

DEPARTMENT OF HEALTH
 HEALTH REGULATION & LICENSING
 ADMINISTRATION

Mailing Address
 825 North Capitol St., NE
 Washington DC 20002
 2nd Floor (2224)
 202-442-8888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility: Williams Assisted Living		Street Address, City, State, ZIP Code: 1437 Potomac Ave., SE Wash., DC 20003		Survey Date: 05/03/10 & 6/17/2010 Follow-up Date(s):	
Regulation Citation Assisted Living Law "DC Code § 44-101.01"	Statement of Deficiencies An annual licensure survey was conducted on May 3, 2010 through June 17, 2010 to determine compliance with Assisted Living Law "DC Code § 44-101.01". The following deficiencies were based on record reviews, observations and interviews. The sample sizes were four (4) resident records based on a census of four (4) residents and two (2) employee records based on a census of two (2) employees.	Ref. No.	Plan of Correction <i>A plan of action is in place to correct all deficiencies and brought in compliance with the Assisted Living Law "DC Code § 44-101.01"</i>	Completion Date	<i>August 10, 2010</i>
Notice of Resident's Rights § 44-105.08		Received 7/27/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002			

Craig Miller for Stephen Miller
 Name of Inspector *Stephen Miller* Date Issued *6/24/2010*

Facility Director/Designee _____ Date _____

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

§ 44-508.08

An Assisted Living Residence (ALR) shall place a copy of a document delineating the resident's rights, as set forth in this chapter, in a conspicuous location, plainly visible and easily read by residents, staff, and visitors and provide a copy to each resident and resident's surrogate upon admission and at the time of any change to the resident's status, level of care, or services available to the resident.

Based on a record review and interview, it was revealed that the facility failed to provide a Notice of Resident's Rights to the resident and resident's surrogate upon admission for three (3) of four (4) residents. (Resident #1, 2 and 4)

The finding includes:

On May 3, 2010, a record review from approximately 1:00 p.m. until 3:00 pm of resident's #1, 2 and 4 record revealed that there was no documented evidence that a Notice of Resident's Rights was provided to the residents or resident's surrogate upon admission.

During a face-to-face interview with the General

The Williams Assisted Living Residence shall follow all rules and Regulations Concerning Resident's Rights according to Regulation No. 44-508.08 Orders shall be complied with.

*July 28
2010*



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Manager on May 3, 2010 at approximately 3:30p.m., the above findings were acknowledged.

§ 44-105.09

Abuse, Neglect, and Exploitation

§ 44-105.09 (c)

An ALR shall post signs that set forth the reporting requirement of this section conspicuously in the employee public areas of the ALR.

Based on an observation and interview, it was revealed that the facility failed to post signs that set forth the reporting requirement of this section conspicuously in the employee public areas of the ALR.

The finding includes:

Observation conducted on May 3, 2010 at approximately 1:15 pm. revealed there were no signs posted in the facility. Setting forth the reporting

The Willman Assisted Living Residential (WALR) is complying with all regulation set forth by Chapter 44-105.09 pertaining to abuse, neglect and exploitation in the employee areas of and public areas of the Assisted Living Residence.

July 28
2010



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
requirements of this section.

During a face-to-face interview with the General Manager on May 3, 2010 at approximately 3:30 p.m., the finding was acknowledged.

§ 44-106.04
Individualized Service Plans

§ 44-106.04
(a) (1)

An ISP shall be developed for each resident prior to admission.

Based on a record review and interview, it was revealed that the facility failed to develop an ISP prior to admission for one (1) of four (4) residents' (Resident # 4)

The findings include:

On May 3, 2010, a record review of resident # 4's record revealed there was no documented evidence of an ISP was developed prior to admission.

Further review of the record revealed there was no date of admission.

A plan of admission is in place to comply with Chapter 44-106-04(a)(1) Individualized Service Plans for each Resident prior to admission to the ALR including the date of admission to Residence.

*July 28
2010*



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

During a face-to-face interview on May 3, 2010 at approximately 3:30 p.m., it was revealed that the owner had removed the resident's record from the facility. It was also revealed that resident # 4 had been admitted to the facility for approximately a couple of month. The finding was revealed during this interview.

§ 44-106.04
Individualized Service Plans

§ 44-106.04
(a) (3)

The ISP shall be written by a health practitioner using information from the assessment.

