

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 C 09/21/2012
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NAME OF PROVIDER OR SUPPLIER JOYE ASSISTED LIVING SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 5131 CALL PLACE SE WASHINGTON, DC 20019
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R 000	<p>Initial Comments</p> <p>On September 19, 2012, the Intermediate Care Facilities Division (ICFD) received notification from the Department of Health Care Finance (DHCF) alleging that Joye Assisted Living Services, located at 5131 Call Place SE, failed to maintain the environment in a safe and sanitary manner. According to the complaint, an unannounced visit was conducted by DHCF on the afternoon of September 19, 2012. DHCF observed mouse droppings in kitchen drawers and cabinets, improper storage of frozen and dried foods, and other "major issues."</p> <p>Based on the nature of the complaint, ICFD initiated an environmental investigation on September 19, 2012. During the course of the investigation, DHCF made available 58 photographs and their investigation report that identified the following allegations:</p> <p>Allegation #1: Dishwasher was broken</p> <p>Finding: Observation of the dishwasher revealed that it was filled with clean dishes, utensils and silverware.</p> <p>Interview with the staff revealed it was used to wash the dishes on the day of the inspection.</p> <p>Conclusion: The allegation could not be substantiated.</p> <p>Allegation #2: Improper storage of frozen and dry food</p>	R 000	<p><i>Received 11/9/12</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
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Health Regulation & Licensing Administration

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

TITLE
Gloria Richards Admin

(X6) DATE

11/02/2012

Health Regulation & Licensing Administration

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R 000 Continued From page 1

R 000

Finding: Observation revealed that prepared foods stored in the refrigerator was not identified or dated. At the time of the investigation, the date the cooked foods were prepared could not be verified.

Conclusion: The allegation was substantiated.

Allegation #3: Mice droppings in the utensil drawer.

Conclusion: A mouse dropping was observed in the utensil drawer in the kitchen.

Finding: The allegation was substantiated.

Allegation #4: Smell of urine in bedrooms

Finding: An odor of urine was detected in one resident's bedroom.

Conclusion: The allegation was substantiated.

Allegation #5: Urinal containing urine in one bedroom

Finding: Pictures submitted by HCFA on 9/20/2012, identified a urinal located in what appeared to be a bedroom. No urinals were observed in any of the residents' bedrooms during the surveyors' inspections.

Conclusion: Based on the pictures submitted by HCFA, the allegation was substantiated.

Allegation #6: Mattress smelled of urine

Finding: During the inspection, one of eight mattresses was noted to have an odor of urine.

Health Regulation & Licensing Administration

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R 000	<p>Continued From page 2</p> <p>Conclusion: The allegation was substantiated.</p> <p>Allegation #7: Broken bedroom furniture (bed frame)</p> <p>Finding: The metal slats, designed to support the mattress on Resident #5's metal bed, were slightly bent in the center. Mobility was observed in the frame when the bed was pushed.</p> <p>Conclusion: The allegation was substantiated.</p> <p>Allegation #8: Expired fire extinguishers</p> <p>Finding: Observation of the inspection tags on the fire extinguishers in the facility revealed they expired In June 2012.</p> <p>Conclusion: The allegation was substantiated.</p> <p>Allegation #9: Improper storage of flammable material</p> <p>Finding: Photographic evidence provided by DHCF revealed that gas cans and the lawn mower were stored in the garage, and that there was evidence of smoking (cigarette butts in dirt in a container) in the garage. The surveyors' inspection revealed that the gas cans had been moved to the exterior of the facility. The lawn mower was relocated to the exterior of the facility during the inspection. Further observation revealed a cigarette butt in the garage. Interview with staff and the administrator confirmed the presence of the cigarette butt in the garage.</p> <p>Conclusion: The allegation was substantiated.</p> <p>Allegation #10: Closet housing water heater was</p>	R 000		

