

Health Regulation & Licensing Administration		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/03/2013
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0004	STREET ADDRESS, CITY, STATE, ZIP CODE 5420 CONNECTICUT AVENUE, NW WASHINGTON, DC 20015	
NAME OF PROVIDER OR SUPPLIER CHEVY CHASE HOUSE		(X4) ID PREFIX TAG	(X5) COMPLETE DATE
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)
<p>R 000 Initial Comments</p> <p>An annual licensure survey was conducted from April 2, 2013 to April 3, 2013, to determine compliance with Assisted Living Law " DC Code § 44-101.01 ". A random sample of ten (10) patient records from a census of 110 patient records were reviewed. Patient observations were conducted through out the survey to determine additional patients to be included in the sample.</p>		R 000	<p>Recewell 4/29/13</p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>
<p>R 481 Sec. 604b Individualized Service Plans</p> <p>(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. [D.C. Official Code § 44-604(b)]</p> <p>Based on record review and interview, the Assistant Living Residence (ALR) failed to include on the individual service plan (ISP) for four (4) of ten (10) residents when and how often services will be provided. (Residents #1, #2, #4 and #6).</p> <p>The findings include:</p> <p>1. On April 2, 2013, at approximately 12:30 p.m., a review of resident #1's record revealed the resident was receiving skilled nursing services (for wound care) which was initiated on March 8, 2013 and physical therapy services starting January 25, 2013, from a licensed home care agency . Further review of the record revealed an ISP dated October 25, 2012 which failed to evidence when and how often the aforementioned services were to be provided.</p>		R 481	<p><u>R481 sec: 604b Individual Service Plans</u></p> <ol style="list-style-type: none"> 1. Corrected documentation was addressed on day of survey on resident in question. (exhibit # 1) 2. An audit was conducted on all similarly situated residents and those deficient records were corrected as per ALR regulations. 3. Licensed Charge Nurses (day, evening and night) have been assigned chart audit responsibilities with a focus on significant change orders requiring skilled nursing intervention. This information will be forwarded on a daily basis to the Director of Clinical Services for inclusion with specifics on the residents ISP record. (Exhibit # 1a) 4. The quarterly safety committee will monitor through random chart audits of said deficient practices and make recommendations for further action and/or resolution. Completion date: 5/30/13 and on-going <p>5/30/13 + on-going</p>

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE: *[Signature]* TITLE: General Manager

DATE: 4/29/2013

STATE FORM 6599 ZJL811 If continuation sheet 1 of 6

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R 481	Continued From page 1 2. On April 3, 2013, at approximately 10:00 a.m., a review of Resident #2's record revealed the resident was receiving skilled nursing services (for wound care) which was initiated on February 10, 2013 from a licensed home care agency. Further review of the record revealed an ISP, dated March 29, 2013 which failed to evidence when and how often the aforementioned service was to be provided. 3. On April 3, 2013, at approximately 11:00 a.m., a review of Resident #4's record revealed the resident was receiving hospice services which was initiated on March 9, 2013. Further review of the record revealed an ISP dated October 9, 2012 which failed to evidence when and how often the aforementioned service was to be provided. 4. On April 3, 2013, at approximately 12:00 p.m., a review of Resident #6's record revealed the resident was receiving skilled nursing services which was initiated on December 14, 2012. Further review of the record revealed an ISP dated December 13, 2012 which failed to evidence when and how often the aforementioned service was to be provided. During an interview with the Director of Clinical Services (DOC) on April 3, 2013, at approximately 2:45 p.m., the DOC stated "I did the update on the ISPs but I was not aware I needed to indicate when and how often those services were to be provided."	R 481		

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R 483	Continued From page 2	R 483		
R 483	Sec. 604d Individualized Service Plans	R 483	<u>R483</u> Sect; 604d Individual Service Plans	
	<p>(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. [D.C. Official Code § 44-106.04 (d)]</p> <p>Based on record review and interview, the Assisted Living Residence (ALR) failed to ensure one (1) of one (1) newly admitted resident's Individualized Services Plan's (ISP's) were reviewed by the the residents' healthcare practitioner. (Resident #7)</p> <p>The findings include:</p> <p>On April 4, 2013, a review of Resident #7's record revealed a pre- ISP's dated February 10, 2013 which failed to evidence the aforementioned ISP had been reviewed by the resident's healthcare practitioner.</p> <p>During a telephone interview on April 4, 2013, at approximately 9:50 a.m. with the Director of Resident Services (DORS), the DORS indicated they didn't have the doctor to sign the pre-ISP.</p>		<ol style="list-style-type: none"> 1. ISP in question addressed and corrected on day of survey. (see exhibit # 2) 2. All resident records were audited and found to be in compliance with health practitioners' signature. 3. Pre ISP coversheet will be attached to ISP forms for multidisciplinary team signatures including PCP. 4. Safety Committee will monitor on a quarterly basis (or more frequently, if necessary) previously cited deficient practices and make recommendations for further action if necessary. <i>Completion date: 5/30/13</i> 	5/30/13
R 602	Sec. 701f Staffing Standards.	R 602		
	<p>(f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form.</p>			

