PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments An annual survey was conducted from October 26, 2016 through November 10, 2016 to determine compliance with the Assisted Living Law "DC Code § 44-101.01." The Assisted Living Residence (ALR) provides care for thirteen (13) residents and employs nineteen (19) employees that include professional and administrative staff. A sample size included five (5) resident records and eighteen (18) employee records were selected for review. The findings of the survey were based on observations, record reviews, and interviews. Listed below are abbreviations used throughout the body of this report. ALA — assisted living administrator ALR — assisted living residence BPH — benign prostatic hyperplasia EMR — electronic medical record HHA— home health aide H&P — history and physical HTN — hypertension ISP — individualized service plan MAR — medication administration record PSA — Prostate Specific Antigen RN — registered nurse SN — skilled nurse TME — trained medication employee	R 000	Received 1/13/17 CM	
R 008	Sec. 102b2 Philosophy of Care (2) The design of services and environment should acknowledge that a significant number of residents may have some form of cognitive impairment. Services and environment should offer a balance between choice and safety in the least restrictive setting. Based on observation and interview, it was	R 008	CORRECTED PLAN OF CORRECTION R 008 1. All residents with diagnosis of dementia or danger of elopement have the potential to be affected by this deficiency.	12/21/16

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/13/2017

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1 determined that the ALR failed to ensure sufficient safeguards were properly in place to prevent potential harm, for thirteen of thirteen residents in the sample. (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13) The findings include: 1. On October 27, 2016, starting at 12:00 p.m., an observation revealed that the windows in resident's apartments and common areas had window stops. The window stops, however, failed to prevent residents from potential elopement or accidental falls as the windows were free to open wide enough for patients to exit. On October 27, 2016, at 12:10 p.m. interview with the ALA revealed that she would follow-up with repositioning the window stops to prevent elopement and accidental falls. 2. On October 26, 2016, starting at 11:00 a.m., during an observation of Apartment #204 it was revealed that the shower area failed to have adequate drainage to prevent water from overflowing onto the bathroom floor. [It should be noted that this concern was found in another apartment during the 2015 annual survey.] The shower area had a tile floor that could potentially be slippery when wet. It should be noted that the ALR provides care for residents with diagnoses of dementia, schizophrenia disorder, delusional disorder, paranoid disorder, depressive episode sever with psychotic behavior. On October 26, 2016, at 11:30 a.m., interview with the ALA revealed that she should would	R 008	10/26/16 2. As for windows, when there is a diagnosis of dementia, schizophrenia disorder, delusional disorder, paranoid disorder, depressive episodes or psychotic behavior or danger of elopement, ISP of the resident will include making changes to the windows, to ensure the resident is not able to exit through same. As for the roll-in shower, in addition to care staff members making sure water escaping the shower is mopped up, non-slip anti-bacteria floor mats have been purchased and placed in the bathrooms with roll-in showers 3. The ALA will ensure that the windows stoppers are adjusted, in a unit where a resident has a diagnosis of dementia or danger of elopement, as well as windows in the common area, so the windows won't open beyond 4". 4. This is now include in the policy and procedure of the ALR. Also the ALA and her designee, will continue to supervise care staff members on making sure water on the bathroom floors is mopped up quickly. Weekly inspections of the units will be performed by the administrator or designee.	

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 2 purchase mats for the all the residents that have shower areas that posed a potential fall hazards. At the time of the survey, the ALR failed to have proper safeguards in place to prevent potential harm to residents.	R 008		10/26/16
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, it was determined that the ALA failed ensure physician orders were followed as prescribed for two (2) of five (5) resident's in the sample. (Residents #2 and #5) The findings include: 1. On October 31, 2016, starting at 10:00 a.m., review of Resident #2's clinical record revealed a physician's order dated October 3, 2016. The physician ordered Pro-Air two (2) puffs three (3) times a day for one (1) week. Continued review of the record revealed a September 2016 MAR. The MAR lacked documented evidence that the Pro-Air was administered as prescribed. [It should be noted that the resident was administered Pro-Air 18 of the 21 times it was prescribed.] On October 31, 2016, at 11:48 a.m., interview with the ALA who is also a LPN, revealed that she had miscounted the aforementioned medication on the MAR, and the Pro-Air was not	R 292	R 292 1. For Resident #2, as stated in statement of deficiencies, Resident #2 was prescribed Pro-Air on October 3, 2016. thus it could not have been in the MAR for September we will make sure, however the deficiency here has been noted and we will follow doctor's orders and it does not happen again. For Resident #5, though the Pharmacy neglected to supply his medication, over the weekend of 12-14 of October 2016, he was back in the ER on the 13th and he was given the medication then. The Pharmacy did not supply the medication as it was not covered by the insurance. 2. All Residents have the potential to be affected by this deficiency.	

