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-0005	A. BUILDING: _____ B. WING _____	10/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYE ASSISTED LIVING SERVICES	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 On October 9, 2013, the Department of Health/ Health Regulation and Licensing Administration (DOH/HRLA) conducted an investigation to determine compliance with the Assisted Living Law "DC Code 44-101.01". Background: On September 27, 2013, DOH/HRLA received an e-mail from the Department of Healthcare Finance (DCHF) regarding environmental concerns at the facility. Additionally, on October 8, 2013, DOH/HRLA received a phone call from DHCF voicing multiple complaints related to medication administration practices, physician orders being unavailable, and diet and fluid restrictions not being followed. Please Note: Listed below are abbreviations used in this report: As needed (PRN) Assistant Living Administrator (ALA) Assistant Living Residence (ALR) At bed time (QHS) By Mouth (PO) Emergency Room (ER) Every Day (QD) Every 6 hours (Q 6 hrs) Every 8 hours (Q 8 hrs) History & Physical (H&P) Individualized Service Plan (ISP) Medication Administration Record (MAR) Milligrams (mg) Three times a day (TID) Trained Medication Employee (TME) Twice a day (BID) Based on observations,medical and administrative record reviews, and staff	R 000		

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R 000	Continued From page 1 interviews, four (4) of twelve (12) complaints were substantiated. Allegation #1: Residents' meals were not prepared in accordance with prescribed diets. Finding: An interview with the ALA revealed that the facility used seasoning salt, steak seasoning and salt to prepare all residents meals. These seasonings were identified to contain sodium. Conclusion: This allegation was substantiated. Allegation #2:The facility does not provide training to residents and staff regarding specialized diets and self-administration of medications. Finding: A review of Resident #4's record revealed monthly nursing notes documenting that the resident could identify his/her medications, including the side effects of these medications, and could safely self-administer his/her own medications . An interview with the ALA revealed that training was provided to non-compliant residents who do not follow the restrictions of their prescribed no added salt diets; however, the training was not documented. Conclusion: This allegation was partially substantiated. Allegation #3:The ALR failed to ensure implementation of a resident's fluid restriction in accordance with a physician order. Finding: A review of Resident #3's record failed to evidence documentation that the fluid	R 000		

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R 000	Continued From page 2 restriction order was being followed by staff. An interview with the ALA revealed that the facility's staff monitors the resident's fluid intake and ensures that the resident stays within the prescribed limitation of 1500 cc daily; however, the monitoring was not documented. Conclusion: This allegation was partially substantiated. Allegation #4: The facility did not have October 2013 MAR's. Finding: A record review revealed that the facility had October 2013 MAR's for six (6) of six (6) residents. Conclusion: This allegation could not be substantiated. Allegation #5: The facilities staff is administering medications from 30 day bubble packs incorrectly. Finding: An interview with the ALA revealed that the staff does not start the 30-day bubble packs according to the calendar date because the bubble packs are not always delivered from the pharmacy on the first of the month. Conclusion: This allegation could not be substantiated. Allegation #6: A resident who was prescribed Metoprolol was not receiving the medication as prescribed. Finding: A review of Resident #2's record revealed the following: a physician order dated	R 000		

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R 000	Continued From page 3 August 2, 2013 that ordered add Metoprolol 25 mg daily at night, a physician order sheet that ordered Metoprolol 50 mg po QD with start date of October 26, 2010, and an order to discontinue Metoprolol 25 mg, dated September 1, 2013. An interview with the ALA revealed that the resident's Metoprolol was increased from 50 mg every day to 75 mg twice a day on August 2, 2013 after an ER visit. After a month the resident's physician decreased Metoprolol back down to 50 mg every day. Conclusion: This allegation could not be substantiated. Allegation #7: The furnace filter was full of dust. Finding: The furnace filter was observed to be free of dust or debris. Conclusion: This allegation could not be substantiated. Allegation #8: There was a cracked window in the facility. Finding: All of the windows in the facility were assessed and a cracked window was observed in the living room. Conclusion. This allegation was substantiated. Allegation #9: There were exposed wires/outlet cords observed through-out the facility. Finding: All rooms were checked during an environmental walk-through and there were no exposed wires/outlet cords observed in the facility.	R 000		

