Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING: ______ B. WING ______	03/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments	R 000		

Initial Comments

An annual survey was conducted from 03/06/19 through 03/12/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq). The Assisted Living Residence (ALR) is licensed for a capacity of 200 residents. Currently the ALR provides care for 165 residents and employs 213 staff members. A random sample of 16 resident records and 18 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident, family and staff interviews. It should be noted that prior and during the course of the survey, the surveying team received residents' concerns that were incorporated as part of the annual survey inspection. The residents' concerns alleged the following:

Allegation #1: Resident #17's air conditioning blew "damp air" last summer, which caused an uncomfortable rise in the humidity in the resident's apartment. The ALR has not yet resolved the issue.

Findings: The facility provided Resident #17 with two dehumidifiers last year to address the issue. The surveyors were unable to assess the humidity in the resident's apartment because the air conditioner was not running.

Conclusion: The allegation was not substantiated.

Allegation #2: The ALR has refused to allow Resident #17 to require care managers to sign-in when entering the resident's apartment.

Findings: The ALR does not have a practice or policy which requires a care manager to sign-in to a resident's apartment.

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING: ______ B. WING ______	03/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Continued From page 1 Conclusion: The allegation was substantiated, however it did not violate the ALR statute or emergency and proposed regulations. Allegation #3: The lifeline buttons, which alert the ALR's staff that a resident is in need of help, do not give an accurate location of the resident after the button is activated. Findings: The complainant did not utilize a lifeline button. However, during the tour of the facility, random emergency buttons were activated by the surveyor. The ALR's staff responded to each specific location in a timely manner. Conclusion: The allegation could not be substantiated. Allegation #4: The ALR's food is greasy because the ALR's chef only uses an artificial butter for cooking. Findings: The facility uses cooking oils, however, residents may make specific modifications to their food, including the use of butter instead of cooking oil. Conclusion: The allegation was partially substantiated, however it did not violate the ALR statute or emergency and proposed regulations. At the time of this survey, the ALR was found to be in substantial compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq). However, deficiencies of the ALR emergency and proposed regulations were cited.	R 000		

CRFMR
Rev. 9/02

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
899 North Capitol St., NE
Washington DC 20002
2nd Floor (2224)
202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Grand Oaks Assisted Living ALR -0006	5901 MacArthur blvd. Washington, DC	03/06/19 through 03/12/19 **Follow-up Dates(s):**

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An annual survey was conducted from 03/06/19 through 03/12/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 *et seq*) and the ALR emergency and proposed regulations. The Assisted Living Residence (ALR) is licensed for a capacity of 200 residents. Currently the ALR provides care for 165 residents and employs 213 staff members. A random sample of 16 resident records and 18 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident, family and staff interviews. Listed below are abbreviations used throughout the body of this report: ADL – Activities of Daily Living ADON – Assistant Director of Nursing ALR - Assisted Living Residence DON - Director of Nursing ED – Executive Director			

