Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING: _____ B. WING _____	05/08/2015

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

Received 6/22/15 CMcSw

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R 000	Initial Comments An annual survey was conducted from April 27, 2015 through May 8, 2015, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. The Assisted Living Residence (ALR) provides care for one hundred -forty nine (149) residents and employs one hundred and sixty (160) staff members. The findings of the survey were based on observation, record review and interview. The findings revealed that 111 of the 149 residents had experienced a total of 340 falls from May 2014 to May 2015. One hundred and eleven (111) falls resulted in injuries (e.g. minor head injuries, skin tears, bruises, lacerations and fractures), 23 of which resulted in emergency room visits. Due to the findings, it was determined that conditions found posed a serious and immediate risk to residents ' health and safety. Specifically, the findings revealed: (1) a systemic failure to provide supportive services to ensure residents' risk of falling had diminished; and (2) a failure to identify the root cause of the resident falls. It should be noted that the findings of the previous year ' s survey completed on June 4, 2014, revealed that from December 1, 2013 through May 9, 2014 71 residents experienced a total of 166 falls. Fifty-one (51) of the falls resulted in injuries (e.g. minor head injuries, skin tears, bruises, laceration, and a hip fracture). Additionally, 40 residents sustained injuries of unknown origin (e.g. skin tears, bruises and lacerations). According to the review of the submitted plan of corrections dated July 10, 2014, the assisted living residence indicated that procedures would be implemented including the following as stipulated in the facility ' s " Fall Policy " :	R 000	Grand Oaks is filing this response for the sole purpose of confirming compliance with requests of DOH in receipt of the survey report related to the survey conducted between April 27, 2015 and May 8, 2015. This response is based on cooperative discussions with DOH and is not an admission of liability or statement of agreement with respect to issues identified in discussions with the agency but is submitted to demonstrate regulatory compliance. **504.1 Accommodation of Needs** To receive adequate and appropriate services and treatment with reasonable accommodation of individual need and preferences consistent with their health and physical and mental capabilities and their health or safety of other residents I. Corrective Action Residents #1, #2, #3, #4, #6, #8, #9 and #10 have all had referrals for therapy services	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 06/22/15

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R 000	Continued From page 1 · Nursing staff would document on the " Post Fall Evaluation/Huddle Tool " to detail circumstances of the fall and establish precautions to ensure resident safety; · The " Morse Falls Scale " would be used to determine the resident ' s fall risk score; · The " Fall Risk Assessment, Prevention and Management Tool ' would be used to determine the safety precautions that would be implemented based on the falls risk score; · The fall risk score and the safety precautions implemented would be documented on the " Post Fall Evaluation/Huddle Tool " ; · Nursing staff would document an evaluation of the resident post fall daily for 72 hours following a fall resulting in injury; · Nursing staff would complete a referral to the rehabilitation provider after any fall sustained by a resident; · The resident ' s ISP would be updated with any changes in the resident ' s status along with approaches to prevent or minimize further incidents and · In addition a resident that experiences more than two falls without injury in 72 hours would have a medication review performed by a nurse practitioner or consultant pharmacist and the results and/or medication changes would be documented. Further review of the submitted plan of corrections dated July 10, 2014, revealed the	R 000	(Residents #5 and #7 have since passed away). In response to Resident #1 and hourly monitoring recommendations, Grand Oaks will initiate a Shared Responsibility Agreement with the resident and son to document the resident's and the POA's declination of Private Duty assistance and their desire to exercise the right to autonomy regarding these matters. In addition, Resident #1 will be reevaluated with regard to the appropriateness of a reacher as an effective assistive device. In response to Resident #2 and use of ETOH, Grand Oaks will also initiate a Shared Responsibility Agreement with the resident and family to document the resident's desire to exercise the right to autonomy with regard to their ability to make individual decisions.	07/20/2015 07/20/2015

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R 000	Continued From page 2 assisted living residence indicated that procedures would be implemented including the following as stipulated in the facility ' s " Unwitnessed Injury Policy " : · The resident's primary physician will be notified by telephone and facsimile. The findings of the current survey, however, failed to provide evidence that the aforementioned procedures had been consistently implemented. Please Note: Listed below are abbreviations used in this report. Assistance Living Administrator (ALA) Assisted Living Residence (ALR) At bedtime (qhs) Director of Nursing (DON) Emergency Room (ER) Ethanol Alcohol (ETOH) Executive Director (ED) Interdisciplinary Team (IDT) Individualized Service Plan (ISP) Medication Administration Record (MAR) Milligrams (mg) Nurse Practitioner (NP) Occupational Therapy (OT) Physician Order Sheet (POS) Physical Therapy (PT) Private Duty Aide (PDA) Plan of Care - (POC) By mouth - (PO) Complained of - (c/o) Assistant Director of Nursing - (ADON)	R 000	Resident #2 ISP has been updated to reflect the resident's preference regarding ETOH consumption. Based on Resident #2's ISP and noncompliance with medical recommendations contact guard is not an appropriate intervention to meet Resident #2's needs. The recommendation to that effect previously noted by PT in Resident #2's record – apparently made without knowledge of all the information in Resident #2's ISP and history of noncompliance with medical recommendations – was therefore inappropriate. In response to Resident #2 pharmacy consult, pharmacist will review all current medications and provide current recommendations to be sent to the physician. In response to Resident #3, Grand Oaks will continue to encourage Resident –	