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R 000	Continued From page 4 Conclusion: This allegation could not be substantiated. Allegation #10: Rat droppings were observed in the facility. Finding: All rooms were checked during an environmental walk-through and there were no rat droppings observed in the facility. Conclusion: The allegation could not be substantiated. Allegation #11: One of the smoke detectors in the facility needed a battery and another smoke detector was inoperable. Finding : During an environmental walk-through all smoke detectors were checked and observed to be operable. Conclusion: This allegation could not be substantiated. Allegation #12: The fire extinguishers in the facility had not been serviced. Finding : During an environmental walk-through it was observed that all of the fire extinguishers in the facility had been serviced. Review of the "Kitchen/Extinguisher job ticket" revealed that all of the fire extinguishers in the facility were serviced on October 8, 2013. Conclusion: This allegation could not be substantiated.	R 000		

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R 292	Continued From page 5	R 292		
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; [D.C. Official Code § 44-105.04] Based on interview and record review, the ALR failed to provide appropriate and adequate service for six of six residents' in the sample. (Residents #1, #2, #3,#4, #5 and #6) The findings include: 1. On October 9, 2013, starting at approximately 9:00 a.m., a review of Resident #2, #3, #5 and #6's records revealed that the residents' were prescribed no added salt diets. During an interview with the ALA on October 9, 2013, starting at approximately 12:30 p.m., it was revealed that the facility prepares all meals with salt, seasoning salt, steak seasoning and basil seasoning. The ALA presented the seasoning containers, which were observed to contain sodium. 2. On October 9, 2013, starting at approximately 9:00 a.m., a review of Resident #1, #2, #3, #4, #5 and #6 ' s records failed to document diet training provided by the facility ' s ALA. During an interview with the ALA on October 9, 2013, starting at approximately 12:30 p.m., the ALA stated, "A few of the residents are non-compliant with the no added salt diet. I have one resident who will bring in salt packets from the day program. Because the residents are	R292 #1 AND #2.	ALL RESIDENTS AND STAFF WERE IN-SERVICED ON NO ADDED SALT DIET AND THE EFFECTS OF SODIUM TO THE CARDIAC SYSTEM. ALL REGULAR SALT, STEAK SEASONING HAVE BEEN REPLACED WITH A LOW SODIUM SALT. AND OTHER SALT FREE SEASONING. TO PREVENT THIS DEFICIENT PRACTICE FROM RECURRING STAFF WILL REINSTRUCT RESIDENTS WHO ARE NON-COMPLIANT WITH THEIR DIET AND WILL DOCUMENT NON-COMPLIANCE	10/12/13 AND ONGOING

