HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0006	(X2) MULTIPLE CONSTRUCTION A, BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 06/04/2014

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	R000	Grand Oaks Assisted Living is filing the following plan of correction for purposes of regulatory compliance, in response to the complaint investigation and annual licensure survey conducted on May 19, 2014. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein.	

A complaint investigation, in conjunction with an annual licensure survey were initiated on May 19, 2014 and completed on June 4, 2014. The Assisted Living Residence (ALR) provides care for one hundred fifty-seven (157) residents and employed two hundred- fifteen (215) employees to include professional and administrative staff. The survey/investigation was conducted to determine compliance with the Assisted Living Law " DC Code§ 44-101.01."

On January 30, 2014, a resident's family member filed a complaint that alleged the ALR committed numerous medication errors, e.g. administering the wrong dosage and when not needed; (2) administering Bacid when not indicated for a terminal resident; and (3) allowing an administrative staff to administer Morphine. The investigation findings revealed that the wrong dosage (5 times the prescribed dosage) of Morphine was administered 3 times by 3 different nurses. The other allegations concerning Bacid and unlicensed staff administrating medications were not substantiated.

The annual licensure survey revealed that from December 1, 2013 through May 9, 2014 a total of 166 falls affecting 71 residents. Fifty one (51) of the falls resulted in injuries (e.g. minor head injuries, skin tears, bruises, lacerations, and a hip fracture). Additionally, 40 residents sustained injures of unknown origin (e.g. skin tears, bruises and lacerations).

Throughout this plan of correction, reference is made to a "statistically significant sample" for chart auditing in the "Monitoring" sections. The following algorithm was used to determine the sample size. Population size, for this plan of correction, refers to either all patients with falls, or all new admissions, or the entire census (depending on the particular surveyor findings for each deficiency).

The following sample sizes are considered minimum requirements for statistical significance:

- For a population size of fewer than 30 cases, sample 100% of available cases
- For a population size of 30 to 100 cases, sample 30 cases
- For a population size of 101 to 500 cases, sample 50 cases
- For a population sixe greater than 500 cases, sample 70 cases

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

RECEIVED JUL 10 2014

Paul M. Kelley
PAUL M. Kelley
Executive Director
July 10, 2014

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R000	Continued From page 1 On May 28, 2014, the facility's governing body was notified of the health and safety concerns; and on May 30, 2014 the facility submitted a plan to remove the urgent concerns. The facility implemented immediate strategies " to reduce or minimize resident falls and resident falls with injury at Grand Oaks Assisted Living; to maximize resident safety and independence with functional mobility throughout the day; to enable resident freedom of choice and support resident rights in the healthcare decision process regarding falls and safety. If the resident refuses recommended interventions, Grand Oaks will consider the use of a shared responsibility agreement." The ALR also took immediate action to address medication management which included: "A 24-hour chart-check will be completed by a licensed nurse, which will include verification of new physician orders with the medication administration record (MAR). When administering medications to a resident, the licensed nurse will verify the order and medication label with the MAR and check the "5 Rights" of medication administration: right resident, right medication, right dose, right route, and right time. The 24-hour chart-check will be completed on the 11P-7A shift. II Please Note: Listed below are abbreviations used in this report.	R000		

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R000	Continued From page 2 Assisted Living Residence (ALR) Director of Nursing (DON) Individualized Service Plan (ISP) Interdisciplinary team (IDT) Licensed Practical Nurse (LPN) Milligrams (mgs) Milliliters (ml) Medication Administration Record (MAR) Occupational Therapy (OT) Physical Therapy (PT) Physician Order Sheet (POS) Primary Care Physician (PCP) Private Duty Aide (PDA) She/ He (S/he) Shortness of Breath (SOB) Speech Therapy (SLP) Status Post (S/P) Sublingual (SL)	R000		
R292	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 failed to ensure appropriate and adequate treatment was provided for five (5) of eighteen (18) residents' in the sample. (Residents' #5, #6, #7, #18 and #1) The findings include: **1. The ALR failed to provide timely assessment and treatment as evidenced by the following:**	R292	The following comments are for R292: **1. Individual Responsible for the Corrective Action:** Director of Nursing (DON) **2. Corrective Action for Identified Residents:** a. Four of the 5 residents cited by the surveyors (#1, #5, #6, and #7) remain in the facility and are being addressed under this plan of correction. Resident #18 was discharged. b. The DON completed a case review of cited deficient practices with clinical nursing staff and documented this in the staff meeting minutes. **3. Corrective Action for All Residents/Systemic Changes:** a. Other residents with the potential of being	6/25/14

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R292	Continued From page 3 On May 9, 2014, at approximately 1:41 p.m., review of the Resident #5's clinical record revealed that the resident was admitted to a local hospital for right hip fracture following a fall. During an interview with the wellness nurse (LPN #8), on May 15, 2014, at approximately 11:34 a.m., LPN #8 indicated that the resident fell during the night shift. A PDA (#5), who was on duty, failed to report the fall to the nurse. According to LPN #8, the PDA reported the fall to the next shift staff (PDA #6), approximately 45 minutes after the fall. PDA #5 was interviewed, via telephone, on June 4, 2014 at approximately 9:10a.m. PDA#5 stated "[the resident] fell while I was helping her to get dress. I helped [the resident] back to bed and then I gave a report to the relieving aide. I did not tell the nurse because she [the resident] was not in pain." PDA #6 was also interviewed, via telephone, on June 4, 2014, at approximately 11:32 a.m. The PDA stated that "the night aide [PDA #5] told me that [the resident] fell. [The resident] was not in pain and just wanted to sleep. I don't remember how long the resident was sleeping, but when she woke-up, she could not walk to the bathroom, so I called the nurse. The nurse checked [the resident] and told me to take [the resident] to the ER in a wheelchair." During a telephone conference with LPN #9 on June 4, 2014, at approximately 12:40 p.m., the LPN stated, "The aide [PDA#6] came to the office after 1:00 requesting I check the resident. I asked if the resident fell and the aide [PDA #6] said yes, with the night shift aide. I	R292	affected by the same deficient practices will be addressed by the following plan of correction to ensure (1) timely reporting of fall incidents; (2) timely evaluation post-fall by licensed staff; (3) safe transport of residents who have fallen and need to be seen in the hospital ER; (4) administration of medications as ordered by a physician; (5) safe self-administration of medications by residents; and (6) efforts to reduce fall frequency: **3A. Policy & Procedure:** a. The Falls Policy presented to the surveyors on-site as a draft policy was further revised, finalized, and approved, to include procedures for timely reporting of all fall incidents to licensed staff, appropriate resident post-fall evaluation with implementation of safety precautions, and safe resident transport post-fall. b. The Private Duty Aide (PDA) Policy was finalized and approved, to include procedures for coordination of care with all PDAs. c. The Medication Errors Management and Reporting Policy draft was finalized and approved to help prevent medication errors by including a twenty-four (24) hour chart check to verify new physician orders with the Medication Administration Record (MAR). d. The Medication Administration Policy draft was finalized and approved, to include procedures for the six rights of medication administration (where "Right Medication" includes verifying the name and dosage on the medication label with the MAR). e. The Self-Administration of Medications Policy draft was finalized and approved, to	 7/8/14 7/7/14 7/7/14 7/7/14 7/7/14

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R292	Continued From page 4 tried to do range of motion [to lower extremities] but it was too painful so I told the aide [PDA #6] to take the resident to the ER in a wheelchair. A follow-up interview with LPN #8, at approximately 1:15 p.m., via telephone, was conducted to ascertain the facility's practice of transporting residents to the emergency room. The LPN indicated that if a resident is responsive, the resident is transported to the emergency room via wheelchair; and if the resident is unresponsive, the facility calls 911. There was no evidence that the facility (1) ensured that PDAs reported a fall incident timely; (2) ensure that the resident was assessed, after a fall by a licensed registered nurse as required by the nurse practice act; and (3) ensure that the resident was transported to the ER safely to prevent possible injury. **2. Review of sample residents ' records and the ALR incident report log failed to provide an effective system to reduce fall frequency as evidence by the following:** On May 15, 2014, starting at approximately 9:00 a.m., review of the facility's incidents from December 1, 2013 through May 9, 2014 a total of 166 falls affecting 71 residents. Fifty one (51) of the falls resulted in injuries (e.g. minor head injuries, skin tears, bruises, lacerations, and a hip fracture). Additionally, 40 residents sustained injures of unknown origin (e.g. skin tears, bruises and lacerations). During an interview with the ALA on April 20,	R292	include a regular assessment of the resident's ability to self-administer medications and updating the Individualized Service Plan (ISP), as appropriate. **3B. Documentation:** a. The Resident Post-Fall Evaluation/Huddle Tool was implemented with nursing staff to investigate the cause of the fall, document a re-assessment of the resident's fall risk level, and re-establish necessary fall precautions. b. The Nursing Handoff Communication 24-Hour Report has been and will continue to be used by nursing staff to include shift-to-shift handoff of information, including post-fall evaluation information. c. The PDA Handoff Report Log will be implemented to allow for licensed nursing coordination of care delivered by PDAs by requiring PDAs to complete a written handoff communication at the end of their shift for the licensed nurses. d. The PDA orientation packet will be finalized and implemented to educate PDAs on policy and procedure regarding coordination of care delivered by PDAs to help ensure timely resident assessment and treatment. e. The Assessment of Self-Administration of Medication tool was implemented for the four cited residents to document the resident's knowledge and skills necessary for safe self-administration of medications and for registered nurses to use every 45 days in assessing the capability of the resident to continue to self-medicate. f. The Assessment of Self-Administration of Medication tool will continue to be rolled out	 7/9/14 Ongoing 8/11/14 8/11/14 7/9/14 8/11/14