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R 292	Continued From page 3	R 292		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; Based on observation, record review, and interview, the ALR failed to: (1) provide services to reduce and eliminate frequent falls; (2) ensure necessary supervision/monitoring; (3) provide supportive services as identified in policy or as recommended; and (4) make certain a recommendation from the pharmacist had been addressed in accordance with each resident's needs, for 10 of 10 patients in the sample. (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) The findings include: I. The ALR failed to ensure residents received supportive care to reduce and eliminate frequent falls. On April 28, 2015 through May 7, 2015, review of the electronic event reporting system revealed from May 10, 2014 through May 7, 2015, Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 experienced the following incidents of falling: a. Resident #1's record revealed he/she sustained sixteen (16) falls. b. Resident #2's record revealed he/she sustained nineteen (19) falls. c. Resident #3's record revealed he/she sustained two (2) falls. d. Resident #4's record revealed he/she sustained six (6) falls.	R 292	individually and in meetings with Resident #3 and daughter – to utilize walker, wear call pendant, and call for assistance when needed. Grand Oaks will also initiate a Shared Responsibility Agreement with Resident #3 and daughter to document their desire that Resident #3 exercise the right to autonomy with regard to Resident #3's ability to make individual decisions in light of and notwithstanding the countervailing risks of falls or other injuries. In response to Resident #4, Grand Oaks followed up promptly regarding the resident's fall history and coordinated a new ISP effective 04/17/2015 with a new primary physician for the resident and other members of a multidisciplinary team. The resident has had no further falls.	07/20/2015

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R 292	Continued From page 4 e. Resident #5's record revealed he/she sustained eight (8) falls. f. Resident #6's record revealed he/she sustained one (1) fall. g. Resident #7's record revealed he/she sustained fourteen (14) falls. h. Resident #8's record revealed he/she sustained thirteen (13) falls. i. Resident #9's record revealed he/she sustained seven (7) falls. j. Resident #10's record revealed he/she sustained five (5) falls. Interview was conducted with the DON on May 7, 2015, at 2:00 p.m., to ascertain information regarding how the ALR addressed resident falls. According to the DON, the ALR utilizes a "Fall Policy" as needed to address the aforementioned incident type. Review of the "Fall Policy" dated July 7, 2014, on May 4, 2015, at approximately 10:00 a.m., revealed a sectioned entitled, "Post-Fall Actions and Documentations". "Morse Falls Scale". The section describes a morse falls scale that would be used after each fall to determine the resident's fall risk by assigning a score. Based on the fall risk score, a "Fall Risk Assessment, Prevention and Management tool" would be used to determine safety precautions to be implemented. The scale and corresponding safety precautions would then be added to a "Post-Fall Evaluation/Huddle Tool" that would further assist in identifying precautions to be implemented to ensure the resident's safety. Additional review of	R 292	In response to Resident #5, Grand Oaks followed up promptly regarding the resident's fall, evaluated the matter, and recommended that Resident #5 receive an evaluation for physical and occupational therapy. Given the severity of Resident #5's cognitive impairment, however, it was further determined that the resident was not appropriate for physical therapy's caseload. Grand Oaks also interacted repeatedly with the resident's POA proposing options to limit risk of injury. Resident #5 had no additional fall history after 01/28/15 and, at Grand Oak's initiation, was subsequently evaluated for and placed in hospice therapy. As noted, Resident #5 had no additional falls after 01/28/15 and died recently while in hospice. In response to Resident #6, the resident's one fall as identified by root cause was	

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R 292	Continued From page 5 the aforementioned residents' records from April 28, 2015, through May 7, 2015, failed to provide evidence that each fall was provided a score. At the time of the survey, the ALR failed to provide evidence that an effective system had been developed and implemented to reduce and eliminate resident falls. Continued review of the fall policy, in a section entitled, "Falls Reduction Plan", revealed that if a resident has more than two (2) falls without injury in 72 hours, the resident will have a medication review done by a NP or consultant pharmacist or physician. The results will then be documented in the resident record along with medication changes if ordered. Review of Resident #2's record on May 6, 2015, at approximately 12:45 p.m., however, failed to provide evidence that a medication review had been conducted following falls sustained on February 7, 8, and 9, 2015. It should be noted that the facility had previously been cited on June 4, 2014 for the management of resident falls. According to the review of the submitted plan of corrections dated July 10, 2014, the assisted living residence indicated that procedures would be implemented including the following as stipulated in the facility's "Fall Policy" : · Nursing staff would document on the "Post Fall Evaluation/Huddle Tool" to detail circumstances of the fall and establish precautions to ensure resident safety; · The "Morse Falls Scale" would be used to determine the resident's fall risk score; · The " Fall Risk Assessment, Prevention and Management Tool" would be used to determine the safety precautions that would be implemented	R 292	related to family circumstances which are being addressed through support services provided by Grand Oaks and Resident #6 has had no further falls. In response to Resident #7, Grand Oaks recommended the addition of 24-7 private duty assistance for the resident. Resident #7 and his/her adult child Healthcare POA declined the recommendation and stated they understood the potential consequences of the declination. Resident #7 transitioned to the Oasis Neighborhood (a unit for residents with advanced memory loss). PT began on 01/06/2015 and ended on 01/28/2015 after discharge due to failure of progress. Resident #7 subsequently passed away due to sudden heart attack. In response to Resident #8 and two hour monitoring,	