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R 292	Continued From page 6 non-compliant, I have provided training on diets to all residents on multiple occasions but I did not document the training. " 3. On October 9, 2013, at approximately 9:45 a.m., a review of Resident #2's record revealed a physician order sheet, dated September 2013, ordering 1500 cc fluid restriction QD. Further review revealed an ISP dated June 5, 2013, that documented staff to work on a specific schedule for fluid restriction due to patient ' s diagnosis of psychogenic polydipsia. Further review of the record revealed that there was no documented evidence of the scheduled fluid restriction. During an interview with the ALA on October 9, 2013, at approximately 11:30 a.m., it was revealed that the resident was admitted to this facility in 2009 from a hospital after being treated for psychogenic polydipsia. The resident's admission orders included an order for 1500 cc fluid restriction QD to prevent an electrolyte imbalance secondary to psychogenic polydipsia. The resident was provided a one to one staff to monitor the resident's fluid restriction. The ALA further stated, " The staff did not document the fluid restriction but I have now developed a schedule for the staff to follow for the 1500 cc fluid restrictions." A further review of the record revealed that the resident has not been transferred to the ER or admitted to a hospital for electrolyte imbalance secondary to psychogenic polydipsia since admission to this facility. 4. On October 9, 2013, at approximately 11:45 a.m., a review of Resident #4 ' s record revealed an October 2013 MAR that reflected Lyrica 100 mg po TID. Further review of the MAR revealed the Lyrica had only been administered once a day, at 7:00 a.m., since	R 292 R292 #3	CONTINUED FROM PAGE 6 STAFF TO NOTIFY RN OF NON-COMPLIANCE FOR FURTHER DIET TEACHING. SEE ATTACHMENT #1 STAFF WERE IN-SERVICED ON RESIDENT #2 FLUID RESTRICTION AND A SCHEDULE WITH AMOUNTS OF WATER/ FLUID INTAKE HAS BEEN CREATED AND PLACED IN THE RESIDENTS PERMANENT RECORD AN INTAKE SHEET WAS ALSO CREATED FOR DOCUMENTATION. TO PREVENT THIS DEFICIENT PRACTICE FROM AFFECTING ALL RESIDENTS, THE RN AND OR ALA WILL REVIEW RESIDENTS RECORD TO ENSURE DAILY FLUID INTAKE IS RECORDED ORDER WAS OBTAINED FROM RESIDENTS PRIMARY PHYSICIAN TO OBTAIN MONTHLY CBC AND CMP TO MONITOR RESIDENTS ELECTROLYTES SEE ATTACHMENT #2	10/8/13 AND ONGOING

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R 292	Continued From page 7 October 1, 2013. During an interview with the TME on October 9, 2013, at approximately 1:30 p.m., the TME stated, "I only gave the medication one time a day. It was an error."	R 292 #4.	TME HAS RECEIVED AN IN-SERVICE AND TRAINING ON THE RIGHTS OF MEDICATION ADMINISTRATION RIGHT PERSON, DOSE, TIME AND ROUTE. TO PREVENT THIS DEFICIENT PRACTICE FROM RECURRING ALA WILL REVIEW ALL RESIDENTS MAR WEEKLY FOR PROPER ADMINISTRATION OF MEDICATIONS. SEE ATTACHMENT #3	10/8/13 AND ONGOING
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, interview, and observation, it was determined that the facility failed to ensure that six (6) of six (6) residents in the sample had access to appropriate medical and health services. (Residents' #1, #2, #3, #4, #5 and #6) The findings include: 1. On October 9, 2013, starting at approximately 8:00 a.m., a review of Resident #1, #2, #3, #4, #5 and #6 ' s records revealed MAR's dated from January 2012 through October 2013 that failed to document allergies for any of the residents. During an interview with the ALA on October 9, 2013, at approximately 1:30 p.m., the ALA stated, "The pharmacy who pre-prints the MAR's normally documents the residents' allergies. I will document all the residents' allergies on the October 2013 MAR's." 2. On October 9, 2013, starting at approximately	R 293 R293 #1	ALL MARS WERE CORRECTED TO INDICATE ANY ALLERGIES AND THE PHARMACY WAS MADE AWARE OF THE OMISSION OF ALLERGIES ON THE ALLERGY SECTION. TO PREVENT THIS DEFICIENT PRACTICE FROM AFFECTING ALL RESIDENTS ALA/RN WILL REVIEW MONTHLY MARS FOR ~~COMPLETENE~~ COMPLETION.	10/9/13 AND ONGOING

