

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  ALR-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 12/27/2013
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NAME OF PROVIDER OR SUPPLIER  WILLIAMS ASSISTED LIVING RESIDENTIAL F/	STREET ADDRESS, CITY, STATE, ZIP CODE 1437 POTOMAC AVENUE SE WASHINGTON, DC 20003
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{R 000} Initial Comments

A subsequent monitoring visit was conducted on December 27, 2013, to determine the facility's compliance with local licensure requirements for Assistance Living Residences, "DC Code 44-101.01". The findings reflect that the facility was not in compliance; posing an immediate and serious threat to the health and safety of residents living at facility. At this time, the Department of Health, Health Regulation and Licensing Administration, restricts the facility license to no new admissions until and unless outstanding deficiencies have been corrected.

{R 000}

*Received 1/24/14*

R 258 Sec. 502b2 A resident of an ALR shall have the right to

(2) Is creatively designed to counter loneliness, depression, dependence, boredom, and designed to manage difficult behavior; Based on interview and record review, the facility failed to ensure that the facility was designed to manage difficult behavior and social needs.

The findings include:

1. Interview with the assisted living administrator (ALA) on December 27, 2013, revealed that Resident # 4 travels independently and can utilize public transportation. The ALA indicated that the ALR has a house rule that all residents must sign in and out; however, Resident #4 seldom complies. The resident will often leave from the ALR and would be missing for weeks. According to the ALA, the resident recently returned to the home on December 26, 2013, after missing for a week. The ALA also indicated on August 14, 2013, the resident was missing for over 1 month. The ALA further indicated that the resident was missing for 4 months in early 2013.

R 258  
(2)

In accordance with DC Code 12-127, Official Code 44-105.02(b)(2).

All residents living in the ALR will have the right to live in an environment that is designed to counter loneliness, depression, dependence, boredom and also designed to manage difficult behaviors and social needs. Will be included in each resident agreement and policy and on ongoing.

Resident #4 attended a scheduled day program every day. Returned home about 4pm, After arriving at ALR resident #4 watched TV, read books, did art work and painting, also to have dinner and evening medications and a good night's sleep. His going missing from the ALR was his own choice, not loneliness, boredom or any of the above listed reasons

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

TITLE

(X6) DATE

*Vera F Williams*

*Director*

*1/15/14*

6589

USWQ13

If continuation sheet 1 of 15

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R 258	<p>Continued From page 1</p> <p>Interviews and record review revealed that Resident #4 has an Axis 1 diagnosis and had been receiving counseling and case management through Green Door. The case manager revealed that the resident informed Green Door that he/she leaves the home for long periods of time because he/she could not "relate" to his/her housemates, and his/her housemates could not relate to him/her. It should be noted at the time of the survey the ALA indicated the other three residents in the home were diagnosed with dementia.</p> <p>It should also be noted that there was no documented evidence that 1) the ALA had been trained to address Resident #4 ' s non-compliance with house rules, or, 2) that the ALR provided social programs designed to actively engage Resident #4 ' s social needs.</p> <p>2. Interview with ALA on December 27, 2013, revealed that Resident#5 travels independently and can utilize public transportation. The ALA indicated that the ALR has a house rule that all residents must sign in and out; however, Resident #5 seldom complies. On December 27, 2013, the ALA informed the surveyor that Resident #5 would regularly leave the residence for destinations unknown. The resident would not sign out, and would become verbally abusive to the ALA and housemates upon return. During periods of aggression, the resident would yell and stand over the ALA pointing his fingers in the ALA ' s face. The ALA stated that if attempts were made to redirect, or if the ALA questioned the behavior, the behavior would escalate. The ALA indicated fear of the resident ' s escalating behavior; therefore, the resident was allowed to " do whatever. " The</p>	R 258	<p>All the residents #1, #2, #3 and #5 communicated with resident #4, Clinton Thompson, whenever he communicated with them. They are all peaceful and friendly residents that will speak when they are spoken to for conversation and communication in their right minds, not as one having dementia or otherwise.</p> <hr/> <p>Resident #4 Clinton Thompson is scheduled for discharge 3/27/2014. His none compliance with house rules was not because of a lack of social programs. He has a mental disorder which the staff at Green Door are aware.</p> <hr/> <p>In accordance with DC Code 12-127, Official Code 44-107.02(a)(4)(e).</p> <p>All ALR staff will be properly trained to be able to demonstrate proficiency in the skills required to effectively meet the requirements necessary to cover and manage difficult and aggressive behavior by the residents living in the ALR at all times. Ongoing</p>	
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R 282	Continued From page 3  face while talking loudly on several occasions. Attempts to redirect the aggressive behavior were unsuccessful. The ALA also expressed "fear" of Resident #5 and concern for the other residents' safety. The ALA stated the family, case manager, and facilities nurse were notified.	R 282		
{R 423}	<p>Sec. 602a2 Resident Agreements</p> <p>(2) The specific nature of any special care that it holds itself out to provide, such as specialty in Alzheimer's disease or Parkinson's disease; [D.C. Official Code ~ 44-602(a) (2)]</p> <p>Based on record review and interview, it was determined that the assisted living residence (ALR) failed to include any special care it provides in the resident agreements for four (4) of 4 residents in the sample. (Resident #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected.</p> <p>On September 16, 2013, starting at approximately 9:00 a.m., a review of Residents' #1, #2, #3, #4 and #5, records revealed all residents had resident agreements however the agreements failed to include special care</p>	{R 423}	<p>Q) What corrective action will be accomplished to address the identified deficiencies practices?</p> <p>A) All resident agreements have been up dated to include any special service being provided by ALR. (See attachments 3, 4, 5&amp;6)</p> <p>Q) What measures will be put into place or what system changes you will make to ensure that the deficient practice does not reoccur?</p> <p>A) The Resident Agreement form has been updated to include all special services provided by ALR. Newly admitted residents will be given these updated forms.</p> <p>Q) How will the corrective actions be monitored to ensure the deficient practice will not reoccur?</p> <p>A) The Administrator will monitor on a quarterly basis all resident agreements to ensure all special services being provided by the ALR has been included.</p>	<p>12/30/13</p> <p>ongoing</p>