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R 292	Continued From page 6 based on the falls risk score; · The fall risk score and the safety precautions implemented would be documented on the "Post Fall Evaluation/Huddle Tool" ; · Nursing staff would document an evaluation of the resident post fall daily for 72 hours following a fall resulting in injury; · Nursing staff would complete a referral to the rehabilitation provider after any fall sustained by a resident; · The resident's ISP would be updated with any changes in the resident's status along with approaches to prevent or minimize further incidents and · In addition a resident that experiences more than two falls without injury in 72 hours would have a medication review performed by a nurse practitioner or consultant pharmacist and the results and/or medication changes would be documented. II. The ALR failed to ensure residents received supervision/monitoring services as recommended: A. Review of Resident #1's record on May 1, 2015, at approximately 10:45 a.m., revealed that Resident #1 sustained a fall on October 4, 2015. On the same day, the nurse documented on a " 72 Hour Observation " form that the resident should be monitored every two hours. Further review of the resident's record revealed a " Post/Fall Evaluation/Huddle Tool " form dated December 16, 2014. The form indicated that the resident sustained a fall on December 16, 2014, and that " hourly rounding " should be	R 292	Grand Oaks will initiate a Shared Responsibility Agreement with the resident and family to document the resident's desire to exercise their right to autonomy with regard to their ability to make individual decisions. In response to Resident #9 monitoring, the current ISP reflects accurate and appropriate interventions. In response to Resident #10, the ISPs for all residents, including Resident #10, will be updated to document PT/OT services to be provided. In response to Resident #11, the resident's physician was made aware of the un-witnessed injury on April 22, 2015 at 11:49 a.m. via facsimile.	07/20/2015

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R 292	Continued From page 7 implemented to ensure the resident' s safety. Continued review of the record revealed that the resident sustained another fall on March 5, 2015. The ALR informed the resident's physician of the fall by fax on the same day. The physician responded to the fax and replied, " Do not leave patient alone for periods of time as impulsive and will try to stand but unable to bear weight due to late effect CVA " . The resident's record, however, failed to provide evidence that monitoring every two hours and hourly rounds had been conducted. Furthermore, the record failed to provide evidence that the resident was not left alone in accordance with physician's instructions. Interview with the Executive Director on May 1, 2015, at approximately 2:39 p.m., revealed " We don't have the staff in an ALR to do two hour monitoring. " Interview with the DON on the same day at approximately 2:45 p.m. revealed that the " hourly rounding " was not done and that the resident is left alone for periods of time. During a telephone conference with the resident ' s physician on May 1, 2015, at approximately 2:39 p.m., the physician stated that he/she was aware of the resident ' s falls. The physician indicated that the fax that he/she signed on March 5, 2015, " was not meant to be an order by any means, it was just a communication for the staff. " Note: Resident #1 sustained a total of sixteen (16) falls from October 4, 2014 through May 2, 2015. In nine (9) of the falls, the resident experienced an injury (e.g. skin tears, bruises, abrasions and a hematoma of the forehead). One (1) of the injuries required a transfer to the ER for further evaluation. At the time of the survey, the ALR failed to	R 292	II. <u>How to Identify Other Residents/Staff</u> Upon admission of a resident to Grand Oaks, a PT/OT evaluation will be completed. The Physical Therapy portion of the evaluation will include bed mobility, gait, transfers, and balance. Additionally, deficiencies will be noted in activity tolerance, cognition/safety awareness, motor coordination, muscle tone, pain, range of motion, reflexes, sensation, and skin integrity. The Occupational Therapy portion of the evaluation includes activities of daily living/self-care deficits, hygiene, toileting, self-feeding, shower/tub use, homemaking abilities. The nurse will review all provider orders for	

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R 292	Continued From page 8 provide evidence that Resident #1 received the recommended monitoring services as indicated. B. 1. On May 4, 2015, at approximately 11:35 a.m., review of Resident #2' s record revealed a history and physical dated April 28, 2010. The history and physical documented that, " [Resident #2] had a tendency to over use ETOH and should not drink unless extremely closely supervised. " Further review of the record revealed POSs and MARs dated from January 2015 through April 2015 that revealed that Resident #2 had diagnoses that include chemical dependency/abuse. On May 6, 2015, at approximately 10:35 a.m., review of Resident #2's ISPs dated October 5, 2014 and April 15, 2015, indicated that according to the resident ' s history and physical; the resident " should not have alcohol unless [he/she] is closely monitored. " Also, the aforementioned ISPs indicated that the resident " may have one glass of white wine with dinner. " On May 6, 2015, at approximately 2:35 p.m., interview with the DON revealed that Resident#2 is supervised in the dining room when he/she consumes the one glass of white wine with dinner, however, the resident does have alcohol delivered directly to his/her apartment. At the time of the survey, the ALR failed to provide evidence that Resident #2 was consistently " extremely closely supervised " when consuming alcohol. 2. Review of Resident #2 ' s record on May 7, 2015, at approximately 3:15 p.m., revealed Resident #2 sustained a fall on September 30,	R 292	implementation or, in the event a recommendation is not appropriate based on all available information, for correction. Grand Oaks has engaged with current pharmacy provider to continue ongoing pharmacy reviews, which began on April 1, 2015. These reviews will continue with 100% completion by October 1, 2015 and continue semiannually for each resident. In addition, Grand Oaks has negotiated pharmacy reviews on an as needed basis as requested by the clinical leadership team. When recommendations are made by the pharmacist, they will be sent to respective providers for review. Falls prevention training will be conducted by	

