2-Dish machine was serviced on 7/30/17 and temperature gauges replaced. In process of replacing dishwasher with new equipment 11/15/17 3-Contracting work to have deteriorating wall rebuilt behind cook line equipment and three compartment sink. 10/11/17 Repairs have been made to seal up hole behind three compartment sink until more permanent solution completed. 9/1/17 4-Missing ceiling tiles have been fixed/replaced 7/28/17 5-Dining Services Director & Maintenance Director will conduct monthly inspection of kitchen to ensure all equipment and kitchen in good repair, structurally sound and sanitary. 10/2/17	

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R 981 Continued From page 6
At the time of the survey, the ALR failed to ensure equipment, walls, and a ceiling was in good repair.

R1032 Sec. 1009 2 Kitchen.
(2) Food preparation areas with cleanable surfaces;
Based on observation and interview, the ALR failed to ensure food preparation surface areas were clean.

The findings include:

On July 20, 2017, at 2:00 p.m., observation of the kitchen revealed the following concerns:

- Live roach activity inside of large mixing bowls located on the prep sink and dish machine area;
- Uncleaned kitchen utensil in storage drawers;
- Employees' personal belongings stored were on the kitchen prep table; and
- Excessive mold build-up present in the interior of the kitchen ice machine.

During an exit conference on July 20, 2017, at 3:00 p.m., the ALA was made aware of the findings mentioned above.

At the time of the survey, the facility failed to ensure all food preparation areas were clean.

R1058 Sec. 1011h Special requirements for ALRs with 17 beds

R1032-Sec.1009 2-Kitchen

- 1-Pest Control contracted company is coming to inspect and treat weekly and is focused on kitchen. 9/12/17
weekly until resolved
9/12/17
- 2-Meeting scheduled with corporate representative of contract pest control company, Dining Services Director and Executive Director monthly until roach activity is resolved.
- 3-All kitchen equipment, storage, utensils has been fully cleaned & properly sanitized. 9/11/17
- 4-Ice Machine was cleaned & mold build up removed upon report of issue from inspector. 7/20/17
- 5-Dining Service/kitchen staff now responsible for cleaning/sanitizing ice machine on a weekly basis. weekly & ongoing
- 6-Dining Services Director & Maintenance Director will conduct monthly inspection to ensure kitchen, equipment, materials, supplies are in good working order & properly cleaned/sanitized. 10/2/17
monthly ongoing
- 7-Employees' personal items were removed. Educate/In-service dining service staff on proper storage of personal items. Dining Services Dir. will monitor proper storage personal items daily. 7/20/17
8/31/17
daily/ongoing

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R1058 Continued From page 7 R1058

(h) An ALR shall ensure that all food is prepared and served in accordance with Chapters 20 through 24 of Title 23 of the District of Columbia Municipal Regulations and shall organize plumbing facilities to insure that food is processed and served so as to be safe for human consumption.
Based on observation and interview, the ALR failed to follow chapter 24, Subtitle A of Title 25 DCMR, Food and Food Operations Regulations, which was formerly Title 23.

The findings include:

On July 20, 2017, at 2:00 p.m., the inspection of the facility's kitchen was conducted by The Department of Health Food Safety and Hygeine Inspection Services Divison. The food inspector observed improper air gap under several sinks with uncleaned drains, and waiter station hand sinks that were not accessible for use because they contained dumped ice.

During an exit conference on July 20, 2017, at 2:45 p.m., the ALA was made aware of the findings mentioned above.

At the time of the survey, the ALR failed to follow Subtitle A of Title 25 DCMR, Food and Food Operations Regulations.

R9999 Final Observations R9999

The following observations were made during the survey process. It is recommended that these areas be reviewed and a determination be made regarding appropriate actions.

On July 20, 2017, The Department of Health

R 1058-Sec.1011h- Special Requirements for ALR's with 17 beds:

- 1-Air gap corrected/resolved by Maintenance Director 9/8/17
- 2-Drains all cleaned daily. On daily cleaning schedule 7/31/17
- 3- Waiter station hand sinks clean and accessible for hand washing 7/20/17
- 4-Kitchen staff to be in-serviced on proper hand washing & proper disposal of ice when cleaning hand washing sinks 9/15/17
- 5-Dining Services Director and Maintenance Director will conduct monthly inspection of kitchen to ensure equipment physical plant and utilities are in good repair and clean. 10/2/17
monthly

