Health Reaulation & Licensma Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0031	A. BUILDING: _____ _ B. WING _____ _	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARIGOLD AT 11TH STREET	2905 11TH STREET NW WASHINGTON, DC 20001

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R 000	Initial Comments On 3/12/18, the Department of Health received a report of a death of resident (Resident #1) who fell from the ALR's loading dock stairs and died the next morning at a local hospital. Based on the nature of the incident, an investigation was initiated on 3/13/18 to determine if the ALR provided adequate supervision and oversight as required by the ALR law. On 3/14/18 the surveying team identified systemic failures that posed an immediate risk to residents' health and safety. The facility was notified on 3/16/18 of the specific violations of the ALR law and was issued a 90 day restricted license for no new admissions. The investigative findings were based on observation of the facility's environment, interview with residents, employees and family surrogate, and the review of administrative, habilitation and clinical records. Please Note. Listed below are abbreviations used in this report. Adult Protective Services - APS Assisted Living Administrator -ALA Blood Pressure -BP Assisted Living Residence - ALR Twice Daily- BID Certified Nursing Assistant - CNA Department of Health- DOH Home Health Aide - HHA Health Regulation and Licensing Administration - HRLA Hypertension - HTN Individual Service Plan -ISP Medication Administration record - MAR Nurse Practitioner- NP	R 000	DISCLAIMER: By identifying corrective actions that it will take in response to the Statement of Deficiencies ("SOD"), The Marigold does not concede the accuracy of the claims made in the SOD. On the contrary, The Marigold takes issue with many of the claims but, in the spirit of cooperation we submit the attached Plan of Correction ("POC"). By submitting the POC, licensee does not admit violations.	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BOLANLE BAYO SOLARIN — TITLE: ADMINISTRATOR — (X6) DATE: 08/13/18

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R 000	Continued From page 1	R000		

Per Oral - PO
Power of Attorney - POA
Primary Care Physician - PCP
Systolic Blood Pressure - SBP
Trained Medication Employee-TME

R272 Sec. 503.1 Dignity. Rm

(1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible;
Based on observation, interview and record review, the ALR failed to ensure a safe environment for 13 of 13 individuals living at the facility.

Findings included:

On 3/12/18 at 7:51 PM, the ALR reported to the licensing agency, via an Adverse Event Reporting form, that on 3/11/18, Resident #1 fell from the facility's loading dock stairs trying to elope from the ALR. The resident subsequently died the next morning at a local hospital. The incident report indicated that the resident's elopement was a "frequent habit for him," and that "the resident's needs cannot be met given the incidence of [sic] and that the facility does not have secured units." Interviews on 3/16/18 and 3/20/18 with the staff, who were on the premises at the time of the incident (Employees #2 and 3), revealed that the resident left the facility, unescorted and without the knowledge of staff, through the kitchen door. The resident was found unconscious at the bottom of the loading dock at approximately 10:55 PM.

On 3/13/18, interviews with the ALA revealed that

R 272 08/06/18

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The Statement of Deficiencies ("SOD") claims that the ALR failed to provide a safe environment for residents. This claim is based on an incident which occurred on 03/11/18. In the evening of that day, Resident #1 was in the facility's community/dining room. On 03/11/18 at 10:40 p.m., he went from the community/dining room to the kitchen through an unlocked door. Once in the kitchen, he opened another door that led onto the loading dock. This door was also a fire exit door that had to remain unlocked at all times.

Resident #1 went out to the loading dock, from which he fell and sustained an injury and died the next day at the hospital. At the time of the incident, the opening of the kitchen door leading to the loading dock triggered an alarm that sounded only in the ALA's office. On-duty staff members were apparently unable to hear the alarm because the office door was shut.

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R 272	Continued From page 2 the resident had a history of wandering and would often leave the facility unescorted and without the staff knowing the resident's whereabouts. The attempts and actual elopements began in January 2018 and increased in frequency in March 2018. The ALA failed to ensure that the ALR provided a safe and secure environment for Resident #1 as evidenced by the following: 1. On 3/13/18, at approximately 7:00 PM, the ALA escorted the surveyors on an onsite security inspection of the dining/multipurpose room, kitchen and loading dock. The observation revealed the following: (a) Upon entrance to the dining/multipurpose room, a ceiling video camera was observed. The camera pointed to the entrance of the kitchen. The camera allowed for staff to view residents and others accessing the kitchen from the dining/multipurpose room. (b) In the dining/multipurpose room an opened counter that connected the kitchen was observed. The counter's metal grate that closed access to the kitchen was broken and could not be lowered or locked. (c) The ALA directed the surveyors to the patio door that was blocked by an easel, and when opened an alarm sounded. The ALA stated that prior to installing the alarm; Resident #1 would leave the ALR using the patio door. Note: Interview with Employees #2 and #3 on 3/20/18, revealed that the door alarm could not be heard on the resident units (second and third floors). (d) Upon entering the kitchen, a sign was	R 272	Corrective actions taken by the facility include requiring staff to keep the door from the community/dining room to the kitchen locked to prevent unauthorized access by residents. As of 4/17/2018, the same door is now only unlocked when the cook is in the kitchen or when meals are served. The door that leads from the kitchen to the loading dock will remain equipped with an alarm and unlocked as it is a fire exit door. As of 6/12/2018 the alarm buzzer was relocated to sound at the receptionist desk at the front door. On 05/01/18 the ALR repaired the metal grate that lowers onto the kitchen counter to prevent unauthorized entrance into the kitchen over the counter. Since 05/01/18 the metal grate is kept closed except when meals are served. The SOD also raised a question about whether staff could continuously monitor the surveillance camera footage when the monitors were only viewable behind the front desk. The camera monitors were moved by 07/26/2018 so that they are more easily viewable by a receptionist as he or she sits facing the main part of the lobby and main front door. The ALR now requires one front desk staff person, through rotating shifts, to face and observe the surveillance camera monitors at all times (24/7). Beginning on 04/15/18 the front desk staff person pays particular attention to the activities in the community/dining room and in addition, the evening staff members, when free from other duties will interact with any residents in the community room.	

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R 272	Continued From page 3 observed on the kitchen door that read "keep door locked at all times." The kitchen door, however, was unlocked. When asked why the door was unlocked, the ALA stated that the door was opened for the convenience of staff to provide snacks for the residents. The door would be locked when there were no residents in the dining/multipurpose room. (e) Observation of the kitchen revealed a gas stove near the entrance of the kitchen that had a high flame on the pilot light. (f) The door leading to the loading dock was affixed with a turn lock that could be easily unlocked. 2. On 3/13/18 at approximately 7:20 PM, the ALA was asked, what safeguards were put in place after learning of Resident #1 's elopement attempt through the loading dock. The ALA indicated that there were no formal safeguards to prevent residents from accessing the kitchen and the loading dock prior to 3/12/18. When asked how a resident would gain access to the loading dock, the ALA stated that the resident entered the loading dock through the kitchen. There was a door separating the dining room from the kitchen, however at the time of the incident, the door to the kitchen was unlocked. ALA also stated that the kitchen door leading to the loading dock chimed when opened. The chime, however, could only be heard in the ALA's office. At the time of the incident, the ALA's door was closed and locked; and therefore, the chime could not be heard by staff. There are also surveillance cameras in the dining room that viewed the entrance to the kitchen, and the entrance to the loading dock; however, the cameras are not	R272	**(2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The ALR increased its efforts to prevent unauthorized and unmonitored access to exits by residents, especially those likely to attempt elopement. The ALR accomplished this task by identifying and mitigating similar risks of elopement and wandering behavior via review of all current ISPs. This review was completed on 05/14/18. Other procedures that have been adjusted for other residents include: • Making cameras easier to monitor from the front desk; • Repositioning alarm buzzer to front desk; and • Checking on residents identified as an elopement risk every two hours. The ALR may find it necessary to keep the community/dining room closed after 7:00 p.m. **(3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** In particular, the ALR has taken the following remedial actions:	