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R 292	Continued From page 9 2014. On the same day, the nurse documented on a " Post/Fall Evaluation/ Huddle Tool " and a " 72 Hour Observation " form that the resident should be monitored every two hours. Further review of the record, revealed " 72 Hour Observation " forms dated September 30, 2014, October 31, 2014, November 1, 4, and 7, 2014. All of which indicated that the resident had fallen on the aforementioned dates and that the resident should be monitored every two hours. The resident ' s record however failed to provide evidence that monitoring every two hours had been conducted. Interview with the Executive Director on May 1, 2015, at approximately 2:39 p.m., revealed " We don ' t have the staff in an ALR to do two hour monitoring. " Note: Resident #2 sustained a total of nineteen (19) falls from May 10, 2014 through April 18, 2015. In eight (8) of the falls, the resident experienced an injury. (e.g. skin tears , a right hip hematoma and a facial contusion). At the time of the survey, the ALR failed to provide evidence that Resident #2 received the recommended monitoring as indicated. C. On April 28, 2015, at approximately 11:30 a.m., review of Resident #5's clinical record revealed that the resident had fallen on January 28, 2015, December 2, 2014, and December 11, 2014. Review of the corresponding Post Fall Evaluation/Huddle Tools revealed that the nurse documented that thirty (30) minutes checks would be conducted to ensure the resident's safety. Review of the 72-hour observation sheets dated December 3, December 4, December 5, 2014,	R 292	Director of Nursing (DON), or designee, to Grand Oaks team members. Falls Prevention training will utilize the curriculum of Senior Living University via supplemental DVD training. This training will take an interdisciplinary approach. Grand Oaks will partner with its PT/OT provider to conduct this training. Grand Oaks will schedule a Falls awareness seminar for residents, families, and POAs to improve awareness of fall prevention. This seminar will be conducted in partnership with PT/OT provider to educate using an interdisciplinary approach. III. <u>Systemic Changes</u> The Grand Oaks Fall Management Policy will	

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R 292	Continued From page 10 December 11, December 12 and December 13, 2014, also revealed that the nursing staff documented that checks would be conducted every 30 minutes as an intervention. Continued record review on April 28, 2015 at approximately 11:45 a.m., revealed an updated ISP dated December 2, 2014. The ISP documented new interventions that included positioning and environment checks every thirty minutes. Review of the record failed to provide evidence that "thirty minutes checks" had been conducted. During an interview with the DON on May 7, 2015, at approximately 2:30 p.m., the DON stated that the "thirty minutes checks" had not been done. Note: Resident #5 had six (6) falls from September 3, 2014, through January 28, 2015, two (2) of which resulted in injury (skin tear and a hematoma to the face). The record indicated that Resident #5 was seen in the emergency room for further evaluation of the facial hematoma. At the time of the survey there was no evidence that "thirty minute checks" had been conducted. D. On May 6, 2015, at approximately 12:20 p.m., review of Resident #7's clinical record revealed an ISP dated November 20, 2014, that documented "hourly checks" should be implemented to ensure the resident's safety. Further review of the record failed to provide evidence that "hourly checks" had been implemented and/ or conducted. On May 6, 2015, at approximately 1:00 p.m., review of Resident "7's 72 Hour Observation	R 292	be updated to augment the current strategies addressing falls in the community. Fall Management tools will be modified to reflect assisted living standards and ensure interdisciplinary team involvement. Grand Oaks will utilize the Shared responsibility agreement to augment resident ISPs and review interventions. A Weekly interdisciplinary meeting will be conducted to review residents with recent care changes. This meeting will include at a minimum the DON, Oasis Coordinator, and Rehabilitative representative or appropriate designees. Executive Director, or designee, will conduct	

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R 292	Continued From page 11 sheets dated March 29, 2015 and April 9, 2015, revealed that Resident #7 should be monitored every two hours for safety measures. Further review of the record, however, failed to provide evidence that the resident was monitored every two hours as indicated. Interview with the Executive Director on May 1, 2015, at approximately 2:39 p.m., revealed, "We don't have the staff in an ALR to do two hour rounds." Interview with the DON on May 7, 2015, at approximately 2:00 p.m., revealed that "hourly rounds had not been done." Note: Resident #7 had a total of fourteen (14) falls from September 27, 2014 through April 7, 2015, nine (9) of which were after the recommended rounds were to be implemented. In three (3) of the falls, the resident experienced an injury (e.g. skin tears, bruise, head laceration). At the time of the survey there was no documented evidence that the aforementioned monitoring had been conducted. E. Review of Resident #8's record on May 7, 2015, at approximately 1:30 p.m., revealed the resident sustained a fall on January 7, 2015. On the same day, the nurse documented on a " 72 Hour Observation" form that the resident should be monitored every two hours. Further review of the record revealed the resident sustained another fall on April 8, 2015. On the same day, the nurse documented on a " 72 Hour Observation" form that the resident should be monitored every two hours. The record, however, failed to provide evidence that the monitoring every two hours had been conducted. Interview with the Executive Director on May 7,	R 292	monthly leadership meeting to review weekly interdisciplinary findings, to include falls trending and therapy caseload. For the next year, Grand Oaks will offer semi-annual educational seminars for providing professionals and contracted services to review skilled nursing versus assisted living language to reinforce appropriate recommendations and orders. DON, or designee, will partner monthly with the reviewing pharmacist to identify recommendations that may require additional nursing support. This will continue for the next 6 months, at which time the process will be reevaluated.	