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R9999	<p>Continued From page 8</p> <p>Food Safety and Hygiene conducted an inspection of the facility's kitchen and the following violations were cited under Title 25A of the District of Columbia Municipal Regulations:</p> <ol style="list-style-type: none"> 1. Improper/lack of proper hand washing before donning gloves, during food preparation; 2. Improper cooling methods in the walk-in refrigeration unit; the food containers were tightly covered and did not allow the transfer of heat. Proper cold holding temperatures are between 41°F and lower. Items included: tuna salad dated 07/12/17 was 42 °F, fish dated 07/16/17 was 42 °F, and chicken salad dated 07/19/17 was 43 °F. The items mentioned were discarded during the inspection; 3. Improper cold holding temperature in the top load refrigeration unit located on the cook line. Proper cold holding temperatures are between 41°F and lower. Items included: sliced tomatoes 52 °F, cut lettuce 48 °F, and turkey 42°F. The items mentioned were discarded during the inspection; 4. Expired containers of wholesome farms sour cream stored in refrigeration units dated 07/15/17, item discarded during the inspection; 5. Containers of strawberries with mold present stored in kitchen prep area of reach-in refrigeration unit, item discarded during the inspection; 6. Raw shell eggs stored above ready-to-eat food items in the reach-in refrigeration unit located on the cook line; 7. A garden hose stored in the cambro was being 	R9999	<p>R9999 Final Observations:</p> <ol style="list-style-type: none"> 1-Improper/lack of hand washing before donning gloves, during food preparation. Educate/In-Service Dining Staff on proper hand washing Dining Services Director to monitor proper hand washing prior to donning gloves. 8/13/17 daily/ongoing 2-Improper cooling methods in walk-in refrigeration unit. All expired items have been discarded. Cooks/Prep cooks/Dining Services Director monitor dates on food items daily and temperatures on walk-in's. 7/20/17 daily/ongoing 3-Improper cold holding temperature in the top load refrigeration unit located on the cook line. Food items disregarded. Reach through unit not used until it was repaired and fully operational. 8/15/17 Cooks/ Prep Cooks/Dining Services Director monitor dates & food temperatures daily on top load refrigeration unit. daily/ongoing All refrigeration units have 2 thermometers inside them and temperatures are recorded daily. 8/31/17 daily 4 & 5-Expired/Molded Food items-discarded at time of inspection .Dining Service Staff monitor food items daily and dispose of expired items daily. 7/20/17 daily/ongoing 6-Raw shell eggs stored above in reReach through unit not used until it was repaired and fully operational. 8/15/17 Cooks/ Prep Cooks/Dining Services Director monitor dates & food temperatures daily on top load refrigeration unit Staff/Dining Services Director to monitor reach-in equipment and proper storage of food items daily Daily/ongoing 7-Garden hose and cambro portable sink removed from kitchen. In-Service on Proper food handling and safe 7/20/17 8-Dumpster lids in bad repair. Contact has been made to dumpster contracted company to exchange dumpster for a different type of dumpster. New dumpster request has been made as of 9/1/17. New dumpster to be delivered by 10/15/17 9/1/17 9-Files in mop room were removed and dining service educated on proper storage of kitchen items. Dining Services staff/ Dining Services Director to monitor daily. 9/8/17 10-Reach-in refrigeration units failed to have thermometers. Two thermometers have been placed in reach-in refrigeration. Monitor & record temperatures daily. 8/31/17 Daily/ongoing 	
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R9999	<p>Continued From page 9</p> <p>used to thaw hamburger meat in the portable sink;</p> <p>8. Dumpster's noted with bird activity due to lids being in a bad repair and missing;</p> <p>9. Flies were in the mop room;</p> <p>10. Reach-in refrigeration units failed to have thermometers;</p> <p>11. In-use utensils stored on the cook line stove door, and not under a continuous flow of water or water temperatures of 135°F; and</p> <p>12. Lack of a dip well to provide a constant flow of water for utensil used to scoop ice cream.</p> <p>During an exit conference on July 20, 2017, at 2:46 p.m., the ALA was made aware of the findings mentioned above.</p> <p>At the time of the survey, the ALR failed to follow Subtitle A of Title 25 DCMR, Food and Food Operations Regulations.</p>	R9999	<p>R9999 Continued:</p> <p>11-In-use utensils stored on cook line stove door. 8/31/17 Removal of utensils from cook line stove door. Educated/In-Service all Dining Service Staff on proper techniques for handling in-use utensils. Dining Service Director will monitor proper techniques daily. Daily/ongoing</p> <p>12-Lack of dip well to provide constant flow of water for utensil used to scoop ice cream. Currently obtaining estimate to have dip well installed. Dining Service Director will order Dip Well. Maintenance Dir. will ensure dip well installed within 30 days. 9/11/17 9/15/17 10/15/17</p> <p>Educate/In-service dining service staff on proper ice scooping techniques until dip well is installed and fully operational. Dining Services Director to monitor ice scooping techniques of dining services staff per meal/daily</p>	
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