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{R 423}	<p>Continued From page 4 provided.</p> <p>During an interview with the assisted living administrator (ALA) on September 16, 2013, starting at approximately 11:00 a.m., it was revealed that the facility provides special care services for the visually impaired, dementia and mental health residents.</p> <p>On April 12, 2013, starting at approximately 9:00 a.m., a record review of the aforementioned resident agreements failed to evidence any special care the ALR provides.</p> <p>During a meeting with the general manager (GM) on April 12, 2013, at approximately 9:30 a.m., it was revealed that the ALR staff provides care to residents who have the been diagnosis with blindness, dementia and mental health disabilities. Additionally, the GM stated, "Just put whatever's missing in the agreements in your report and we will fix it."</p>	{R 423}		
{R 424}	<p>Sec. 602a3 Resident Agreements</p> <p>(3) An identification of services to be included and excluded, part of which is the ISP; [D.C. Official Code ~ 44-602(a )(3)]</p> <p>Another re-visit survey was conducted on December 27, 2013, to verify if the facility had come into compliance with deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected, as evidenced in the report that follows.</p>	{R 424}	<p>Q) What corrective actions will be accomplished to address the identified deficient practice?</p> <p>A) Residents # 1,2,3,and 5, resident agreement form have been updated to include all medication delivered by pharmacy is paid for by the ALR.</p>	12/30/13

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{R 424}	Continued From page 5  On September 16, 2013, starting at approximately 9:00 a.m., a review of the records for Residents' #1, #2, #3, #4 and #5, revealed all residents had resident agreements; however, the resident agreements failed to include the parties responsible for purchasing medications.  During an interview with the assisted living administrator (ALA) on September 16, 2013, starting at approximately 11:00 a.m., it was revealed that medications are purchased by the residents' and are not purchased by the ALR.	{R 424}	Q) What measures will be put into place or what system change will you make to ensure that the deficient practice does not reoccur?  A) Resident #4 resident agreement form has been updated to include that Green Door purchases all his medications. (see attachments 3,4, 5 and 6) All newly admitted residents Resident Agreement forms will include who is responsible for purchasing medication  Q) How will the corrective action be monitored to ensure the deficient practice will not reoccur?  A) The administrator will monitor on a quarterly basis all Resident Agreements to ensure who responsible for purchasing medications has been included.	12/30/13  Ongoing
{R 426}	Sec. 602a5 Resident Agreements  (5) Unit assignment and procedures if changes occur; [ D.C. Official Code ~ 44-602(a) (5) ]  Based on record review and interview, it was determined that the assisted living residence (ALR) failed to include the residents' room assignment and the procedure if the resident 's room assignment should change for four (4) of four 4 residents in the sample. (Residents #2 , #3, #4 and #5)  The findings include:  On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained	{R 426}	Q) What corrective actions will be accomplished to address the identified deficient practice?  A) All Resident Agreements have been updated to include the resident room assignments and the procedure if the resident's room assignment should change. (see attachment 3,4,5,6,)  Q) What measure will be put into place or what system changes will make to ensure that the deficient practices does not reoccur?	12/30/13  Ongoing