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R 292	Continued From page 12 2015, at approximately 3:30 p.m., revealed "We don't have the staff in an ALR to do two hour monitoring. " Note: Resident #8 sustained a total of thirteen (13) falls from December 11, 2014 through April 29, 2015. In four (4) of the falls, the resident experienced an injury (e.g. bruising and/or c/o pain). One (1) of the injuries required a transfer to the ER for further evaluation. At the time of the survey, the ALR failed to provide evidence that Resident #8 received the recommended monitoring services as indicated. F. On May 6, 2015, beginning at 2:08 p.m., review of the clinical records revealed that Resident #9 had fallen seven (7) times from May 10, 2014 through May 7, 2015. According to the " Post Fall Evaluation/Huddle Tool " dated August 15, 2014 and August 25, 2014, the nurse documented to monitor the client closely every thirty (30) minutes to an hour for safety precautions. Further review of the records also revealed a document called the " 72-hour observation sheet ". The 72-hour observation sheets dated April 15, 2015, December 12, 2014 and September 24, 2014, all indicated to monitor the resident closely every 30 minutes to an hour for safety precautions. Interview conducted with the DON on May 7, 2014, at 2:05 p.m., revealed that the aforementioned checks were not done. Interview with the ED on the same day at 2:39 p.m. revealed that "we don't have staff in an ALR to do two hour rounds". At the time of the survey, there was no	R 292	IV. Monitoring Process DON, or designee, will partner monthly with the reviewing pharmacist to identify recommendations that may require additional nursing support. This will continue for the next 6 months, at which time it the process will be reevaluated. Quality Assurance (QA) Nurse, or designee, will conduct weekly review of fall management guidelines for completion and reconcile discrepancies for next 90 days and then monthly thereafter. V. Date of Completion August 1, 2015	08/01/2015

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R 292	Continued From page 13 documented evidence that Resident #9 was monitored as required. III. The ALR failed to ensure that residents received supportive services as identified in policy or as recommended: A. On April 27, 2015, at approximately 10:00 a.m., review of the facility's "Unwitnessed Injury Policy" dated July 7, 2014, revealed the resident's primary physician will be notified by telephone call and fax of an unwitnessed injury. On April 27, 2015, at approximately 11:45 a.m. observation of the Oasis unit revealed that Resident #11 was sitting in a common area and was noted to have a bruise on his/her forehead above his/her left eye. It should be noted that interview with the Oasis RN Coordinator at approximately 1:50 p.m. was conducted to ascertain the cause of the injury. According to the coordinator the cause of injury was uncertain but, the coordinator speculated that the resident may have walked into a door. On April 27, 2015, at approximately 12:30 p.m., review of Resident #11's record revealed a nursing note dated April 21, 2015. The nurse documented, " Resident noted with a small bump above left eye, ice pack applied ..." Further review of the record failed to provide evidence that the resident's physician had been made aware of the unwitnessed injury. On April 27, 2015, at approximately 1:50 p.m., interview with the Oasis RN Coordinator revealed that she was unable to verify if the resident's physician had been made aware of the	R 292		

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R 292	Continued From page 14 unwitnessed injury. At the time of the survey, the ALR failed to provide evidence that aforementioned policy had been implemented as outlined. It should be noted that the facility had previously been cited on June 4, 2014 for the management of resident incidents. According to the review of the submitted plan of corrections dated July 10, 2014, the assisted living residence indicated that procedures would be implemented including the following as stipulated in the facility' s " Unwitnessed Injury Policy " : · The resident's primary physician will be notified by telephone and facsimile. B. On May 1, 2015, at approximately 10:45 a.m., review of Resident #1's clinical record revealed an OT note dated October 20, 2014. According to the OT note, Resident #1 fell on October 17, 2014, while attempting to pick up something from the floor. The OT note also indicated that Resident #1 had a reacher" and had been using it after the fall. On May 1, 2015, at approximately 2:22 p.m., observation of Resident #1's room revealed that the resident was in his/her bed, but, the "reacher" was in the closet and not within Resident #1's reach. An interview was conducted with the ADON on May 1, 2015, at approximately 2:23 p.m., to ascertain why the "reacher" was in the closet. The ADON stated that Resident #1 calls for staff assistance when he/she needs to use the "reacher". Interview with the DON on the same day revealed that Resident #1 can use the "	R 292		

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R 292	Continued From page 15 reacher " safely independently. At the time of the survey, there was no evidence that the resident had immediate access to the "reacher ". C. On May 4, 2015, at approximately 10:45 a.m., review of Resident #2's record revealed that the resident had fallen on February 7, 8, and 9, 2015. Further review of the record revealed that on February 9, 2015, the resident sustained a right hip hematoma and bruising as a result of the fall. On May 6, 2015, at approximately 11:30 a.m., review of Resident #2' s record revealed a POS dated February 9, 2015, which ordered a PT/OT consult to evaluate the falls and the resident's unsteady gait. On May 6, 2015, at approximately 1:15 p.m. review of Resident #2's OT POC dated February 9, 2015, revealed that Resident #2 had diagnoses that included a personal history of falls, muscle weakness and joint pain. Further review revealed that Resident #2's current functional level included, "stand by assistance (close enough to reach patient if assist needed)". Additionally, the Berg Balance test administered to Resident #2 as part of the assessment revealed that Resident #2 performed at a score of 15/56 which indicated that the resident was wheelchair bound and a high risk for falls. Continued review of the record revealed OT progress notes dated March 23, 2015 and April 6, 2015 that revealed Resident #2's current functional level included, " bed mobility with contact guard assist (contact with patient due to unsteadiness) " and " transfer to toilet requiring stand by assistance (close enough to reach patient if assist needed)" .	R 292		

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R 292	Continued From page 16 Interview with the DON on May 4, 2015, at approximately 2:50 p.m., revealed that the nursing staff did not provide Resident #2 with contact guard assistance as recommended by OT. Interview with Resident#2 on May 6, 2015, at approximately 2:00 p.m., revealed that he/she had fallen several times and he/she uses a wheelchair. Note: Resident #2 sustained two (2) additional falls (March 5, 2015 and April 18, 2015) which were after the aforementioned OT recommendation. At the time of the survey, there was no documented evidence that the nursing staff provided Resident #2 with contact guard assistance as recommended by OT. D. On May 5, 2015, at approximately 11:00 a.m., review of Resident #3' s clinical record revealed a physician order dated September 11, 2014. The document indicated that Resident #3 needed a " PDA 24/7 " to ensure resident safety, following a fall on September 7, 2014 where he/she sustained a fractured wrist. Review of Resident #3' s record failed to provide evidence that 24-hour PDA services were implemented. During an interview with the DON on May 7, 2015, at approximately 2:00 p.m., the DON stated that Resident #3 was only receiving eight (8) hours of PDA services due to family request. Note: Resident #3 sustained a fall on July 16, 2014 and sustained a fractured left wrist. Resident #3 also fell on September 7, 2014 and fractured his/her left wrist. Each of the injuries required a transfer to the ER for further	R 292		

