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-0030	A. BUILDING: _____ B. WING _____	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING ON CONNECTICU	5111 CONNECTICUT AVE NW WASHINGTON, DC 20008

(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 000	Initial Comments	R 000	Received 8/18/16 cm	

An annual survey was conducted from June 27, through July 15, 2016, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. The Assisted Living Residence (ALR) provides care for one hundred fifteen (115) residents and employs one hundred seventy (170) staff members. The sample size included nine (9) current resident record, one (1) discharged resident record record and seventeen (17) employee records. The findings of the survey were based on observations, record reviews, and interviews.

During the survey it was revealed that a total of 367 falls occurred in the ALR from May 2015 through June 2016. Out of the 367 falls, a total 47 injuries were sustained to include fractures, skin tears, bruises and abrasions.

Note: Listed below are abbreviations used throughout the body of the report.

ALA -- Assisted Living Administrator
ALR --- Assisted Living Residence
BID -- twice a day
BMP -- basic metabolic panel
cap -- capsule
c/o -- complained of
DON--Director of Nursing
EMR -- electronic medical record
ER -- emergency room
GERD -- Gastroesophageal Reflux Disease
ISP -- individualized service plans
LPN -- licensed practical nurse
mcg -- micrograms
MD -- physician
mg -- milligram

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R 000	Continued From page 1 ml -- milliners PCP -- primary care physician PDA -- private duty aides po -- by mouth PT -- Physical Therapy RN -- registered nurse QAM -- every morning QD -- every day QPM -- every night IQ 12 hrs. -- every 12 hours tab -- tablet TID -- three times a day	R 000		
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 record review and interview, the ALR failed to: (1) ensure physician orders were followed as prescribed; (2) inform physicians of important patient information; (3) follow it's Fall policy to decrease falls; and (4) follow it's Skin Integrity Management policy for five (5) of ten residents in the sample that sustained multiple falls. (Residents #1, #2, #7, #8 and #9) The findings include: I. The ALR failed to provide evidene that physician's orders were implemented as prescribed. a. Review of Resident #1's clinical record, on June 27, 2016, at 1:45 p.m., revealed that the resident was admitted on November 8, 2015, and had the following diagnoses: congestive heart	R 292	R 292 Response: The Director of Nursing (DON) reviewed resident #1 and #2's physician orders to ensure all orders are current and are needed. All orders that are care related and do not require a licensed nurse to provide the care, a discontinue order was obtained and the individual service plan (ISP) for the residents were updated with the care the residents need and are receiving. The order for fluid restriction for resident #1 was written by Primary MD for May 20, 2016 and was discontinued July 18, 2016. The DON discussed with Primary MD and an order was discontinued on July 18, 2016. See attached copy of Primary MD order. Resident # 1's BP checks were ordered for three days by Primary MD and not done. Primary MD notified - no further order given. Resident #2's order for BMP ended. Primary MD notified - no further order given at this time. resident's current orders do not include BMP checks. If future orders require BMP checks, orders will be followed, results documented, and shared with Primary MD as required. See attached tickler.	8/10/16 8/15/16 8/15/16 8/12/16

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R 292	Continued From page 2 failure, atrial fibrillation, hypertension, hyperlipidemia and status post transcatheter aortic valve replacement. Further review of the record revealed a prescription dated April 10, 2016, which prescribed "check blood pressure, heart rate and temperature every shift for three (3) days and fax results to MD." The record lacked documented evidence that the ALR's nursing staff had monitored the resident's vital signs and faxed the physician a copy of the results as ordered. Further review of Resident #1's record revealed a prescription dated May 20, 2016, that ordered the resident to be on a fluid restriction of 1500 ml / 24 hours for congestive heart failure. The record lacked documented evidence that the nursing staff ensured that the resident followed the fluid restriction order from June 1, 2016 to June 28, 2016. Continued review of the record revealed a prescription dated February 2, 2016, that ordered the staff to assist the resident to the toilet routinely at 4:30 a.m.. The record lacked documented evidence that the facility's staff toileted the resident routinely at 4:30 a.m., as prescribed. Interview with the DON on June 27, 2016, at 3:00 p.m., revealed that she was unable to find documentation that the vital signs were taken every shift for three days as ordered by the physician. Additionally, the DON indicated that she would develop a new form to ensure that the fluid restriction ordered was followed as prescribed. The DON also indicated the toileting was implemented in an effort to decrease the resident's falls.	R 292	The DON and wellness staff completed an audit of all resident orders to ensure all orders are accurate and current. All orders that are care related and do not require a licensed nurse to provide the care, a discontinue order was obtained and the individual service plan (ISP) for the resident was updated with the care the resident needs and is receiving. The Regional Director of Resident Care (RN) and DON provided an in-service to all staff that provide medication administration and are responsible for taking vital signs for the purpose of medication administration on reviewing primary physician orders, implementation of primary physician orders, documentation on the electronic medication administration record (E-Mar) and the communication process with primary physicians to relay results as required. All licensed nurses follow the orders listed on the E-Mar and communicate vital sign results and other required parameter results to the individual resident physicians. Any discrepancies will be brought to the attention of the DON for corrective action. The DON monitors the E-Mar system via the dash board to ensure that all orders have been completed during each shift and within the appropriate time frames. Parameters are ordered by the Primary MD and are set up in E-Mar with instructions for the LPN or RN to notify Primary MD by telephone, if outside of parameters.	8 /15/16 8/9/16 8/10/16 8/9/16 8/9/16 8/9/16