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R 272	Continued From page 4 monitored at all times. It should be noted that observation of the monitors were positioned behind the receptionist desk which did not allow for constant monitoring. On 3/13/18, at approximately 7:30 PM, Employee #1 was interviewed concerning Resident #1 's elopement behaviors. The employee stated that he was aware of the resident's elopement behaviors. The employee recalled an incident, prior to the 3/11/18 fall, when the resident attempted to leave the facility through the loading dock. The employee found the resident at the top of the loading dock gate trying to climb over it to leave the facility. With the employee's encouragement and assistance, the resident climbed down safely and was escorted back to the facility. The employee stated that the incident was not documented, but the administrator was made aware of the attempted elopement. 4. On 3/14/18, the ALA was questioned as to frequency of the elopements. The ALA shared incident reports that revealed Resident #1 eloped from theALR on 1/21/18 and 1/24/18, and 2 attempted elopements on 3/2/18 and 3/6/18. He explained that if the resident can be found around the parameters of the building and the police was not involved, the incident was not documented. Interview with Employee #1 on 3/13/18, and the review of staff progress notes, clinical records, and case management notes, revealed that there were other attempts and actual elopements that were not documented as an incident. The resident's current ISP, dated 10/11/17, required "staff to inform the administrator if [Resident #1] cannot be found within 2 hours, call and inform the police also delegating nurse of the incident." Based on this requirement, the investigation could not determine the frequency of the	R272	(a) All external doors leading out of the facility are either locked or equipped with alarms to alert staff on duty when any attempt is made to leave unescorted from these exits or monitored by the receptionist. For example, an alarm was installed in February on the community/ dining room door leading out to the patio that is audible from the front desk by staff on 24/7 duty to prevent Resident #1 from attempting to elope from that door. On 6/12/18 the alarm buzzer for the kitchen door, the back door at the lobby and the 2nd floor exit were moved to the receptionist desk. (b) On 03/13/18 personnel were trained on reporting suspected abuse, neglect and exploitation and on how to secure the facility in general. Since 03/15/2018, one staff member is required to be at the front desk 24/7 to ensure that entry and exit from the community is documented and to monitor the CCTV cameras. **Minutes of Training and Sign-In Sheet is attached and marked Attachment 1-1a.** All staff members were given notice of individuals with elopement risks on 03/13/18. More particularly, the front desk staff were again trained on how to handle residents who are elopement risk at the training of 06/12/18. **See Attachment 13 & 13a.** Currently the ALR has no other residents that are elopement risks.	

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R 272	Continued From page 5 resident's actual or attempted elopements. At the time of the investigation, the facility failed to ensure a safe and secure environment to prevent harm.	R272	(c) The broken serving hatch door was repaired on 05/01/18 and, beginning on that date, it will be locked except when meals are served and a staff member is in the kitchen. Beginning on 4/2//18, the door leading to the kitchen from the community/dining room has been kept locked except during meal hours and when a staff member is in the kitchen. (d) As of 03/15./18, staff at the front desk, using the camera monitors, and staff temporarily free from other duties focus attention on residents using the community/dining room.	
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 interview and record review, the facility failed to provide adequate services in accordance with resident needs for one of one resident in the investigation (Resident #1). Findings included: On 3/19/18, review of Resident #1 's clinical record revealed that the resident's PCP, and the resident's financial POA recommended admission, to the ALR on 9/7/17. The PCP identified in the physical assessment, dated 8/21 /17, that the resident was diagnosed with Alzheimer's, dementia, and abnormal weight loss. The PCP also identified the resident's need for assistance with ambulating, transferring, dressing and bathing, and the resident's behavior of wandering. On 3/19/18, a review of Resident #1 's ISPs, dated 09/10/17, 09/13/17, 10/05/17, and 10/11/17, revealed the resident needed assistance with activities of daily living to include monitoring for elopement risk. The ISPs, however, failed to adequately address the resident's needs to ensure safety as evidenced below:	R 292	**(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be implemented?** The ALR has established an Oversight Committee that meets at least monthly starting in June to address compliance issues. From now on that oversight committee will address compliance with the Plan of Correction, set forth herein, and other compliance and safety needs that may arise. The committee has four (4) members: (1) the ALA, (2) a representative from MIA Senior Management D.C., (3) a representative from the District of Columbia Housing Authority, and (4) the registered nurse (RN). Minutes of the committee's meeting will be produced and a file kept of same. Attached and marked as Attachment 2 is the Oversight Committee Policy.	

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R 292	Continued From page 6 1. The ISP identified that the resident was an elopement risk. On 3/14/18, the ALA was questioned as to frequency of the elopements. The ALA shared incident reports that revealed Resident #1 eloped from the ALR on 1/21/18 and 1/24/18, and 2 attempted elopements on 3/2/18 and 3/6/18. He explained that if the resident can be found around the parameters of the building and the police was not involved, the incident was not documented. Interview with Employee #1 on 3/13/18, and the review of staff progress notes, clinical records, and case management notes, revealed that there were other attempts and actual elopements that were not documented as an incident. The resident's current ISP, dated 10/11/17, required "staff to inform the administrator if [Resident #1] cannot be found within 2 hours, call and inform the police also the delegating nurse of the incident." Based on this requirement, the investigation could not determine the frequency of the resident's actual or attempted elopements. There was no evidence that the ALR assessed the resident to ensure that the resident could travel in the community safely. Interviews with the ALA and staff, and the review of progress notes and incident records revealed that the resident would frequently leave the ALR unescorted and without the knowledge of the staff. Further interview with the ALA and review of records revealed that the resident was at times escorted back to the facility by police or good Samaritans after he could not return independently. The ALA/NP failed to update the current ISP, dated 10/11/17, to identify additional interventions to address the increase in the resident's eloping behaviors.	R 292	At the meeting of the Oversight Committee on 7/10/18, the ALA reported on completion and ongoing compliance with the POC, including the functioning of all safety features and documented evidence of compliance with revised policy and procedures by staff. See Oversight Committee Meeting Minutes **Attachment 14 – 14b.** Reports to included results of monthly reviews of camera footage to ensure effective monitoring within the community and for quality control assurance purposes. As stated in the responses to R 390 and 392, the ALA will now use the expanded definition of elopements found in the revised elopement policy. **Attached and Marked Attachment 3** is the Revised Elopement Policy. **R 292** **(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SOD found that, with respect to Resident #1, the ALR failed to provide adequate service in accordance with his needs. This was based on a finding that all incidents of elopement were not documented, that the resident was not provided assistance with personal care and that support was not provided to prevent the resident from falling.	04/17/18