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R 292	Continued From page 17 evaluation. At the time of the survey, the ALR failed to provide evidence that Resident #3 received the ordered supportive services. E. On May 6, 2015, at approximately 1:45 p.m., review of Resident #7's clinical record revealed that Resident #7 was to receive PT/OT services from Legacy Healthcare Services which was to start on January 6, 2015, following a fall sustained on December 18, 2014. Further review of the record failed to provide evidence the PT/OT services were provided. During an interview with the PT on May 7, 2015, at approximately 2:00 p.m., the PT indicated that he/she did not have rehabilitation notes for services that began on January 6, 2015. At the time of the survey, the ALR failed to provide evidence that PT/OT services were provided to Resident #7. IV. The ALR failed to ensure a recommendation from the pharmacist had been addressed for Resident #2: On May 7, 2015, at approximately 12:35 p.m., review of Resident #2's record revealed a pharmacist consult dated December 12, 2014. The consult indicated that the resident had a "history of polysubstance abuse" and had an order for Lunesta 2mg po qhs. Further review of the aforementioned consult revealed that the pharmacist recommended decreasing the Lunesta to 1mg po qhs. Review of the POSs and MARs from December 1, 2014 through May 6, 2015 revealed that the Lunesta 2mg po qhs had continued to be ordered by the physician and	R 292		

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R 292	Continued From page 18 administered by the facility's nurses. On May 7, 2015, at approximately 3:15 p.m., interview with the DON revealed that the pharmacist is to fax his/her recommendation directly to the resident's PCP. Further interview revealed that the ALR had not received any verbal or written communication from the resident's PCP addressing the pharmacist's recommendation. At the time of the survey, there was no documented evidence that the pharmacist's consult was presented to the PCP..	R 292	**604b Individualized Service Plans** The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. I. Corrective Action Resident #1, #2, #6, #10 ISPs have been reviewed and updated to reflect the frequency of the current PT/OT services (Resident #7 has since passed away).	07/01/2015
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on record review and interview, the ALR failed to ensure residents' ISPs detailed specific information regarding the provision of PT and/or OT services, for five (5) of seventeen (17) residents in the sample. (Residents' #1, #2, #6, #7 and #10) The findings include:	R 481	II. How to Identify Other Residents/Staff The current residents receiving therapy services will have their ISPs updated to include the following information: when and how o the services will be p ided, and how and by v all services will be p led and assessed. F ving admission of a r nt to Grand Oaks, if the	

1. On May 4, 2015, at ften imately 10:45 a.m., review of Resident #1' rovi l record revealed that Resident #1 recei vhom /OT services from Legacy Healthcare Se or difficulty walking and muscle weakness rovic started on October 6, 2014 . Further revie e record revealed ISP's dated Septembe ollo 014, October 2, 2014 and November 2 eside The ISP's, however, failed to pro specific

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R 481	Continued From page 19 information regarding the PT/OT services that would be provided. During an interview with the DON on May 4, 2015, at approximately 2:00 p.m., the DON indicated that PT/OT are not apart of the ISP meetings, but going forward, they would be and they would document all PT/OT services to be provided. At the time of survey, the ALR failed to ensure that Resident #1's ISPs documented detailed information regarding the provision of PT/OT services. 2. On May 4, 2015, at approximately 10:45 a.m., review of Resident #2's record revealed that Resident #2 received OT services from Legacy Healthcare Services due to a personal history of falls, muscle weakness, and joint pain which started on February, 9 2015. Further review of the record revealed ISP's dated October 5, 2014, and April 15, 2015. The ISP's, however, failed to provide any specific information regarding the OT services that would be provided. During an interview with Resident #2 on May 4, 2015, at approximately 1:57 p.m., it was confirmed that he/she had fallen several times. Further interview revealed that he/she was receiving OT services two (2) times a week. On May 6, 2015, at approximately 2:45 p.m., interview with the OT also confirmed that Resident #2 was receiving OT services 2 times a week. At the time of survey, the ALR failed to ensure that Resident #2's ISPs documented detailed information regarding the provision of OT services.	R 481	PT/OT evaluation indicates appropriateness for caseload, the ISP will be updated with the services provided. III. Systemic Changes A Weekly interdisciplinary meeting will be conducted to review residents with recent care changes. This meeting will include at a minimum the Director of Nursing, Oasis Coordinator, and Rehabilitative representative or appropriate designees. For the next year, Grand Oaks will offer semi-annual educational seminars for providing professionals and contracted providers to review skilled nursing verses assisted living language to reinforce appropriate recommendations and orders. Executive Director, or designee, will conduct monthly leadership meeting to review interdisciplinary	