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 292	Continued From page 3 administered as prescribed. 2. On October 31, 2016, starting at 4:00 p.m., review of Resident #5's clinical record revealed a physician's order dated August 12, 2016. The physician ordered Tylenol #3 one (1) to two (2) tabs by mouth [for pain] every six (6) hours. Continued review of the record revealed that the resident had two procedures performed on August 11, 2016 to include a Transrectal Ultrasound-Guided Biopsy, and a Foley catheter insertion. The record lacked documented evidence that the resident's pain level had been assessed or that Tylenol #3 had been administered. On October 31, 2016, at 4:40 p.m., interview with the ALA revealed that the Tylenol #3 prescription was sent to the pharmacy on August 12, 2016 but was not available until August 15, 2016, because it was a weekend. At the time of the survey, the ALA failed to ensure physician orders were implemented as prescribed.	R 292	3. A new policy on discharge meeting will be held between the RN, the interdisciplinary team and the hospital before the discharge The request to be involved in the ISP, particularly from the health care provider, will be documented By the ALA. 4. The RN has retrained the ALA and TMEs on medication administration and follow-up continuing education will be done every 3 months. Also the RN will review physician orders monthly and whenever there is a new order. The practice of the Pharmacy not supplying medication on weekends has stopped and the pharmacy will be delivering medication as stipulated in their contract. The Administrator has dual responsibility, as a administrator and as LPN. The RN will only supervise the administrator's clinical duties and the management company will supervise the administrator duties.	10/31/16
R 293	Sec. 504.2 Accommodation Of Needs. (2) To have access to appropriate health and social services, including social work, home health, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being; Based on record review and interview, it was determined that the ALR failed to develop a system to ensure appropriate and effective	R 293		