Health Regulation & Licensing Administration

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R 000	Continued From page 3 not ventilated Finding: The surveyors observed that the water heater installed in the closet of the basement level was surrounded by large bags of clothing and other household items. The door was partially obstructed by a walker. Conclusion: The allegation was substantiated. Allegation #11: Stairway was partially impeded by an inoperable chair lift Finding: Observation of the stairway leading to the upper level of the facility revealed a chair lift was installed on the left side. Conclusion: The allegation was substantiated. Allegation #12: Possible citing of "mold". Finding: A large black irregularly shaped area was observed on the ceiling, directly above the window in the garage. Observation of the exterior of the window frame revealed caulking in poor repair. The black substance was possibly mold. Conclusion: The allegation was substantiated. The aforementioned deficient practices are cited throughout this report.	R 000		
R 915	Sec. 907e Medication Control. (e) Medications shall be refrigerated separately from lab specimens and food. Based on observation and interview, the facility failed to ensure that medication was refrigerated separately from food.	R 915		

Health Regulation & Licensing Administration

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R 915	Continued From page 4 The finding includes: On September 21, 2012, at 1:53 p.m., two boxes containing insulin were observed stored on the door of the refrigerator located in the kitchen. Further observation of the refrigerator revealed that it also contained cooked and raw foods. Interview with the administrator at 1:55 p.m., who accompanied the surveyors during the observations revealed that the insulin should be stored in the medication refrigerator located in the dining room, and not in the kitchen refrigerator.	R 915	STAFFS HAVE RECEIVED IN-SERVICE ON STORAGE OF INSULIN AND OTHER REFRIGERATED MEDICATIONS	09/21/12 AND ONGOING
R 971	Sec. 1003a General Building Exterior (a) An ALR shall ensure that the exterior of its facility, including walkways, yards, porches, chimney, gutters, downspouts, paintable surfaces, and accessory buildings are maintained structurally sound, sanitary, and in good repair. Based on observation and interview, the facility failed to ensure the exterior of the facility was maintained in good repair. The findings Include: 1. On September 21, 2012, at 3:46 p.m., inspection of the exterior walls of the building revealed a small round hole hole in the ground, which was approximately one inch in diameter. Closer observation of the hole revealed it was located in the general proximity of Resident #1's and #3's bedrooms, where small holes were observed at the floor to wall junction of the closet walls. 2. At 3:58 p.m., observation of the basement exit	R 971 R971 #1	ALL HOLES IN EXTERIOR AND INTERIOR OF THE FACILITY HAVE BEEN Filled AND REPAIRED. MAINTENANCE/ ENVIRONMENTAL PERSON SHALL INSPECT BOTH INTERIOR AND EXTERIOR OF FACILITY AND SHALL NOTIFY ALR ADMINISTRATOR FOR ANY REPAIRS	09/23/12 AND ONGOING

Health Regulation & Licensing Administration

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R 971	<p>Continued From page 5</p> <p>door revealed heavily scaling and chipped on the frame of the door.</p> <p>3. At 4:00 p.m., observation of the front entrance door revealed heavily scaling and chipped paint on the frame of the door.</p> <p>4. At 2:58 p.m., observation of the front steps revealed the steps had settled greater than one inch, causing an increase in the distance between several steps. This created a potential hazard when descending the steps. Several of the residents commented, "You have to watch that step"</p> <p>5. At 3:05 p.m., observation of the driveway at the front of the facility revealed numerous cracks in the pavement, creating a trip hazard.</p> <p>6. The facility failed to ensure adequate trash collection and storage facilities.</p> <p>On September 21, 2012, at 3:32 p.m., observation of the trash collection area revealed two bags of trash on the seat of the chairs, placed against the exterior wall of the facility. One of the bags was torn. Additionally, one can was overflowing with uncovered garbage. The lid was observed on the ground.</p> <p>The administrator accompanied the surveyors during the observations and acknowledged that more trash cans were needed. According to the administrator, staff did not return the trash cans to the storage area promptly after the trash was collected, and the other trash cans were stolen.</p> <p>The aforementioned findings were acknowledged by the administrator on September 21, 2012, at approximately 3:30 p.m.</p>	<p>R 971 #2 #3 #4 #5 #6</p>	<p>BASEMENT EXIT DOOR HAS BEEN REPAINTED. SEE R971 #1</p> <p>FRONT ENTRANCE DOOR HAS BEEN REPAINTED. SEE R971 #1</p> <p>STEPS HAVE BEEN RECEMENTED TO PREVENT FALLS SEE R971#1 QA</p> <p>ALL CRACKS HAVE BEEN CEMENTED TO PREVENT FALL SEE R971 #1 QA</p> <p>THREE LARGE TRASH CANS HAS BEEN PURCHASED AND BROUGHT TO THE FACILITY STAFFS HAVE BEEN RE-INSTRUCTED TO BRING IN TRASH CANS AFTER TRASH COLLECTION</p>	<p>9/27/12 AND ONGOING</p> <p>9/21/12 AND ONGOING</p>