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R 292	Continued From page 3 b. Review of Resident #2's clinical record on June 30, 2016, at 9:45 a.m., revealed that the physician ordered BMP every week [Monday] starting December 14, 2015 to March 4, 2016. Further review of the record lacked documented evidence that a BMP had been conducted on the following weeks: - December 21, 2015; - December 28, 2015; - January 4, 2016; - January 11, 2016; - January 18, 2016; - January 25, 2016; - February 8, 2016; - February 15, 2016; - February 22, 2016; and - February 29, 2016. During an interview with the DON on June 30, 2016, at 1:00 p.m., it was revealed that she would provide the lab results for review. It should be noted the DON did provide lab results however, they did not address the aforementioned weeks. At the time of this survey, the facility failed to provide evidence that physician orders were followed as prescribed. II. The nursing staff failed to inform the physician of drug interactions. a. Review of Resident #1's clinical record, on June 27, 2016, at 1:45 p.m., revealed multiple notes that identified possible drug to drug interactions with some of the resident's routinely prescribed medications:	R 292	The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. See attached tickler. The Director of Nursing (DON) scheduled a pharmacy review for resident #1, 2, 7, and 8's medications to be reviewed and possible drug interactions to be identified. The DON informed each residents' primary physician, respectively, of the identified drug interactions. Documentation of primary physician notification is located in residents wellness chart. See attached. The DON provided an in-service to all staff that provide medication administration on how the drug interactions are identified on the E-MAR and the process for reporting the drug interactions to the physician. If a resident has medication that flags for drug interactions, the nurse receives a message electronically on the E-Mar record. The nurse documents the drug interaction that was flagged immediately in E-Mar and prints out the progress note for the Primary MD. The DON will review monthly, all flagged drug interactions.	8/9/16 8/15/16 8/9-10/16 8/10/16

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R 292	Continued From page 4 - On November 11, 2015, the facility's EMR system identified the following possible drug to drug interactions: Caltrate 600+D, give one (1) tab po QD for bone health and Levothroid 50 mcg, one (1) tab po QAM for hypothyroidism. The EMR system identified that Levothroid may decrease the pharmacological effects of Caltrate. Metoprolol 25 mg po Q 12 hrs for atrial fibrillation and Levothroid 50 mcg, one tab QAM for hypothyroidism. The EMR system identified that the pharmacological effects of Levothroid may decreased by Metoprolol. Omeprazole 20 mg, one (1) tab po QD for GERD and Caltrate 600+D one (1) tab po QD for bone health. The EMR system identified that Caltrate may be decrease the gastrointestinal absorption of Omeprazole. Sertaline 50 mg, one (1) tab po QPM for major depression, Levothroid 50 mcg, one (1) tab po QAM for hypothyroidism and Metoprolol 25 mg po Q 12 hrs for atrial fibrillation. The EMR system identified that the pharmacological effects and therapeutic benefits of Sertraline may be decreased by Levothroid. Also, the EMR system identified that the plasma concentration and pharmacological effects of Sertaline may be decreased by Metroprolol. - On December 23, 2015, the facility's EMR system identified the following possible drug to drug interactions: Voltaren Gel, 1% apply 4 grams transdermally TID for right knee pain, Eliquis tab 2.5 mg po BID for unspecified atrial fibrillation, Sertraline 50 mg	R 292	The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. A Shared Responsibility Agreement was put into place by the Community, Resident #9 and the responsible party. Residents #3, #4, #8 & # 9 were re-assessed and ISPs updated by the DON to reflect the residents' needs, fall history and interventions put in place. Resident #6 was discharged from the community on March 25, 2016 and an assessment nor ISP updates can be completed. The DON has completed a Falls Risk assessment on all residents that have been reported as having falls or maybe at risk for falls. The DON was in-serviced on the updated Fall Prevention Program by Regional Director of Resident Care. The DON provided all licensed nurses and care staff with an in-service on the updated Fall Prevention Program, which included; identifying updates to the ISP's, implementation of interventions and communications of changes in conditions with residents. The DON or designee will conduct a falls screening for any new admission and it will be documented in the resident's electronic health record. When a resident falls, the team member calls the nurse and completes a falls investigation with the nurse. The nurse notifies the Primary MD and family.	8/10/16 7/19/16 8/13/16 8/31/16 6/27/16 7/6/16,7/7/16, 7/9/16, 7/12/16, 7/14/16, & 7/27/16 6/27/16