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{R 426}	<p>Continued From page 6</p> <p>uncorrected.</p> <p>On September 16, 2013, starting at approximately 9:00 a.m., a review of residents' #1, #2, #3, #4 and #5 records revealed a one page document with all the residents names and assigned rooms list. The residents individual agreements failed to include the room assignments and the procedures if room assignments should change.</p> <p>During an interview with the assisted living administrator (ALA) on September 16, 2013, starting at approximately 11:00 a.m., the ALA stated, she would include the room assignments and the procedures if room assignments should change in the residents' individual agreements.</p> <p>On April 12, 2013, starting at approximately 9:00 a.m., a record review of the aforementioned resident agreements failed to evidence the resident's room assignment and the procedure if the resident's room assignment should changes.</p> <p>During a meeting with the general manager (GM) on April 12, 2013, at approximately 9:30 a.m., the GM stated, "just put whatever's missing in the agreements in your report and we will fix it."</p>	{R 426}	<p>A) All newly admitted residents Resident Agreement forms will include resident room assignment and the procedure if the resident room assignment should change.</p> <p>Q) How will the corrective actions be monitored to ensure the deficient practice will not reoccur?</p> <p>A) The administrator will monitor on a quarterly basis all Resident Agreements to ensure that room assignments and changes of room assignment should occur has been included.</p> <p>If resident request a room change and space is available, room will be changed within 24 hrs.</p> <p>If space is not available administrator will notify family or responsible party that no space is available, but ALR will assist with transfer to another facility.</p>	Ongoing
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{R 427}	<p>Sec. 602a6 Resident Agreements</p> <p>(6) Admission and discharge policies which include clear and specific criteria for admission, transfer, and discharge; [D.C. Official Code ~ 44-602(a) (6) ]</p> <p>Based on record review and interview, it was determined that the assisted living residence</p>	{R 427}	<p>Q) What corrective actions will be accomplished to address the identified deficient practice?</p> <p>A) All Resident Agreements have been updated to include the Admission, Discharge and Transfer Policies.</p>	12/30/13  Ongoing
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{R 427}	<p>Continued From page 7</p> <p>(ALR) failed to include its admission and discharge policies and transfer procedures in the resident agreements for four (4) of 4 residents in the sample. (Resident #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected.</p> <p>On September 16, 2013, starting at approximately 9:00 a.m., a review of residents' #1, #2, #3, #4 and #5 resident agreements failed to include the transfer policy.</p> <p>During an interview with the assistant living administrator on September 16, 2013, starting at approximately 11:00 a.m., it was revealed the facility did not have a transfer policy but would develop one and include it in the resident agreements.</p> <p>On April 12, 2013, starting at approximately 9:00 a.m., a record review of the aforementioned resident ' s agreements failed to evidence admission and discharge policies and transfer procedures.</p> <p>During a meeting with the general manager (GM) on April 12, 2013, at approximately 9:30 a.m., the GM stated, "Just put whatever's missing in the agreements in your report and we will fix it."</p>	{R 427}	<p>Q) What measure will be put into place or what system changes will you make to ensure that the deficiency does not reoccur?</p> <p>A) All newly admitted residents Resident Agreements will include the Admission, Discharge and Transfer Policy.</p> <p>Q) How will the corrective actions be monitored to ensure that the deficient practices will not reoccur?</p> <p>A) The administrator will monitor on a quarterly basis all Resident Agreements to ensure that Admission, Discharge and Transfer Policies.</p>	Ongoing
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{R 428}	Continued From page 8	{R 428}		
{R 428}	Sec. 602a7 Resident Agreements	{R 428}		
	<p>(7) A description of responsibility for provision or coordination of healthcare, if any; [D.C. Official Code ~ 44-602(a) (7) ]</p> <p>Based on record review and interview, it was determined that the assisted living residence (ALR) failed to include a description of the responsibility for provision or coordination of healthcare services for four (4) of (4) residents in the sample. (Residents #2, #3, #4 and #5).</p> <p>The findings include:</p> <p>On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected.</p> <p>On September 16, 2013, starting at approximately 9:00 a.m., a record review of residents' #1, #2, #3, #4 and #5 resident agreements failed to provide who would be responsible for coordinating home health aide services for Residents' #1, #2, and #3 and mental health services for Residents' #4 and #5.</p> <p>During an interview with the assisted living administrator (ALA) on September 16, 2013, starting at approximately 11:00 a.m., it was revealed that Residents' #1, #2, and #3, receive home health aide services from a licensed home care agency and Residents' #4 and #5 receive</p>		<p>Q) What corrective actions will be accomplished to address the identified deficient practice?</p> <p>A) Residents #2 and #3 Residents Agreements have been updated to include the Health Aide service. The administrator will coordinate with a certified home care agency for the health aide services ordered by the resident's primary care physician.</p> <p>Q) What measure will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?</p> <p>A) Resident's #4 and #5 Resident Agreements have been updated to include Green Door coordinates all mental health services. (see attachments 3,4,5,6)</p> <p>All newly admitted residents Resident Agreements will include who will be responsible for coordinating any specialty services needed by the resident.</p>	<p>12/30/13</p> <p>12/30/13</p> <p>Ongoing</p>