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R 292	Continued From page 7 2. The current ISP, dated 10/11/17, identified that the resident needed assistance with personal care to include assistance with incontinence care. The plan required the HHAs to apply barrier cream to sacral with each incontinent episode. Interview with the resident's POA on 3/20/18 and 4/17/18, revealed that the resident was consistently soiled on each of her visits (at least 31 times a week). The POA stated that she had to assist the resident with showering and incontinent care because the CNAs/HHAs did not provide the care. The POA stated that the CNAs/HHAs informed her that the resident needed a private duty aide like the other residents. 3. The ISP also identified that the resident needed assistance with ambulation and used a rolling walker for mobility. A review of the staff's progress notes revealed that the resident sustained 2 falls on 1/12/18 and 1/26/18. According to the notes, on 1/12/18, the resident fell and was transported to a local hospital's emergency room where he was treated and discharged. On 1/26/18, the resident fell and hit his head. Although the resident complained of pain, the resident refused to be transported to the emergency room. There was no evidence that the resident was seen or assessed by the registered nurse or the NP after the incident. Also there was no evidence that the ALA provided additional support to prevent falls. At the time of the investigation, the ALR failed to provide evidence that an effective system had been developed and implemented to ensure Resident #1 's health and safety.	R 292	The ALR has revised its elopement policy to ensure adequate service is always provided in accordance with resident needs. **See Attachment 3, Revised Elopement Policy. Additionally, the ALR has revised its Incident Reporting Policy, Attachment 4, Admission Policy Attachment 5-5a, and Health Assessment and Individualized Service Plans Policy Attachment 6-6h.** The RN ensures strict compliance with the ISP by all care personnel (e.g., CNAs, HHAs, TMEs) by conducting a review of their progress notes in a group meeting monthly. If staff persons assisting the resident with personal care are unable to provide the required assistance under the ISP, they will make a note of the reason (i.e., resident is combative) and inform the RN so that she may prepare a new ISP. At her discretion, the RN may prescribe alternative methods to ensure the resident's safety and that appropriate personal care assistance is provided. Staff persons have been trained on the difference between a financial POA and a POA authorized to provide care. **(2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	
R 3901	Sec. 509b1 Abuse, Neglect, and Exploitation.	R 390		

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R 390	Continued From page 8 (b)(1) An ALR, employee of an ALR, or other person who believes that a resident has been subjected to abuse, neglect, or exploitation shall report the alleged abuse, neglect, or exploitation immediately to the assisted living administrator who shall take appropriate action to protect the resident. The ALR shall report any allegation of abuse, neglect, or exploitation brought to its attention to the Mayor and the Adult Protective Services Program, administered by the Family Services Administration of the Department of Human Development. Based on interview and record review, the ALR failed to report allegations of neglect for one (1) of 1 resident in the investigation (Resident #1) Findings included: Review of the ALR incident management policy, entitled Adverse Incident Report, revealed that the staff on duty was required to report to the ALA all incidents of abuse or neglect. The ALA was required to forward the report to the Department of Health, Adult Protective Services and the Long-Term Ombudsman's office. On 3/13/18, interviews with the ALA and Employee #1 revealed that Resident #1 had a history of leaving the facility unescorted and without the staff knowing the resident's whereabouts. The attempts and actual elopements began in January 2018 and increased in frequency in March 2018. There was no evidence that the ALR informed the Department of Health of the resident's elopements as evidenced by the following: 1. On 3/13/18, at approximately 7: 15 PM, Employee #1 was interviewed concerning Resident #1 's elopement behaviors. The	R 390	The ALA has conducted a review on 3/13/18 of all residents' records and has determined that no other residents are elopement risks, as was Resident #1. **See Revised Elopement Policy Attachment 3; Uniform Assessment Form Attachment 6.** The ALR will increase the average number of staff on duty so that at no time will there be less than 2 Care Staffs on duty in addition to the receptionist. See **Current Staffing Schedule Attachment 9.** The ALR has revised its practice for documenting Activities of Daily Living services provided to require documentation of services provided by private aides serving individual residents **See Attachment 15-15a.** This will ensure that all residents of the facility are receiving all the services that they need. **See Uniform Assessment Form Attachment 6.** **(3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** As of 3/13/18, residents who appear to be at a risk of elopement are not permitted to leave the ALR unaccompanied. A resident's POA or family member is required to accompany the resident in order to account for their whereabouts.	

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R 390	Continued From page 9 employee stated that he was aware of the resident's elopement behaviors. The employee recalled an incident when the resident attempted to leave the facility through the loading dock. The employee found the resident at the top of the loading dock gate trying to climb over it to leave the facility. With the employee's encouragement and assistance, the resident climbed down safely and was escorted back to the facility. The employee stated that the incident was not documented, but the administrator was made aware of the attempted elopement. 2. Review of the ALR's incident reports revealed that Resident #1 eloped from the ALR on 1/21/18 and 1/24/18, and attempted to elope on 3/2/18 and 3/6/18. ALA stated that there were other elopement attempts, but those incidents were not documented or reported. The ALA explained that the incidents were not reported or documented when the resident was found within the parameters of the building and the police was not involved. 3. It should be noted that the ALA failed to have sufficient staff to effectively monitor Resident #1. The ALR, who had a census of 13 residents, employed only one (1) staff, who functioned as a TME, from 7:00 PM to 11:00 PM. [Also See Citation R- 563] At the time of the investigation, there was no documented evidence that the ALA reported neglect allegations as required.	R 390	The resident and the POA or family member are required to sign out and provide a destination and expected return time. Staff will make inquiries if the resident does not return when expected by calling the phone number of the POA or family member or the number provided for the person or place they went to visit. If the resident's whereabouts are unable to be confirmed, staff persons will follow the Elopement Policy. To enable the ALR to respond more quickly and effectively to the deteriorating conditions of residents, the staff members of the ALR have been retrained on incident reporting as of 04/17/18. As a result, the Facility is more prepared to mitigate the occurrence of any future incidents. Also, the facility is more secure now given all the measures mentioned in the response to R 272. **(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be implemented?** Beginning immediately, the ALA shall strictly monitor all the admission processes and conduct thorough supervision of the staff members by using the methods mentioned in other responses (i.e., monthly reviews and reports). Residents with a history of elopement will not be admitted to the facility since the ALR is not intended to be a secure facility and residents have a right to as much independence as possible.	
R 392	Sec. 509b3 Abuse, Neglect, and Exploitation. (3) An ALR shall thoroughly investigate any allegation of abuse, neglect, or exploitation and	R 392		

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	ALR-0031	A BUILDING:_____ B WING _____	04/17/2018

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R 392	Continued From page 10 shall take appropriate action to prevent further incidents. The ALR shall report the results of its investigation and actions taken, if any, to the Mayor. Based on interview and record review, the ALR failed to thoroughly investigate incidents of neglect (elopements), and to take appropriate action to prevent further incidents, for one of one the resident included n the investigation. (Resident #1) Findings included: 0 , 3/12/18, the licensing agency received an incident report, via email, that on 3'11 /18, Resident #1 allegedly fell from the facility's loading dock stairs and subsequently died at a local hospital. According to the facility staff, the resident left the facility unescorted through the kitchen door at appropriately 10:30 P.M. and was found unconscious at the bottom of the loading dock at 10:55 PM. Interview with the ALA failed to provide evidence that the incident was thoroughly investigated by the facility. There was no evidence of an investigative report. Although there were two witnesses, the ALA presented one (1) staffs written statement. There was no evidence that the ALA interviewed the witnesses or followed-up on the witnesses' statement. 0 , 3/12/18, interviews with the ALA revealed that Resident #1 had a history of wandering and would often leave the facility unescorted and without the staff knowing the resident's whereabouts. The attempts and actual elopements began in January 2018 and increased n March 2018. The ISP identified that the resident was an elopement risk. The plan required the staff to check the resident every 2 hours, and to inform the ALA, police and nurse if	R392	During its monthly meetings, the Oversight Committee will undertake a review of resident's files to determine whether any residents have become an elopement risk and to ensure that proper measures have been undertaken to mitigate any such risk. See Oversight Committee Policy and Checklist. **R 390 and 392** **(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SOD finds that ALR failed to report the incidents of attempted elopement and failed to provide investigative reports for the attempted elopements and incident on 3/11/18 where Resident #1 was injured. Beginning on 03/13/18, the ALR has been using an expanded definition of elopement. **See Revised Elopement Policy, Attachment 3.** All staff are now required to apply this definition in defining a "reportable incident" that must be reported to the ALA, who in turn will report and investigate the same, depending on their significance to the appropriate authorities. **See Revised Incident Reporting Policy, Attachment 4.** Adverse reports will continue to be done for all appropriate incidents, especially those resulting in injuries. Moreover, the facility has revised its staffing schedule and ratios to reduce the likelihood of similar incidents. **See Current Staffing Plan Attachment 9.**	08/06/18