Health Regulation & Licensing Administration

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R 981	<p>Sec. 1004a General Building Interior</p> <p>(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 observations and interview, the assisted living residence failed to ensure that the interior of the facility was maintained sanitary, and in good repair.</p> <p>The findings:</p> <p>During the inspection on September 19, 2012, beginning at 3:00 p.m., and on September 21, 2012, the following concerns were identified.</p> <ol style="list-style-type: none"> 1. A broken face plate was observed on the light switch in Resident #2's bedroom. 2. Carpeting in various areas of the facility was observed to be soiled and to have light colored stains. Interview with the administrator revealed that many of the stains were the result of staff using bleach to clean the carpet. 3. The service tags on the fire extinguishers were noted to have expired in June 2012. 4. Mouse droppings were observed in the silverware drawer, the canned food storage cabinet, beside the trash can in the kitchen, in the bedrooms of Residents #3, #6, #7, the live-in staff, the linen closet, and the living room. Interview with the administrator on September 21, 2012, at 1:05 p.m., revealed that a pest control inspection was conducted on September 20, 2012, and that the invoice would be provided to the Health Regulation and Licensing Administration (HRLA). 	R 981	<p>ALL FACE PLATES IN THE FACILITY HAVE BEEN REPLACED WITH METAL FACE PLATES. MAINTENANCE PERSON SHALL INSPECT ALL INTERIOR AND EXTERIOR OF FACILITY WEEKLY AND NOTIFY ALR ADMINISTRATOR OF FINDINGS FOR REPAIRS</p> <p>ALL CARPETS IN FACILITY HAS BEEN CHANGED. STAFFS AND HAVE BEEN IN SERVICE ON CLEANING OF FACILITY AND RECEIVED NEW CLEANING FORM AND SCHEDULE TO BE FILLED OUT DAILY AND SIGNED MAINTENANCE AND ENVIRONMENTAL PERSON SHALL INSPECT FACILITY WEEKLY AND NOTIFY ADMINISTRATOR OF ANY ABNORMALITIES. SEE ATTACHMENT #1</p> <p>NEW FIRE EXTINGUISHERS HAVE BEEN INSPECTED BY GUARDIAN FIRE AND SAFETY. ALL STAFFS HAVE BEEN INSTRUCTED ON FIRE AND SAFETY, TO NOTIFY GUARDIAN FIRE</p>	<p>9/23/12 AND ONGOING</p> <p>9/25/12 AND ONGOING</p>