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 293	Continued From page 4 urinary catheter care for one (1) of one (1) resident's in the sample. (Resident #5) The finding includes: On October 31, 2016, at 4:00 p.m., review of Resident #5's clinical record revealed the following: The resident was seen in the hospital on August 11, 2016 and diagnosed with an elevated PSA. The resident had two procedures performed: (1) Transrectal Ultrasound-Guided Biopsy; and (2) Foley catheter inserted. On October 31, 2016, at 4:30 p.m., interview with the ALA revealed two ER visits since the resident's hospitalization of August 11, 2016. The first visit was on August 13, 2016, for hematuria. The second visit occurred on August 27, 2016, after the resident complained of abdominal pain. He was diagnosed with hypokalemia and urinary retention. It should be noted during the week of August 27, 2016, the resident's indwelling urinary catheter had been removed by the urologist. Also, while in the ER on August 27, 2016, the resident had a urinary indwelling catheter inserted. On October 31, 2016, at 4:45 p.m., the ALA was asked about the care of the catheter. The ALA revealed that the resident was capable of caring for his catheter and prior to August 27, 2016, a home care agency nurse was also providing catheter care. Review of the resident ' s nursing notes on the same day at 5:00 p.m., failed to provide evidence of nursing notes from either the home care agency or the facility ' s RN that documented any	R 293	R 293 1. Unfortunately there a lot of misunderstandings and misconceptions in the review of the care of Resident #5. Whereas, the home care nursing commenced promptly on August 17,2016 exactly a week after his discharge. His catheter was changed every month in compliance with the doctors' orders. However, this was wrongly documented due to the absence of proper nursing notes. For the record, Resident #5 catheter was changed September 27th and not August 27th 2016 by the home care nursing agency and attached is their nursing notes evidencing this. 2. All residents have the potential to be affected by this deficiency. 3. The ALR had put in place a new protocol to ensure adequate communication with 3rd party agencies that are providing care/nursing services to our residents. This will bring about proper documentation of coordination as to the services being provided by the 3rd parties and the ALR. Nursing/Progress notes are now to be shared between parties on all visits by 3rd party agencies.	10/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0031	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 293	Continued From page 5 catheter care. The notes also failed to provide evidence of any teaching or monitoring of the resident's competency in managing his catheter. Although the ALA indicated that there were nursing notes available that were not a part of the clinical record, the last nursing note in the record was dated July 25, 2016. On November 4, 2016, at 10:00 a.m., review of the home care agency ' s POC revealed that the resident had a diagnosis of *BPH. The POC indicated that the nurse was to assess and evaluate the resident for BPH and hematuria, instruct patient and caregiver in indwelling catheter management including care of the Foley catheter, assess for sign and symptoms of complication, provide perineal care, and tube and bag replacement. *BPH is an enlarged prostate gland. The prostate gland surrounds the urethra, the tube that carries urine from the bladder out of the body. As the prostate gets bigger, it may squeeze or partly block the urethra. This often causes problems with urinating. On November 4, 2016, at 11:00 a.m., a telephone interview with the home care agency's nurse revealed that skilled nursing services for Resident #5 was started on August 17, 2016, for the principal diagnosis of BPH. The nurse confirmed that the resident could safely and independently manage and provide care for his catheter. However, the nurse indicated that the resident was prescribed skilled nursing services to remove the indwelling urinary catheter and insert a new indwelling urinary catheter monthly. The nurse also indicated that the last time she changed the resident's indwelling urinary catheter was on	R 293	4. The ALA will oversee the services rendered by said 3rd party agencies. Staff members had been trained on this new policies and the ALA/LPN had also been trained by the RN on the care of urinary catheter. Care of the catheter will be done by a 3rd party or in care emergency by the RN or LPN.	

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 293	Continued From page 6 August 27, 2016. The nurse revealed that home care services were discontinued on August 27, 2016, due to the lack of insurance coverage. Although the resident and the ALR were given proper notice of the termination of home care services, the ALA failed to ensure the continuation of nursing care. On November 4, 2016, at 11:15 a.m., the ALA, a licensed LPN, was asked about the continuation of nursing care for the resident. She indicated that the resident manages his own care; but confirmed that the order to change the catheter monthly was not implemented. She was asked if the agency had a policy or protocol on urinary catheterization, she stated no. When asked, when the last time the catheter had been changed, she stated August 27, 2016, and then stated "I will send the resident to the ER to have the catheter changed today." Later in the interview, she agreed to notify the resident ' s physician of the patient's condition. At the time of the survey, the ALR failed to ensure Resident #5 was provided indwelling urinary catheter care in accordance with his physician orders. Additionally, the ALR failed to provide evidence that services were coordinated effectively with the home are agency.	R 293		
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 observation, record review and interview, it was determined that the ALR failed to	R 481		

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 481	Continued From page 7 ensure ISPs included when, how often, and by whom services will be provided for five (5) of five (5) residents in the sample. (Residents #1, #2, #3, #4 and #5)) The findings include: 1. On October 27, 2016, at 10:40 a.m., observation of the facility's lobby revealed that a HHA helped Patient #1 put on his/her coat. On October 27, 2016, at 11:30 a.m., review of Patient #1's clinical record revealed an ISP dated October 27, 2016. The ISP also indicated that resident required assistance with dressing, grooming and housekeeping, however, it lacked documented evidence of who would provide all the services the resident required. On October 27, 2016, at 12:00 p.m., interview with the ALA revealed that Resident #1 received HHA services five (5) days a week. The ALA also indicated that she would include the HHA services on the patient's ISP and who would provide all services the resident required. On October 31, 2016, at 10:00 a.m., interview with the HHA revealed that she had been working with Resident #1 for five (5) months. The HHA also indicated that she worked Monday through Friday for five (5) hours a day. 2. On October 27, 2016, at 11:30 a.m., observation of the dining room revealed that Resident #2 ambulated with a rolling walker. On October 31, 2016, at 10:30 a.m., review of Resident #2's clinical record revealed a H&P dated August 19, 2016 that indicated the resident used a walker for ambulation. The H&P also	R 481		

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
R 481	Continued From page 8	R 481	R 481 & 483	

indicated that the resident received out-patient psychiatric services. Continued review of the record revealed an ISP dated October 27, 2016, that lacked documented evidence of what services the ALR staff would provided for the resident when he/ she ambulated with the rolling walker and when, how often, and by whom the psychiatric services were to be provided. Additionally, ISP revealed that the resident required assistance with dressing and grooming, however, it lacked documented evidence of who would provide the services.