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R 292	Continued From page 5 one (1) tab po QPM for major depression and Furosemide 20 mg give three (3) tabs po QD for heart failure. The EMR system identified that the use of Eliquis with Voltaren may increase bleeding. It further revealed that toxic effects may be increased with concurrent administration of Voltaren Gel and Sertraline and the risk of upper gastrointestinal bleeding may be increased. Also, the EMR system identified the pharmalogical effects of Furosemide may decrease Voltaren. - April 10, 2016, the facility's EMR system identified the following possible drug to drug interactions: Tussin DM syrup 100-10 mg/5 ml, give 5 ml po BID for 14 days and Sertraline 50 mg, one (1) tab po QPM for major depression. The EMR system identified that Sertraline may increase plasma concentration and toxic effects of Tussin DM syrup, central nervous system toxicity (visual hallucinations) may occur and Serotonin syndrome may result. Further review of the record lacked documented evidence the physician was made of the aforementioned alerts. It should be noted that at the time of survey the the resident was still receiving all the aforementioned medications except for Tussin DM syrup. b. Review of Resident #2's clinical record, on June 30, 2016, at 9:45 p.m., revealed multiple notes that identified possible drug to drug interactions with some of the resident's routinely prescribed medications:	R 292	The resident is monitored every shift for the next 72 hours. A medication review is sent to the pharmacy and the ISP is updated to reflect fall and interventions. The ALA and DON discuss falls at weekly Resident Care Meeting with the Interdisciplinary Team. The DON enters details of the fall on the electronic medical record and reviews electronic dashboard daily for updates. The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The falls are reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. Resident #2 and #5 were reassessed by DON to ensure current needs are captured. The ISPs have been updated to reflect the residents' needs, skin integrity and interventions put in place. The DON completed a review of all residents with wounds to ensure monitoring is taking place on a weekly basis and documented with specific details per the Skin Care and Pressure Ulcer Management Program. The DON was in-serviced on the updated Skin Care and Pressure Ulcer Management Program. The DON provided all licensed nurses and care staff with an in-service on the updated Skin Care and Pressure Ulcer Management Program. See attached attendance sheet. When a team member identifies a skin care need for a resident, the team member calls the nurse and provides information on what was observed. The nurse notifies the Primary MD and family. The nurse carries through the orders for treatment from the Primary MD. The ISP is updated to reflect the skin care treatment, frequency and whom it will be completed by.	8/1/16 8/1/16 8/13/16 8/15/16 8/9/16 8/9/16 & 8/10/16 8/1/16

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R 292	Continued From page 6 - On November 8, 2015, the EMR system identified that the resident was prescribed Ibandronate Sodium 150 mg tab po on the 10th of every month for osteoporosis and further indicated that it was outside the recommended dose. - On January 19, 2016, the facility's EMR system identified the following possible drug to drug interactions: Celecoxib 100 mg cap, one (1) po BID for pain and Boniva 150 mg, po in the morning every four (4) weeks on Monday. The system identified gastrointestinal adverse effects may be increased with concurrent administration of Boniva and Celecoxib. - On January 20, 2016, the facility's EMR system identified the following possible drug to drug interactions: Doxycycline 100 mg, one (1) cap po BID for wound, Vitron-C 65-125 mg, one (1) tab po QAM for supplement and Magnesium Oxide 400 mg, one (1) tab po QD for supplement. The system identified Vitron C may impair the gastrointestinal absorption and decrease the antimicrobial effectiveness of Doxycycline. Additionally, the antimicrobial effectiveness of Doxycycline may be decreased by Magnesium Oxide. Further review of the record lacked documented evidence the physician was made of the aforementioned alerts. c. On June 27, 2016, at 10:30 a.m., review of	R 292	The ALA and DON discuss skin and pressure ulcer management at weekly Resident Care Meeting with the Interdisciplinary Team. The DON enters details of the skin care needs on the electronic medical record and reviews electronic dashboard daily for updates.	7/18/16

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R 292	Continued From page 7 Resident #7's clinical record revealed a physician 's order dated November 8, 2015, on the facility's EMR system that identified the following possible drug to drug interactions: - Fludrocortisone acetate, 0.1 mg tablet by mouth every morning related to essential primary hypertension. -Aspirin Chewable 81 mg, give one tablet by mouth one time a day for prophylaxis. The EMS system identified that "concomitant use of Fludrocortisone acetate and Aspirin may increase the risk of gastro-intestinal toxicity." In addition, pharmacological effects of Fludrocortisone acetate may be decreased by the use of Aspirin Chewable 81 mg. The nursing note failed to identify that the physician was informed of this alert. d. On June 28, 2016, at 1:00 p.m., review of Resident #8's clinical record revealed a physician's order dated January 1, 2016, on the facility ' s EMR system that identified the following possible drug to drug interactions: - "Ibuprofen Tablet 600 mg, one (1) tablet by mouth two times a day related to pain in left shoulder." - "Furosemide 20 mg tablet, one tablet by mouth in the evening every Mon, Wed, Fri for edema." - "Triamterene W/HCTZ 37.5-25 mg tablet, one tablet by mouth one time a day related to Post Procedural Hypertension." The EMS system indicated the following drug to drug interactions with the aforementioned	R 292		

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medications. The use of Ibuprofen (Tablet 600 mg) may decrease the diuretic effect of the Furosemide (20 mg tablet). Sodium retention and Hypervolemia may occur. The combination of Ibuprofen 600 mg and Triamterene W/HCTZ 37.5-25 mg tablet may cause a sudden onset of nephrotoxicity. The nursing note failed to identify that the physician was informed of this alert.

Interview with the DON on June 27, 2016, at 3:00 p.m., revealed that the EMR system was new to the facility and the nurses did not inform the resident's physician of the aforementioned possible drug interaction. The DON also indicated that going forward the nurse will inform the physicians of any drug interactions and document the physician recommendations.

At the time of the survey, the facility failed to ensure each residents physician was informed of possible drug to drug interactions.