Based on record review and interview, it was revealed that the facility failed to have three (3) of three (3) resident's ISP's written by a health practitioner. (Resident #1, 2 and 3)

The findings include:

On May 3, 2010, a record review from approximately 1:30 p.m. until 3:00 p.m. revealed there was no documented evidence that aforementioned ISP were written by a health practitioner.

During a face-to-face interview on May 3, 2010 at approximately 3:30 p.m. with the general manager, the finding was acknowledged.

I [redacted] Resident [redacted] July 28 2010
Director removed the record to the family to carry to the hospital, the information was used for the doctors to review.

According to Regulation 44.106.04 (a)(3) Individualized Service Plans (ISP) shall be written by a health care practitioner is being complied with according to specifications.
July 28 2010



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

§ 44-106.04

Individualized Service Plans

§44-106.04
(d)

The ISP shall be reviewed 30 days after admission and at least 6 months thereafter.

Based on a record review and interview, it was revealed that the facility failed to review ISP's for three (3) of four (4) residents every 6 months. (Resident #1, 2, and 3).

The finding includes:

On May 3, 2010 at approximately 1:00 p.m. until 3:00p.m., a record of the aforementioned records revealed there was no documented evidence the ISP's were reviewed every 6 months as required.

Further review of the record revealed all aforementioned residents' had an ISP in their record dated May 1, 2009.

During a face-to-face interview on May 3, 2010 at approximately 3:30 p.m. with the general manager, the finding was acknowledged.

*The WALKR is complying with Chapter 44-106.04
ISP shall be reviewed 30 days after admission and at least 6 months thereafter as being complied with according to regulations.*

*July 28
2010*



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

§ 44-106.04

Individualized Service Plans

§ 44-106.04
(a) (5)

The ISP shall be signed by the resident, or surrogate, and a representative of the ALR.

Based on record review and interview, the facility failed to have one (1) of four (4) ISP's signed by the resident, or surrogate, and a representative of the ALR. (Resident #1)

The finding include:

On May 3, 2010 at approximately 1:30 until 3:00 p.m., a record review of resident #1 record revealed an unsigned ISP dated May 1, 2009.

During a face-to-face interview on May 3, 2010 at approximately 3:30 p.m., the finding was acknowledged.

§ 44-107.01

Staffing Standards

§ 44-107.01

An Assisted Living Administrator (ALA) shall:

*Accord to ISP Regulations
Chapter No. 44-106.04
all ISP shall be signed
by the resident. It is
being complied with
according to specifications*

*July 26
2010*



DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(d) § 44-107.01 (d) (6)

Assure that there is at least one staff member within the ALR at all times who is certified in first aid and CPR.

Based on record review and interview, it was revealed that the facility failed to ensure that one (1) of two (2) staff members were certified in first aid and CPR. (ALA/TME)

The finding include:

On May 3, 2010, a record review of the ALA employee record approximately 3:40 p.m. revealed there was no documented evidence of the of first aid and CPR certification.

During a face-to-face interview on May 3, 2010 at approximately 4:00 p.m., the finding was acknowledged. The general manager indicated that the ALA/TME is the only staff member with the resident's most times. The general manager also stated, "I'm sure she has a current first aid and CPR certification. I just can't find at this time. I'll fax it to you."

§ 44-107.01 (d) (13)

Complete the training required by § 44-107.02 and 12 additional hours of training, annually, conducted by a nationally recognized organization that possess

The WALK will assure that at least one staff member within the ALR ~~is~~ at all time ~~is~~ is certified in First Aid and CPR as required by Chapter 44-107-01

July 28 2010

The WALK management will assure that the training required by 44-107.02 will be complied with

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
experience in training staff in dementia care, such as Alzheimer's Disease and Related Disorders Association, on managing residents who are living with cognitive impairments.

Based on record review and interview, it was revealed that the facility ALA failed to 12 hours of annual training conducted by a nationally recognized organization that possess experience in training staff in dementia care, such as Alzheimer's Disease and Related Disorders Association, on managing residents who are living with cognitive impairments.

The finding include:

On May 3, 2010, a record review of the ALA employee record at approximately 3:40 p.m. revealed there was no documented evidence of the above 12 hour required annual training for 2009.

During a face-to-face interview on May 3, 2010 at approximately 4:00 p.m., the finding was acknowledged.

and 12 additional hours of training annually will be included according to specifications in 44-107-01 (b)(3) beginning August 10, 2010

*August 30
2010*

The WALK began training in house July 10, 2010 with all staff members. The Alzheimer's Association will conduct training August 10, 2010 in house to the staff, in all areas requested by 44-107-01



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

§ 44-107.01

(1)

Employees shall be required on an annual basis to document freedom from tuberculosis (TB) in a communicable form.