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R292	Continued From page 5	R292	to all other current self-medicating residents to document the resident's knowledge and skills necessary for safe self-administration of medications and for registered nurses to use every 45 days in assessing the capability of the resident to continue to self-medicate.	
	2014, at approximately 2:45p.m., the ALA indicated that the ALR had a policy and procedures to address fall incidents. The review of the policy included the following:		**3C. Education:**	
	"After any fall, staff members will meet briefly (huddle) to discuss the details of the fall, reassess the patient's risk level and re-establish the necessary precautions to ensure safety....If a fall occurs or if the resident claims to have fallen....a notation of the events must be documented in the ISP. Changes in the resident status as a result of the fall should be addressed in the resident's ISP."		a. Educated all nursing staff on the Falls Policy, Post-Fall Evaluation/Huddle Tool documentation, and Nursing Handoff Communication 24-Hour Report via instructor-led training and documented this education on staff transcripts.	7/9/14
	The ALR failed to follow its fall policy as evidenced below:		b. Educated all Certified Nursing Assistants (CNAs) and all other non-nursing Grand Oaks staff on the Falls Policy via instructor-led training and documented this education on staff transcripts.	7/3/14
	a) On May 15, 2014, at approximately 12:00 p.m., review of Resident# 6's record revealed that the resident fell nine (9) times from December 14, 2013 through April21, 2014 (December 14, 2013; January 17, 2014; February 3, 2014; March 25th and 31st, 2014; and April 7th and 8th, and 21st (twice) 2014).		c. Nursing staff will be educated on the PDA Policy via staff in-service and documented this education in staff meeting minutes.	8/11/14
	The review of the clinical records revealed no evidence that the staff "huddle" to reassess the resident's risk level and re-establish necessary precautions after every fall as required by the facility's policy.		d. All PDAs will be educated on the PDA Policy, including the requirements for PDAs to immediately report all fall events to nursing and to complete the PDA Handoff Report Log at the end of every shift, via the PDA orientation packet.	8/11/14
	Review of the resident's updated ISP, dated February 24, 2014, instructed the care managers to "check on [the resident] every two hours to prevent falls." It should be noted that there was no evidence that the care manager monitored the resident every 2 hours as instructed by IDT. It should be noted that the resident fell 6 additional times since the ISP was updated on February 24, 2014.		e. Informed all residents and families of the PDA Policy, including the requirements for PDAs to immediately report all fall events to nursing and to complete the PDA Handoff Report Log at the end of every shift, via a presentation to the Grand Oaks Family Council (7/8/14) and a letter to residents and families (7/9/14).	7/9/14
			f. Educated nursing staff on the Medication Errors Policy, Medication Administration	7/9/14

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R292	Continued From page 6 During an interview with the ALC on May 15, 2014, the ALC stated that the resident was monitored daily and presented the surveyor with daily logs that documented monitoring. The daily logs however, failed to provide evidence that the resident was monitored every two hours consistently. It reflected inconsistent dates and times, and failed to provide details on the results of each monitoring visit. b) On May 15, 2014, at approximately 12:00 p.m., review of Resident #7's record revealed that the resident fell nine (9) times from December 1, 2013 throughApri128, 2014 (December 1st, 16th and 19th, 2013; January 11, 2014; March 29, 2014; and April 7th, 11th, 20th and 28th, 2013). The review of the clinical records revealed no evidence that the staff "huddle" to reassess the resident's risk level and re-establish necessary precautions after every fall as required by the facility's policy. Review of the resident's updated ISP, dated April 12, 2014, revealed a recommendation that the ALR asked the family to provide new shoes." His [resident] shoes has [sic] been too wide and don't fit him [resident]." The ISP also recommended "no more than one drink (Martini) with son." It should be noted that since the update, the resident has fallen two additional times. There was no evidence that the family provided the appropriate size shoes, and that the resident alcohol intake was limited.	R292	Policy, and Self-Administration of Medication Policy, to include: (1) completion of the tool for documenting resident self-administration knowledge and skills and (2) registered nurse documentation, at least every 45 days, of an assessment of residents' ability to continue to self-administer medications. Education was completed via instructor-led training and documented on staff transcripts. g. Assessed medication administration competency for all nursing staff and documented this competency on staff transcripts. **4. Monitoring:** a. A statistically significant random sample of resident records with falls will be audited monthly by the DON or designee for staff compliance with Falls Policy documentation requirements until 90% or greater compliance is sustained for 4 continuous months, and then periodically to monitor continued compliance. Audits will be reported to the Assisted Living Administrator (ALA), DON, and Vice President (VP). b. A statistically significant random sample of residents with PDAs will be audited monthly by the DON or designee for completion of a PDA Handoff Report Log each shift until 90% or greater compliance is sustained for 4 continuous months and then periodically to monitor continued compliance. Audits will be reported to the ALA, DON, and VP. c. A statistically significant random sample of resident records will be audited monthly by the DON or designee for nursing staff compliance with the 24-hour chart check documentation requirement and for documentation of an assessment every 45 days of resident ability to continue self-	 7/9/14 7/3/14 and monthly 8/11/14 and monthly 7/9/14 and monthly

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R292	Continued From page 7 **3. The ALR failed to ensure that medications were administered as ordered by a physician.** **a)** On May 9, 2014 at approximately 1:00 p.m., review of Resident #18's clinical record revealed an interim order, dated October 2, 2014, from the resident's hospice physician. The order was for " Dilaudid 3 milligrams SL every 2 hours as needed for pain or SOB," and approved by the resident' s primary care physician. A review of the resident's October 2013 MARs revealed that the order for Dilaudid was transcribed as " Dilaudid 1 mg/cc solution take 3 teaspoonfuls ml 3 mg every 2 hours as needed for pain or SOB". The MAR also documented that LPN #6 administered 3 teaspoons (15 mls) of the medication on October 2, 2014 at approximately 8:15p.m. A review of the "Individual Narcotic or Control Sheet,",dated October 2, 2013, documented that Dilaudid 15 mls (5 times the prescribed dose) was administered as follows: - LPN # 6 -administered Dilaudid 15 mls on October 2, 2014 at 8:15p.m.; - LPN #5 - administered Dilaudid 15 mls on October 3, 2014 at 7:00a.m.; - LPN #7 - administered Dilaudid 15 mls on October 3, 2014 at 3:00p.m. It should be noted that the hospice physician prescribed Dilaudid 3 ml; however, the nurse transcribed and administered 3 teaspoon which	R292	administration of medications until 90% or greater compliance is sustained for 4 continuous months and then periodically to monitor continued compliance. Audits will be reported to the ALA, DON, and VP. **5. Incorporation into Quality Assurance Performance Improvement Process:** a. Any staff practice identified which does not adhere to compliance as described above will be addressed. Any individual who intentionally does not adhere to policy and procedure will be addressed through the Human Resources disciplinary process. b. Falls data will be monitored for trends and opportunities for improvement and reported, as appropriate, to the D.C. DOH and to the quarterly Quality, Safety, and Service Committee by the ALA or the DON on an ongoing basis. c. PDA handoff communication data will be monitored for trends and opportunities for improvement and reported by the ALA or DON to the residents and families and/or the agency who supplied the PDA, as appropriate, on an ongoing basis. d. Medication administration data will be monitored for trends and opportunities for improvement and reported to the quarterly Quality, Safety, and Service Committee by the ALA, DON, and VP on an ongoing basis. **6. All corrective actions for R292 cited deficiencies will be completed by 8/11/14, with reporting at scheduled quarterly meetings beginning 8/26/14.** **7. Exhibits:** a. Falls Policy b. Private Duty Aide (PDA) Policy	 8/26/14 and ongoing Ongoing 8/26/14 and ongoing 8/11/14

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R292	Continued From page 8 is equivalent to 15 mls (five (5) times the prescribed dosage). Review of nursing notes revealed that on October 3, 2013, at 5:40 p.m. the DON documented, "nurse brought to my attention an error on the label of the Dilaudid medication ... Dilaudid bottle it read administer 3 teaspoons/ ml 3 mg. The order stated give Dilaudid 3 mg SL every 2 hours as needed..." An October 4, 2013 incident report, from the pharmacy who dispensed the Dilaudid, Documented "[Hospice nurse] called to report that the sig [directions for medication] on the label of Rx #841333 was incorrect. Instead of 3ml/2hr/prn, the label stated take three teaspoonsful (3mg) every two hours as needed. Upon further investigation, this occurred because the short code for the sig was not done correct." On May 19, 2014, LPN #6 was interviewed at approximately 10:30 a.m. to ascertain information on how the medication error occurred. The LPN stated, "I transcribed the order for 3 teaspoons on the MAR but I can't 100% say if the order was for 3 teaspoons or 3 mls. I gave the first dose of three teaspoons." On May 19, 2014, LPN #7 was interviewed at approximately 10:52 a.m., and stated, "I gave the medicine according to the MAR and the bottle that said 3 teaspoons". LPN #5 was also interviewed on May 19, 2014, starting at approximately 11:10 a.m. LPN #5 stated, "I can't remember what happened, but I do remember we had an in-service on narcotics."	R292	c. Medication Errors Policy d. Medication Administration Policy e. Self-Administration of Medications Policy	

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R292	Continued From page 9	R292		

Although the surveyor requested to review the pharmacy label, the label was not made available for review.

b) The facility failed to ensure that Resident #1 was safely self-administering medications as evidence by the following:

On May 8, 2014, at approximately 11:00 a.m., the review of Resident #1 ' s clinical records revealed that the resident was admitted to the facility on May 20, 2013, and was diagnosed with hypertension, cardio-vascular-accident (CVA), Parkinson ' s disease, anemia, peripheral vascular disease (PVD), Vitamin 812 Deficiency and Rhabdomyoly-resolved. At the time of admission, the resident's June 2013 physician order sheet ordered: Aspirin, Azilect, HCTZ, Diltiazem, Florastor, Prednisone, and Zantac. The June 2013 physician order sheet also documented "the resident was mentally alert and physically unable to take her own medication." Based on the physician's documentation, the facility assisted the resident with medication administration.