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R 293	Continued From page 8 8:30 a.m., a review of Resident #1's record revealed an October 2013 MAR that reflected Lipitor 10 mg po every PM and V-C Forte one cap po twice a week. Further review of the record revealed an H&P, signed by the resident ' s physician and dated December 31, 2012, that ordered V-C Forte one tab po QD. On October 9, 2013, starting at approximately 10:00 a.m., an observation of Resident #1's medications revealed that Lipitor was unavailable at the time of this survey. Additionally, there was no documented evidence of an order for V-C Forte one tab po twice a week. During an interview with the TME on October 9, 2013, at approximately 10:15 a.m., it was revealed that the Lipitor was last administered on the evening of October 8, 2013. Additionally, the TME stated, that the ALA was aware and would pick-up medication from pharmacy today. 3. On October 9, 2013, at approximately 9:45 a.m., a review of Resident #2's October 2013 MAR's reflected vitamin D 1000 unit tablets po QD. Additionally, on the same day, at approximately 10:45 a.m., an observation of Resident #2's medications revealed Vitamin D 1000 units tablets were unavailable at the time of this survey. During an interview with the TME on October 9, 2013, at approximately 12:00 p.m., it was revealed that the Vitamin D 1000 units was last administered at 8:00 a.m. on October 9, 2013. Additionally, the TME stated, "The ALA is aware and will pick up medications from pharmacy today."	R 293 #2	RESIDENT #1 ORDER FOR VC-FORTE 1 TAB BY MOUTH TWICE WEEKLY HAS BEEN OBTAINED FROM THE PRIMARY PHYSICIAN AND HAS BEEN PLACED IN THE RESIDENTS PERMANENT RECORD. PHARMACY HAS BEEN INSTRUCTED TO DELIVER ALL REFILLS 3 DAYS BEFORE THE MEDICATIONS RUN OUT AND IF UNABLE TO DELIVER IN A TIMELY MANNER TO NOTIFY ALA FOR MEDICATION PICK UP. TO PREVENT THIS DEFICIENT PRACTICE FROM AFFECTING ALL RESIDENTS JALS STAFF TME TO NOTIFY ALA OF ALL MEDICATIONS ~~THAT SHOULD~~ HAVE FIVE DAYS AHEAD OF TIME PRIOR TO LAST DOSE FOR TIMELY DELIVERY AND OR PICK UP OF MEDICATIONS R293 #3 SEE RESPONSE TO R293 #2	10/13/13 AND ONGOING 10/13/13 AND ONGOING 10/13/13 AND ONGOING

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R 293	Continued From page 9 4. On October 9, 2013, at approximately 10: 30 a.m., an observation of Resident #3's room revealed a bottle of HCTZ 12.5 mg/Lisinopril 10 mg and a bottle of multivitamins. Further observation revealed, multiple amounts of filled, non-expired current medication bottles. On the same day, at approximately 10:45 a.m., a review of Resident #3's record revealed the following: an October 2013 MAR that reflected Lisinopril 10 mg po QD and an H&P dated January 14, 2012 that ordered Lisinopril 2.5 mg po QD. The record failed to evidence an order for HCTZ 12.5 mg/ Lisinopril 10 mg. During an interview with the ALA on October 9, 2013, at approximately 11:00 a.m., it was revealed that the resident receives all medications from the Veterans Administration Hospital and they dispense a three-month supply of medications at one time. The ALA then stated,"I will get a copy of the order for HCTZ 12.5 mg/ Lisinopril 10 mg from the resident's physician and I will store the excess medications." 5. On October 9, 2013, at approximately 11:45 a.m., a review of Resident #4's record revealed a October 2013 MAR that reflected ASA EC 81 mg po QD, Tylenol 500 mg Q 6 hrs prn for pain, and Cheratussin syrup two teaspoon Q 8 hrs prn for cough. The record failed to evidence a physician order for Tylenol 500 mg Q 6 hrs prn for pain or Cheratussin syrup two teaspoon Q 8 hrs prn for cough. On October 9, 2013, at approximately 12:00 p.m., an observation of Resident #4's medication revealed that ASA EC 81 mg, Tylenol 500 mg and Cheratussin syrup were unavailable at the	R 293 #4	AN ORDER FOR HCTZ 12.5mg/LISINOPRIL 10 MG HAS BEEN OBTAINED FROM RESIDENT'S PH #3 PRIMARY PHYSICIAN AND HAS BEEN FILED IN THE RESIDENTS PERMANENT RECORD. ALL EXCESS MEDICATIONS HAVE BEEN STORED IN THE MEDICATION LOCKED CABINET. TO PREVENT THIS DEFICIENT PRACTICE FROM RECURRING ALL REFILLS WILL BE STORED IN THE MEDICATION CABINET. SEE ATTACHMENT # 4	10/11/13 AND ONGOING
		R293 #5.	A PHYSICIAN ORDER TO DISCONTINUE CHERATUSSIN SYRUP AND TYLENOL 500mg WAS RECEIVED FROM RESIDENT #4's PRIMARY PHYSICIAN ASA 81 mg WAS PICKED UP ON OCTOBER 9TH. TME AND RN WAS INSTRUCTED TO NOTIFY ALA IF REFILLS ARE NOT RECEIVED BY THE FACILITY THREE DAYS PRIOR TO THE LAST DOSE BEING	10/12/13 AND ONGOING

