

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER THE GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 2512 Q STREET NW WASHINGTON, DC 20008		
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R 000	Initial Comments An annual licensure survey was conducted April 23, 2014, and April 24, 2014 to determine compliance with Assisted Living Law " DC Code § 44-101.01. " The Assisted Living Residence provides care for fifty-six (56) residents and has fifty-eight (58) staff to include professional and administrative staff. The findings of the survey were based on observations, record review, and interview with staff and residents. Please refer to the list provided below for all abbreviations used in this report: Assistant Living Administrator (ALA) Assistant Living Residence (ALR) Home Health Aides (HHA) Individual Service Plan (ISP) Speech Language Pathologist (SLP) Coronary Artery Disease (CAD) Hypertension (HTN) Registered Nurse (RN) Treatment Administration Record (TAR)	R000	INITIAL COMMENTS: The Plan of Correction is presented below in response to deficiencies identified in the licensure survey of April 23 rd through April 24 th , 2014. Please note that April 23 rd , 2014 was the first day of employment for the Director of Health Services. <i>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002 6/26/2014</i>	
R293	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 facility failed to ensure that five (5) of six (6) residents in the sample had access to appropriate medical and health services. (Residents' #1, #2, #3, #5 and #6) The findings include:	R293	Please see next page.	

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

TITLE

(X6) DATE

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R 293	Continued From page 1 1. On April 23, 2014 starting at approximately 11:00 a.m., a review of Resident #1's clinical record revealed a Speech Language Pathologist note, dated December 18, 2013, recommending that the Resident receive a consultation with a Gastroenterologist (GI) for swallowing difficulties. There was no documentation in the clinical record that the Resident #2 was seen by a Gastroenterologist. interview with the Resident #1's niece on April 23, 2014, at approximately 1:30 p.m. revealed that the niece is completely responsible for Resident #1's medical care. The niece stated that she had taken the Resident to the Resident's primary care physician who did not recommend a GI consultation, so no GI consult was done. There was no documentation in the clinical record regarding this event. Review of Resident #1's clinical record revealed a document titled "Monthly Summary". This document provides a complete assessment of the Resident's condition on a monthly basis and is completed by the nursing staff. Review of the clinical record revealed monthly summaries dated July 27, 2012, March 24, 2014, and April 14, 2014. There was no evidence that monthly summaries were completed on Resident #1 from July 27, 2012, to March 24, 2014. During an interview with the ALA on April 24, 2014 at approximately 10:30 a.m. the ALA stated that the monthly summary should be completed by the nurses on a monthly basis. Review of the ALR policy titled "Title V 111 Resident Assessment" given to this surveyor on April 24, 2014, at approximately 10:30 a.m. by the ALA revealed a monthly summary form among	R 293	CORRECTIVE ACTIONS regarding R 293: The Georgetown Assisted Living Residence will ensure that residents have access to appropriate medical and health services, and that follow-up actions are promptly and accurately documented in the chart. MEASURES: 1. A Nurse Consultant has been hired to review and reorganize each resident chart, assist with policy development and conduct nursing staff training regarding documentation no later than August 31 st , 2014. 2. The resident charts will be better organized to facilitate clinical problem identification and follow-up with appropriate medical and health services. a. Chart assembly will be standardized in accordance with best practices to facilitate data entry and retrieval. b. Chart design will include discrete sections for clinical, diagnostic, and ancillary services to support more effective documentation. c. A master problem list will be incorporated to facilitate clinical review. 3. A Nursing Training Session will be held regarding completion of Monthly Nursing Summary Notes, no later than July 31 st , 2014. a. The documentation training will include process flow regarding monitoring of lab values, medication adjustments and physician orders. It will also include review of these survey results with the nursing staff.	