Six months later, on December 5, 2013, the ALR received a physician order sheet confirming that Resident #1 was not capable of self-administrating medications. However, on January 15, 2014, a second prescription was received from the resident's primary care physician. The physician documented," it is my opinion that [Resident #1] is capable of self-medication [sic]. "

On May 8, 2014, at approximately 11:30 a.m., review of the "Monthly Service and Health Update", dated February 28, 2014 and March 29, 2014, revealed medication assessments, conducted by the wellness nurse/LPN #8. The

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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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R292	Continued From page 10 LPN documented that Resident #1's knows the medication names, the reason for medications, the dosage, the times and side effects of her medications. However, an interview with the wellness nurse/LPN #8, on May 8, 2014, at approximately 2:00p.m., indicated that the resident could not safely self-administer her medications. She stated that the resident could not identify the name, dosage, or side effects of her medication. The nurse was questions as why there was contradiction in the assessment. The LPN indicated that it was her belief that the family was assisting with medication administration. On May 8, 2014, the ED was interviewed to explain the "Monthly Service and Health Update" that documented the resident could self-medicate. The ED explained that the documented was computer generated and if the nurse entered data that reflected the resident required help with medication administration it would automatically charge the resident's account. There was no evidence that the resident, who was assessed by the facility's nurse as not being capable of safely administering medications, was provided assistance after January 15, 2014 with medication administration.	R292		
R471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on record review and interview, the ALR failed to develop an ISP for two (2) of five (5) newly admitted resident's (Residents #1 and #2).	R471	The following comments are for R471: **1. Individual Responsible for the Corrective Action:** Assisted Living Administrator (ALA) and Director of Nursing (DON)	

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R471	Continued From page 11 The findings include: 1. On May 8, 2014, at approximately 10:10 a.m., a review of Resident #1's record revealed an admission date of May 20, 2013. Further review of the record failed to evidence a pre-admission ISP. During an interview with the wellness nurse on May 8, 2014, at approximately 11:50 a.m., the wellness nurse/LPN #8 indicated the pre-admission ISP had not been developed prior to admission. 2. On May 9, 2014, at approximately 9:15a.m., a review of Resident #2's record revealed an admission date of May 2, 2014. Further review of the record failed to evidence a pre-admission ISP. During an interview with the wellness nurse on May 9, 2014, at approximately 11:23 a.m., the wellness nurse/LPN #8 indicated that the pre-admission ISP had not been developed prior to admission.	R471	**2. Corrective Action for Identified Resident(s):** a. The 2 residents cited by the surveyors (#1 and #2) remain in the facility and are being addressed under this plan of correction. b. The DON completed a case review of cited deficient practices with clinical nursing staff and documented this in the staff meeting minutes. **3. Corrective Action for All Residents/Systemic Changes:** a. Other residents with the potential of being affected by the same deficient practices will be addressed by the following plan of correction: to ensure that all future residents have their ISP developed prior to admission. **3A. Policy & Procedure:** a. The draft ISP Policy was finalized and approved to include the requirement that an ISP be developed for each resident prior to admission. **3B. Education:** a. Educated all Interdisciplinary Team members on the requirement to develop and sign ISPs prior to admission via instructor-led training and documented this education on staff transcripts. **4. Monitoring:** a. All new admission resident records from 7/7/14 forward will be audited monthly by the DON or designee for staff compliance with completion of a pre-admission ISP until 90% or greater compliance is sustained for 4 continuous months, and then periodically to monitor continued compliance. Audits will be reported to the ALA, DON, and Vice President (VP).	6/25/14 (2b) 7/7/14 (3A) 7/9/14 (3B) 7/7/14 and ongoing (4)

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R471	Continued From page 12	R471	**5. Incorporation into Quality Assurance and Performance Improvement Process:** a. Any staff practice identified which does not adhere to compliance as described above will be addressed. Any individual who intentionally does not adhere to policy and procedure will be addressed through the Human Resources disciplinary process.	
			b. Pre-admission ISP audit data will be monitored for trends and opportunities for improvement by the ALA, DON, and Vice President (VP).	Ongoing
			6. All corrective actions for R471 cited deficiencies will be completed by 7/9/14.	7/9/14
			7. Exhibits: a. ISP Policy	
R481	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 record review and interview, the ALR failed to include all services being provided, when and how often services will be provided, and how and by whom all services will be provided on the ISP for three (3) of eighteen (18) residents in the sample. (Residents' #3, #9 and #12) The findings include: 1. On May 9, 2014, at approximately 9:45a.m., review of Resident #3's clinical record revealed a physician order dated April 21, 2014, for PT evaluation and treatment for "deconditioning for diagnosis of status post hospitalization of	R481	The following comments are for R481: **1. Individual Responsible for the Corrective Action:** Assisted Living Administrator (ALA) and Director of Nursing (DON) **2. Corrective Action for Identified Resident(s):** a. Two of the 3 residents cited by the surveyors (#9 and #12) remain in the facility and are being addressed under this plan of correction. Resident #3 was discharged.	
			b. The DON completed a case review of cited deficient practices with clinical nursing staff and documented this in the staff meeting minutes.	6/25/14
			c. Individualized Service Plans (ISPs) for resident #9 and #12 were reviewed and updated to include all services being	8/26/14

HEALTH REGULATION & LICENSING ADMINISTRATION

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R481	Continued From page 13 stroke like symptoms." Further review of the record revealed and ISP dated February 8, 2013 that had not been updated to include April 21, 2014 physician order for PT services. On May 9, 2014, at approximately 11:00 a.m., the wellness nurse/LPN #8 was asked to provide the PT records, however upon the survey exit; the records were not made available for review. 2. On May 7, 2014, at approximately 10:00 A.m., review of Resident #9's clinical record revealed a physician order dated February 16, 2014 for PT services for leg weakness. Further review of the record revealed an ISP dated March 31, 2014 that had not been updated to include February 16, 2014 physician order for PT services. The record failed to evidence PT services was provided. 3. On May 7, 2014, at approximately 2:00p.m., review of Resident #12's clinical record revealed a physician order dated February 5, 2014, for PT, OT, and SLP following a CVA (stroke) on February 1, 2014. Further review of the record revealed an ISP dated December 6, 2013 that had not been updated to include February 5, 2014 physical order for PT, OT, and SLP services. The record failed to evidence PT, OT, SLP services had been provided. During an interview with the wellness nurse/LPN#8 on May 7, 2014, at approximately 2:30p.m., the nurse stated, "All therapy services were done at the hospital."	R481	provided, when and how often services are to be provided, and how and by whom all services are to be provided. **3. Corrective Action for All Residents/Systemic Changes:** a. Other residents with the potential of being affected by the same deficient practices will be addressed by the following plan of correction: to ensure that all future residents' ISPs include (1) services to be provided; (2) when and how often the services will be provided; and (3) how and by whom all services will be provided.	
			b. All other current residents' ISPs will be reviewed and historical documentation omissions updated to include services provided, when and how often the services are provided, and how and by whom the services are provided and accessed.	8/26/14
			c. Contemporaneously, all current residents' ISPs will be reviewed and updated if there are new services or a change in services provided. All new admissions will have their ISPs reflect: (1) services to be provided; (2) when and how often the services will be provided; and (3) how and by whom all services will be provided.	7/7/14 and ongoing
			3A. Policy & Procedure: a. The ISP Policy was finalized and approved to include requirements regarding documenting on the ISP: (1) the services to be provided; (2) when and how often the services will be provided; and (3) how and by whom all services will be provided and accessed.	7/7/14
			3B. Education: a. Educated all Interdisciplinary Team members on the requirement to include on	7/9/14

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R481	Continued From page 14	R481	the ISP: (1) all services provided; (2) when and how often the services will be provided; and (3) how and by whom all services will be provided and accessed. The education was completed via instructor-led training and documented on staff transcripts.	
			4. Monitoring: a. A statistically significant random sample of resident records will be audited quarterly by the DON or designee for staff compliance with updating ISPs with all services provided until 90% or greater compliance is sustained for 2 quarters, and then periodically to monitor continued compliance. Audits will be reported to the ALA, DON, and VP.	7/9/14 and quarterly
			5. Incorporation into Quality Assurance and Performance Improvement Process: a. Any staff practice identified which does not adhere to compliance as described above will be addressed. Any individual who intentionally does not adhere to policy and procedure will be addressed through the Human Resources disciplinary process.	
			b. ISP audit data will be monitored for trends and opportunities for improvement by the ALA, DON, and Vice President (VP).	Ongoing
			6. All corrective actions for R481 cited deficiencies will be completed by 8/26/14.	8/26/14
			7. Exhibits: a. ISP Policy	
R483	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	R483	The following comments are for R483: **1. Individual Responsible for the Corrective Action:** Assisted Living Administrator (ALA) and Director of Nursing (DON)	

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R483	Continued From page 15 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, it was determined that the ALR failed to ensure ISP's were reviewed by the interdisciplinary team, the healthcare practitioner, the resident, or the residents surrogate at least every six (6) months or more frequently with significant changes in the residents condition for eleven of eighteen (18) residents in the sample (Residents' #5, #6, #7, #8, #9, #11, #12, #13, #15 , #16 and #17). The findings include: 1. On May 9, 2014, at approximately 1:41 p.m., review of Resident #5's clinical record revealed an ISP dated February 4, 2013. There was no evidence that after the February 2013 ISP meeting the healthcare practitioner reviewed the ISP every six (6) months as required. 2. On May 15, 2014, at approximately 12:00 p.m., review on Resident #6's clinical record revealed an ISP dated October 28, 2013. There was no evidence that after the October 2013 ISP meeting the IDT and/or the healthcare practitioner reviewed the ISP every six (6) months as required. 3. On May 15, 2014, at approximately 1:00 p.m., review of Resident 7's clinical record revealed an ISP dated January 9, 2014. The	R483	**2. Corrective Action for Identified Resident(s):** a. Ten of the 11 residents cited by the surveyors (resident #5, #6, #7, #8, #9, #11, #12, #15, #16, and #17) remain in the facility and are being addressed under this plan of correction. Resident #13 was discharged. b. The DON completed a case review of cited deficient practices with clinical nursing staff and documented this in the staff meeting minutes. c. All 10 of the resident ISPs cited by the surveyors were brought current with updates for significant changes in resident condition and review/signature by the healthcare practitioner. **3. Corrective Action for All Residents/Systemic Changes:** a. Other residents with the potential of being affected by the same deficient practices will be addressed by the following plan of correction: to ensure that all future residents' ISPs are reviewed: (1) every 30 days after admission; (2) at least every 6 months thereafter; and (3) more frequently if there is a significant change in the resident's condition. b. a. All other current resident ISPs will be reviewed and brought current on historical updates 30 days after admission; (2) at least every 6 months thereafter. c. Contemporaneously, all current residents' ISPs will be reviewed and updated if there is a significant change in any resident's condition. All new admissions will have their ISPs reviewed 30 days after admission, every 6 months thereafter, and more frequently with significant changes in the	6/25/14 (b) 7/9/14 (c) 8/26/14 (3b) 7/7/14 and ongoing (3c)