Health Regulation & Licensing Administration

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R 981	<p>Continued From page 7</p> <p>Interview with the administrator on September 19, 2012 at 3:00 p.m., revealed that the last pest control inspection was conducted on May 22, 2012. Further discussion with the administrator indicated that the pest control contract was not scheduled to expire until November 20, 2013.</p> <p>5. The closets in the bedrooms of Residents #3 and Resident #1 were observed to have holes in the wall, at the floor to wall junction, creating the potential for rodent entry (2:46 p.m. and 3:00 p.m. respectively).</p> <p>6. A black substance was observed above the window in the garage. Observation of the outside of the window revealed there was space above the window that lacked adequate caulking to prevent water from entering above the window (3:19 p.m.).</p> <p>7. There was approximately 1/3 inch space observed around all the edge of the Resident #2's bedroom walls. Further observation revealed there was no baseboard molding was in place to cover the space. Interview with the administrator revealed the space was present because the carpeting was removed (2:28 p.m.).</p> <p>8. Open space was observed where the plumbing pipes exited the wall underneath the bathroom sinks, which created a potential entrance for pests.</p> <p>9. The window screen in the kitchen window was noted to be bent upward in the middle, at the bottom. This created a potential entrance for pests.</p> <p>10. One of two doors on the storage units came off when it was opened during the inspection</p>	<p>R 981</p> <p># 4</p> <p># 5</p> <p># 6</p> <p># 7</p> <p># 8</p> <p># 9</p>	<p>AND SAFETY FOR REINSPECTION ONE MONTH PRIOR TO EXPIRATION OF TAGS. ENVIRONMENTAL PERSON SHALL INSPECT TAGS MONTHLY AND SHALL FOLLOW UP WITH NOTIFYING GUARDIAN 9/26/12</p> <p>ALL AREAS HAVE BEEN CLEANED AND VACUUMED OF ALL MOUSE DROPPINGS. JOYE ASSISTED LIVING HAS SIGNED A NEW CONTRACT WITH ORKIN FOR MONTHLY EXTERMINATION OF FACILITY. STAFFS HAVE RECEIVED IN SERVICE ON CHECKING FOR MOUSE DROPPINGS AND TO NOTIFY ORKIN AND ADMINISTRATOR OF ANY FINDINGS AND PESTS INFESTATION SHALL BE REPORTED TO HRLA. 9/22/12</p> <p>HOLES IN THE WALL AT THE FLOOR JUNCTIONS IN ALL THE ROOMS HAVE BEEN SEALED. MAINTENANCE AND ENVIRONMENTAL PERSON SHALL INSPECT ALL AREAS OF THE FACILITY WEEKLY AND SHALL NOTIFY ADMINISTRATOR OF ANY ABNORMAL FINDINGS FOR REPAIRS. 9/23/12</p> <p>ALL WINDOWS HAVE BEEN SEALED WITH CAULKING AND PAINTED. SEE #5.</p> <p>BASEBOARD MOLDING HAS BEEN REPLACED. SEE #5</p> <p>OPEN SPACE IN BATHROOM HAS BEEN CLOSED SEE #5</p> <p>WINDOW SCREEN HAS BEEN REPLACED. SEE #5</p>

Health Regulation & Licensing Administration

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R 981	<p>Continued From page 8 (2:15 p.m.).</p> <p>11. A large amount of trash bags, clothing, shoes and other items were observed stored directly on the floor of the closets in the bedrooms of Residents #6, #7, the linen closet, the live-in staff's bedroom, and the water heater closet.</p> <p>13. The mattresses of Resident #3, #6, and #7 were observed to be stained. Resident #4's bed mattress was observed to be heavily stained with an unknown substance.</p> <p>14. The bed pillows of Residents #4, #5, #6, and #7 were observed to be heavily stained with an unknown substance. The vinyl covering on Resident #4's bed pillow was noted to be heavily cracked.</p> <p>15. Resident #4's chest of drawers was observed to be broken at the bottom. Further observation revealed that the bottom drawer was also broken. Books were observed stacked on the floor in Resident #3's and #6's bedrooms.</p> <p>16. A knob was missing from one of the drawers in Resident #7's storage chest (11:42 a.m.).</p> <p>17. The knob was missing from one of Resident #3's bedroom closet door (2:41 p.m.).</p> <p>18. The bottom of the cabinet under the sink in the bathroom of Residents #6 and #7 was completely filled with various types of cleaning agents. Interview with the administrator revealed that the facility purchased the cleaning agents for the home, however they were stored in the bathroom of Residents #6 and #7 (11:38 a.m.).</p> <p>19. The chair in Resident #4's bedroom was</p>	<p>R 981 # 10</p> <p># 11</p> <p># 13</p> <p># 14</p> <p># 15</p> <p># 16</p> <p># 17</p>	<p>NEW SCREWS HAVE BEEN PLACED 9/23/12 ON THE STORAGE UNIT. SEE # 5</p> <p>SHelves HAVE BEEN BUILT 9/28/12 IN ALL THE CLOSETS STAFFS AND CLIENTS HAVE BEEN INSTRUCTED NOT TO PLACE ANY ITEMS ON THE FLOOR. STAFFS WILL CHECK ALL CLOSETS DAILY TO ENSURE NO ITEMS ARE PLACED ON THE FLOOR. ENVIRONMENTAL PERSON SHALL CHECK ALL CLOSETS AND ENTIRE FACILITY WEEKLY.</p> <p>RESIDENT # 3, 6, 7 AND 4 MATTRESSES HAVE BEEN REPLACED. STAFFS/ENVIRONMENTAL PERSON SHALL INSPECT ALL BEDS/ BEDDING WEEKLY FOR ANY STAINS. ALL BEDS NOW HAVE CERTIFIED BED BUG PLASTIC COVERING WHICH IS LAUNDERED WEEKLY BY STAFFS.</p> <p>NEW PLASTIC COVERED PILLOWS HAVE REPLACED OLD PILLOWS 9/22/12 STAFFS AND ENVIRONMENTAL PERSON SHALL INSPECT PILLOWS WEEKLY. PILLOWS WITH STAINS SHALL BE LAUNDERED.</p> <p>RESIDENT # 4 DRESSER HAS BEEN REPLACED. SEE # 5 and # 11</p> <p>KNOB IN # 7 STORAGE CHEST HAS BEEN REPLACE. SEE ANSWER # 5</p> <p>KNOB HAS BEEN REPLACED IN RESIDENT # 3 BEDROOM CLOSET.</p>