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R 392	Continued From page 11 the resident cannot be found within 2 hours. The care plan also required that if the resident leaves the facility, the resident be accompanied by a family member or taken by Metro Access. Review of the ALR's incident reports on 3/13/18 revealed Resident #1 had left the facility unescorted on 1/1/18, 1/24/18, 3/2/18, 3/6/18 and 3/11/18. Further review of the records failed to evidence that an investigation had been completed or reported to the State Surveying and Licensing Agency as required.	R 392	**(2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** As mentioned in the response to R 292, staff members received training on 03/13/18 and 04/17/18 on incident reporting to increase the effective monitoring of residents' potentially worsening conditions. See Revised Incident Reporting Policy; Revised Elopement Policy. Further, the RN and the licensed practical nurse (LPN) monitor all residents' conditions and when a significant change in condition occurs, including but not limited to frequent falls, elopements, a lack of appetite, confusion, etc., the RN prepares a revised ISP as required by regulation. **See Uniform Assessment Form Attachment 6.** **(3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The incident of 03/11/18 was investigated by the ALA and the ALA shared his investigative findings with the investigators verbally during their visit on 03/13/18 and also during subsequent interviews. Nonetheless, on 04/17/18 all staff members were retrained on incident reporting and what constitutes a reportable incident, attached and marked **Attachment 7-7a** is the minutes and sign-in sheets of the said training.	
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interview and record review, the ALA failed to ensure the development of an ISP prior to admitting Resident #1 to the ALR. Finding Included: Review of Resident #1 's clinical records on 3/13/18 revealed that the resident's PCP, and the resident's financial POA recommended admission to the ALR on 9/7/17. The PCP identified, in the physical assessment, dated 8/21 /17, that the resident was diagnosed with Alzheimer's, dementia, and abnormal weight loss. The PCP also identified the resident's need for assistance with ambulating, transferring, dressing and bathing, and the resident's behavior of wandering unescorted. Further review of the resident's records revealed an ISP, dated 9/10/17, 3 days after the resident was admitted to the ALR. The ISP identified that the resident was an elopement and fall risk. The	R471		

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R 471	Continued From page 12 ISP also identified that the resident needed assistance with personal care to include bowel and bladder incontinence. There was no evidence that an ISP was completed prior to the resident's admission to ensure that the ALR could provide for the resident's care and safety. Additionally, there was no evidence that the ISP was based on the ALR assessments to determine the resident specific habilitation and personal care needs.	R471	in particular, an incident of suspected abuse or neglect. See also **Attachment 1-1a.** Revised Incident Reporting Policy (standardized form documenting the nature of the incident, its resolution, and any need for further action, **Attachment 16-16b).** **(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be implemented?** Beginning on 4/17/18, the ALA shall ensure all reportable incidents, especially suspected abuse or neglect, are reported, reviewed and investigated. See Revised Incident Reporting Policy. Additionally, the ALA will report all instances of attempted elopements. See Revised Elopement Policy. The ALA shall further report and send to the appropriate authorities his investigative findings on those incidents that are reportable at that level. During its monthly meetings, the Oversight Committee will ensure that the ALA has properly performed these responsibilities by reviewing the handling of any incidents that may have occurred. See Oversight Committee Policy. **R 471 & 473**	06/12/18
R 473	Sec. 604a3 Individualized Service Plans (3) The ISP shall be written by a healthcare practitioner using information from the assessment. Based on interview and record review, the ALA failed to ensure that the nurse practitioner developed an ISP based on resident's functional assessments for one (1) of one (1) resident in the investigation. (Resident #1) Finding Included: [Cross Reference Citation R-0292] Review of the Resident #1 's clinical records on 3/13/18 revealed that the resident's PCP, and the resident's financial POA recommended admission to the ALR on 9/7/17. The PCP identified, in the physical assessment, dated 8/21/17, that the resident was diagnosed with Alzheimer's, dementia, and abnormal weight loss. The PCP also identified the resident's need for assistance with ambulating, transferring, dressing and bathing, and the resident's behavior of wandering unescorted. Review of the resident records failed to provide evidence that the ALR assessed the resident's functional assessment prior to development the	R473	**(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	

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R 473	Continued From page 13 resident's ISP. The ISP, dated 9/10/2017, 3 days after the resident was admitted to the ALR, identified that the resident was an elopement and fall risk, and needed assistance with personal care to include bowel and bladder incontinent. There was no evidence that the ISP was based on the ALR assessments to determine the resident specific habilitation and personal care needs. R 4751 Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on record review, the ALR failed to ensure the ISP was signed by the resident, surrogate or a representative of the ALR for one of one residents in the investigation (Resident #1). Findings included: On 03/13/18 at 6:40 PM, review of Resident #1 's ISP dated 10/05/17 showed a change in the ALR's management of the resident's elopement risk to include that the "resident goes out most of the time to a center (recreational youth center) three times/week. POA is educated that she should inform the administrator when ever she will come over and take the resident out." The ISP contains no documented evidence that the ISP was signed by the resident and the resident's surrogate. At the time of the investigation, the ALR failed to ensure that the ISP was signed by the resident and the surrogate.	R 473 R475	Since December 2017, the ALA has required the preparation of a completed and signed ISP prior to a resident's admission and has required the RN to verify that a written ISP has been prepared for a resident before the resident's application to the facility is approved. See Uniform Health Assessment and Individualized Service Plans Policy; Revised Admission Policy. Since December 2017, the facility has ensured that an ISP is completed prior to all admissions. See Oversight Committee Policy. Since October 2017 there have been no new admissions without a completed ISP. **(2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** On 04/17/18, the ALA conducted a review of all residents' records and determined that Resident #1 is the only current resident who had been admitted before a written ISP for the resident had been submitted for the resident's signature since he had been admitted prior to the October 2017 policy change. Continued quality assurance will be provided by the facility's Oversight Committee. See Oversight Committee Policy. **(3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	