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R 602	Continued From page 3 { D.C. Official Code § 44-107.01 (f) } Based on record review and interview, it was determined that the Assistant Living Administrator (ALA) failed to ensure that employee's were tested on an annual basis to determine if employee's were free from tuberculosis in a communicable form for one (1) of seven (7) of employees in the sample. [Certified Nursing Assistant #5 (CNA#5)] The finding includes: On April 3 2013, at approximately 10:45 a.m., a review of CNA#5 employee file failed to evidence that CNA #5 had been tested for tuberculosis in 2012 . During the exit interview on April 3, 2012, at approximately 2:50 p.m., the Assistant Living Administrator (ALA), Director of Nursing (DON) and the Director of Resident Services (DORS) was made aware of the finding and would obtain and place this document in CNA #5's personnel record.	R 602	<u>R602 Sec 701f Staffing Standards</u> 1. Evidence of compliance with respect to #5 was presented to surveyor and also faxed to DOH as follow-up. (exhibit # 3) 2. refer to # 1 3. refer to # 1 4. refer to # 1	4/3/13
R 669	Sec. 702b Staff Training. (b) Within 7 days of employment, an ALR shall train a new member of its staff as to the following: { D.C. Official Code § 44-107.02 (b) } Based on record review and interview, it was determined that the facility failed to ensure that new employees' received the required orientation within 7 days of employment for three (3) of seven (7) employees in the sample. [Certified Nursing Assistant #3 (CNA#3), Certified Nursing Assistant #4 (CNA #4) and Certified Nursing Assistant #5 (CNA#5)]	R 669		

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R 669	<p>Continued From page 4</p> <p>The finding includes:</p> <p>On April 2, 2013 and April 3, 2013, starting at approximately 1:45 p.m. review of CNA#3, CNA#4 and CNA #5's employee files failed to evidence all had received the required orientation classes.</p> <p>During the exit interview on April 3, 2013, at approximately 2:50 p.m., the Assistant Living Administrator (ALA), Director of Nursing (DON) and the Director of Resident Services were made aware of the finding and indicated training would be provided.</p>	R 669	<p><u>R 669 Sec: 702b Staff Training</u></p> <ol style="list-style-type: none"> 1. An ALR orientation guide, for temporary agency personnel, has been developed as a prerequisite for agency staff working at Chevy Chase House. (Exhibit #4) 2. All vendors supplying temporary staff to CCH will be requested to meet with ALR administrators to discuss orientation for staff and criteria for continued business with CCH. (Exhibit # 5) 3. CCH will maintain/monitor records (files) of all agency staff to ascertain compliance with facility and state regulations. 4. Quarterly Safety committee will monitored and review said records quarterly (or more often as necessary) to assure compliance. <p>Completion date: 5/30/13 and on-going</p>	5/30/13 + on-going
R 960	<p>Subheading Fire Safety.</p> <p>Sec. 1002. Fire safety.</p> <p>An ALR shall comply with the Life Safety Code of the National Fire Protection Association, NFPA 101, 1997 edition as follows: { D.C. Official Code § 44-110.02 }</p> <p>Based on record review and interview, it was determined the facility failed to conduct fire drills at least quarterly on each shift for 2012.</p> <p>The finding includes:</p> <p>On April 2, 2013, at approximately 11:50 a.m., review of the Fire Drill Book failed to evidence fire drills were conducted in January, February, March, May, June, July, August, September, October and November of 2012.</p> <p>During the exit interview on April 3, 2013, at approximately 2:50 p.m., the Assistant Living Administrator (ALA), Director of Nursing (DON)</p>	R690	<p><u>R690 Sec. 1002 Fire Safety</u></p> <ol style="list-style-type: none"> 1. Records for quarterly fire drill conducted in 2012 were missing and remain unrecoverable. 2. Fire drills for the first quarter of 2013 were held for all staff. (12/26/12 & 3/21/13) All residents were invited to attend a special fire drill /fire safety informational exercise on 4/10/2013. (resident participation of more than 30% was evidenced) 3. Quarterly fire drills for the facility shall be reestablished and monitored by the General Manager. 4. Quarterly fire drills will be included in the Preventive Maintenance Schedule and monitored at the quarterly safety committee meetings. Completion date; 4/29/13 and on-going. 	4/29/13

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R 960	Continued From page 5 and the Director of Resident Services were made aware of the finding.	R 960		
R 981	Sec. 1004a General Building Interior (a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair. Based on observation and staff interview, the facility failed to ensure the facility interior was maintain in a structurally sound, sanitary, and in good repair. The findings include: During an environmental inspection on April 2 2013, at approximately 10:25 a.m., the following deficiencies were observed: 1. The third floor hallway had several areas of chipping and peeling paint. There was also chipping and peeling paint observed in the in the housekeeping closet. There was a missing window screen in the hall way and a torn window screen. 2. The second floor the laundry room located on the right side was missing. In the same laundry room the dryer was out of order. During the exit interview on April 3, 2013, at approximately 2:50 p.m., the Assistant Living Administrator (ALA), Director of Nursing (DON) and the Director of Resident Services (DORS) were made aware of these finding.	R 981 <u>R981</u> Sec 1004a General Building Interior 1. Surveyor observations were addressed and repairs made immediately on both the 2 nd and 3 rd floors. 2. A process of daily rounds though the building by the facilities Maintenance Director ad the General Manager was initiated with the development of a work ticket process to record interior/exterior building issues and deficiencies. 3. (exhibit # 6) 4. All management staff and front desk personnel have been in-serviced on the development and utilization of work tickets and the distribution to the appropriate departments. 1. The safety committee shall be responsible for monitoring the effectiveness and efficiency of work production based on work ticket distribution. Any and all revisions, amendments or modifications to the process will be reviewed.	4/17/13 # on-going	