On October 31, 2016, at 1:00 p.m., interview with the ALA revealed that the she would include the resident's use of a rolling walker for ambulation. Continued interview with the ALA revealed that the resident was seen by psychiatric out-patient services on September 22, 2016. Additionally, the ALA indicated that she would include psychiatric services to the resident's ISP.

3. On October 31, 2016, at 1:50 p.m., review of Resident #3's clinical record revealed an ISP dated October 27, 2016. The ISP indicated that the resident required assistance with bathing, dressing and housekeeping, however, the ISP lacked documented evidence of who would provide those services.

4. On October 31, 2016, at 2:30 p.m., review of Resident #4's clinical record revealed an ISP dated October 31, 2016. The ISP indicated that the resident required assistance with dressing and housekeeping, however, the ISP lacked documented evidence of who would provide the services.

5. On October 31, 2016, at 4:00 p.m., review of Resident #5's clinical record revealed an ISP

1. Resident #1, #2, #3, #4 and #5 service plans were reviewed after the survey and deficiency came about due to incomplete documentation, which has been fixed. The rest were in the EMAR but couldn't be accessed because the ALA couldn't pull same out. 10/31/16

2. All Residents have the potential of being affected by this deficiency.

3. The RN has reviewed all residents ISPs not just those of resident's #1 - #5 and all necessary missing documentation are properly drafted ISPs, as stated in the regulations and the policy and procedures of the facility have been put into all. Except for some documentation from health care practitioners whose documentation remain difficult to get, all the other necessary parties' information has been received and they have signed their portions.

4. The RN will follow the established policies on the frequency of review and updating of the ISPs. Accordingly, A calendar of due dates for residents' ISPs will be made by the ALA and same will be made available to the RN, Case Managers and residents' surrogates ahead of due dates.

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 481	Continued From page 9 dated October 31, 2016. The ISP indicated that the resident required assistance with dressing, grooming, toileting and housekeeping, however, the ISP lacked documented evidence of who would provide the services. On October 31, 2016, interview with the ALA at 4:30 p.m., revealed that the RN should have included who would be responsible to provide the services to the residents in the ISP. At the time of the survey, the aforementioned ISPs lacked documented evidence of who would provide all services to the residents.	R 481		
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, it was determined that the ALR failed to ensure ISPs were reviewed by the resident's healthcare practitioner, the resident and the resident's surrogate thirty days after admission, at least every 6 months, and more frequently for significant changes for five (5) of five (5) residents in the sample (Residents #1, #2, #3, #4 and #5) The findings include:	R 483		

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 483	Continued From page 10	R 483		

1. On October 27, 2016, at 10:40 a.m., review of Resident #1's clinical record revealed that Resident #1 was admitted on September 5, 2014. The record contained only one ISP dated which was dated October 27, 2016. The record contained only one ISP which was dated October 27, 2016. The ISP, however, lacked documented evidence that it had been reviewed prior to the aforementioned date, and that it had been reviewed by the resident's healthcare practitioner, the resident or the resident's surrogate.

On October 27, 2016, at 1:00 p.m., interview with the ALA revealed that the RN had reviewed the ISP every six (6) months, but the he did not update the ISP with the correct date. The ALA also indicated that the resident's healthcare practitioner had reviewed the ISP. Additionally, the ALA indicated that she would fax the ISP reviewed by the resident's healthcare practitioner to the surveyor by 9:00 a.m. on November 1, 2016. [It should be noted that the surveyor did not receive the ISP.]