III. The ALRs staff failed to follow it's Fall policy after every fall.

Interview with the DON on June 27, 2016, at 1:00 p.m. revealed that after a resident falls the following should occur:

-call physician;
-call family;
-nursing document fall in the record;
-update the resident's ISP;
-RN re-assessment;
-review interventions;
-therapy screen;
-check environment;
-complete an incident report;
-72 hours follow assessment every shift by nursing staff;

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R 292	Continued From page 9 -neurological checks times 72 hours for head injury and any unwitnessed falls; - and medication review by pharmacy and DON every three months. a. Review of Resident #9's clinical record on June 30, 2016, at 10:00 a.m., revealed that the resident had a total of twenty eight (28) falls from May 1, 2015, to June 30, 2016. The falls resulted in injuries including; a fractured right shoulder, a laceration to the scalp requiring nine (9) staples and a cerebral concussion (that occurred concomitantly with the laceration to the scalp). The record lacked consistent documented evidence that the fall policy was implemented as outlined. After each fall, the resident's record failed to provide evidence that the resident's ISPs were updated, RN reassessments were conducted, interventions were reviewed, neurological checks were conducted (following the head injury) and the environment was checked. b. Review of Resident #3's clinical record, on July 1, 2016, at 10:00 a.m., revealed that the resident had a total of seven (7) falls from July 14, 2015 to June 16, 2016. The record lacked documented evidence that the resident's ISPs were updated, RN reassemments were conducted, interventions were reviewed, environment was checked, therapy screen was conducted and 72 hour follow up nursing assessments every shift were conducted after every fall. Additionally, the record lacked documented evidence a neurological assessments had been conducted after every unwitnessed fall.	R 292		

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c. Review of Resident #4's clinical record, on June 27, 2016, at 1:45 p.m., revealed that the resident had a total of six (6) falls from December 8, 2015 to March 8, 2016.

The record lacked documented evidence that the resident's ISPs were updated, RN reassemments were conducted, interventions were reviewed, environment was checked , 72 hour follow up nursing assessments every shift were conducted after every fall. [It should be noted that the resident had swelling to the back of the head and was transferred to the ER for the fall that occurred on February 1, 2016.]

d. Review of Resident #6's clinical record, on July 7, 2016, at 9:50 a.m., revealed that the resident had fell in the elevator on January 31, 2015. The resident sustained a right forearm skin tear, swollen lip and c/o right shoulder pain and bumping his/her head. Further review of the record, revealed that first aid was provided for the skin tear and Tylenol #3 was administered for the shoulder pain. Additionally, the record revealed that the resident's daughter took the resident to the ER for evaluation of a right shoulder bruise and pain on February 2, 2016. The resident returned on the same day with diagnosis of clavicle fracture, nasal fracture and head injury [non-serious]. Further review of the record lacked evidence that the resident's ISP was updated, a RN re-assessment was conducted, a interventions were reviewed, environment check, 72 hour follow up nursing assessments every shift were conducted after every fall and neurological checks had been conducted.

Interview with the DON on July 7, 2016, at 2:30 p.m., revealed that the resident had been

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R 292	Continued From page 11	R 292		

discharged from the ALR on March 25, 2015.

e. Review of Resident #8's clinical record on June 28, 2016, at 1:00 p.m., revealed that the resident had a fall on March 24, 2016, resulting in a fracture of the head of humerus on the right arm. This injury resulted in the resident having a surgical procedure (open reduction/internal fixation of the arm) to repair the fracture. Additionally, the resident was receiving intravenous antibiotic (Vancomycin) which was administered by a home care agency post-surgery.

The record lacked documented evidence that the resident's ISPs were updated, RN reassessments were conducted and interventions were reviewed.

Interview with the ALA and DON on June 27, 2016, at 3:30 p.m., revealed the company had developed a new Fall policy for staff to implement after training was provided. [It should be noted that the nursing staff were to start training the following week].

At the time of this survey, the ALR failed to follow it's current Fall policy.

IV. The ALRs staff failed to follow it's Skin Integrity Management policy, as indicated below:

Review of the Skin Integrity Management policy #SUN-RH-076 documented the following:

- The licensed nurse is responsible for promptly reporting
[skin integrity issue] to the health care practitioner.

- Any health care practitioner orders received will

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R 292	Continued From page 12 be verified, implemented and monitored; and - For each identified skin integrity issue, the Sunrise licensed nurse will observe, evaluate and document in the resident's record at least weekly, or more frequently as documentation frequency is dictated by healthcare practitioner order. Documentation should include, but not limited to: location, size, color, temperature, edema, odor, moisture, appearance of surrounding skin, exudates, and drainage. 1. Review of Resident #2's clinical record on June 30, 2016, at 9:45 a.m., revealed the following nursing notes: - May 7, 2016, the nurse documented, "left heel blood filled discoloration, no swelling, skin intact." The record lacked documented evidence the physician was made aware of the skin integrity issue and the size of the left heel wound. The record lacked documented evidence of the size of the left heel wound. Additionally, the record lacked documented evidence that the left heel wound was monitored after May 7, 2016. - A physician order dated May 13, 2016, documented, " clean presacral ulcer with normal saline cover with Allevyn 3x3 QD until healed. The record lacked documented evidence of the characteristic of the wound as identified in the Skin Integrity Management policy. [It should be noted that the resident's hospital discharge paperwork documented that on admission of May 14, 2016, the resident had a stage 3 sacral wound, left heel black unstageable pressure ulcer, a stage 2 midline back pressure ulcer and a right buttock chronic pressure ulcer.] Interview with the DON on June 30, 2016, at 2:00	R 292		