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{R 430}	<p>Continued From page 10 (Residents #1, #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected.</p> <p>On September 16, 2013, starting at approximately 9:00 a.m., a record review of Residents' #1, #2, #3, #4 and #5, records revealed that all residents had resident agreements however the agreements failed to include the disposition of the residents property upon discharge, transfer, or death.</p> <p>During an interview with the assistant living administrator on September 16, 2013, starting at approximately 11:00 a.m., the ALA stated, I didn't know I had to include that in the agreements.</p> <p>On April 12, 2013, starting at approximately 9:00 a.m., a record review of the Residents #1, #2, #3, #4 and #5 agreements failed to evidence the disposition of the residents property upon discharge, transfer, or death of the resident.</p> <p>On April 20, 2013, at approximately 11:30 a.m., the ALA was interviewed to ascertain the whereabouts of Resident #6 and #7, who were previously living at the residence during the 2010 survey. The ALA revealed that Resident #6 and #7 died. There was no evidence that the ALA submitted proper notification or had a death</p>	{R 430}	<p>Q) What measures will be put into place or what systematic changes will you make to ensure that the deficient practices does not reoccur?</p> <p>A) All newly admitted residents Resident's Agreements will include the disposition of resident's property upon discharge transfer of death.</p> <p>Q) How will the corrective actions be monitored to ensure the deficient practice will not reoccur?</p> <p>A) The administrator will monitor on a quarterly basis all Resident's Agreements will include the disposition of resident's property upon discharge transfer of death. All resident property will be available for family or responsible party for pickup upon discharge, transfer or death.</p>	Ongoing
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{R 430}	Continued From page 11  policy. Also there was no evidence on how the ALA handled the residents ' property/belongings.	{R 430}		
{R 481}	<p>Sec. 604b Individualized Service Plans</p> <p>(b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. [D.C. Official Code § 44-604(b ) Based on record review and interviews, the assisted living residence (ALR) failed to document on the individual service plan (ISP) include all services being provided for four (4) of four 4 residents in the sample. The findings include: On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected.</p>	{R 481}	<p>Q) What corrective actions will be accomplished to address the identified deficient practice?</p> <p>A) Resident #5 ISP has been updated to include OPD services provided 3 days per week from 9:15am to 2:15pm (see attachment #7)</p> <p>Resident #2 ISP has been updated to include Day program service provided by Seabury Aging Services. Monday thru Friday from 10am to 2pm and home health aide service provided by Nursing Unlimited 7 days a week from 11pm to 7am (see attachments)</p> <p>Resident #3 ISP has been updated to include home health aide service provided by Nursing Unlimited 7 days a week from 11pm to 7am (see attachment 9)</p>	<p>10/28/13</p> <p>12/30/13</p> <p>10/28/13</p>
	<p>1. On September 16, 2013, starting at approximately 9:00 a.m., a review of Resident #5's record revealed an ISP dated April 15, 2013. The ISP failed to evidence day program services being provided on Monday, Wednesday and Friday from 9:15 a.m. until 2:15 p.m.</p> <p>2. On September 16, 2013, starting at approximately 9:00 a.m., a review of Resident #2's record revealed an ISP dated May 15, 2013. The ISP failed to evidence day program services being provided by a new day program provider Monday through Friday and home health aide (HHA) services provided seven days a week, eight hours a day.</p>		<p>Q) What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?</p> <p>A) All residents who may require additional services ISP's will be updated immediately prior to the start of the services.</p>	<p>Ongoing</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/27/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WILLIAMS ASSISTED LIVING RESIDENTIAL F/</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1437 POTOMAC AVENUE SE WASHINGTON, DC 20003</b>