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R 481	Continued From page 20 3. On May 6, 2015, at approximately 1:20 p.m., review of Resident #6's clinical record revealed that Resident #6 received PT/OT services from Legacy Healthcare Services due to muscle weakness and a personal history of falls which started on April 10, 2015. Further review of the record revealed ISP's dated October 6, 2014, and March 11, 2015. The ISP's, however, failed to provide any specific information regarding the PT/OT services that would be provided. On May 7, 2015, at approximately 2:30 p.m., interview with Resident #6 revealed that he/she received PT/OT services "several times a week". During an interview with the DON on May 4, 2015, at approximately 2:00 p.m., the DON indicated that PT/OT are not apart of the ISP meetings, but going forward, they would be and they would document all PT/OT services to be provided. At the time of survey, the ALR failed to ensure that Resident #6's ISPs documented detailed information regarding the provision of PT/OT services. 4. On May 6, 2015, at approximately 1:45 p.m., review of Resident #7's clinical record revealed that Resident #7 was to receive PT/OT services from Legacy Healthcare Services which was to start on January 6, 2015, following a fall sustained on December 18, 2014. Further review of the record revealed ISP's dated August 15, 2014, and November 20, 2014. The ISP's, however, failed to provide any specific information regarding the PT/OT services that would be provided.	R 481	findings, to include therapy caseload and services provided. IV. Monitoring Process QA Nurse, or designee, will conduct weekly review to ensure therapy caseload is reflected on the ISP for next 90 days and then monthly thereafter. QA Nurse, or designee, will report compliance at weekly interdisciplinary meeting. V. Date of Completion August 1, 2015 **604d Individualized Service Plan** The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be	08/01/2015

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R 481	Continued From page 21 During an interview with the DON on May 4, 2015, at approximately 2:00 p.m., the DON indicated that PT/OT are not apart of the ISP meetings, but going forward, they would be and they would document all PT/OT services to be provided. At the time of survey, the ALR failed to ensure that Resident #7's ISPs documented detailed information regarding the provision of PT/OT services. 5. On May 5, 2015, at approximately 10:45 a.m., review of Resident #10's clinical record revealed that Resident #10 received PT/OT from Legacy Healthcare Services for muscle weakness and difficulty walking which started on May 23, 2014. Further review of the record revealed ISPs' dated May 9, 2014, and October 11, 2014. The ISP's, however, failed to provide any specific information regarding the PT/OT services that would be provided. During an interview with the DON on May 4, 2015, at approximately 2:00 p.m., the DON indicated that PT/OT are not apart of the ISP meetings, but going forward, they would be and they would document all PT/OT services to be provided. At the time of survey, the ALR failed to ensure that Resident #10's ISPs documented detailed information regarding the provision of PT/OT services.	R 481	conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. I. Corrective Action Resident #1, #2, #3, #6, #8, and #10 ISPs will be reviewed and updated to include the necessary interdisciplinary team involved (Residents #5 and #7 have since passed away). II. How to Identify Other Residents/Staff ISPs for current residents will be reviewed and updated with the interdisciplinary team involved upon admission, after 30 days and at least every 6 months. DON, QA nurse or designee will conduct full audit of current resident ISPs to ensure	07/01/2015
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after	R 483		

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R 483	Continued From page 22 admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on record review and interview, the ALR failed to ensure ISP's were reviewed as required and documented significant changes in a resident ' s condition, for eight (8) of seventeen(17) residents in the sample. (Residents' #1, #2, #3 #5, #6, #7 #8 and #10) The findings include: A. On May 4, 2015, at approximately 10:45 a.m., review of Resident #1's clinical record revealed that Resident #1 received PT/OT services from Legacy Healthcare Services for difficulty walking and muscle weakness, which started on October 6, 2014. Further review of the record revealed ISPs' dated September 23, 2014, October 2, 2014 and November 2, 2014 which failed to provide evidence they had been reviewed by PT/OT. Additionally, the aforementioned ISPs' failed to provide evidence that they had been reviewed by Resident #1 and Resident #1's surrogate. During an interview with the DON on May 4, 2015, at approximately 2:00 p.m., the DON indicated that the PT/OT are not a part of the ISP meetings. At the time of the survey, the ALR failed to provide evidence that Resident #1 ' s ISP had been reviewed as required.	R 483	appropriate review by healthcare practitioner. Grand Oaks will engage Medical Director to review outstanding ISPs. III. Systemic Changes DON, Associate Director of Nursing (ADON), Oasis Coordinator, or designee will conduct ISP reviews with the interdisciplinary care team upon admission, after 30 days and at least every 6 months. IV. Monitoring Process Wellness Nurse, or designee, will conduct monthly review of ISPs to ensure they have been reviewed by all appropriate interdisciplinary providers. DON, or designee, will conduct random monthly audits for the next 6	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 483	Continued From page 23 B. On May 4, 2015, at approximately 10:45 a.m., review of Resident #2's record revealed that Resident #2 received OT services from Legacy Healthcare Services for personal history of falls, muscle weakness, and joint pain which started on Februay,9 2015. Further review of the record revealed ISP's dated October 5, 2014 and April 15, 2015; which failed to provide evidence that they had been reviewed by the OT. Additionally, the aforementioned ISPs' failed to provide evidence that they had been reviewed by Resident #2. During an interview with the DON on May 4, 2015, at approximately 2:50 p.m., the DON confirmed that the OT and the resident had not reviewed the aforementioned ISPs. At the time of the survey, there was no documented evidence the aforementioned ISP's were reviewed by the OT and Resident #2. C. On May 4, 2015, at approximately 11:40 a.m., review of Resident #3's clinical record revealed an ISP dated November 21, 2014, that documented OT services were to be implemented from November 14, 2014 through November 24, 2015. Further review of the ISP failed to provide evidence that it had been reviewed by the OT, Resident #3 and the resident's surrogate. During an interview with the DON on May 7, 2015, at approximately 2:00 p.m., the DON indicated that all interventions should be updated on the ISP. The DON also indicated that OT had not been a part of the ISP meetings, but going forward, they will be a part of the ISP meetings to ensure all OT services are documented. At the time of the survey there was no	R 483	months to ensure ISPs have been reviewed by healthcare practitioner. V. Date of Completion August 1, 2015	08/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING _____ B. WING _____	05/08/2015