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R 292	Continued From page 13 p.m., revealed she would look for additional documentation for wound monitoring and provide it for review. The DON also indicated that the ALR was implementing a new Skin Integrity policy and would be implementing it when staff was trained. The wound documentation provided on July 1, 2016, was only for the mid-back pressure ulcer. The nursing notes were dated May 21, 2016, June 3, 2016, June 9, 2016 and June 24, 2016. 2. A review of Resident #5's clinical record on July 6, 2016, at 10:00 a.m., revealed a nursing note dated April 28, 2016, that indicated the resident returned from the hospital and had stage 2 bilateral buttocks pressure ulcers. Further review of the record lacked documented evidence of the characteristic of the wounds and that they were monitored at least weekly. Interview with the DON on July 6, 2016, at 3:15 p.m., revealed that she would provide the wound care order and nursing notes for review. [It should be noted that the wound care order and/or nursing notes documenting wound care was not provided for review.] At the time of the survey, the ALR failed to follow it's current Skin Integrity Management policy.	R 292		
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 ISPs included when, how often, and by whom services will be provided for five (5)	R 481	R 481 response: The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The ISPs are reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	8/1/16

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R 481	Continued From page 14 of ten residents in the sample. (Residents #1, #3, #4, #8, #9, and #10) The findings include: 1. A review of Resident #1's clinical record conducted on June 27, 2016, at 1:45 p.m., revealed that the resident had a total of seven (7) falls from December 8, 2015 through March 8, 2016. Further review of the record revealed the resident was receiving PT services three (3)times a week from December 11, 2015 through May 31, 2016. However, review of the resident's ISP dated January 7, 2016 lacked documented of the PT services. Interview conducted on June 27, 2016, at 3:00 p.m., with the DON revealed that the frequency , when and how often PT services were to be provided was not documented on the aforementioned ISPs. The DON indicated that she would update the resident's ISP to include the frequency, when and how often PT services were to be provided. 2. Interview with the DON on July 1, 2016, at 10:00 a.m., revealed Resident #3 receives companion services Monday through Friday for four (4) hours a day. The DON also indicated that the resident had been receiving the companion services since his/her admission in 2014. A review of Resident #3's clinical record on the same day, at 10:30 a.m., revealed ISPs dated June 8, 2015 and March 2, 2016. The aforementioned ISPs lacked documented evidence of when , how often and by whom companion services were to be provided.	R 481	Residents #1 and #3 ISPs were updated to include when, how often and by whom PT services were being provided. Resident #4's ISP was updated to include the PT services that were provided with start and discontinuation dates and information. In addition the resident's use of a Baclofen pump was added, along with the resident ability to use and what services care staff provide in regards to the Baclofen pump. Resident # 8's ISP was updated to include current skin care management services and when, how often and by whom companion services were being provided. Resident # 9's ISP was updated to include fall history, interventions, and electronic medical records to include incident with head wound and sutures. Resident #10 ISP was updated to include hospice services that were provided including provider name, services provided and frequency. An audit will be completed by the DON and ALA to ensure all ISPs contain services provided, frequency of services, and name of provider. Any new admission will have an initial, 30-day, 6 month and change of condition ISP that includes additional services provided, frequency of services and name of provider. The Regional Director of Resident Care conducted trainings for all nurses on nursing process, documentation, skin protocol, primary physician orders and documentation on ISPs. All nurses and care managers are responsible for reporting when care is being provided and not identified on the ISP. The DON will review documentation during the 45-day resident RN assessments.	8/13/16 7/25/16 8/13/16 8/13/16 8/13/16 8/31/16 8/9/16 & 8/10/16 8/31/16

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R 481	Continued From page 15 A second interview with the DON , at 11:00 a.m. revealed that she would update the resident's ISP to include when , how often and by whom companion services are to be provided. 3. A review of Resident #4's clinical record conducted on July 6, 2016, at 1:45 p.m., revealed that the resident had a total of four (4) falls from January 26, 2016 through April 22, 2016. Further review of the record revealed the resident was receiving PT services three (3) times a week from February 19, 2016 through March 19, 2016 and June 10, 216 to July 8, 2016. The resident ISPs dated January 8, 2016 and June 22, 2016, lacked documented evidence they had been updated with PT when and how often PT services were to be provided. Additionally, the record revealed that the resident had a Baclofen pump he/she managed for medication administration. The aforementioned ISPs lacked documented evidence of what services the ALR would provide for the Baclofen pump. Interview with the DON on July 6, 2016, at 3:30 p.m., revealed she would update the resident's ISP to include the frequency, when and how often PT services are to be provided. Additionally, the DON indicated that the only service they provided for the resident's Baclofen pump was to send the resident to ER if there were any concerns with the pump. The DON also stated, she would add the Baclofen pump services to the resident's ISP. 4. On June 28, 2016 at 10:30 a.m., review of Resident #8's clinical record revealed that on March 23, 2016, at 12:49 p.m., the resident was found on the floor in her bathroom following a fall. The resident was sent to Sibley Hospital ER for	R 481	The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	8/10/16

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evaluation and returned to the facility at 8:30 p.m. The resident was diagnosed with a closed displaced fracture of distal end of right humerus. It should be noted that the record revealed that the resident was in the company of a PDA at the time the resident returned to the facility following the ER visit.