[signature] Name of Inspector | 3/29/19 Date Issued | Facility Director/Designee | Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	EPP – Emergency Preparedness Plan ER – Emergency Room PDA – Private Duty Aide			
10115.05	**An ALR shall conform to the notices and the procedures for involuntary discharge, transfer, or relocation provided by subchapter 3 of Chapter 10 of Title 44 of the District of Columbia Official Code (D.C. Official Code §§ 44-1003.01 - 1003.13).** Based on interview and record review, the ALR failed to notify the Department of Health of all resident transfers and discharges for 40 of 54 residents. Findings included: On 03/14/19 at 12:34 PM, the ADON provided the surveyor with a list of the ALR's discharges and transfers since their last annual survey (05/07/19). The list contained 54 total resident discharges and transfers, with 40 involuntary, since the adoption of the emergency and proposed rulemaking (08/16/18). At 1:22 PM, interview with the ED and DON showed that the ALR failed to report the discharges and transfers to the Department of Health. The ED said that, going forward, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	ALR would report discharges and transfers to the Department of Health.			
10125.02	**In addition to the requirements to report abuse, neglect, and exploitation of a resident provided in Section 509 of the Act (D.C. Official Code §44-105.09), each ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone immediately, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day.** Based on record review and interview, the facility failed to notify the Department of Health of all unusual incidents, for 57 of 280 incidents. Findings included: On 03/14/19 at 12:34 PM, the ADON provided the surveyor with a list of the ALR's incidents since their last annual survey (05/07/18). The list of 280 total incidents contained 57 resident falls with injury. For instance, on 02/09/19 a resident fell, sustained a head injury, and was transferred to the ER. From 03/06/19 through 03/11/19, the review of a sample of the 57 falls showed that the ALR followed their Falls Management Policy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	At 1:22 PM, interview with the ED and DON showed that the ALR failed to report the incidents to the Department of Health. The ED said that, going forward, the ALR would report all unusual incidents to the Department of Health.		
10110	**10110.01(k) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR & 483.73;** The regulation is not met as evidenced by: 1. Based on interview and record review, the ALR failed to ensure that each staff demonstrated knowledge of the emergency procedures for five of 213 employees. Findings included: On 03/11/19 at 12:41 PM, the Director of Facilities said during an interview that the ALR team developed an EPP that included risk assessments, policy and procedures, communication plan and training. The Director of Facilities said that policies and procedures were developed regarding the identified risks for this facility to include but not limited to: power outage, steam outage, internal floods, missing persons, extreme temperatures, thunderstorms, tornadoes and snow storms.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

On 03/11/19 between 1:50 PM and 2:44 PM, five ALR staff were interviewed about the ALR's EPP. All five individuals stated that they had some training on EPP, and knew how to respond in case of a fire. When asked about other risks (i.e. power outage, snow storm, extreme heat, etc.), the staff could not identify what to do in those emergency situations at the time of the interviews.

At 3:38 PM, the Director of Facilities was asked about staff's knowledge of the ALR's EPP. The Director of Facilities said that staff received training on the EPP during a presentation on 12/18/18. When asked whether the presentation addressed the entire EPP, the Director of Facilities replied by saying, "no." The Director of Facilities stated that presentation only captured a portion of the EPP. The surveyors shared with the Director of Facilities that five ALR staff interviewed were only able to identify what to do in case of a fire and had no response to other emergency situations (i.e. power outage, snow storm, etc.). The Director of Facilities stated that more than fire drills were discussed during the training presentation on EPP.

At 3:50 PM, review of ALR's EPP book confirmed the Director of Facilities' interview that staff had received training on the EPP presentation on 12/18/18. Review of the presentation failed to evidence that all of the identified risks has been included. The training presentation did address missing persons and power outage.

At the time of the survey, the facility failed to ensure that all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

staff demonstrated knowledge of the emergency procedures.

2. Based on observation, interview and record review, the ALR failed to ensure that essential adaptive equipment and staffing needs were incorporated into the EPP, for approximately 40 of 165 residents, as strategies used to evacuate the most vulnerable residents during an emergency.

Findings included:

On 03/06/19 through 03/12/19, observations conducted throughout the facility showed there were oxygen tanks, wheelchairs, four-wheeled walkers, two-wheeled walkers, and canes in some of the residents' apartments. Further observations showed care managers and PDAs assisting residents during lunch time and group activities.

On 03/11/19 at 12:41 PM, the Director of Facilities said during an interview that there were over 40 vulnerable residents who were especially at risk during an emergency due to the severity of the their overall healthcare needs. Further interview with the Director of Facilities revealed that some of the residents received ADL assistance from care managers and PDAs who worked various hours within a 24-hour time span, and the residents used wheelchairs, walkers, and canes to assist with ambulation.

On 03/11/19 at 3:55 PM, review of the EPP showed that the plan identified vulnerable residents as those who utilized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

wheelchairs. The EPP, however, failed to address individualized strategies and supports that would be used to assist vulnerable residents with evacuations during an emergency.

At 3:58 PM, the Director of Facilities said during a follow-up interview that there were no individualized strategies used to evacuate the most vulnerable residents written in the EPP. The Director of Facilities stated that this information would be added to the EPP.

At the time of the survey, the ALR failed to ensure that the EPP included essential adaptive equipment and staffing supports to ensure residents' health and safety during and after an emergency evacuation.