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R483	Continued From page 16 ISP was reviewed by the healthcare practitioner on April 24, 2014 (104 days after the IDT). Additionally, the ISP failed to evidence it had been updated to include significant changes in the resident's condition; the resident fell nine (9) times from December 14, 2013 through April28, 2014. The ISP failed to evidence what services were to be provided for the multiple falls. 4. On May 15, 2014, at approximately 2:00p.m., review of Resident 8's clinical record revealed an ISP dated May 6, 2014. The ISP failed to evidence it had been updated to include significant changes in the resident's condition; the resident sustained a left arm skin tear and a right elbow skin tear [both were injuries of unknown origin]. The ISP failed to evidence what services were provided for the injuries. Interview with the wellness nurse/ LPN #8 on May 15, 2014, at approximately 2:10p.m., was conducted to ascertain why the ISP's were not updated as required by the regulations. The nurse indicated that the previous DON was responsible for the ISP updates. 6. On May 7, 2014, at approximately 10:00 a.m., review of Resident #9 ' s clinical record revealed an ISP dated March 31, 2013. There was no evidence that after the March 2013 ISP meeting the IDT and/or the healthcare practitioner reviewed the ISP every six (6) months as required. 7. On May 7, 2014, at approximately 11:45 a.m., review of Resident #11 ' s clinical record revealed ISP's dated September 6, 2013 and March 6, 2014, failed to evidence that they had been reviewed by a healthcare practitioner.	R483	resident's condition. **3A. Policy & Procedure:** a. The ISP Policy was finalized and approved to include requirements for reviewing the ISP: (1) 30 days after admission; (2) at least every 6 months thereafter; and (3) more frequently if there is a significant change in the resident's condition. b. The Unwitnessed Injury Policy was finalized and approved to include a requirement to update the ISP with approaches to prevent or minimize future incidents, if indicated. **3B. Education:** a. Educated all Interdisciplinary Team members on the ISP Policy requirements to review and sign the ISP: (1) 30 days after admission; (2) every 6 months thereafter; and (3) more frequently if there is a significant change in resident condition. Education was completed via instructor-led training and was documented on staff transcripts. b. Educated all Interdisciplinary Team members on the Unwitnessed Injury Policy requirement to update the ISP, if indicated. Education was completed via instructor-led training and was documented on staff transcripts. c. Educated all Interdisciplinary Team members on the Falls Policy requirement to update the ISP with changes in resident status as a result of a fall, as well as approaches to prevent or minimize future incidents, if indicated. Education was completed via instructor-led training and was documented on staff transcripts.	3A a: 7/7/14 3A b: 7/7/14 3B a: 7/9/14 3B b: 7/9/14 3B c: 7/9/14

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R483	Continued From page 17 8. On May 7, 2014, at approximately 2:00p.m., review of Resident #12's clinical record revealed an ISP dated December 6, 2013. The ISP failed to evidence it had been reviewed by a healthcare practitioner. There was no evidence that after the December 2013 ISP meeting, the IDT and/or the healthcare practitioner reviewed the ISP every six (6) months as required. Additionally, the ISP failed to evidence it had been updated to include a significant change in the resident's condition; the resident had a stroke on February 1, 2014. 9. On May 8, 2014, at approximately 9:30a.m., review of Resident #13 ' s clinical record revealed an ISP dated March 25, 2014. The ISP failed to evidence it had been reviewed by a healthcare practitioner. 10. On May 8, 2014, at approximately 10:30 a.m., review of Resident #15 ' s clinical record revealed ISP's dated January 16, 2013 and June 30, 2013, failed to evidence they had been reviewed by a healthcare practitioner. There was no evidence that after the June 2013 ISP meeting, the IDT and/or the healthcare practitioner reviewed the ISP every six (6) months as required. 11. On May 8, 2014, at approximately 11:30 a.m., review of Resident #16's clinical record revealed an ISP dated March 28, 2013. There was no evidence that after the March 2013 ISP meeting, the healthcare practitioner reviewed the ISP every six (6) months as required. The next ISP was dated February 20, 2014, which failed to evidence it had been reviewed by a healthcare practitioner. During an interview with the wellness nurse/	R483	**4. Monitoring:** a. A statistically significant random sample of resident records will be audited quarterly by the DON or designee for staff compliance with reviewing ISPs: (1) 30 days after admission; (2) every 6 months thereafter; and (3) more frequently if there is a significant change in the resident's condition, until 90% or greater compliance is sustained for 2 quarters and then periodically to monitor continued compliance. Audits will be reported to the ALA, DON, and VP. **5. Incorporation into Quality Assurance and Performance Improvement Process:** a. Any staff practice identified which does not adhere to compliance as described above will be addressed. Any individual who intentionally does not adhere to policy and procedure will be addressed through the Human Resources disciplinary process. b. ISP audit data will be monitored for trends and opportunities for improvement by the ALA, DON, and Vice President (VP). **6. All corrective actions for R483 cited deficiencies will be completed by 8/26/14.** **7. Exhibits:** a. ISP Policy b. Unwitnessed Injury Policy c. Falls Policy	7/9/14 and quarterly Ongoing 8/26/14

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R483	Continued From page 18 LPN #8 on May 15, 2014, at approximately 3:10p.m., the nurse indicated that the previous DON was responsible for residents' #9, #11, #12, #13, #15 and #16 ISP updates. 12. On May 9, 2014, at approximately 10:00 a.m., review of Resident #17's clinical record revealed an ISP dated August 27, 2013. There was no evidence that after the August 2013 ISP meeting the healthcare practitioner reviewed the ISP every six (6) months as required. The ISP had not been updated with significant changes in the resident's condition; the resident had four falls from December 6, 2013 through April4, 2014 with injuries. The fall on April 4, 2014 required sutures to head. Additionally, nursing notes indicated that the resident sleep walks and the injuries may have occurred during those episodes. The ISP's was not updated to include services to be provided when the resident sleep walks. Note: During an interview with LPN # 4, at 12:45 p.m., on May 9, 2014, the LPN indicated that there is no one to one staff available when the resident sleep walks.	R483		
R782	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 residents were provided an initial medication assessment for three (3) of five (5) newly admitted residents in the sample. (Residents #1, #2, and #6). The findings Include:	R782	The following comments are for R782: **1. Individual Responsible for the Corrective Action:** Director of Nursing (DON) **2. Corrective Action for Identified Residents:** a. The 3 residents cited by the surveyors (#1, #2, and #6) remain in the facility and are being addressed under this plan of correction.	

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R782	Continued From page 19 1. On May 8, 2014, a starting at approximately 11:00 a.m., review of Resident #1's clinical record revealed that the resident was admitted on May 20, 2013. The record failed to evidence an initial medication assessment had been conducted. [See #R 292] 2. On May 9, 2014, a starting at approximately 9:15a.m., review of Resident #2's clinical record revealed that the resident was admitted on May 2, 2014. The record failed to evidence an initial medication assessment had been conducted. 3. On May 15, 2014, starting at approximately 12:00 p.m., review of Resident #6's clinical record revealed that the resident was admitted on October 9, 2013. The record failed to evidence an initial medication assessment had been conducted. Interview with the wellness nurse/LPN #8 on May 15, 2014, at approximately 1:00 p.m., was conducted to ascertain copies of the initial assessments. The nurse stated, "I don't see the assessments."	R782	b. The DON completed a case review of all cited deficient practices with clinical nursing staff and documented this in the staff meeting minutes.	6/25/14
			c. All 3 residents cited by the surveyors were re-assessed for current capability of self-administering medications and this was documented in their records.	7/9/14
			3. Corrective Action for All Residents/Systemic Changes: a. Other residents with the potential of being affected by the same deficient practices will be addressed by the following plan of correction: to ensure that all future newly admitted residents are provided an initial medication assessment.	
			b. All other currently self-medicating residents will be re-assessed for current capability of self-administering medications and this was documented in their records.	8/11/14
			3A. Policy & Procedure: a. The Self-Administration of Medications Policy was finalized and approved, including an initial assessment of the resident's ability to self-administer medications.	7/7/14
			3B. Documentation: a. The Assessment of Self-Administration of Medications Form was implemented to document the resident's knowledge and skills necessary for safe self-administration of medications.	7/9/14
			3C. Education: a. Educated nursing staff on the Self-Administration of Medication Policy, including completion of the tool for documenting resident self-administration knowledge and skills. Education was completed via	7/9/14