Further review of the clinical record revealed that the resident was again sent to Sibley Hospital ER on March 27, 2016, at approximately 5:15 p.m., with complaint of generalized pain. The resident was re-admitted to the facility on April 5, 2016, at approximately 2:45 p.m., with an indwelling Foley catheter.

Continued review of the clinical record revealed a nurse's note dated April 8, 2016, at 4:04 p.m., stating that the PCP had seen the resident earlier that morning and referred the resident to an orthopedist for further evaluation of " the incision site". The note further stated that the PDA later called the facility from the doctor's office to report that the resident was sent to Sibley Hospital ER for further evaluation. The record revealed that the resident was admitted following the ER visit and returned to the facility on April 15, 2016. Review of a nurse's note dated April 15, 2016, at 11:33 p.m., revealed that the resident returned with decubiti; one to the sacrum measuring 2.5 cm. by 2 cm., one the right buttocks measuring 6.5 cm. by 3.5 cm., and one on the left buttocks measuring 5.0 cm. by 4.0 cm.

On April 15, 2016, the physician ordered "Dry dressing change daily to the surgical wound with abdominal pad and four (4) inch ace wrap for swelling. Barrier paste for pressure ulcer stage II to right and left buttocks every shift. Apply silver powder to wound bed and cover with calazime

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R 481	Continued From page 17 skin barrier cream on left sacral area." Additionally, review of a nurse's note dated April 17, 2016, at 6:10 a.m., revealed that the resident was receiving intravenous antibiotic (Vancomycin). Review of the ISP dated April 8, 2016 (last ISP on record), failed to provide evidence of how and by whom all of the above mentioned services will be rendered. Additionally, the ISP failed to include the services of a PDA, the start and end date of the PDA, and the hours worked. Furthermore, the ISP failed to mention the presence of a Foley catheter or any information regarding the care and services rendered. 5. On June 30, 2016, at 10:00 a.m., review of Resident # 9's clinical record from May 27, 2015, to June 21, 2016, revealed that the resident fell twenty eight (28) times. Further review of the clinical record revealed a nurse's note dated February 9, 2016, at 10:20 p.m., that stated the resident was found on the floor complaining of pain to the shoulder. The resident was taken to George Washington Hospital Emergency Room by ambulance and was diagnosed with a fractured right shoulder. Review of a nursing note dated February 15, 2016, at 3:43 a.m., revealed that the resident was found sitting on the floor in her room bleeding from the right side of her head. The ambulance was called and the resident was taken to George Washington Hospital Emergency Room where the resident was diagnosed with a cerebral concussion and received sutures to the wound on the head. Review of the ISP dated January 7, 2016 (last	R 481		

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R 481	Continued From page 18 ISP on record), failed to provide evidence that it was updated to reflect when, how often, and by whom wound care to the head and neurological assessments would be conducted following the laceration and concussion. Interview with the DON on July 6, 2016, at 2:00 p.m., revealed that he/she was not able to update the ISP to reflect the above mentioned significant changes in the resident's condition. The DON further stated that the facility planned to hire another RN to ensure documentation remained updated in the clinical records. 6. On July 1, 2016, at 9:45 a.m., review of Resident #10's clinical record revealed that the resident had a diagnosis of cancer of the skin, scalp and neck. Review of the physician's orders revealed that hospice care was ordered on October 1, 2015, and the resident was admitted to Vitas hospice on October 7, 2015. Review of ISPs dated October 15, 2015, and April 4, 2016, failed to include when and how often hospice services would be provided. Additionally, it failed to document how and by whom all services will be assessed. Interview with the DON on July 6, 2016, at 3:00 p.m., revealed that he/she was not able to update the ISP to reflect the above mentioned services ordered by the physician. The DON further stated that the facility planned to hire another RN to ensure documentation remained updated in the clinical records. At the time of the survey, the ALR failed to update ISPs with when , by whom and how often services were to be provided.	R 481		

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R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the 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 by the resident and/or the residents surrogate at least every six (6) months or updated more frequently with significant changes for five (5) of ten residents in the sample. (Residents' #2, #5, #6, #8 and #9) The findings include: 1. A review of Resident #2's clinical record on January 30, 2016, at 9:45 a.m., revealed a nursing noted dated January 30, 2016, that indicated the resident had returned on that day to the ALR following a hospital admission. The nurse also documented that the resident had a "pressure ulcer on mid-upper spine." The note, however, failed to document the characteristics of the pressure ulcer. Additionally, the record contained a physician order for wound care to the mid-spine once daily. Continued review of the record revealed a nursing note nursing dated May 20, 2016, that indicated the resident had returned on that day to the ALR following a hospital admission. The	R 483	R 483 Response: DON reassessed Resident #2 and updated ISP to reflect care provided. Weekly wound assessment conducted by DON. See attached. Resident #5 assessed by DON and ISP updated to reflect wound care services provided. Resident #6 no longer resides at the community as of, March 23, 2016. Unable to re-assess and/or update the ISP. Resident #9 reassessed by DON due to significant change and updated to reflect accurate history and care being given. An audit will be completed by the DON and ALA to ensure all ISPs contain services provided, frequency of services, and name of provider. Any new admission will have an initial, 30 day, 6 month and change of condition ISP that includes additional services provided, frequency of services and name of provider. The Regional Director of Resident Care conducted trainings for all nurses on nursing process, documentation, skin protocol, physician orders and documentation on ISPs, to include services provided, frequency of services and name of provider. The RDRC also instructed nurses and care managers on significant change in status. The DON to reassess residents upon readmission from hospital, upon transition to hospice, and any significant change in status. Additionally, the DON will review documentation during the 45-day resident RN assessments.	8/13/16 7/15/16 8/13/16 8/13/16 8/15/16 8/9-10/16 8/13/16