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R 513	Continued From page 14	R 513	Since the acceptance of the POC after the October 2017 survey, no applicant has been accepted for admission unless a written, executed ISP is included as part of the application package. See Revised Admission Policy; Health Assessment and Individualized Service Plans Policy; Oversight Committee Policy. Beginning with the next new admission, the notes from the RN's assessment will be included in the resident's record so that the basis for the ISP will be fully understood and documented.	
R 513i	Sec. 606 3 Resident Records (3) A physician's statement, including medical orders and rehabilitation plans; Based on interview and record review, the ALR failed to follow medical orders for vital sign monitoring, drug dosing, and reporting parameters specified by the healthcare practitioner for one of one resident in the investigation (Resident #1). Findings included: 1. Review of the medical orders for Resident #1 on 03/13/18 showed that vital sign monitoring was ordered daily times one week beginning 09/27/17 to assess for elevated BP. Additionally, the orders contained parameters specified by the healthcare practitioner (NP) on 09/27/17 for the ALR staff to report episodes of HTN to the NP "for a SBP > 155." Review of Resident #1 's MAR for 09/07/17 to 09/30/17 showed that a BP of 157/91 was measured on 09/30/17. There was no documentation, however, that the ALR staff had alerted the NP as ordered. 2. Continued review of the medical orders for Resident #1 on 03/13/18 showed an order by the NP dated 01/15/18 for "Carvedilol 3.125mg PO BID for HTN" with instructions to "hold [for] SBP less than 110." Record review of the MAR for January 2018 and February 2018 showed that doses of Carvedilol were administered to Resident #1 when a SBP of less than 110 was measured on the following dates: 01/19/18, 01/23/18, 01/25/18, 01/29/18, 01/30/18, 02/01/18, 02/12/18, 02/18/18, and 02/20/18.	R 513	**(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be implemented?** Beginning with the next new admission, the ALA will review the application package for each new admission before the applicant enters the facility and will postpone any admission if a written ISP is not included in the package until such an ISP is completed. Because the ALA has the final decision over admissions, the ALA shall be able to verify that ISPs are written before admission. During its monthly meetings, the Oversight Committee will ensure that the application package for each new admission is marked "complete" and contains a written ISP by having the RN review progress notes to determine the adequacy of the ISP.	

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R 513	Continued From page 15 3. Review of a staff progress note on 03/13/18 at 6:40PM indicated that Resident #1 had a witnessed fall on 01/26/18 at 10:42PM, at which time he hit his head and reported pain. The NP was notified and ordered for vital signs to be monitored at each shift times three days. No additional reporting parameters were indicated on the medical order. During shifts on 01/27/18, 01/28/18, and 01/29/18, Resident #1 refused to have his vital signs taken. There was no documentation within the resdient's record that the NP had been notified of the resident's refusal and that the ALR had been unable to obtain vital sign measurements as ordered for monitoring purposes. 4. Review of a staff progress note dated 03/07/18 at 10AM indicated that Employee #5 received a telephone order from the NP for, "Ativan 0.5mg by mouth BID PRN [for] agitation/dementia." Record review of the MAR for March 2018 showed the dosing times were 9AM and 9PM, however the MAR showed that two 9PM doses of Ativan were administered by Employee #5 on 03/08/18 at 10PM. At the time of the investigation, the ALR failed to follow medical orders for vital sign monitoring, drug dosing, and reporting parameters specified by the healthcare practitioner for Resident #1.	R 513	See Uniform Health Assessment and Individualized Service Plans Policy; Oversight Committee Policy. **R 475** **(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SOD alleges that the ALR failed to ensure the ISP was signed by the resident, surrogate or a representative of the ALR for Resident #1. This allegation is based on the finding that Resident #1's ISP dated 10/05/17, contains no documented evidence that the ISP was signed by the resident and the resident's surrogate. The ALR has a policy of ensuring that ISPs are signed by the resident, or surrogate, and a representative of the ALR. The Oversight Committee shall ensure the policy is followed by seeking a report from the ALA on his quarterly review of the ISPs. See Checklist for Oversight Committee Meetings, attached and marked as **Attachment 14.** Beginning with the next new admission or ISP update, the ALR shall implement procedures to ensure all ISPs are signed by the residents and/or their surrogates, and representatives of the ALR. See Uniform Health Assessment and Individualized Service Plans Policy; Revised Admission Policy; Oversight Committee Policy.	06/12/18
R 563	Sec. 701 b Staffing Standards. (b) The ALA shall ensure that each resident has access to appropriate medical, rehabilitation, and psychosocial services as established in the ISP and that there is appropriate oversight, monitoring, and coordination of all components of the ISP, including necessary transportation and	R 563		

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R 563	Continued From page 16 the delivery of needed supplies. Based on interview and record review, the ALA failed to provide adequate staffing to ensure the safety of 13 of 13 residents and to prevent the neglect of 1 resident. Findings included: 1. On 3/20/18 at approximately 10:45 AM., Employee #3 was interviewed via telephone to ascertain her knowledge of the incident involving Resident #1. Employee #3, who identified herself as a **TME,** revealed that she was the only direct care staff scheduled to work from 3:00 **P.M.** to 11:00 P.M. on 3/11/2018. She was asked to describe her work task on that evening. She stated that her responsibilities included assisting the front desk receptionist in preparing and serving dinner, washing dishes and cleaning the dining room after dinner, and administering medications at 5:00 P.M., 8:00 P.M. and 9:00 **P.M.** When asked if she provided or monitored residents in their living units, she stated that all residents received their medication in the dining/multipurpose room. She was again asked if she provided any care to residents who were in need of personal care assistance such as those who are incontinent. The employee indicated that residents, who were incontinent, were capable of providing for their own personal care. She said that she only provided care to one resident (Resident #3) who needed assistance in dressing for bed. She indicated that all other residents were independent or had private duty aides. The employee was asked to describe the supervision given to Resident #1 from 3:00 PM to the time he was discovered missing from the facility. The employee stated the following:	R 563	Additionally, starting on 06/12/18 the ALA will oversee this process and review all new ISPs to ensure each has been properly signed quarterly as a finding to be reported at the Oversight Committee meeting. **(2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** On 04/17/18 the ALR re-emphasized the importance of obtaining the required signatures to the registered nurse "RN" who is tasked with the completion and maintenance of ISPs. See Sign-in Sheet for 4/17/18 Meeting, as **Attachment 7-7a.** On 06/12/18, the ALR reviewed all ISPs and found them to be in full compliance with applicable law and policies. **(3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The ALR has revised procedures and re-trained the RN as of 04/17/18 in order to ensure that all ISPs are signed by the necessary parties. See Health Assessment and Individualized Service Plans Policy; Revised Admission Policy; Oversight Committee Policy. To evaluate the effectiveness of the retraining, staff will be tested on their understanding of the protocol for ISPs through simulations of defective ISPs and discussions at a meeting to be held monthly	

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R 563	Continued From page 17 (a) Resident #1 was observed, after dinner, sitting with his peers in the dining/multipurpose room. (b) At approximately 7:00 PM, the receptionist left the facility. (Electronic timesheet's revealed that the receptionist clocked-out at 6:30 PM) At that time, Resident #1 was still in the dining/multipurpose room with his peers. (c) At approximately 9:00 PM, the residents were administered medications in the dining/multipurpose room. After which all residents, with the exception of Resident #1, went upstairs, unescorted, to their living units. Resident #1 remained seated in the dining/multipurpose room. (d) After the employee administered the 9:00 PM medications, the employee set at the front desk, leaving Resident #1 alone in the dining/multipurpose room. The employee stated that she used the video camera, located at the front desk, to monitor the resident. (e) Employee #2 arrived to the facility between 10:00 PM and 10:30 PM. After acknowledging Employee #3 and Resident #1 from the lobby, Employee #2 went upstairs. [Although the employee was scheduled to work from 11:00 PM to 7:00 AM, the electronic timesheet failed to show that Employee #2 clocked-in on 3/11/18. According to the ALA, the employee forgot to clock-in due the excitement of the incident] (f) At approximately 10:45 PM, Employee #2 came downstairs to the lobby and immediately noticed that Resident #1 was not in the dining/multipurpose room. The employee asked Employee #3 if she knew the resident's	R 563	Employees who test poorly in the ALA's discretion will be required to attend another training session to be scheduled soon after. **(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented?** On 04/17/18, the ALR implemented the quality assurance program described above, i.e., .review all residents' charts on a quarterly basis to ensure all necessary documents are present and properly executed and that the services and care provided are in compliance with the ISP. As part of its monthly meetings, the Oversight Committee will ensure that the quality assurance program is being properly followed. See Oversight Committee Policy. **R 513** **(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SOD alleges that the ALR failed to follow medical orders for vital sign monitoring, drug dosing, and reporting parameters specified by the healthcare practitioner for Resident #1. This allegation is based on four findings:	04/26/18

