

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2012
NAME OF PROVIDER OR SUPPLIER JOYE ASSISTED LIVING SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 5131 CALL PLACE SE WASHINGTON, DC 20019		
(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 licensure survey was conducted on January 31, 2012 to determine compliance with Assisted Living Law " DC Code § 44-101.01." The survey was based on clinical and administrative record reviews, staff and patient interviews. The sample size was three (3) resident records based on a census of seven (7) residents and four (4)employee records.	R 000	<i>Received 3/6/12</i> Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
R 253	Sec. 502a2 Self-determination, choice (2) Respectfully; Based on observation, the facility failed to ensure respect was provided for one of the three residents included in the sample. (Resident #4) The finding includes: On January 31, 2012, at approximately 1:50 p.m., Resident #4 was observed to be nude when accompanied to the facility's bathroom by a home health aide (HHA), and upon completion of her bath, she was observed to leave the bathroom nude. At the time of the survey, the facility failed to ensure Resident #4 was treated with respect while providing assistance with activities of daily living (bathing).	R 253	HOME HEALTH AIDES HAVE 2/2/2012 BE RETRAINED ON RIGHTS AND AND RESPONSIBILITIES AND ON GOING PRIVACY ACT BY AGENCY ADMINISTRATOR AND SHALL BE MONITORED MONTHLY BY AGENCY RN / LPN. ROBES HAVE BEEN PROVIDED TO ALL RESIDENTS TO WEAR WHEN GOING TO THE BATHROOM TO BATHE AND AFTER BATHING TO MAINTAIN RESPECT AND PERSONAL DIGNITY AND INDIVIDUALITY SEE R253	
R 254	Sec. 502a3 Self-determination, choice (3) With full recognition of personal dignity and individuality; and Based on observation, the facility failed to ensure full recognition of personal dignity was provided for one of the three residents included in the sample. (Resident #4)	R 254		2/2/12 AND ON GOING

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: *Gloria Richards RN/ADMIN* (X6) DATE: *2/6/12*

STATE FORM

6899

00QD11

If continuation sheet 1 of 6

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R 254 Continued From page 1

The finding includes:

On January 31, 2012, at approximately 1:50 p.m., Resident #4 was observed to be nude when accompanied to the facility's bathroom by a home health aide (HHA), and upon completion of her bath, she was observed to leave the bathroom nude.

At the time of the survey, the facility failed to ensure Resident #4 was treated with dignity while providing assistance with activities of daily living (bathing).

R 254

SEE TAG R253

2/2/12
AND
ONGOING

R 255 Sec. 502a4 Self-determination, choice

(4) With assurance of privacy and the opportunity to act autonomously and share in the responsibility for decisions. Based on observation, the facility failed to ensure privacy was provided for one of the three residents included in the sample. (Resident #4)

The finding includes:

On January 31, 2012, at approximately 1:50 p.m., Resident #4 was observed to be nude when accompanied to the facility's bathroom by a home health aide (HHA), and upon completion of her bath, she was observed to leave the bathroom nude.

At the time of the survey, the facility failed to ensure Resident #4 was afforded privacy providing assistance with activities of daily living (ADL) (bathing).

R 255

SEE TAG R253

2/2/12
AND
ONGOING

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R 292	Continued From page 3 could provide no evidence to verify a referral for podiatry services. 2. The facility failed to provide documented evidence of notification to the physician when resident #3's blood sugar level when less than 80 or greater than 200 as prescribed by his physician. Interview with the HHA on January 31, 2012, at approximately 10:20 a.m. revealed that Resident #3 did his finger sticks independently. The staff then documents the blood sugar levels on a log sheet. Record review on January 31, 2012 at approximately 10:30 a.m. revealed on December 7, 2011, his blood sugar was 71. On December 30, 2011 it was 77, 317 on December 31, 2011, 380 on January 1, 2012. The log sheet revealed the resident's blood sugar was 312 at 5:18 p.m. on January 1, 2012. The HHA revealed that they had been instructed to notify the administrator when Resident #3's blood sugar was less than 60. At the time of the survey, the facility failed to provide evidence that the physician was notified when Resident #3's blood sugar results were (less) than < 80 and > (greater) than 200 as prescribed.	R 292 RESIDENT #1 SHALL CONTINUE TO BE REASSESSED MONTHLY FOR ANY OTHER ADDITIONAL NEEDS 2/2/2012 AND ON GOING R292 CLARIFICATION OF BLOOD SUGAR READING HAS BEEN OBTAINED FOR RESIDENT #3 SEE ATTACHMENT #2 SHARED RESPONSIBILITY WAS OBTAINED FOR NON-COMPLIANCE WITH DIABETIC DIET WHEN AT THE DAY PROGRAM. AFTER SEVERAL ATTEMPTS ON TEACHING ON DIABETIC DIET HAS BEEN MADE SEE ATTACHMENT #3. 2/2/2012 AND ON GOING	
R 403	Sec. 601b Admissions (b) Prior to admission of a resident, the ALA or designee shall determine that the resident is appropriate for admission to the ALR and that the resident's needs can be met in addition to the needs of the other residents. Based on interview and record review, the facility failed to ensure that a determination was made regarding the appropriateness of placement and	R 403 THE RIGHT FORMS HAS BEEN COMPLETED BY RESIDENT #3 PRIMARY MD ALR SHALL ENSURE THAT ALL APPROPRIATE DOCUMENTS ARE FILED OUT IN LT'S ENTIRETY. QA OF ALL CHARTS SHALL BE CONDUCTED	