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R 981	Continued From page 9 noted to be heavily stained (12:58 p.m.). There were two chairs at the dining room table that had stained seats (2:15 p.m.). 20. There was no thermometer in the kitchen refrigerator to monitor food temperatures (2:12 p.m.). 21. Area rugs used on the floor in various locations of the facility lacked appropriate non-skid backing, which allowed them to move on the floor when pressure was applied, creating potential trip hazards.	R 981 # 18 # 19 # 20	ALL CLEANING SUPPLIES HAVE BEEN PLACED IN THE APPROPRIATE/DESIGNATED AREAS CHAIRS IN RESIDENT # 4 AND DINING ROOM HAS BEEN CLEANED. STAFFS HAVE BEEN INSTRUCTED ON CLEANING SCHEDULE THERMOMETER HAS BEEN PLACED IN KITCHEN, MEDICATION AND DEEP FREEZER. STAFFS HAVE BEEN INSTRUCTED ON OBTAINING AND RECORDING TEMPERATURES WEEKLY ON THE NEW FORM. SEE ATTACHMENT # ALL AREA BATHROOM RUGS HAVE BEEN REPLACED. STAFFS HAVE RECEIVED INSTRUCTION ON APPROPRIATE CLEANING OF RUGS TO PREVENT WEAR AND TEAR. STAFF SHALL REPORT ALL WEAR AND TEAR TO ALR ADMINISTRATOR FOR REPLACEMENT 9/23/12 9/22/12
R 983	Sec. 1004c General Building Interior (c) An ALR shall install and maintain assist handrails or grab bars, whenever practicable, on each side of interior stairways and on one side of corridors and in bathrooms. Based on observation and interview, the facility failed to ensure that handrails and grabs were installed in the facility to meet the needs of the residents. The findings include: 1. The facility failed to ensure a handrail was installed on the stairway leading from the first to the second level of the building. Observation during the inspection on September 21, 2012, at 3:59 p.m., revealed no hand railing was installed on the steps. A chair lift was noted to be installed on one side of the stairs. The seat of the chair lift was observed tied in an upward position at the top of the stairs. The administrator, who accompanied the surveyors during the observations on September	R 983 R 983 # 1	CHAIRLIFT HAS BEEN TAKEN DOWN AND SHALL BE REINSTALLED IN THE EVENT THAT A CLIENT BECOME UNABLE TO AMBULATE DUE TO HIGH RISK OF FALL HANDRAILS HAVE BEEN PLACE BOTH OUTSIDE AND ON THE STAIRWAY LEADING FROM THE FIRST TO THE SECOND FLOOR. MAINTENANCE PERSON SHALL INSPECT ALL HANDRAILS WEEKLY 9/21/12

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER JOYE ASSISTED LIVING SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 5131 CALL PLACE SE WASHINGTON, DC 20019		
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R 983	Continued From page 10 21, 2012, stated that the chair lift was not needed by any of the residents, and was scheduled to be removed. She stated that installation of a hand railing on the stairs would be considered. 2. On September 21, 2012, at 12:35 p.m., the grab bar installed in the bathroom of Residents #6 and #7 was observed to have rust on it and was not tightly secured to the bathtub. The administrator, who accompanied the surveyors during the observations on September 21, 2012, acknowledged the finding.	R 983 R283 #2.	GRAB BARS IN RESIDENT #6 AND SEVEN BATHROOMS HAS BEEN REPLACED AND PAINTED WITH RUST PROOF PAINT. MAINTENANCE PERSON SHALL INSPECT INTERIOR AND EXTERIOR OF FACILITY FOR ANY REPAIRS.	