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R 563	Continued From page 18 whereabouts. Employee #3 stated that the resident was last observed on the monitor at approximately 10:30 PM. (g) Employees #2 and #3 searched for the resident and Employee #2 found the resident at the bottom of the loading dock. Employee #2 administered CPR and Employee #3 called 911. 2. Interview with the ALA and review of the visitor log revealed that seven (7) residents have private duty aides (HHAs) that provide care for 8 hours, 7 days a week. Six (6) of the seven (7) aides arrive at 7 AM and leave by 4:00 PM, and one (1) aide provides 12 hours a day, and leaves the ALR at 11:00 PM. After the private duty aides leaves, the residents are not adequately monitored as evidenced by the following: On 3/23/2018, the ALR's staffing schedule and electronic timesheet's were reviewed and revealed the following: The 7:00 AM to 3:00 PM shift one (1) employee (TME) was scheduled to provide direct care support to 13 residents. The 3:00 PM to 11:00 PM shift one (1) employee (TME) was scheduled to provide direct care support to 13 residents. A review of the electronic timesheet, confirmed that 1 staff (TME) reported to work the 3:00 PM to 11:00 PM shift. The 11:00 PM to 7:00 AM shift two (2) employees, a TME and a CNA, were scheduled to provide direct care support to 13 residents. The ALA was questioned as to the increase in staff on the overnight shift. The ALA stated that the two (2) employees were assigned for night security. The ALA was also asked about the need for a	R 563	(a) The first finding alleges that Resident #1's medical orders directed the ALR staff to report episodes of HTN to the NP for a SBP greater than 155 and that, on 9/7/2017, Resident #1's BP was 157 but was not reported. (b) The second finding alleges that the ALR staff administered Carvedilol to Resident #1 on nine separate occasions when his SBP was below 110, even though Resident #1 was not supposed to be given Carvedilol when his SBP was below 110. It is unclear whether these readings were taken before or after the resident was given medication. Beginning on 4/26/18, the ALR has made clear in the patient's records that BP readings are taken before and after the administration of medication. (c) The third finding alleges that the ALR failed to adhere to reporting obligations after Resident #1 fell and hit his head. Beginning on 04/17/18, the ALR has redefined a "reportable incident" to include medication errors and falls and included procedures to ensure that all incidents of this nature are properly reported. See Revised Incident Reporting Policy.	

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	ALR-0031	A. BUILDING: _____ B. WING _____	04/17/2018

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R 563	Continued From page 19 TME during the overnight shift. The ALA stated that several residents received 5:00 AM medications. A review of the electronic timesheet, confirmed that 2 staff (TME and CNA) reported to work during the 3:00 PM to 11:00 PM shift. Interview with the ALA on 4/17/18 revealed that only one direct care staff is scheduled on the 1st and 2nd shift. The TMEs are only required to administer medications. When asked who provides personal care and monitors residents, the ALA indicated that they were provided private duty aides from home care agencies. The ALA was asked to explain who was responsible for the care and monitoring of residents after the private aides leave the facility, the ALA indicated that there were no other staff, other than the TM Es. Review of the staffing schedule confirms that only TM Es are scheduled for the 7:00 AM to 3:00 PM and the 3:00 PM to 11:00 PM. It should be noted, however, that the schedule allows for 2 direct care staff (HHA/CNA/TME) to be on duty from 3:00 PM to 7:00 PM during the week days.	R 563	(d) The fourth finding alleges that medication was administered to Resident #1 twice at 9:00PM, in violation of the NP's order which directed that the medicine be given once at 9:00AM and then at 9:00PM. The ALR retrained the staff on 4/26/18 to ensure that reporting medication administration is accurate and thorough. The RN as supervisor of the TMEs has an improved monitoring system in place to assure that the required record keeping is being done. **(2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** On 04/17/18, the ALR performed a self-audit and review resident medical records to identify and correct any similar issues. Additionally, on 04/26/18 the ALR met with all staff responsible for administering medicine and reemphasized the importance of following medical orders for vital sign monitoring, drug dosing, and reporting parameters specified by the residents' healthcare practitioners.	
R 584	Sec. 701d1a Staffing Standards. (A) The health, mental condition, and psychosocial needs of the residents; Based on interview and record review, the ALA failed to develop a staffing plan that ensured the safety and proper care of the residents in the ALR. Findings included: [Cross Reference Citation R-063] Interview with the ALA and review of the visitor log revealed that	R 584	**R 563 and 584** **(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	08/06/18

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R 584	Continued From page 20 seven (7) residents have private duty aides (HHAs) that provide care for 8 hours, 7 days a week. Six (6) of the seven (7) aides arrive at 7 AM and leave by 4:00 PM, and one (1) aide provides 12 hours a day, and leaves the ALR at 11:00 PM. After the private duty aides leaves, the residents are not adequately monitored as evidenced by the following: On 3/23/18, the ALR's staffing schedule and electronic timesheet's were reviewed and revealed the following: The 7:00 AM to 3:00 PM shift one (1) employee (TME) was scheduled to provide direct care support to 13 residents. The 3:00 PM to 11:00 PM shift one (1) employee (TME) was scheduled to provide direct care support to 13 residents. A review of the electronic timesheet, confirmed that 1 staff (TME) reported to work the 3:00 PM to 11:00 PM shift. The 11:00 PM to 7:00 AM shift two (2) employees, a TME and a CNA, were scheduled to provide direct care support to 13 residents. The ALA was questioned as to the increase in staff on the overnight shift. The ALA stated that the two (2) employees were assigned for night security. The ALA was also asked about the need for a TME during the overnight shift. The ALA stated that several residents received 5:00 AM medications. A review of the electronic timesheet, confirmed that 2 staff (TME and CNA) reported to work during the 3:00 PM to 11:00 PM shift. Interview with the ALA on 4/17/18 revealed that only one direct care staff is scheduled on the 1st and 2nd shift. The TMEs are only required to	R 584	The SOD alleges that the ALA failed to provide adequate staffing to ensure resident safety. This allegation is based on a review of the ALA's staffing plan prior to the incident with Resident #1. The ALR has a policy of ensuring that each resident has access to appropriate medical, rehabilitation, and psychosocial services as established in the ISP and that there is appropriate oversight, monitoring, and coordination of all components of the ISP, including necessary transportation and the delivery of needed supplies. All staff members have been refreshed on this policy as of 04/17/18 and will be regularly reminded of this policy going forward. At the Marigold, during the evening hours when the incident occurred, there were two (2) staff persons on duty, one (1) private duty HHA and thirteen (13) residents. Nevertheless the ALR is in the process of hiring additional staff members to bolster oversight capacity. Prior to the incident, TMEs only provided TME services. Now, TMEs are responsible for both medication distribution as well as direct care. These new staff members will be briefed on all policies when hired. **The Current Staff Schedule is attached as Attachment 9.** **(2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