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R293	<p>Continued From page 2</p> <p>the other required documents that should be found in the clinical record.</p> <p>2. Resident #2 was admitted to the ALR on September 19, 2012, with diagnoses including Parkinson's disease, Coronary Artery Disease (CAD) and Hypertension (HTN). Resident #2's record review on April 23, 2014, at 1:30 p.m. revealed that the Resident had surgery on November 26, 2013, for a pulse generator insertion for deep brain stimulation (DBS), a procedure used in the treatment of Parkinson's disease. Continued review of the clinical record revealed a nurse's note dated November 26, 2013, during the 7:00 a.m. to 3:30 p.m. shift, that indicates the Resident returned to the facility following surgery and was complaining of headaches, nausea and vomiting. The note stated that a message was left for the surgeon who was still in the operating room. There was no additional nursing documentation in the clinical record until November 28, 2013, regarding the Resident #2 post-surgical recovery, and another nursing note dated December 5, 2013, regarding a complaint of discomfort in the groin area.</p> <p>Additional review of Resident #2's clinical record revealed a nursing note dated December 12, 2013, indicating that the Resident had hernia repair that morning. The note further states that Resident #2 returned to the residence at 5:00 p.m. following the surgery with complaint of pain, but refused pain medication. A follow up nursing note dated December 13, 2013, indicates that the Resident #2 was alert and responsive with no complaint of pain. There was no further nursing in the note regarding the Resident's condition until April 13, 2014. Additionally, there was no monthly summary in the Resident's record.</p>	R 293	<p>Continued from Page 2</p> <p>4. A Tracking/Tickler System will be established to confirm that resident appointments have been met. The specifics of this system are currently being developed in conjunction with IT support.</p> <p>5. All outside agencies seeing residents on site regarding clinical specialties such as nursing/wound care/hospice as well as physical, occupational and speech therapies, will be required to document in the resident's chart with each visit.</p> <p>6. All residents are provided a copy of The Georgetown form "Record of Medical Appointment/Follow-Up/Treatment.". The tracking system will be used to monitor receipt of this form when completed by off-site providers.</p> <p>MONITOR:</p> <p>1. The Director of Health Services will monitor documentation regarding changes in patient condition for any urgent issues.</p> <p>2. A Tracking Form will be utilized for each resident to document Monthly Nursing Note completion and it will be monitored by the Director of Health Services.</p>	

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R293	<p>Continued From page 3</p> <p>3. Resident #3 was admitted to the facility on November 27, 2007, with diagnoses that include CAD, HTN and Diabetes Mellitus (DM). Resident #3's clinical record was reviewed on April 23, 2014, at approximately 3:00 p.m. and revealed a nursing note dated March 25, 2014, indicating that the Resident had a superficial injury to the leg and the physician's office was notified. The nursing note further stated that the physician requested to see the Resident on April 10, 2014 for blood work and rectal examination. Further review of Resident #3's clinical record revealed a nurse practitioner note dated April 10, 2014, with instructions to have the Resident's right foot evaluated at the Medstar Georgetown University wound clinic. Continued review of the clinical record revealed a nursing note dated April 18, 2014, stating that the Resident #3 left the facility for Medstar Georgetown University wound clinic. There was no documentation in the record regarding orders for wound care.</p> <p>Interview with the ALA on April 24, 2014, at approximately 10:30 a.m. revealed that physician's orders were done electronically and the ALA provided the surveyor with a printed physician's order that states "Bacitracin/Poly B (double strength) ointment apply to leg ulcers every day during dressing changes for anti-infective. Schedule: Daily at 10:00". The ALA also provided a document titled "TAR" that contained the above mentioned order for the wound care and the initials of the staff administering the wound care. At the time of the record review, there was no documentation containing a description of the wound, or its progress or deterioration.</p> <p>4. Resident #5 was admitted to the ALR on June 1, 2007 with diagnoses that include HTN, Gastric</p>	R293	<p>Continued from Page 3</p> <p>3. The Resident Appointment/Tracking System will be routinely reviewed by the nursing staff and weekly by the Director of Health Services.</p> <p>4. Chart reviews will otherwise be conducted by the Director of Health Services equivalent to 10% of charts monthly on a rotating basis.</p> <p>5. Interdisciplinary meetings will be established on a monthly basis with the Facility Medical Director to ensure clinical review and follow-up.</p> <p>6. Outside agency clinical specialty notes will be reviewed monthly in conjunction with the Interdisciplinary meeting.</p>

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R293	<p>Continued From page 4</p> <p>Reflux and Hypothyroidism. Review of Resident #S's clinical record on April 24, 2014, at approximately 10:00 a.m. revealed a nursing note dated December 5, 2013, during the 7:00 a.m. to 3:30 p.m. shift, indicating that the Resident had an episode of loose stools and self-medicated him/her self for fluid in the ears. The note further stated that the RN on duty was called to the Resident's room and the Resident will be "further monitored". There was no additional documented evidence that the Resident was further monitored. Additionally, the monthly summary found in the Resident's record was dated April 9, 2011.</p> <p>5. Resident #6 was admitted to the ALR on December 5, 2013, with diagnoses that include HTN, Emphysema, Alcohol Abuse, Liver Cirrhosis and Neuropathy. Review of Resident #6's clinical record on April 24, 2014, at approximately 11:00 a.m. revealed no monthly summary written by the staff.</p> <p>During an interview with the ALA on April 24, 2014, at approximately 10:30 a.m., the ALA acknowledged that monthly summaries should be done by the nursing staff and documentation must be improved.</p>	R 293		
R 3	<p>Sec. 604d Individualized Service Plans</p> <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,</p>	R 483		