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R 483	Continued From page 24 documented evidence that the aforementioned ISP had been reviewed by OT, Resident #3 and the resident's surrogate. D. On May 5, 2015, at approximately 1:00 p.m., review of Resident #6's clinical record revealed that Resident #6 sustained a fractured right hip after a fall on March 21, 2015. Further review of the record revealed an ISP, dated March 11, 2015, which failed to evidence the significant change (right hip fracture). Further review of the aforementioned ISP documented "PT/OT as ordered." The ISP, however, failed to provide evidence it had been reviewed by the PT/OT and Resident #6. During an interview with the DON on May 7, 2015, at approximately 2:00 p.m., the DON stated that all interventions should be updated on the ISP. The DON also stated that the PT/OT had not been a part of the ISP meetings, but going forward they, will be a part of the ISP meetings to add all PT/OT services. At the time of the survey there was no documented evidence of the significant change (right hip fracture) on the aforementioned ISP. Additionally, there was no documented evidence that the Resident #6 ' s ISP had been reviewed by the PT/OT and Resident #6. E. On May 6, 2015, at approximately 1:45 p.m., review of Resident #7's clinical record revealed an ISP dated November 20, 2014, that documented PT/OT services would be implemented. The aforementioned ISP, however, failed to provide evidence that it had been reviewed by the PT/OT, Resident #7 and the resident's surrogate.	R 483		

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	ALR-0006	A. BUILDING: _____ B. WING _____	05/08/2015

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R 483	Continued From page 25 During an interview with the DON on May 7, 2015, at approximately 2:00 p.m., the DON indicated that all interventions should be updated on the ISP. The DON also indicated that the PT/OT had not been a part of the ISP meetings, but going forward, they will be a part of the ISP meetings to ensure all PT/OT services are documented. At the time of the survey, there was no documented evidence that the aforementioned ISP had been reviewed by the PT/OT, Resident #7 and the resident's surrogate. F. On May 7, 2015, review of Resident 8's clinical record at approximately 11:30 a.m., revealed that Resident #8 received PT/OT services from Legacy Healthcare Services for difficulty walking and muscle weakness, which started on May 21, 2014. Further review of the record revealed the ISP dated February 5, 2015 and the update of the ISP on February 25, 2015 that failed to provide evidence they had been reviewed by PT/OT. During an interview with the DON on May 4, 2015, at approximately 2:00 p.m., the DON indicated that the PT/OT are not a part of the ISP meetings. At the time of the survey, the ALR failed to provide evidence that Resident #1 ' s ISP had been reviewed as required. G. On May 5, 2015, at approximately 10:45 a.m., review of Resident #10's clinical record revealed an ISP dated October 11, 2014. Further review of the ISP failed to provide evidence it had been reviewed by Resident #10 and/or the resident's surrogate. During an interview with the DON on May 7, 2015, at approximately 2:00 p.m., the DON was	R 483		

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R 483	Continued From page 26 made aware that the aforementioned ISP had not been reviewed by Resident #10 and/or the resident's surrogate. At the time of this survey, the ALR failed to provide evidence that the aforementioned ISP had been reviewed by Resident #10 and/or the resident's surrogate. H. On April 28, 2015, at approximately 11:30 a.m., review of Resident #5's clinical record revealed an ISP dated October 3, 2014. The ISP failed to provide evidence it had been reviewed by a healthcare practitioner. During an interview with the DON on May 7, 2015, at approximately 2:00 p.m., the DON was made aware that the aforementioned ISP had not been reviewed by a healthcare practitioner. At the time of the survey there was no documented evidence that the aforementioned ISP had been reviewed by a health care practitioner.	R 483	**701f Staffing Standards** Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. I. Corrective Action CM #4 will receive annual tuberculosis screening to include documentation that the team member is free from tuberculosis in a communicable form. II. How to Identify Other Residents/Staff Human Resource (HR) Department, or designee, will conduct a review of all team members to ensure appropriate documentation that all are free from tuberculosis in a communicable form. III. Systemic Changes HR Department will conduct monthly reviews of upcoming tuberculosis screenings and provide	
R 602	Sec. 701f Staffing Standards. (f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Based on interview and record review, it was determined that the ALR failed to ensure that an employee annually tested free from tuberculosis in a communicable form, for one (1) of sixteen (16) staff in the sample. [Care Manager #4 (CM#4)] The finding includes:	R 602		

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	ALR-0006	A. BUILDING _____ B. WING _____	05/08/2015

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R 602	Continued From page 27 On April 28, 2015, at approximately 2:20 p.m., review of CM #4's employee file revealed the employee ' s date of hire was April 14, 2014. Further review of the employee file failed to provide evidence that CM #4 had been tested for tuberculosis after March 2014. During an interview on with the Assistant Vice President of Human Resources and Human Resources Generalist on April 28, 2015, at approximately 2:50 p.m., revealed they would inform the facility staff that CM #4's last tuberculosis test on file was for March of 2014.	R 602	notification to Grand Oaks leadership team to initiate compliance. Grand Oaks leadership team will ensure compliance to include documentation that team members are free from tuberculosis in a communicable form. IV. Monitoring Process HR Department, or designee, will conduct a review of all team members to ensure appropriate documentation that all are free from tuberculosis in a communicable form. HR Department will conduct ongoing monthly reviews of upcoming tuberculosis screenings and provide notification to Grand Oaks leadership team to initiate compliance. V. Date of Completion August 1, 2015	08/01/2015