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R 584	Continued From page 21 administer medications. When asked who provides personal care and monitors residents, the ALA indicated that they were provided private duty aides from home care agencies. The ALA was asked to explain who was responsible for the care and monitoring of residents after the private aides leave the facility, the ALA indicated that there were no other staff, other than the TMEs. Review of the staffing schedule confirms that only TMEs are scheduled for the 7:00 AM to 3:00 PM and the 3:00 PM to 11:00 PM. It should be noted, however, that the schedule allows for 2 direct care staff (HHA/CNA/TME) to be on duty from 3:00 PM to 7:00 PM during the week days.	R 584	The ALR will perform self-audits and performance reviews at least once every six months to identify and correct any similar issues, and on a monthly basis if the magnitude and/or number of errors pose a threat to the health and safety of residents. Additionally, the ALR will regularly reemphasize the importance of ensuring each resident has access to the necessary medical, rehabilitation, and psychosocial services as established in the ISP. Further, the ALR will ensure that there is appropriate monitoring and coordination of all components of the ISP, including necessary transportation and the delivery of needed supplies. See Uniform Health Assessment and Individualized Service Plans Policy; Revised Incident Reporting Policy. Like in the response to R. 292, adherence by care personnel to the ISP will be monitored through a monthly meeting led by the RN, in which the RN shall review the progress notes of all care personnel in a discussion.	
R 782	Sec. 901 1 Responsibilities Of The ALR Personnel (1) Is capable of self-administering his or her own medications; Based on record review and interview, the ALA failed to ensure a resident was provided an initial assessment which identified their ability to self-medicate for one of one resident in the investigation (Resident #1). Findings included: On 03/13/18 at 6:40 PM, review of Resident #1 's clinical record revealed that the resident was admitted on 09/17/17. The clinical record failed to evidence an initial medication assessment had been conducted. During an interview with Employee #6 on 03/20/18 at 11:45 AM, she stated that her responsibilities as the Registered Nurse Consultant for the ALR include pre-admission	R 782	**(3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The ALR has performed the aforementioned audits and provided the aforementioned systemic personnel training on 04/17/18 to ensure the practice at issue does not recur	

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R 782	Continued From page 22 assessments and 45-day medication assessments. Subsequent review of the contractual agreement titled "Registered Nurse Consultant Agreement" dated 02/27/17 showed that Employee #6 was to complete all initial resident assessments as a part of her assigned duties. At the time of the investigation, the ALA failed to ensure that an initial assessment was performed to evaluate Resident #1 's ability to self-medicate.	R 782	Changes in personnel will be made in accordance with the findings of the Oversight Committee's periodic review once every three months. Furthermore, the ALR will review the adequacy of the staffing plan upon the admission of each new resident. This Current Staffing Schedule ensures that at least two staff members will be present to address any resident needs at all hours in addition to a receptionist who is at the front desk 24/7 and the six private aides. See Current Staffing Schedule.	
R 801	Sec. 903 1 On-Site Review. (1) Supervise the administration of medications by Trained Medication Employees; Based on interview and record review, the ALR failed to provide supervision of medication administration by TM Es for one of one resident in the investigation (Resident #1). Findings included: Review of the clinical records for Resident #1 on 03/13/18 showed that Employee #6 completed 45-day assessments on 09/17/17, 11/03/17, 12/18/17, and 01/31/18. As a part of this periodic assessment by the RN, the ALR's form titled, "45-Day Nursing Assessment" includes the following criteria for evaluation by the RN related to supervision of TM Es: a "Problems encountered regarding documentation, administration, competency, storage, etc."; and b "Actions taken if problems encountered" The criteria specified on the ALR's 45-day assessment form was not accurately and completed evaluated by Employee #6 as	R 801	**(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented?** Starting on 04/17/18, the ALR has redoubled its efforts to vet all new hires with multiple designations to ensure that the team can provide the around the clock care and attention the residents need. All staff underwent an extensive orientation training as well as monthly in-service training by ALA, R.N. and MIA. As a part of the vetting process, the ALA will review the performance of new hires on service and adherence to protocol in accordance with ALR's human resources procedures. Performance evaluations are conducted at least once a year of all staff members by the ALA. Current employees with singular designations will be encouraged to obtain multiple designations to better address staffing needs. This is included in the current job descriptions.	

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R 801	Continued From page 23 evidenced by the following: 1. On 03/13/18, review of the visit notes from the NP dated 09/27/17 showed that the NP ordered for vital signs to be measured for Resident #1 each day and for the ALR to report a SBP greater than 155. On 09/30/17, Employee #1 measured a BP of 157/91. There was no documented evidence that Employee #1 reported this to the NP as ordered. Further record review showed the 45-Day Nursing Assessment was completed on 11/03/17 and indicated that the MAR, medications, and orders were reviewed by Employee #6. The form, however, showed no documented evidence that Employee #6 provided remediation training to Employee #1 on following reporting parameters specified by the healthcare practitioner. Review of the ALR's contract with Employee #6, titled "Registered Nurse Consultant Agreement" and dated 02/27/17, showed that the duties of Employee #6 included, "[supervision] (sic] of delegation of the administration of medication by unlicensed trained staff," and "supervision of the medication management function and oversight of the direct care staff." 2. On 03/13/18, review of the December 2017 MAR showed documentation by Employee #1, Employee #7, and Employee #5 that Resident #1 refused the morning doses of his medications on 12/23/17, 12/24/17, 12/27/17, 12/28/17, and 12/29/17. Further record review showed the 45-Day Nursing Assessment was completed on 01/31/18. On the 01/31/18 assessment, Employee #6 did not identify and document Resident #1 's medication refusal as a problem encountered by the medication technicians and LPN. It should be noted that there was no documented assessment conducted by the RN closer to the time of the December 2017	R 801	The ALA will report on the staff performance and results of the periodic audits mentioned above at the monthly Oversight Committee meetings. See Oversight Committee Policy. R 782 **(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SOD alleges that the ALA failed to ensure Resident #1 was provided an initial assessment to identify his ability to self-medicate. This allegation rests on the absence of documentation of an initial medication assessment in Resident #1's clinical record. **See Medication Self Administration Assessment Sheet Marked Attachment 10.** (Note: This was not easily available for review at the time of DOH's investigation). The ALR has a policy of conducting initial assessments of residents in order to continue to ensure they possess the ability to self-medicate. The ALR strictly adheres to this policy and beginning with the next admission will ensure that such assessments are memorialized in writing by auditing clinical records. See Health Assessment and Individualized Service Plans Policy. This practice began on 10/24/17. Starting with the next new admission, Medication Self-Administration Assessments will be made easily accessible as part of the initial assessment.	04/17/18