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R 483	Continued From page 5 the resident's surrogate, if necessary, and the ALR. Based on record review and interview, it was determined that the ALR failed to ensure an ISP was updated with a significant change in the residents condition, reviewed by the interdisciplinary team and the healthcare practitioner, for two (2) of six (6) residents in the sample. (Residents #2 and #3) The finding includes: 1. Resident #2 was admitted to the ALR on September 19, 2012, with diagnoses including Parkinson's disease, Coronary Artery Disease (CAD) and Hypertension (HTN). Review of Resident #2's clinical record review on April 23, 2014, at 1:30 p.m. revealed that the Resident had surgery on November 26, 2013, for a pulse generator insertion for deep brain stimulation (DBS), a procedure used in the treatment of Parkinson's disease. Continued review of the clinical record revealed a nurse's note dated November 26, 2013, during the 7:00 a.m. to 3:30 p.m. shift, that indicates the Resident returned to the facility following surgery and was complaining of headaches, nausea and vomiting. The note stated that a message was left for the surgeon who was still in the operating room. There was no additional nursing documentation in the clinical record until November 28, 2013, regarding Resident #2's post-surgical recovery, and another nursing note dated December 5, 2013, regarding a complaint of discomfort in the groin area. Additional review of Resident #2's clinical record revealed a nursing note dated December 12, 2013, indicating that the Resident had hernia repair that morning. The note further states that the Resident #2 returned to the residence at 5:00	R 483	CORRECTIVE ACTION regarding R 483 The Georgetown Assisted Living Residence will ensure that Individualized Service Plans (ISP) shall be reviewed 30 days after admission and at least every six 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. MEASURE: 1. 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. 2. The Director of Health Services will update the resident's ISP and collaborate with the resident/resident surrogate and interdisciplinary team regarding any significant change in resident condition. 3. Resident charts will be annotated (via a mechanism to be determined in conjunction with the updating of policies and procedures cited above) to facilitate easy (visual) identification of charts to be reviewed each month. Continued on Page 7	

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R 483	Continued From page 6 p.m. following the surgery with complaint of pain, but refused pain medication. A follow up nursing note dated December 13, 2013, indicates that the Resident #2 was alert and responsive with no complaint of pain. There was no further nursing note regarding the Resident's condition until April 13, 2014.	R 483	Continued from Page 6 MONITOR: 1. A tracking system will be established to monitor ISP dates and to facilitate communication between the interdisciplinary team and resident or resident surrogate regarding schedule planning.	
	Further review of Resident #2's clinical record revealed an ISP dated March 26, 2014 that was identified as "Resident 6 month ISP". There was no documented ISP in the clinical record reflecting the resident's significant change in condition during the November 26, 2013, and December 12, 2013, surgical episodes. 2. Resident #3 was admitted to the facility on November 27, 2007, with diagnoses that include CAD, HTN and Diabetes Mellitus (DM). Resident #3's clinical record was reviewed on April 23, 2014, at approximately 3:00 p.m. and revealed a nursing note dated March 25, 2014, indicating that the Resident had a superficial injury to the leg and the physician's office was notified. The nursing note further stated that the physician requested to see the Resident on April 10, 2014 for blood work and rectal examination. Further review of Resident #3's clinical record revealed a nurse practitioner note dated April 10, 2014, with instructions to have the Resident's right foot wound evaluated at the Medstar Georgetown University wound clinic. Continued review of the clinical record revealed a nursing note dated April 18, 2014, stating that the Resident #3 left the facility for Medstar Georgetown University wound clinic. There was no documentation in the record regarding orders for wound care. Interview with the ALA on April 24, 2014, at approximately 10:30 a.m. revealed that physician's orders were done electronically and		2. Tracking system information will be reviewed monthly at the Interdisciplinary Meeting to establish planning for ISP's due during the coming month.	

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R 483	Continued From page 7 the ALA provided the surveyor with a printed physician's order that states "Bacitracin/Poly B (double strength) ointment apply to leg ulcers every day during dressing changes for anti-infective. Schedule: Daily at 10:00)". The ALA also provided the surveyor a document titled "TAR" that contained the above mentioned order for the wound care and the initials of the staff administering the wound care. At the time of the record review, there was no documentation containing a description of the wound, or its progress or deterioration. Further review of Resident #3's clinical record revealed an ISP dated March 25, 2014 that was identified as "Resident 6 month ISP". There was no documented ISP in the clinical record reflecting the resident's significant change in condition as a result of the right foot wound. During the exit interview on April 24, 2014, at 2:00 p.m. the ALA and Medical Director acknowledged that ISP's and other documentation should have been done to reflect the resident ' s conditions.	R 483		