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R 483	Continued From page 20 nurse also documented the resident had a "sacral pressure ulcer, stage 3". [It should be noted that the record lacked documented evidence of an order to address the stage 3 sacral wound.] The resident's ISPs dated February 27, 2015, September 27, 2015, May 7, 2016, and May 27, 2016, all lacked documented evidence that they had been updated to include the altered skin integrity that required the nursing staff to provide daily wound care. Interview with the DON on June 30, 2016, at 2:00 p.m., revealed that the nursing staff did provide the resident's wound care as prescribed. The DON also indicated that they would update all of the resident's ISPs with significant changes, if needed. 2. A review of Resident #5's clinical record on July 6, 2016, at 10:00 a.m., revealed a nursing note dated April 28, 2016, that indicated the resident returned from the hospital and had stage 2 bilateral buttocks pressure ulcers. The resident's ISP dated April 14, 2016, lacked documented evidence it had been updated to include the bilateral buttocks stage 2 wounds. Interview with the DON on July 6, 2016, at 3:15 p.m., revealed that she would find the wound care order and nursing notes for review. [It should be noted that the wound care order and/ nursing notes documenting wound care was not provided for review.] 3. Review of Resident #6's clinical record, on July 7, 2016, at 9:50 a.m., revealed that the resident had a fall on January 31, 2015. The resident	R 483	The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	8/13/16

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R 483	Continued From page 21 sustained a right forearm skin tear, swollen lip and c/o right shoulder pain and bumping his/her head. Additionally, the record revealed that the resident's daughter took the resident to the ER for evaluation of right shoulder bruise and pain. The resident returned on the same day with diagnoses of clavicle fracture, nasal fracture and head injury [non-serious]. Continued review of the record revealed that PDA service was started on February 2, 2016, for safety following the fall. The resident's ISP dated February 11, 2015, lacked documented evidence it had been updated with the significant change of PDA services for safety. Interview with the DON on July 7, 2016, at 2:40 p.m., revealed that PDA service was provided 24 hours a day for 2 weeks. The DON also indicated that going forward she would document all PDA services provided on the resident's ISP. 4. On June 28, 2016 at 10:30 a.m., review of Resident #8's clinical record revealed that on March 23, 2016, at 12:49 p.m., the resident was found on the floor on her bathroom following a fall. The resident was sent to Sibley Hospital ER for evaluation and returned to the facility at 8:30 p.m., with a diagnosis of closed displaced fracture of distal end of right humerus and in the company of a PDA. Further review of the clinical record revealed that the resident was sent to Sibley Hospital ER on March 27, 2016, at approximately 5:15 p.m., with complaint of generalized pain and was re-admitted to the facility on April 5, 2016, at approximately 2:45 p.m., with an indwelling Foley	R 483		

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R 483	Continued From page 22 catheter. Continued review of the clinical record revealed a nurse's note dated April 8, 2016, at 4:04 p.m., stating that the PCP had seen the resident earlier that morning and referred the resident to an orthopedist for further evaluation of " the incision site". The note further stated that the PDA later called the facility from the doctor's office to report that the resident was sent to Sibley Hospital ER for further evaluation. Review of a nurse's note dated April 15, 2016, at 11:33 p.m., states that the resident returned to the facility from Sibley Hospital at approximately 6:00 p.m., with decubiti to the sacrum measuring 2.5 cm. by 2 cm, the right buttocks measuring 6.5 cm. by 3.5 cm, and on the left buttocks measuring 5.0 cm. by 4.0 cm. On April 15, 2016, the physician ordered "Dry dressing change daily to the surgical wound with abdominal pad and four (4) inch ace wrap for swelling. Barrier paste for pressure ulcer stage II to right and left buttocks every shift. Apply silver powder to wound bed and cover with calazime skin barrier cream on left sacral area." Additionally, review of a nurse's note dated April 17, 2016, at 6:10 a.m., revealed that the resident was receiving intravenous antibiotic (Vancomycin). Review of the ISP dated April 8, 2016, failed to evidence that it was updated to reflect the above mentioned significant changes in the resident's condition. 5. On June 30, 2016, at 10:00 a.m., review of Resident #9's clinical record from May 27, 2015, to June 21, 2016, revealed that the resident fell twenty eight (28) times. Further review of the clinical record revealed a nurse's note dated	R 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0030	A. BUILDING: _____ B. WING _____	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING ON CONNECTICU	5111 CONNECTICUT AVE NW WASHINGTON, DC 20008