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R 801	Continued From page 24 medication refusal. Review of the ALR's contract with Employee #6, titled "Registered Nurse Consultant Agreement" and dated 02/27/17, showed that the duties of Employee #6 included, "[supervision] [sic] of delegation of the administration of medication by unlicensed trained staff," and "assessment of the healthcare needs of residents [sic] and the need of a resident to be referred to a physician." 3. Review of the medical orders for Resident #1 on 03/13/18 showed an order by the NP dated 01/15/18 for"Carvedilol 3.125 mg PO BID for HTN" with instructions to "hold [for] SBP less than 110." Record review of the MAR for January 2018 and February 2018 showed that doses of Carvedilol were administered by Employee #1, Employee #4, and Employee #8 to Resident #1 when a SBP of less than 110 was measured on the following dates: 01/19/18, 01/23/18, 01/25/18, 01/29/18, 01/30/18, 02/01/18, 02/12/18, 02/18/18, and 02/20/18. Further record review showed the 45-Day Nursing Assessment was completed on 01/31/18 and Employee #6 documented that, "there were no medication errors since last review." Review of the ALR's contract with Employee #6, titled "Registered Nurse Consultant Agreement" and dated 02/27/17, showed that the duties of Employee #6 included, "[supervision] [sic] of delegation of the administration of medication by unlicensed trained staff," and "train LPN and TME/CNA staff as needed." During an interview with Employee #6 on 03/20/18 at 11:45 AM, she verified that she worked at the ALR ten hours per week and her responsibilities included overseeing the TMEs, completing 45-day assessments, responding to changes in residents' condition, and triaging incidents involving residents upon alerts by staff.	R 801	**(2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The ALA has performed a self-audit of other residents' records on 04/17/18 to ensure that each contains a written assessment of each resident's ability to self-medicate. See Medication **Self Administration Assessment Sheet Marked Attachment 10.** **(3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The ALR implemented a policy of memorializing initial assessment of residents' ability to self-medicate prior to admission. See Health Assessment and Individualized Service Plans Policy; Revised Admission Policy; Oversight Committee Policy. It will make sure that they are easily accessible as part of the residents' records starting with the next new admission. **(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented?** The ALR will add additional oversight to its admission process to ensure continued compliance with the initial medical assessment requirement.	

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R 8j1	Continued From page 25 At the time of the investigation, the ALR failed to provide R,1 supeNision of medication administration bf TMEs for Resident #1.	R 8j1	Specifically, the initial assessment documents of a resident's ability to self-medicate are now considered a condition precedent to admission and a part of a complete assessment package. See Revised Admission Policy; Uniform Assessment Form. The ALA will ensure compliance with this policy and will report on compliance at the monthly Oversight Committee meetings. See Oversight Committee Policy.	
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on inteNiew and record review, the ALR failed to perform a complete assessment of the resident's response to medication for one of one resident if the investigation (Resident #1)	R802	**R 801 and 802**	08/06/18
	Findings included: Review of the clinical records for Resident #1 on 03/13/18 showed that Employee #6 completed 45-day assessments on 09/17/17, 11/03/17, [illegible] and 01/31/18. As a part of this periodic assessment by the RN, the ALR's form titled, "45-Day Nursing Assessment" includes the following criteria for evaluation by the R,1 related to the assessment of the resident's response to medication: a "hospitalizations/physician visits since last review;" b "[medication/treatment] changes since last review"; c " esults of review of MAR, medications, and orders;" d "effectiveness of medications/treatments;" and e "is the environment safe for the resident?" The criteria specified on the ALR's 45-day assessment form was not accurately and completely evaluated by Employee #6 as evidenced bf the following:		**(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SOD alleges that the ALR failed to provide supervision of medication administration by TMEs for Resident #1 and that the ALR failed to perform a complete assessment of Resident #1 's response to medication. Additional allegations of deficiencies are based on an alleged failure to report that Resident #1 was refusing morning doses of medication in the 45-Day Nursing Assessment completed on January 31, 2018. Although it is the ALR's policy to report a resident's refusal to take prescribed medicine, this is done in the regular electronic records	

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R 802	Continued From page 26	R 802		

1. On 03/13/18, review of the visit notes from the NP dated 09/27/17 showed that the medication order for Aspirin 81 mg was discontinued on the same day related to an allergy identified for Resident #1. Further record review showed that the 45-Day Nursing Assessment, dated 11/03/17, indicated this medication change was implemented on 10/19/17. Review of the ALR's contract with Employee #6, titled "Registered Nurse Consultant Agreement" and dated 02/27/17, showed that the duties of Employee #6 included, "supervision of the medication management function," and "assist in the development of health assessment/service plans [sic] upon change of condition."

2. On 03/13/18, review of the staff progress notes from January 2018 showed that Resident #1 had fallen with acute head injury on 01/10/18 and 01/26/18. The resident was taken to the emergency room after the 01/10/18 fall. Resident #1 refused emergency medical care after the 01 /26/18 fall and remained at the ALR under monitoring orders issued by the NP for three days beginning on 1/26/18.

Further review of the medical orders from the same time frame indicated that the NP placed an order on 01/15/18 for a new medication, Carvedilol 3.125 mg, to control Resident #1 's high blood pressure and with instructions to "hold [for] SBP less than 110." Record review of the MAR for January 2018 showed that doses of Carvedilol were administered by Employee #1, Employee #4, and Employee #8 to Resident #1 when a SBP of less than 110 was measured on the following dates: 01/19/18, 01/23/18, 01/25/18, 01/29/18, 01/30/18.

. The ALR will provide training to applicable personnel to ensure that the 45-Day nursing assessment includes this information in the future. See Revised Incident Reporting Policy and **Medication Error Reporting Policy marked Attachment 11-11d.** The TMEs were retrained on 04/26/18 see minutes of training and sign-in sheet by the RN.

(2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The ALR has performed a self-audit on 04/17/18 to identify and correct any similar practices quarterly, with increased monthly frequency if the magnitude and/or number of deficient practices pose a threat to the health and safety of residents. Additionally, the ALR has emphasized the importance of always ensuring that Trained Medication Employees are supervised by the RN in administering medication to residents on 04/26/18. See Oversight Committee Policy

(3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

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THE MARIGOLD AT 11TH STREET	2905 11TH STREET NW WASHINGTON, DC 20001

(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 PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 802	Continued From page 27 Record review of the 45-Day Nursing Assessment, dated 01/31/18, failed to include documented evidence by Employee #6 capturing the resident's falls with sustained injury on 01/10/18 and 01/26/18. Additionally, Employee #6 did not evaluate and document on this assessment the timing and effect of the Carvedilol medication administration on Resident #1 related to the fall sustained on 01/26/18. Employee #6 failed to provide documented evidence on the 01/31/18 assessment that Resident #1 had experienced any side effects and/or an adverse reactions to the medication, and Employee #6 specified that the environment was safe for the resident. Review of the ALR's contract with Employee #6, titled "Registered Nurse Consultant Agreement" and dated 02/27/17, showed that the duties of Employee #6 included, "supervision of the medication management function," and "monitor the condition of the residents and report any significant change in the resident's condition." During an interview with Employee #6 on 03/20/18 at 11:45 AM, she verified that she worked at the ALR ten hours per week and her responsibilities included overseeing the TMEs, completing 45-day assessments, responding to changes in residents' condition, updating ISPs, and triaging incidents involving residents upon alerts by staff. At the time of the investigation, the ALR failed to perform a complete assessment of the resident's response to medication for Resident #1.	R 802	The ALR has performed the audit and provided the personnel training on 04/26/18 to ensure the deficient practice does not recur. **See Training and Sign-In sheets marked Attachments 12-12a.** Additionally, the ALR's RN will review the MARs of all residents and reconcile all medication administered with the medication in the medication cart on a weekly basis. The RN will then contact the resident's PCP to report any adverse or suspected adverse responses to medication by the residents. The RN will be subject to quality assurance via the Oversight Committee. See Oversight Committee Policy. **(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented?** The ALR will use the results of the aforementioned audit to ensure that Trained Medication Employees (TMEs) are subjected to adequate supervision. Additionally, the ALA will hold a care assessment meeting with nurses on a weekly basis wherein issues of medication administration and response shall be discussed. The RN shall scrutinize the MAR records and notes of the bi-weekly meetings before completing any 45-Day Nursing Assessments. The Oversight Committee will review the ALR's staffing plan and ensure that coverage is adequate to meet the residents' needs. See Oversight Committee Policy.	