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R 403	<p>Continued From page 4</p> <p>that the resident's needs could be met in an Assisted Living Residence (ALR) prior to admission for one of the three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>Interview with Home Health Aide (HHA) and record review on January 31, 2012 at approximately 10:07 a.m., revealed Resident #3 was admitted on July 30, 2011. Further review of the clinical record on the same day revealed a document used for "admission/annual/medical certification" dated July 29, 2011. Review of the document revealed a section entitled "Level of Care Recommendation" that listed Assisted Living Residence (ALR) or Skilled Nursing Care. Neither of the categories had been selected. Additionally, the document failed to include the resident's needs for treatment services.</p> <p>At the time of survey, the facility failed to ensure that appropriate determinations had been made regarding resident #3's placement needs or whether his treatment/services needs could be met in an Assisted Living Residence setting.</p>	R 403	<p>MONTHLY BY RN/LPN SEE ATTACHMENT #4</p> <p>2/2/2012 AND O'DGOWS</p> <p>R 403 SEE RESPONSE ON R403 SEC. 601B</p> <p>2/2/2012 AND O'DGOWS</p>
R 831	<p>Sec. 905a Medication Administration.</p> <p>(a) Licensed nurses, physicians, physician assistants, and TMEs may administer medications to residents or assist residents with taking their medications. Based on observation and interview, the facility failed to ensure only licensed nurses, physicians, physician's assistants and trained medication employees (TMEs) administered medications for one of three resident's included in the sample. (Resident #5)</p>	R 831	

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R 831 Continued From page 5
The finding includes:

Interview with Home Health Aide (HHA) #1 on January 31, 2012, at approximately 10:20 a.m. revealed that the HHA assisted resident #5 with her medication. The HHA demonstrated that she opened the resident pill box and poured the residents medication into her hand.

Interview with both HHA's employed by the facility revealed that they had completed medication training, however, at the time of the survey, they had not been certified as trained medication employees (TME).

R 831
FACILITY'S HHA WERE REINSTRUCTED ON MEDICATION RULES AND REGULATIONS. FACILITY SHALL ENSURE THAT RN/LPN IS PRESENT DURING MEDICATION ADMINISTRATION PRIOR TO AIDS PASSING THE BOARD OF NURSING EXAMINATION FOR TME
2/1/2012
AND
ON GOING

R 982 Sec. 1004b General Building Interior

(b) An ALR shall ensure that floors and stairways provide a clean, slip-resistant, and safe surface, free of tripping hazards. Based on observation during the environmental inspection, the facility failed to ensure that the carpeting on the floors were clean.

The finding includes:

An environmental inspection on January 31, 2012, at approximately 4:10 p.m. revealed the carpeting throughout the facility to be stained with large dirty areas.

Interview with the administrator on January 31, 2012 revealed that she cleaned the carpet on a monthly basis and they she had considered removing the carpet from the floor.

R 982
FACILITY'S CARPET WAS STAMPED AGAIN ON 02/01/2012 PRIOR TO BEING REPLACED ON 02/22/2012. NEW FLOORING WILL CONTINUE TO BE MAINTAINED IN A GOOD CONDITION BY CLEANING SERVICE
02/01/2012
02/22/2012
AND
ON GOING