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R782	Continued From page 20	R782	instructor-led training and documented on staff transcripts.	
			4. Monitoring: a. All newly admitted resident records will be audited monthly for staff compliance with documentation of an initial medication assessment until 90% or greater compliance is sustained for 4 continuous months, and then periodically to monitor continued compliance. Audits will be reported to the ALA and VP.	7/11/14 and ongoing
			5. Incorporation into Quality Assurance Performance Improvement Process: a. Any staff practice identified which does not adhere to compliance as described above will be addressed. Any individual who intentionally does not adhere to policy and procedure will be addressed through the Human Resources disciplinary process.	
			b. Medication administration data will be monitored for trends and opportunities for improvement by the ALA, DON, and Vice President (VP).	Ongoing
			6. All corrective actions for R782 cited deficiencies will be completed by 8/11/14.	8/11/14
			7. Exhibits: a. Self-Administration of Medications Policy	
R802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record review and interview, it was determined that the ALR's registered nurse failed to assess the resident response to medications every forty-five six (6) of eighteen	R802	The following comments are for R802: **1. Individual Responsible for the Corrective Action:** Director of Nursing (DON) **2. Corrective Action for Identified Residents:** a. Five of the 6 residents cited by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **ALR-0006**	(X2) MULTIPLE CONSTRUCTION A, BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C **06/04/2014**
NAME OF PROVIDER OR SUPPLIER **GRAND OAKS ASSISTED LIVING**		STREET ADDRESS, CITY,STATE, ZIP CODE **5901 MACARTHUR BLVD NW WASHINGTON, DC 20016**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R802	Continued From page 21 (18) residents in the sample. (Residents' #3, #4, #5, #6, #7 and #8) The findings Include: 1. On May 9, 2014, starting at approximately 9:45 a.m., review of Resident #3's clinical record failed to evidence that the nurse assessed the resident to determine the effectiveness to his/her medications. 2. On May 9, 2014, starting at approximately 10:40 a.m., review of Resident #4's clinical record failed to evidence that the nurse assessed the resident to determine the effectiveness of his/her medications. 3. On May 9, 2014, starting at approximately 1:41 p.m., review of Resident #5's clinical record failed to evidence that the nurse assessed the resident to determine the effectiveness of his/her medications. 4. On May 9, 2014, starting at approximately 2:00 p.m., review of Resident #6's clinical record failed to evidence that the nurse assessed the resident to determine the effectiveness of his/her medications. 5. On May 15, 2014, starting at approximately 11:00 a.m., review of Resident #7's clinical record failed to evidence that the nurse assessed the resident to determine the effectiveness of his/her medications. 6. On May 15, 2014, starting at approximately 12:00 p.m., review of Resident #8's clinical record failed to evidence that the nurse assessed the resident to determine the effectiveness of his/her medications.	R802	surveyors (#4, #5, #6, #7 and #8) remain in the facility and are being addressed under this plan of correction. Resident #3 was discharged. b. The DON completed a case review of all cited deficient practices with clinical nursing staff and documented this in the staff meeting minutes. **3. Corrective Action for All Residents/Systemic Changes:** a. Other residents with the potential of being affected by the same deficient practices will be addressed by the following plan of correction: to ensure residents are assessed by a registered nurse every 45 days for resident response to medication. **3A. Policy & Procedure:** a. The Medication Administration Policy was finalized and approved, to include an on-site review by a registered nurse every 45 days to assess the resident's response to medication. **3B. Documentation:** a. The 45-Day Medication Review Form was implemented to document the registered nurse assessment of the resident's response to medications. **3C. Education:** a. Educated nursing staff on the Medication Administration Policy, including completion of the 45-Day Medication Review Form via instructor-led training, and documented this education on staff transcripts. **4. Monitoring:** a. A statistically significant random sample of resident records will be audited monthly by the DON or designee for registered nurse	 6/25/14 7/7/14 7/9/14 7/9/14 7/11/14 and ongoing

HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0006	(X2) MULTIPLE CONSTRUCTION A, BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 06/04/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R802	Continued From page 22 During an interview with the wellness nurse/LPN #8 on May 9, 2014, starting at approximately 11:15 a.m., the nurse stated, "I didn't add the residents' response to medications but I will start adding it." There was no documented evidence that the facility's nurses or health practitioners were assessing the effectiveness of residents' medications. END OF DOCUMENT	R802	compliance with documentation of an assessment every 45 days of resident response to medication, until 90% or greater compliance is sustained for 4 continuous months, and then periodically to monitor continued compliance. Audits will be reported to the ALA and VP. **5. Incorporation into Quality Assurance Performance Improvement Process:** a. Any staff practice identified which does not adhere to compliance as described above will be addressed. Any individual who intentionally does not adhere to policy and procedure will be addressed through the Human Resources disciplinary process. b. Medication review data will be monitored for trends and opportunities for improvement by the ALA, DON, and Vice President (VP). **6. All corrective actions for R802 cited deficiencies will be completed by 7/11/14.** **7. Exhibits:** a. Medication Administration Policy END OF DOCUMENT	Ongoing 7/11/14

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: MEDICATION ADMINISTRATION & MANAGEMENT

NO:________________ **APPROVED:** ______________________

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ______________________

PURPOSE:
To establish standards for the safe administration of medications:

1. To identify those employees who may administer medications.
2. To define the circumstances under which non-licensed personnel may administer medications.
3. To describe medication administration utilizing the Six Rights.
4. To describe the process for patient identification prior to medication administration.
5. To reduce the risk of medication errors from administering high risk/high alert medications and anticoagulation therapy.
6. To establish guidelines for the safe storage of medications.

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES: Self-Administration of Medications Policy

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297

DEFINITIONS:

"ALA" – Assisted Living Administrator

"Medications" - For the purposes of this policy, medications are defined to include prescription and over-the-counter drugs, vitamins/mineral/dietary supplements, herbal remedies and other alternative therapies.

"MAR"- Medication Administration Record

"High Risk/High Alert Medications"- include medications that have increased potential for patient harm due to high toxicity; narrow therapeutic safety index; high volume use; low volume/high risk; require special patient monitoring during administration; risk of abuse; problem prone products; non-standard/special preparations; age specific nature; look alike/sound alike.

"Anticoagulation or anticoagulation therapy" - high risk treatments that include warfarin (Coumadin®), heparin, Argatroban, enoxaparin (Lovenox®), dalteparin (Fragmin®), lepirudin (Refludan®) and fondaparinux (Arixtra™). Other drugs that are similar include antiplatelet drug, (i.e., aspirin and clopidogrel (Plavix®). Other drug classes may also possess pharmacologic properties that alter normal hemostasis and

predispose patients to bleeding events like anticoagulants.

"Complete Orders" – For the purposes of this policy, complete orders require the medication name, strength (if applicable), dose, route, rate (if applicable), frequency and duration (if applicable). For all "PRN" orders, the indication is also required.

POLICY:

Grand Oaks staff may administer medications according to the policies and procedures of Grand Oaks and current medical and professional standards, consistent with the scope of their license and/or practice. Grand Oaks provides ongoing training, monitoring, and documentation of medication competency.

PROCEDURE:

A. Pre-Admission Medication Management Assessment

1. Within 48 hours prior to admission, the prospective resident's physician will provide a hard-copy medication list, including
   - Current medication profile, including a review of nonprescription drugs;
   - Possible adverse interactions;
   - Common expected or unexpected side effects; and
   - An indication for each medication listed

B. On-site Review by Registered Nurse

1. Every 45 days, a registered nurse will assess and document the resident's response to medication (See Appendix A – 45-Day Medication Review Form).

C. Medication Administration

1. The staff member who prepares the medication is the individual who administers the dose, except where unit-dose medication distribution is utilized. Medication administration by Nursing shall be documented appropriately in the patient's medication administration record.
2. In any situation where the staff member administering the medication is unfamiliar with the medication, the administration route, dosage, calculation, or compatibility and is unable to find sufficient information, he or she is obligated to check the medication with a second nurse, a pharmacist or a physician prior to administration.
3. Based on the resident's condition and assessed needs, education on the safe and effective use of all medications is provided. Before administering a new medication, the resident or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication.

D. Medication Administration According to the Six Rights

1. Prior to the administration of medications and intravenous products, all Six Rights must be completed and verified. The medication administration record (MAR), and the medications should be brought to the resident apartment or designated medication point in the community. Only one resident's medications should be pulled for administration at a time. The following Six Rights must be completed:

   (1) Right Resident– the resident must be identified by their photo in the MAR prior to drug administration. If a staff member does not know the resident, the resident must be identified by a second staff

member.

(2) Right Medication – A twenty-four (24) hour chart check is completed by a licensed nurse on the 11PM – 7AM shift, including verification of new physician orders with the MAR. The name of the medication found on the medication package/label must be compared to the medication listed on the MAR to verify that the medication selected is correct. Drugs prescribed for one resident shall not be administered to another resident.

- The medication is to be visually inspected for particulates, discoloration, or other loss of integrity prior to administration.
- Verification that the medication has not expired is performed.
- Verifies that no contraindications to the administration of the medication exist.

(3) Right Dosage – The dosage of the medication must be compared to the order listed on the MAR to verify that it is correct.

(4) Right Route – The route of administration must be compared to the order listed on the MAR or the medication order to verify that it is correct.

(5) Right Time – The time the medication is ordered to be administered must be verified with the order on the MAR. If the time of administration varies from the time found on the MAR by greater than 30 minutes, then the actual administration time must be documented on the MAR.

(6) Right Documentation – The administration of all medications must be documented on the MAR by initials of the person administering the medication.

E. Administration of High-Risk Medications

1. All identified high-risk medications require verification by the administering practitioner. If there is any discrepancy in the verification process, two health care providers will be required to double check.

2. The nurse documents all patient/family education appropriately in the resident's record.

F. Administration of Anticoagulation

1. Administration of anticoagulants is subject to the requirements for high risk medications.

G. Self-Administration of Medications

1. Refer to Grand Oaks "Self-Administration of Medications Policy".

H. Reporting

1. Drug errors and suspected adverse drug reactions (ADR), must be reported immediately to the DON or designee, the physician, prescriber, pharmacist, resident (or surrogate, as appropriate), and document in the resident's record and in the electronic reporting system.
   - Refer to Grand Oaks Medication Error Policy.

I. Medication Storage

1. Medications shall be stored in a secured area and kept locked when not in use.
2. All medications shall be kept in their original packaging and shall be properly labeled and identified.
3. Single use and disposable items shall not be reused.
4. No stock supply of prescription medications shall be maintained, unless prior approval is obtained from the Mayor.
5. Discontinued or expired medications shall be removed from the facility.
6. Residents who self-administer may keep and use prescription and nonprescription medications in their units, secured from other residents.