§ 44-107.01

Staffing Standards

Based on a record review and interview, it was revealed that the facility failed to document that two (2) of two (2) employees were free from communicable TB. (ALA/TME and General Manager).

The findings include:

A record review of the on May 3, 2010 at approximately 3:45 p.m. of the ALA/TME and General Manager records revealed there was no documented evidence that the aforementioned employees were free of communicable tuberculosis.

During a face-to-face interview on May 3, 2010 at approximately 4:00 p.m., the finding was acknowledged. The general manager stated, "We did have our physicals done. I just can't find them at this time."

The WALK Employees is required on an annual basis to turn in documentation showing freedom from tuberculosis (TB) in a communicable form. according to Regulation 44-107-01(B)

*July 28
2010*



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

§ 44-107.02 (c)	§ 44-107.02 <u>Staff Training</u>	After first year of employment, and at least annually thereafter, a staff member shall complete a minimum total of 12 hours of in-service training in the following: <i>Emergency procedures and disaster drills.</i> <i>Rights of the residents.</i> <i>Four hours covering cognitive impairments in an in-service training approved by a nationally recognized and creditable expert such as the Alzheimer's disease and Related Disorder Association.</i>	<p>The WALK with Confly August 30 to all Regulation by 44-107.02(c) required by 44-107.02(c)(1) 44-107.02 (c)(2) 44-107.02 (c)(3)</p> <ol style="list-style-type: none"> ① Emergency procedures and disaster drills ② Rights of the residents ③ Four hours covering cognitive impairment in those services training such as Alzheimer's disease and Related Disorder Association
§ 44-107.02 (c)(2) ③ (3)	The findings include:	Based on a record review and interview, it was revealed that the facility failed to ensure that one (1) of one (1) employee's had the aforementioned 12-hour annually required in-services. (General Manager)	
A record review of the on May 3, 2010 at approximately 3:45 p.m. of the General Manager employee record revealed there was no documented evidence had the aforementioned 12 hour annually required in-services.			



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

During a face-to-face interview on May 3, 2010 at approximately 4:00 p.m., the finding was acknowledged.

§ 44-108.02
Medical, Rehabilitation, and Psychosocial Assessment

Confirmation that the applicant is free from communicable TB and from other active, infectious, and reportable communicable diseases.

Based on a record review and interview, it was revealed failed to ensure one (1) of four (4) residents' was free from communicable TB. (Resident #1)

The findings include:

On May 3, 2010 from approximately 1:00 p.m. until 3:00 p.m., a record review of resident #1 record revealed a government approved medical, rehabilitation and psychosocial assessment form dated 12/10/09, which failed to have documented evidence of the resident's TB status.

During a face-to-face interview on May 3, 2010 at approximately 3:30 p.m., the finding was acknowledged.

The WALR will comply with the regulation No. 44.108.02 (c)(4) confirming that the applicant is free from communicable TB and from other active, infectious and reportable communicable diseases.

*July 28
2010*

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

§ 44-109.06

§ 44-109.06
(c)

Medication Management Training Programs
*In order to maintain certification, every 2 years a
Trained Medication Employee (TME) shall
successfully complete a clinical update or refresher
course approved by the Mayor.*

Based on a record review and interview, it was revealed
that the facility failed to maintain certification for one
(1) of one (1) TME's.

The finding include:

On May 3, 2010, a record review on ALA/TME at
approximately 3:35 p.m. employee record revealed there
was no documented evidence that the TME had
successfully completed a clinical update or refresher
course approved by the Mayor.

Further review of the record revealed a TME
certification approved by the District of Columbia with
the expiration date of 10/13/09.

During a face-to-face interview with the general
manager on May 3, 2010 at approximately 4:00 p.m., the

*The WARR will comply
with regula (c) The
44-109.06 (c) The
Trained Medication
Employee (TME)'
certification is in
place*

*July 28
2010*

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

finding was acknowledged. The general manager also stated, "I believe the TME has a current certificate I just can't find it at this time. I will fax it to you."

§ 44-109.04

Individualized Service Plans

Based on a record review and interview, it was revealed that the facility failed to review ISP's for three (3) of four (4) residents every 6 months. (Resident #1, 2, and 3).