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R 293	Continued From page 10 time of this survey. During an interview with the TME on October 9, 2013, at approximately 12:15 p.m., the TME stated, "I gave the resident ASA EC this morning 8:00 a.m. and the resident has not been given or needed Tylenol 500 mg and Cheratussin syrup in a while." During an interview with the ALA on October 9, 2013, at approximately 12:30 p.m., the ALA stated, "I will pick up the ASA EC today from pharmacy and I will also call the resident's physician to get the orders for Tylenol 500 mg and Cheratussin syrup."	R 293 #5	CONTINUED FROM PG 10 OF 12 BY THE RESIDENT. TO PREVENT THIS DEFICIENT PRACTICE FROM RECURRING ALA WILL PICK UP ALL MEDICATIONS FROM THE PHARMACY THREE DAYS BEFORE MEDICATIONS RUN OUT AND WILL OBTAIN DISCONTINUE ORDER FOR ALL MEDICATIONS WITHOUT REFILL ORDER. SEE ATTACHMENT #5.	
R 821	Sec. 904e8 Medication Storage (8) Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep them secured from other residents. Based on observation and interview, the ALR failed to ensure one (1) of one (1) resident's included in the sample secured their medications from other residents. (Resident #3) The finding Includes: On October 9, 2013, an observation of Resident #3's room at approximately 11:30 a.m., revealed multiple filled pill bottles in a black book bag. It should be noted that the resident's room was not locked and easily accessible to all other residents in the facility. During an interview with the ALA, on October 9, 2013, at approximately 1:40 p.m., the ALA stated,	R 821 R 821	AND CURRENT ALL EXCESS MEDICATIONS BELONGING TO RESIDENT # 3 HAS BEEN STORED IN THE LOCK MEDICATION DRAWER. SINCE RESIDENT IS NON-COMPLIANT WITH KEEPING HIS MEDICATIONS IN A LOCKED BOX. TME RECEIVED INSTRUCTION TO	10/9/13 AND ONGOING

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R 821	Continued From page 11 "I brought the resident a lock box to secure medications but I don't where the resident put it . I will buy another one so [the resident] medications can be locked -up."	R 821	CONTINUED FROM PAGE 11 OF 12 KEEP ALL NEW REFILLS LOCKED IN THE MEDICATION BE CABINET. TO PREVENT THIS DEFICIENT PRACTICE FROM RECURRING ALL JALS RESIDENTS MEDICATIONS WILL BE STORED IN THE LOCKED MEDICATION CABINET	
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 interview, the ALR failed to ensure that all of the windows in the facility were maintained in good repair. The finding includes: During an environmental walk-through on October 9, 2013, at approximately 11:35 a.m., a cracked window was observed in the living room. During a face to face interview with the facility's director on October 9, 2013, at approximately 1:10 p.m., it was stated that the living room window was scheduled to be repaired on Octber 10, 2013.	R 981	R981 THE CRACKED WINDOW WAS REPLACED ON OCTOBER 10TH PER THE WORK ORDER RECEIVED. TO PREVENT THIS DEFICIENT PRACTICE FROM RECURRING THE DESIGNATED HANDYMAN WILL INSPECT BOTH OUTER AND INNER ASPECT OF THE FACILITY ONCE EVERY TWO WEEKS AND WILL SUBMIT ALL ABNORMAL FINDINGS TO ALA FOR FILING. SEE ATTACHMENT #6	10/10/13 AND ONGOING