APPROVALS:

[signature] RN
Director of Nursing, Grand Oaks

7/7/14
Date

[signature]
Executive Director, Grand Oaks

7.7.14
Date

TO BE COMPLETED AT LEAST EVERY 45 DAYS OR SOONER IF NEEDED

RESIDENT NAME: ______________________ ROOM#: ________ D.O.B: ____________

DATE OF ADMISSION: ______________

SELF MEDICATE: ☐ YES ☐ NO DATE COMPLETED: ____________ NEXT 45 DAY DUE: __________________

ALLERGIES- Indicate any changes.	**DIAGNOSIS**- Indicate any changes.

MEDICATION/ TREATMENTS

RESIDENT RESPONSE TO MEDICATION ASSESSED: ☐ YES ☐ NO

MEDICATION EFFECTIVE: ☐ YES ☐ NO

ACTION TAKEN: ☐ YES ☐ NO ☐ N/A

COMMENT: (INCLUDING ANY SIDE EFFECT/ ADVERSE EFFECT/ OBSERVATION)

FOR SELF MEDICATE: DOES PHYSICIAN ORDER SHEET MATCH MEDS IN APARTMENT ☐ YES ☐ NO

ARE ALL MEDS LOCKED ☐ YES ☐ NO

ACTION TAKEN:

ADDITIONAL COMMENTS:

RN Signature: ______________________ Print Name: ______________________ Date: ________

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: INDIVIDUALIZED SERVICE PLAN (ISP)

NO: ____________________ **APPROVED:** ______________________________

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ______________________________

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES:

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297

DEFINITIONS:
Assisted Living Residence or ALR means Grand Oaks.

Individualized Service Plan or ISP means a plan written by a healthcare practitioner in conjunction with the resident (and/or surrogate, if appropriate), based on the assessment, which identifies services that Grand Oaks will provide or arrange for the resident, when and how often the services will be provided, and how and by whom all services will be provided and accessed. The ISP is maintained as part of the resident's medical record.

A Shared Responsibility Agreement is negotiated between the resident or surrogate and the ALR whenever disagreements arise as to lifestyle, personal behavior, safety, and service plans in an attempt to recognize the resident's right to autonomy in making individual decisions regarding the ISP.

POLICY:
Individualized Service Plans (ISPs) are developed by Grand Oaks with the resident or surrogate as a full partner, and are based on the medical, rehabilitation, psychosocial, and functional assessments of the resident in a manner that supports the resident's preferences and independence. ISPs shall be completed according to the following schedule to ensure they accurately reflect the residents' current service needs and preferences and reviewed by an interdisciplinary team that includes the healthcare practitioner, the resident (and surrogate, if necessary), and the ALR:

- Prior to admission
- Upon completion of the post-move-in assessment
- 30 days following move-in
- At least every 6 months thereafter
- Updated more frequently upon a significant change in a residents' condition

PROCEDURE:

A. DEVELOPING RESIDENT INDIVIDUALIZED SERVICE PLANS

1. When developing an ISP for a resident, summarize information regarding the resident's condition and health status in the "Background Information / Health History" section of the ISP form (see Appendix A). When developing a resident's ISP prior to move-in, health history information should be obtained from the resident's history and physical.

2. For each service area listed on the ISP form, write those tasks with which staff will be providing assistance. Be sure to be as specific as possible. For example, instead of just stating "assist with shower," write in the type of assistance needed (e.g., assisting into the shower, adjusting the water temperature, washing the resident's back and feet, assisting out of the shower, putting lotion on his/her feet, etc.). Also note in this section the desired outcome for each task provided. All issues which have been identified during the assessment process should be included on the ISP.

3. Define specifically who will provide each service listed, ("Tasks to be performed by others"), record all tasks that will be performed by individuals other than staff members (e.g., family members, a home health agency, etc.). Any task which will be performed by a third-party on an ongoing basis should be documented. For example:

    - A family member may wish to take the resident to doctor appointments on a regular basis, do the resident's personal laundry, or take care of the resident's pet.
    - A home-health nurse may come in on a regular basis to irrigate the resident's catheter.
    - A physical therapist may provide physical therapy to the resident on a regular basis.

4. Include all resident preferences/additional information in the verbatim section of each service category and note any information about the resident that relates to the service area that may be helpful to staff. This information may include resident preferences, idiosyncrasies, background information, or special habits / routines.

5. When medication assistance, treatments, and/or the taking of vital signs are listed as services for the staff to provide, detailed instructions for the task should be included on the resident's medication / treatment sheet.

6. Review the ISP to ensure that the language used on the plan is specific and concrete enough to ensure that all needed services could be performed according to the resident's preferences by individuals with no prior knowledge of the resident.

7. All ISPs need to be signed upon completion and when updates occur. The signatures required on the plan are: Resident or surrogate, a representative of the ALR, and a healthcare practitioner.

8. On the first page of the ISP, write the Start Date for the plan and the Estimated Date of the next scheduled review.

9. Place the ISP in the Service Plan binder behind the tab with the resident's name and apartment number.

10. All resident assistants, the DON, Activity Director, Administrator, and other employees as designated by the Administrator should be familiar with residents' ISPs. When an initial ISP is developed for a new resident or an ISP is revised, these staff members should review the ISP and document this review by signing their initials at the top of the plan and as needed, discuss/review the plan with relevant staff/team members.

11. The ISP shall include a shared responsibility agreement, when necessary.

B. INDIVIDUALIZED SERVICE PLAN REVISIONS

1. Minor changes in a resident's service needs or preferences may be made on the resident's ISP by writing in any new information in the appropriate space, crossing out any outdated information, and initialing the changes.

2. When significant changes in a resident's condition occur (e.g., the resident has fallen and broken a hip, was hospitalized due to pneumonia, had a stroke, etc.), the resident's ISP should be revised to reflect the corresponding changes in the resident's service needs. If appropriate, these changes should be documented in the resident's permanent record.

- If no significant changes occur in a resident's condition, review his/her ISP at least every six months and revise as needed.

3. When reviewing and revising resident ISPs, obtaining feedback from staff who are directly involved with the resident's care is important. To facilitate this process:

- Indicate on blank ISP forms the names of those residents scheduled for ISP reviews. Copy these forms and approximately one week before the scheduled service planning meetings give the forms to those staff members who are directly involved with the care of the indicated residents.

- These staff members should review the ISPs of the residents indicated on the ISP forms and then note on the forms any changes that have occurred in the residents' needs and preferences.

- The Administrator (or designee) should review the completed forms and compile the information submitted for each resident, updating the resident's assessment and incorporating the changes into the resident's ISP.

- The Administrator (or designee) should meet with the resident (and his/her surrogate, DON or designee, and/or others as requested by the resident) to review the revised ISP. Obtain feedback from the resident and incorporate this feedback into the ISP. The revised ISP should be signed by the resident or surrogate, a representative of the ALR, and a healthcare practitioner.

4. Place the new ISP in the ISP book and file the prior plan in the resident's service record.

5. Incorporate any changes in the services provided to the resident by staff onto staff task lists.

APPROVALS:

D Phillips RN
Director of Nursing, Grand Oaks

7/7/14
Date

Executive Director, Grand Oaks

7.7.14
Date

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: FALLS POLICY

NO:____________________ **APPROVED:** ______________________________

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ______________________________

PURPOSE: To establish a policy and procedure for identifying and managing residents at risk of falls.

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES:

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297

DEFINITIONS:
"Fall" refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. An assisted fall is one in which a staff member attempts to minimize the impact of the fall by easing the resident's descent or in some manner attempts to break the resident's fall.

POLICY:
The goal is to reduce or minimize resident falls and resident falls with injury at Grand Oaks Assisted Living; to maximize resident safety and independence with functional mobility throughout the day; to enable resident freedom of choice and support resident rights in the healthcare decision process regarding falls and safety. If the resident refuses recommended interventions, Grand Oaks will consider the use of a shared responsibility agreement. While it is unreasonable to think that all resident falls in assisted living are avoidable, we strive to reduce the incidence and severity of injuries resulting from falls. Grand Oaks prioritizes early identification of fall risks and the use of interventions targeted to the specific resident.

PROCEDURE:

A. Assessment:
   1. Within the first 72 hours after admission, there will be a safety screening of the resident's new home and an assessment documented by the PT/OT on the Falls Prevention Screening Form to determine functional mobility and performance of ADLs (in conjunction with the physician H&P, the nursing assessment prior to move-in, and the therapy screening upon move-in).

B. Post-Fall Actions and Documentation:
Upon occurrence of a fall event, with or without injury:

1. Have resident remain on the floor till help arrives; keep the resident calm and quiet.
2. Contact on-duty nurse to evaluate resident for bleeding or injury, begin first-aid if necessary, and document the resident's vital signs.
3. If the injury is determined to require more than basic first aid, the nurse will obtain first-aid or treatment by another healthcare professional by calling "911".
4. Notify resident's family and primary physician.
5. Nursing will document a Post-Fall Evaluation/Huddle Tool in the resident record immediately after a fall (see Appendix A) to detail circumstances of the fall and establish/re-establish necessary precautions to ensure resident safety.
   a. The Morse Falls Scale is used to determine the resident's falls risk score (see Appendix B) and the Fall Risk Assessment, Prevention and Management Tool (see Appendix D) is used to determine the safety precautions to implement based on the falls risk score.
   b. The falls risk score and the safety precautions implemented will be documented on the Post-Fall Evaluation/Huddle Tool.
6. Nursing will document an evaluation of the resident post-fall daily for 72 hours following each fall with injury requiring additional treatment.
7. After any fall, the nurse on duty will complete a falls referral to the Rehab Provider.
8. After any fall or if a resident claims to have fallen, an online occurrence report must be completed. Any fall with severe injury must be reported directly to Risk Management.
9. The resident's ISP is updated with changes in resident status as a result of a fall, if indicated, as well as approaches to prevent or minimize future incidents.
10. Nursing hand-off communication between shifts includes post-fall evaluation information (see Appendix B).