The finding includes:

On May 3, 2010 at approximately 1:00 p.m. until 3:00p.m., a record of the aforementioned records revealed there was no documented evidence the ISP's were reviewed every 6 months as required.

Further review of the record revealed all aforementioned residents' had an ISP in their record dated May 1, 2009.

During a face-to-face interview on May 3, 2010 at approximately 3:30 p.m. with the general manager, the finding was acknowledged.

§ 44-109.04

Medication Storage

The WALE is complying with Chapter 44-109.04 Individualized Service Plans (ISPs) shall be reviewed every 6 months as required by Regulations
July 28



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

§ 44-109.04

(b)

The storage area shall be kept locked when not in use.

Based on an observation and interview, it was revealed the facility failed to ensure the medication storage was locked when not in use.

The finding include:

Observation conducted on May 3, 2010 at approximately 1:15 pm, revealed an unlock medication cabinet in the dining area.

During a face-to-face interview with general manager on May 3, 2010 at approximately 3:30 p.m., the finding was acknowledged.

§ 44-109.04

Medication Storage

§ 44-109.04
(c) (1)

All medications shall be kept in their original packaging and shall be properly labeled and identified.

Based on an observation and interview, it was determined that the facility failed to store medication in their original package for five (5) of five (5) resident's.

The WALK is complying with regulation 44-109.04 the storage area is being locked when not in use.

The WALK is complying with regulation 44-109.04 all medications shall be kept in their original packages and is properly labeled and identified.



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

The finding includes:

An observation of the medication cabinet on April 26, 2010 at approximately 10:00 a.m. revealed that all resident's medication had been removed for their original packages and place in individual's weekly pillboxes.

During a face-to-face interview with the CEO/Administrator on April 26, 2010 at approximately 1:30p.m., the finding was acknowledged.

1003

General Building Exterior

1003 (b) (b) An ALR that provides services to wheel-chair bound residents, shall make reasonable accommodations to render the ALR accessible to residents who are wheel-chair bound through the installation of a chair lift, curb cuts, and exterior ramp, or like accommodations

Based on observation and interview, it was determined that the ALR failed to have access to building for wheel chair bound residents.

*Continue on page, Top of July 28
page 17
2015*

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

The findings include:

During an inspection on June 17, 2010, at approximately 10:00 a. m., it was determined that the wheel-chair lift on the outside of the facility was in operable. The Director of the home indicates she is in the process of having the wheel-chair lift repaired and provided a contract that indicates the contractor is ordering a part to repair the wheel-chair lift.

1004

General Building Interior

1004 (a) (a) An ALR shall ensure the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and good repair.

Based on observation and interview, with the ALR Director it was determined that the ALR failed to maintain the facility in good repair.

The findings include:

The ALR shall comply with wheel chair lift ~~requirements~~ accommodations according to 1003(b) installation was completed July 10, 2010.

July 28
2010

The ALR shall ensure that the interior of the facility meet the requirements of 1004(b) they are being complied with according to the regulations 1004(a)

August 30
2010

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

During the inspection of the facility on June 17, 2010 at approximately 10:30 a.m. revealed the following:

1. The kitchen floor had separated floor tiles.
2. There was water stained ceiling tiles in the kitchen.
3. The window exhaust fan in the kitchen had dust on it.
4. Food in the refrigerator was out of its original packaging and not dated.
5. The hood in the kitchen has grease on it and the fan is not working.

Upstairs:

1. The bathroom window had evidence of chipping and peeling paint.
2. The wall located above the sink evidence blistering.
3. The bathroom floor was dirty around the wall.
4. In bedroom #1 in the rear upstairs the curtains are not hung properly, also, there was a broken glass lampshade on the nightstand.

The wall shall comply with General Building Interior Regulations according to 1004(a) an ensure that the interior of this facility including walls, ceilings, doors, windows equipment and fixtures are maintained structurally sound, sanitary and good repair, according to regulations.

August 30
2010



DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

5. The clients have no clothes hampers.
6. The linen in the linen closet does not look fresh.
7. There was a strong urine odor on the second floor.
8. In bedroom #3, the ceiling light cover had evidence of dead bugs.
9. The venetian blinds throughout the house were dusty.

The WALL is Complying
with regulations (oodie)
Upper Stairs: continue
Bedroom hampers
in place for each
resident
9. Linen closets are
being complied with.
We are complying with
the regulations request
4. The ceiling light cover in
bedroom #3 has been
solved, (no dead bugs).
Venetian blinds
throughout the house
are cleaned.