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R 483	Continued From page 23 February 9, 2016, at 10:20 p.m., which states that the resident was found on the floor and was complaining of pain to the shoulder. The resident was taken to George Washington Hospital Emergency Room by ambulance and was diagnosed with a fracture right clavicle. Review of nursing note dated February 15, 2016, at 3:43 a.m., revealed that the resident was found sitting on the floor in her room bleeding from the right side of her head. The ambulance was called and the resident was taken to George Washington Hospital Emergency Room where the resident was diagnosed with a cerebral concussion and received sutures to the head. Review of the ISP dated January 7, 2016, failed to evidence that it was updated to reflect the above mentioned significant changes in the resident's condition. Interview with the DON on July 6, 2016, at 2:00 p.m., revealed that he/she was not able to update the ISP to reflect the abovementioned significant changes in the resident's condition. The DON further stated that the facility plan to hire another RN to ensure updated documentation in the clinical records.	R 483		
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record review and interview, the ALR's failed to ensure a RN assessed the resident's response to medications every forty-five days for seven (7) of 10 residents in the sample. (Residents #1, #2, #3, #7, #8, #9, and #10)	R 802	R 802 Response: The DON completed a current medication review for resident #2, #3, #8, #9, #10 and documented it in the resident's clinical record.	7/7/16

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R 802	Continued From page 24 The findings include: 1. A review of Resident #1's clinical record, on June 27, 2016, at 1:45 p.m., revealed that monthly medication reviews were conducted from January 6, 2016 to April 5, 2016. The aforementioned monthly medication reviews lacked documented evidence of the resident's response to his/her medications. Additionally, the medications reviews had been conducted by LPNs and not an RN as required. 2. A review of Resident #2's clinical record, on June 30, 2016, at 9:45 a.m., revealed that monthly medication reviews were conducted from February 5, 2016 to June 5, 2016. The aforementioned monthly medication reviews lacked documented evidence of the resident's response to his/her medications. Additionally, the medications reviews had been conducted by LPNs and not an RN as required. 3. A review of Resident #3's clinical record, on July 1, 2016, at 9:00 a.m., revealed that monthly medication reviews were conducted from July 10, 2015 to June 7, 2016. The aforementioned monthly medication reviews lacked documented evidence of the resident's response to his/her medications. Additionally, the medications reviews had been conducted by LPNs and not an RN as required. 4. On June 27, 2016, at 10:30 a.m., review of Resident #7's clinical record revealed the resident was prescribed medications including Simvastatin, Mirtazapine, Fludrocortisone acetate and Aspirin. Continued review of the clinical	R 802	The DON completed an audit to determine if any other residents were lacking 45-day medication reviews completed by an RN. Any identified, the DON completed the medication review and filed the documentation in the residents record. The DON or designee (RN) completes a medication review upon admission and at a minimum every 45 days. The documentation is maintained in the residents' clinical record. The DON created a tickler to ensure 45-day reviews are completed. See attached tickler. The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	8/15/16 8/1/16 8/15/16 8/15/16

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R 802	Continued From page 25 record from November 19, 2015, through June 17, 2016, lacked documented evidence that the RN had assessed the resident's response to medications. 5. On June 28, 2016, beginning at 10:30 a.m., review of Resident #8's clinical record revealed the resident was prescribed medications including Ibuprofen, Levothyroxine, Oxycodone, and Furosemide. Continued review of the clinical record from January 1, 2016, through June 28, 2016, lacked documented evidence that the RN had assessed the resident's response to medications. 6. On June 30, 2016, at 10:00 a.m., review of Resident #9's clinical record revealed the resident was prescribed medications including Levodopa, Entacapone, Lexapro, and Ibuprofen. Continued review of the clinical record from January 4, 2016, through June 30, 2016, lacked documented evidence that the RN had assessed the resident's response to medications. 7. On July 1, 2016, at 9:45 a.m., review of Resident #10's clinical record revealed the resident was prescribed medications including Acetaminophen, Levothyroxine, Citalopram and Remeron. Continued review of the clinical record from December 14, 2015, through July 1, 2016, lacked documented evidence that the RN had assessed the resident's response to medications. Interview with the DON on July 8, 2016, at 3:30 p.m., revealed that they were in the process of hiring a new RN to complete the 45 day medication response assessments for all residents.	R 802		

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R 803	Continued From page 26	R 803		
R 803	Sec. 903 3 On-Site Review. (3) Assess the resident's ability to continue to self-administer his or her medications. Based on record review and interview, the ALR's registered nurse failed to assess the resident's ability to safely continue to self-administer his/her own medications every forty-five days for one (1) of one (1) resident in the sample who self medicated. (Resident #2) The finding includes: A review of Resident #2's clinical record, on June 30, 2016, at 9:45 a.m., revealed that medication reviews were conducted on July 29, 2015, August 27, 2015 and October 27, 2015. Further review of the aforementioned medication reviews revealed they had been conducted by an LPN. Additionally, the medication reviews lacked documented evidence that the resident could safely continue to administer his/her medications. Interview with the DON on June 30, 2016, at 1:00 p.m., revealed that she would ensure that all medications reviews were conducted by a registered and would include if the resident could safely continue to administer his/her own medications.	R 803	R 803 Response The DON completed a current medication review for resident #2 and documented it in the resident's clinical record. The review includes the resident's ability to continue to self-administer medications. The DON completed an audit to determine if any other residents that self-administer medications were lacking 45-day medication reviews completed by an RN that indicate their continued ability to self-administer medications. Any identified, the DON completed the medication review and filed the documentation in the residents record. The DON or designee (RN) completes a medication review upon admission and at a minimum every 45 days and documents the residents' ability to self-administer medications. The documentation is maintained in the residents' clinical record. The DON created a tickler to ensure 45-day reviews are completed. See attached tickler. The DON or designee is responsible for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance and Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	8/15/16 8/15/16 8/1/16 8/15/16 8/15/16