C. Falls Reduction Plan:

1. A resident that meets the following criteria will undergo additional assessment and be enrolled in a documented falls reduction plan:
   - More than 2 falls without injury in 72 hours
   - Any fall with significant injury (bone break; concussion; severe bleeding; significant change in functional or mental status)
2. The following fall reduction strategies will be implemented if the above criteria are met:
   - Resident will have medication review done by NP or Consultant Pharmacist or physician; results will be documented in resident record; and medication changes if ordered will be documented.
   - Resident will be referred to the Rehab Provider for PT/OT Screen; possible follow up treatment if PCP is in agreement and provides order.
   - Resident's living environment will be assessed for safety by the Rehab Provider.
   - Resident's ISP will be updated.
   - Residents will be assessed for a higher level of supervision/care.

- Inter-disciplinary team will meet and discuss ISP; and any additional oversight that may be needed to keep the resident safe.

APPROVALS:

Director of Nursing, Grand Oaks — 7/7/14 Date

Executive Director, Grand Oaks — 7.7.14 Date

Appendix A

RESIDENT POST-FALL EVALUATION/ HUDDLE TOOL

Resident Name: ______________________________ Room #: ____________

Date of fall: __________________________ Time: ______________

1. Was the fall the result of a seizure? No ___ Yes___ **If yes, go to signature line.**
2. Was this fall observed? No___ Yes___ If yes, by whom: ______________________
3. Did Staff Member or Private Duty Aide lower / assist resident to the floor? No ____ Yes ____
4. Did the fall result in injury? No ___ Yes___ Type of injury: ______________________
5. Location of fall (be specific): ______________________________
6. List any adaptive equipment used by this resident: ______________________
7. Was adaptive equipment a factor in the fall? No ___ Yes ___ If yes, describe: ____________

   ____
8. Does this resident have a history of falls? No__ Yes __ If yes, # of falls in the last 3 months: ____
9. Was therapy involved prior to fall? No___ Yes___ Type:______________________
10. Describe footwear (e.g., untied laces, wrong shoes, etc.) that may have been a factor in the fall:

    ____
11. Note any relevant behavioral issues that may have been a factor: ________________

    ____
12. Note any medical issues that may have been a factor: ______________________

    ____
13. Note any medications taken within 8 hours of the fall that may have been a factor: ________

    ____
14. Note any environmental issues that may have been a factor: ____________________

    ____
15. Other factors that may have caused the fall: ______________________

    ____
16. Fall risk: ________________ Fall precautions implemented to ensure resident safety

    (specify): ____

Signature of Nurse Completing the Form: ______________________ Date: ________

Appendix B **Nursing Handoff Communication 24 Hour Report**

Date: _____________

Census:____ Admit:____ Discharge:____ Hospitalization:____ LOA:_____ Other Transfers:_____ Deaths:_____

NEW MD ORDERS	ALTERATION SKIN INTEGRITY	STATUS POST FALL	RESIDENT AWAY FROM #
INFECTION- ATB THERAPY	O2 THERAPY	HOSPICE	
FINGERSTICKS			FOLEY CATHETER

Each nurse to initial the 24 hour Report that it has been read.

DAY SHIFT	**EVENING SHIFT**	**NIGHT SHIFT**
1st & 4th floor ____	1st & 4th floor___	1st & 4th floor ____
2nd floor ________	2nd floor _______	2nd floor ________
3rd floor ________	3rd floor _______	3rd ________

24 Hours Report　　　　Date: ______________

APT	Resident Name	Day	Evening	Night
100				
102				
104				
106				
108				

APPENDIX C **Morse Falls Scale & Post-Fall Safety Interventions**

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	______
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	______
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	 0 15 30	______
4. Intravenous therapy/heparin lock	No 0 Yes 20	______
5. Gait Normal/bedrest/wheelchair Weak* Impaired†	 0 10 20	______
6. Mental status Oriented to own ability Overestimates/forgets limitations	 0 15	______
Total Score‡: Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		______

* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).
† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.
‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. *Soc Sci Med* 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. *Can J Aging* 1989;8;366-7.

POST-FALL SAFETY INTERVENTIONS:

LOW FALL RISK

Maintain safe unit environment, including:

- Remove excess equipment/supplies/furniture from rooms and hallways
- Assure adequate lighting, especially at night
- Keep floors clutter/ obstacle free (with attention to path between bed and bathroom/commode)
- Coil and secure excess electrical and telephone wires
- Clean all spills in resident room or in hallway immediately. Place signage to indicate wet floor danger.
- Restrict window openings

The following are examples of basic safety interventions:

- Orient patient to surroundings, including bathroom location, use of bed, and location of call light
- Educate resident/family about fall risk assessments, fall injury risks, routine and special interventions for fall prevention
- Encourage residents/families to call for assistance when needed
- Use properly fitting nonskid footwear or shower slippers
- Display special instructions for vision and hearing
- For resident that requires assistive devices, ensure that patient is safe and independent with use prior to leaving device within reach

MODERATE FALL RISK:

- Communicate fall risk
- Communicate fall risk to other providers during transport and transfers

Implement measures listed under low fall risk and:

- Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate
- Reorient confused patients

Evaluate need for:

- PT consult if patient has mobility impairment, decreased strength, decreased balance and /or decreased endurance.
- Notify family

HIGH FALL RISK

Communicate Fall Risk:

- Communicate fall risk to other providers

Implement measures listed under low/moderate risk and consider:

- Activated bed alarm (use chair alarm, if indicated) on Oasis

Evaluate need for the following:

- PT consult if patient has a mobility impairment, decreased strength, decreased balance and /or decreased endurance.
- Pharmacy review for potential medication changes
- Visual acuity exam

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: UNWITNESSED INJURY POLICY

NO: ____________ **APPROVED:** ______________________________

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ______________________________

PURPOSE: To establish a policy and procedure for managing unwitnessed resident injuries.

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES: Abuse, Neglect and Exploitation Policy

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297, Title V, Sec. 509

DEFINITIONS:
An unwitnessed injury is an injury that occurred outside of the direct knowledge or view of Grand Oaks staff and is subsequently discovered by Grand Oaks staff either by personal observation or report from an outside source.

POLICY:
This policy provides direction, when in the course of daily care, the Grand Oaks staff identify an issue such as a bruise, skin tear or skin integrity issues that need additional investigation.

PROCEDURE:
1. Upon discovery of an unwitnessed injury, the staff will contact the nurse on duty for immediate evaluation. If the injury is severe, the nurse will obtain additional treatment (first-aid or treatment by another healthcare professional by calling 911).
2. Following the immediate evaluation and treatment of the resident, the following steps will be taken:
   a. Staff who provided care to the resident will be interviewed to determine the cause of injury.
   b. The resident will be interviewed, if appropriate, to assist in determination of the cause of injury.
   c. Findings from the incident investigation will be documented in the electronic event reporting system, the resident record, and, as appropriate, in the resident's ISP.
   d. The ISP will be updated with approaches to prevent or minimize future incidents, if indicated.
   e. If it was determined by the investigating team that the incident was caused as a result of resident abuse or neglect, the policy for investigation of abuse and neglect will be implemented and reports submitted to Adult Protective Services and the D.C. Department of Health.

f. The resident's family will be notified.
g. The resident's primary physician will be notified by telephone call and fax.

APPROVALS:

Director of Nursing, Grand Oaks — 7/7/14
Date

Executive Director, Grand Oaks — 7.7.14
Date

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: SELF-ADMINISTRATION OF MEDICATIONS

NO: xxx **APPROVED:** ______

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ______

PURPOSE: To establish a policy and procedure for resident self-administration of medications

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES:

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297, Title IX,

DEFINITIONS:
"Self-Administration of Resident's Own Medications" means self-administration of ALL medications.

POLICY:
Residents are permitted to self-administer medications, if this practice has been determined safe. Medications for self-administration must be stored and recorded as outlined below.

PROCEDURE:

1. The Interdisciplinary Team will determine if self-administration of medication is safe through an initial medication assessment that identifies whether the resident is:
   - Capable of self-administering his or her own medications;
   - Capable of self-administering his or her own medications, but requires a reminder to take medications or requires physical assistance with opening and removing medications from the container, or both;
   - Requires that medications be administered by a licensed nurse.

2. The resident's physician will write the orders for self-administration of medications or to stop the self-administration of medications if it becomes applicable.

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

4. Residents who self-administer medication may do so with or without assistance. All residents who self-medicate will be assessed every 45 days on the following:

a. The resident will be able to state the name, strength, dose and frequency of medication taken.
b. The resident will demonstrate how to correctly administer, inject or apply the medication.
c. The resident will be able to state if medication requires blood pressure or pulse monitoring.
d. The resident will be able to state how and where to store medications.
e. The resident will be able to state the common side effects of the medication

6. A registered nurse reviews all of the competency assessment tools, in conjunction with all other subjective and objective information from other members of the healthcare team, to assess the resident's ability to continue to self-administer medications (See Appendix A – Assessment for Self-Administration of Medications Form).

7. In the event a resident is assessed to not be safe self-administering medications, the licensed nurse shall inform the resident, call the family and inform them of the assessment results, inform the physician and obtain a new order for Nursing to administer medications, and update the resident's ISP.

8. Any resident that makes the choice not to follow this policy will be required to enter into a "Shared Responsibility Agreement" with Grand Oaks.