2. On October 31, 2016, at 10:00 a.m., review of Resident #2's clinical record revealed that Resident #2 was admitted on August 29, 2016. Additionally, the record contained an ISP dated October 27, 2016. The record, however, lacked documented evidence that the ISP had been reviewed thirty days after admission, and that it had been reviewed by the resident healthcare practitioner, the resident or the resident's surrogate.

On October 31, 2016, at 11:48 a.m., interview with the ALA revealed that the RN reviewed the ISP thirty days after admission, but he did not know how to the change the date in the EMR.

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 483	Continued From page 11 Additionally, the ALA indicated that she would have the resident's healthcare practitioner, the resident and/or the resident's surrogate review all ISPs going forward. 3. On October 31, 2016, at 1:50 p.m., review of Resident #3's clinical record revealed that the resident was admitted on June 16, 2015. The record contained only one ISP which was dated October 27, 2016. The ISP, however, lacked documented evidence that it had been reviewed prior to the aforementioned date, and that it had been reviewed by the resident's healthcare practitioner, the resident or the resident's surrogate. On October 31, 2016, at 2:20 p.m., interview with the ALA revealed that the resident's physician would not review the ISP. Also, the interview revealed that the resident would only speak with the casemanager about any services provided. 4. On October 31, 2016, at 2:30 p.m., review of Resident #4's clinical record revealed that the resident was admitted on August 15, 2016. The record contained only one ISP which was dated October 31, 2016. The ISP, however, lacked documented evidence it had been reviewed prior to the aforementioned date, and that it had been reviewed by the resident's healthcare practitioner, the resident or the resident's surrogate. On October 31, 2016, at 11:48 a.m., interview with the ALA revealed that the RN reviewed the ISP thirty days after admission, but he did not know how to the change the date in the EMR. Additionally, the ALA indicated that she would have the resident's healthcare practitioner, the resident and/or the resident's surrogate review all ISPs going forward.	R 483		

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 483	Continued From page 12	R 483		

5. On October 31, 2016, at 4:00 p.m., review of the Resident #5's clinical record revealed the resident was admitted on November 19, 2015. Additionally the record revealed the the following:

- The resident was seen in the hospital on August 11, 2016 and diagnosed with an elevated PSA. Also, the resident had two procedures performed: (1) Transrectal Ultrasound-Guided Biopsy (2) Foley catheter inserted;
- The resident was seen in the ER on August 13, 2016 and diagnosed with hematuria; and
- The resident was seen in the ER on August 27, 2016 and diagnosed with hypokalemia and urinary retention.

The record lacked documented evidence that the ISP dated November 17, 2015, had been reviewed thirty days after admission and at least every six months [May 2016].

Further review of the record revealed an ISP dated October 31, 2016. The ISP lacked documented evidence it had been updated with resident's significant change in condition [The indwelling urinary catheter insertions]. The ISP also lacked documented evidence that it had been reviewed by the resident and the resident's health care practitioner.

On October 31, 2016, at 5:30 p.m., interview with the ALA revealed that the ISP had been reviewed thirty days after admission and in May of 2016, but the RN did not enter the correct date on the EMR. The ALA also indicated that she would update the ISP with the resident's significant change in condition [Foley catheter care].

FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 483	Continued From page 13 At the time of the survey, the aforementioned ISPs lacked documented evidence it had been reviewed thirty days after admission, at least every six (6) months, updated with significant changes, and that the ISPs had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.	R 483		
R 602	Sec. 701f Staffing Standards. (f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. .The facility policy on destroying or discarding medications indicates that medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and the disposition shall be documented in the resident's record. The medications must be returned to the pharmacist if unopened and properly labeled. All other medications must be destroyed and witnessed by two people one of which shall be the administrator. Based on record review and interview, it was determined that the ALA failed to ensure that employees were free from tuberculosis in a communicable form for eight (8) of eighteen (18) employees in the sample (Employees #4, #6, #8, #9, #11, #15,#16, #18 and the ALA). The finding includes: Review of personnel records between October 27, 2016, and October 31, 2016, beginning at 1:05 p.m., revealed Employees #4, #6, #8, #9, #11,	R 602		

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 602	Continued From page 14 #15, #16, #18 personnel records failed to evidence that a current health clearance for tuberculosis had been conducted annually. On October 31, 2016, at 11:45 a.m., an interview with the ALA revealed that she would obtain the health clearances for the aforementioned employees and forward the clearances to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA) by the close of business on November 1, 2016. It should be noted that the DOH/HRLA did not receive the health clearances. At the time of this survey, there was no documented evidence that the aforementioned employees were free from tuberculosis in the communicable form.	R 602	R 602 1. All staff members are free from tuberculosis and all other forms of contagious diseases and the required documentation is on file. During the survey most of the staff members listed herein has evidence of health clearances, but same couldn't be accessed as they were kept in a confidential file as required by HIPPA. 2. The few staff members who were in default because their clearances had to be renewed within a few days to the survey have now complied and their paperwork is available now and attached to this plan of correction. The ALA and her designee have put in place measure where all staff members' health clearances will be checked monthly and advance notice given to staff to stay in compliance or else get out of shift.	11/2/16
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record review and interview, it was determined that the ALR failed to ensure that the RN assessed the resident's response to medications every forty-five days for one (1) of five (5) residents in the sample. (Resident #1) The finding includes: On October 27, 2016, at 10:40 a.m., review of Resident #1's clinical record lacked documented evidence that the RN assessed the resident's response to medications between September 25, 2015 through June 29, 2016. On October 27, 2016, at 11:20 a.m., review of the resident's MARs revealed that all of his/her	R 802	R 802 1. Resident #1 like all other resident have already had their 45 day medication reviews done. During the survey the said medication reviews were actually done but the EMAR and not then accessible by the ALA. The ALA has now gotten access to those record, including documentation of the when the review were completed.	

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 802	Continued From page 15 medications were administered by the TME. The resident also received medication for HTN. On October 27, 2016, at 11:00 a.m., interview with the ALA confirmed that the nurse failed to assess the resident's responses to his medications regime every 45 days as required. At the time of the survey, the RN failed to assess Resident #1's response to his/her medications.	R 802	2. All residents have the potential to be affected by this deficiency. 3. The RN will perform assessments according to the ALR policy, which is every 45 days, as recommended by the DOH. He will also ensure that follow-ups to assessments of responses to medications are done.	11/2/16
R 820	Sec. 904e7 Medication Storage (7) Discontinued or expired medications shall be destroyed within 30 days in the ALR, or, if unopened and properly labeled, returned to the pharmacy. All medication destroyed in the ALR shall be witnessed and documented by two persons, one of whom shall be the ALA or the ALA designee. Based on observation and interview, it was determined that the ALR failed to return discontinued medications to the pharmacy for seven (7) of seven (7) bags of medication. The finding includes: On October 26, 2016, at 1:29 p.m., observation of the medication closet on the first floor revealed seven (7) medium sized sealed bags that were full with various medications. On October 26, 2016, at 1:35 p.m., interview with the ALA revealed that the seven bags contained discontinued medications for current residents and medications for discharged and deceased residents.	R 820		

PRINTED: 12/01/2016
FORM APPROVED

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-0031	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 961	Continued From page 17 prohibited in all healthcare occupancies]. The finding includes: On October 26, 2016, starting at approximately 11:30 a.m., observation of Apartment #103 revealed a portable operating space heater in the bedroom. On October 26, 2016, at 12:00 p.m., during an interview with the ALA, she indicated that the resident might have brought the the heater in when he/she moved in. The ALA also indicated that she would have the family remove the electric heater. Continued observation of the facility on the same day at 2:10 p.m., revealed an electric heater in the lobby of the facility. The ALA who accompanied the surveyor during the observations removed the electric heater from the lobby. Additionally, the ALA indicated that she did not know why the electric heater was in the lobby. At the time of the survey, the ALR failed to follow the Life Safety Code of National Fire Protection Association.	R 961	R 961 1. The said regulation is one which the ALR is just being made aware of. 2. All residents had the potential to be affected by this deficiency. 3. All portable heaters in the ALR were removed as soon as the violation was pointed out, during the survey. Also all residents and staff members had been informed about this violation and the strict compliance with the said regulation. 4. The ALA or her designee, shall weekly walk through the ALR to make sure this regulation strictly.	10/26/16