APPROVALS:

D. Phillips RN
Director of Nursing, Grand Oaks — Date: 7/7/14

Janet M. Kelley
Executive Director, Grand Oaks — Date: 7.7.14

APPENDIX A ASSESSMENT FOR SELF- ADMINISTRATION OF MEDICATION

RESIDENT'S NAME: ____
ROOM #____________

RESIDENT OBJECTIVES:	DATES: ______ 1	______ 2	______ 3
1. The resident can state the name, dose, times, strength and frequency of his/her medication.	yes no	yes no	yes no
2. The resident can recognize color of his/her medications.	yes no	yes no	yes no
3. The resident can read the prescription label (including his/her name, and drug information).	yes no	yes no	yes no
4. The resident can demonstrate that he/she can pour/punch out, open/place medication into mouth when given a bottle, blister pack or medication package; or inject or apply medication correctly.	yes no	yes no	yes no
5. The resident can state if his/her medication requires blood pressure or pulse monitoring.	yes no	yes no	yes no
6. The resident can demonstrate his/her ability to safely store their medication. Medications to be stored in: ______________________	yes no	yes no	yes no
7. The resident can state the purpose of the medication and why he/she is taking it.	yes no	yes no	yes no

1. Reviewer's Signature ______________________ Date: ____________
2. Reviewer's Signature ______________________ Date: ____________
3. Reviewer's Signature ______________________ Date: ____________

Additional Observations and Comments: ______________________

____

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: PRIVATE DUTY AIDE (PDA) POLICY

NO: xxx **APPROVED:** ____________

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ____________

PURPOSE: To coordinate resident care delivered by family- or resident-hired private duty aides.

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES:

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297

DEFINITIONS:

POLICY:
Grand Oaks Assisted Living is committed to optimizing resident safety by requiring family- or resident-hired private duty aides to contact the licensed nurse on duty immediately if any unusual event occurs while care is provided by the PDA, including but not limited to, falls, bruises, and skin tears.

PROCEDURE:

1. The licensed nurse is responsible for coordination of the care provided by all private duty aides.

2. Any agency sending private duty aides to Grand Oaks must provide the following information before their employees can be utilized by Grand Oaks. Agency-employed private duty aides receive an orientation packet to Grand Oaks prior to their first visit with a resident.

   Agency Credentials:

   - Copy of the agency's current business license
   - Copy of the agency's insurance coverage to include Workers' Compensation and Professional Liability
   - Copy of current fees and charges
   - Copies of all appropriate skills lists and job descriptions

- Copies of all tests/evaluations used by the agency to select employees (if applicable)
- Organizational policies in the following areas:
    - Drug Use and Testing
    - Criminal Background Check
    - Sexual Harassment

Individual Agency-Employed PDA Credentials:

- Active District of Columbia licensure as a Certified Nursing Assistant or Home Health Aide
- Primary source verification of licensure
- Verification of drug screen
- Criminal Background Check
- Completion of National Background Check through the D.C. Dept. of Health
- Office of Inspector General Check
- Photo Identification
- Verification of I-9 status
- Verification of current PPD and/or chest x-ray and annual physical exam
- Signed Job Description

3. Private duty aides not employed by an agency are required to provide photo identification on their first visit and pick up an orientation packet for Grand Oaks. In addition, private duty aides not employed by an agency are required to provide the facility with a certified copy of a criminal background check, verification of drug screen, as well as current PPD and/or chest x-ray, annual physical exam, and active District of Columbia licensure.

4. At the end of each visit, the private duty aide will provide a written hand-off report to the licensed nurse summarizing the care provided and any unusual events. The private duty aide documents on the Handoff Report Log sheet (see Appendix A) and additionally calls the licensed nurse immediately if there are any unusual events.

5. All private duty aides will be instructed to immediately notify the licensed nurse of any unusual events including but not limited to falls, bruises, and skin tears.

APPROVALS:

Director of Nursing, Grand Oaks — Date: 7/7/14

Executive Director, Grand Oaks — Date: 7.7.14

Appendix A **Private Duty Aide Report Log**

Date: ______________________________ **Time:** ______________________________

Resident Name: ______________________ **Room #:** _________ **Self-Medicate:** Yes___ No____

Private Duty Staff Printed Name: ____

Private Duty Staff Signature: ____

If completed by Grand Oaks licensed nurse from verbal private duty staff report, nurse's printed name and signature:____

<table>
<tr><td><u>Fall:</u> No ___ Yes___ If yes, describe:

Injury occurred: No___ Yes___ If yes, describe:

Resident has PT/OT: No _____ Yes _____</td></tr>
<tr><td><u>Any Other Unusual Event:</u> No______ Yes______ If yes, describe:

Injury occurred: No______ Yes ______ If yes, describe:</td></tr>
<tr><td><u>Behavior Change:</u> No___ Yes___ If yes, describe:</td></tr>
<tr><td><u>Pain:</u> No ___ Yes _____ If yes, location/site:

Self-Medicated: No ___ Yes ___ If yes, time last self-medicated:</td></tr>
<tr><td><u>Skin Issue:</u> No ___ Yes _____ If yes, location/site:
Dressing change needed: No ___ Yes ___ If yes, time last changed:
Comments:</td></tr>
<tr><td><u>Appetite/Oral intake</u>: Good___ Fair____ Poor____
Any change in appetite: No _____ Yes _____
Comments:</td></tr>
<tr><td>Any Other Issues: No _____ Yes _____ If yes, describe:</td></tr>
<tr><td><u>Follow Up:</u> Incident report completed for any unusual event: No ___ Yes ___
Nurse notified: No___ Yes ___
Family notified: No___ Yes ___
Physician notified: No ___ Yes ___
Other Comments:</td></tr>
</table>

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: ABUSE, NEGLECT, AND EXPLOITATION POLICY

NO: xxx **APPROVED:**

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:**

PURPOSE: To establish a policy and procedure for investigating allegations of resident abuse, neglect or exploitation.

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES:

REFERENCE: D.C. Assisted Living Residence Regulatory Act of 2000 13-297, Title V, Sec. 509

DEFINITIONS:

"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." (42 CFR §488.301) This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

"Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

"Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

"Physical abuse" includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

"Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

"Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (42 CFR 488.301)

"Exploitation" means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets;

POLICY:
Grand Oaks Assisted Living will not tolerate abuse, neglect, or exploitation of any resident. Signs that set forth the reporting requirement of any suspected or alleged abuse, neglect or exploitation are posted conspicuously in the employee and public areas of Grand Oaks Assisted Living.

PROCEDURE:
1. Any staff person who has knowledge of or suspects that a resident has been the victim of abuse, neglect or exploitation must immediately report the incident to the Director of Nursing (DON) and the Administrator.

2. The occurrence will be placed into the electronic event reporting system.

3. The DON, Administrator, and / or Risk Manager will investigate all allegations made within 24 hours. The Resident Abuse Investigation Report form will be completed by the DON or Administrator.

4. Any staff member cited as contributing to the alleged abuse will be suspended with pay until the investigation is completed. The DON and Administrator will decide on the disposition of the employee involved.

5. If abuse is suspected, staff must act immediately to protect the resident from any additional harm that may occur (e.g., moving the resident to another apartment, having someone stay with the resident at all times, reassigning staff, etc.).

6. The Administrator shall report any allegation of abuse, neglect, or exploitation brought to its attention to the Mayor, the Adult Protective Services Program, administered by the Family Services Administration of the Department of Human Development, the D.C. Health Regulations & Licensing Administration, the Long Term Care Ombudsman, and the police if it is reasonably suspected to be a valid allegation.

7. Grand Oaks Assisted Living will report the results of its investigation and actions taken, if any, to the Mayor.

8. If the allegation is substantiated, the appropriate corrective action will be taken to prevent further incidents, in accordance with State and Federal Law and Regulations and Grand Oaks policy.

APPROVALS:

[signature] RN — 7/7/14
Director of Nursing, Grand Oaks — Date

[signature] — 7.7.14
Executive Director, Grand Oaks — Date

THE GRAND OAKS ASSISTED LIVING POLICY

SUBJECT: MEDICATION ERROR MANAGEMENT AND REPORTING

NO:______________________ **APPROVED:** ________________________________

EFFECTIVE: Final Signature **DISTRIBUTION:** Grand Oaks

REPLACES: New **REVIEWED:** ________________________________

PURPOSE: To establish a process for identifying and reporting medication errors by all licensed nurses, as well as guidelines for patient management when errors occur.

AREAS AFFECTED: Grand Oaks Assisted Living

RELATED POLICIES: Medication Administration and Management Policy

DEFINITIONS:
"Medication Error" - A medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident, or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing, order communication, product labeling, packaging, and nomenclature; compounding; dispensing; distribution, administration, education, monitoring and use.

POLICY:
Medication errors are reported and investigated immediately after discovery. All medication errors must be documented in the resident's record and reported immediately to the Director of Nursing (DON), Administrator, the resident's physician, pharmacist, the resident or responsible party, and to Risk Management. Interventions for the resident's benefit are instituted based upon the severity of the error in accordance with physician's orders.

PROCEDURE:

1. All medications are required to be administered by a licensed nurse (unless it is documented that the resident is permitted to self-administer medications).
2. The licensed nurse must verify the medication label with the Medication Administration Record (MAR) when administering medications, using the six rights of medication administration (right resident, right medication, right dose, right route, right time, and right documentation).
    - Refer to Grand Oaks Medication Administration and Management Policy.
3. A twenty-four (24) hour chart check is completed by a licensed nurse on the 11PM – 7AM shift, including verification of new physician orders with the MAR.
4. All medication errors must be documented in the resident's record and reported immediately to the DON, Administrator, resident's physician, pharmacist, the resident or responsible party and to Risk Management.

5. All medication errors must be documented in the resident record and submitted to the electronic event reporting system.
6. The nurse (and other health care professionals, as required) monitors the resident for possible adverse effects and makes adjustments to the resident's treatment as ordered by the physician, documents the results of the monitoring in the resident's record, and reports the results of the monitoring to the resident's physician.
7. The DON or designee investigates the circumstances surrounding the error and completes the appropriate follow-up section of the event report.
8. Individual(s) are counseled in accordance with the progressive discipline policy. As much as possible, an overall non-punitive approach is taken concerning the reporting of medication errors in order to promote a safer medication use system for patients as well as timely and accurate self-reporting.

APPROVALS:

[signature] RN — 7/7/14
Director of Nursing, Grand Oaks — Date

[signature] — 7.7.14
Executive Director, Grand Oaks — Date