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(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
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{R 481}	<p>Continued From page 12</p> <p>3. On September 16, 2013, starting at approximately 9:00 a.m., a review of Resident #3's record revealed an ISP dated May 15, 2013. The ISP failed to evidence HHA services provided seven days a week eight hours a day.</p> <p>4. On September 16, 2013, starting at approximately 9:00 a.m., a review of Resident #1's record revealed an ISP dated May 15, 2013. The ISP failed to evidence HHA services provided seven days a week eight hours a day. During an interview with the assisted living administrator (ALA) on September 16, 2013, starting at approximately 11:00 a.m., the ALA stated, "I just haven't had time to include all the services on the ISP's."</p> <p>5. On April 12, 2013, at approximately 9:04 a.m., a review of Resident #2's record revealed an ISP dated June 30, 2012. The ISP failed to evidence HHA services and day program services were being provided. During an interview with the general manager (GM) on April 12, 2013, starting at approximately 11:50 a.m., he stated Resident #2 has attended PSI day program since admission (05/24/06). He attends the program five days a week, from 10 a.m. until 2:00 p.m. The resident has also been receiving health aide services for approximately 3 years to assistance him with activities of daily living. The HHA provides services Monday through Friday from 7:00 a.m. to 10:00 a.m., and from 3:00 p.m. to 8:00 p.m. (It should be noted the home health aide is from a licensed home care agency.)</p> <p>6. On April 12, 2013, at approximately 9:39 a.m., a review of Resident #3's record revealed an ISP dated June 30, 2012, which failed to evidence HHA services and day program services being provided. During an interview with the GM on April 12, 2013, starting at approximately 11:50 a.m., he</p>	{R 481}	<p>Q) How will the corrective actions be monitored to ensure the deficient practice will not reoccur?</p> <p>A) The administrator will monitor on a monthly basis all resident ISP's to ensure how often and by whom all service to be provided has been included.</p>	Ongoing
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{R 481}	Continued From page 13  stated Resident #3 has attended Fort Lincoln day program since admission (03/14/02) five days a week from 10 a.m. until 2:00 p.m. and he/she has also been receiving home health aide services Monday through Friday from 7:00 a.m. until 10:00 a.m. and 3:00 p.m. until 8:00 p.m. to assist with activities of daily living for about three (3) years. (It should be noted the home health aide is from a licensed home care agency.) 7. On April 12, 2013, at approximately 9:59 a.m., a review of Resident #4's record revealed an ISP dated June 30, 2012, which failed to identify the day program services. During an interview with the general manager on April 12, 2013, starting at approximately 11:50 a.m., he stated Resident #4 had been attending Green Door day program since his admission on December 10, 2010.	{R 481}		
{R 601}	Sec. 701e Staffing Standards.  (e) Newly hired staff shall have 30 days to document their communicable disease status. For the purposes of this subsection, "newly hired staff" means any individual who is hired by an ALR regardless of the individual's previous work experience. An employee who is transferring from one ALR to another ALR that is under the same management or ownership, without break in service, shall not be considered newly hired staff. [D.C. Official Code § 44-107(1)(e)]  Based on record review and interview, it was determined the assisted living administrator (ALA) failed to ensure that all employees had health clearances prior to their employment for one (1) of (3) new employees in the sample. (Employee #9)	{R 601}	Q) What corrective actions will be accomplished to address the identified deficient practice?  A) Employee # 9 failed to return to work after 9/16/2013. Employee #9 is no longer employed with the ALR.	9/20/13  Ongoing

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{R 601}	Continued From page 14  The finding includes:  On December 27, 2013 a second re-visit survey was conducted to verify if the facility had abated the deficiencies identified in the previous surveys on September 16, 2013 and April 12, 2013. The facility submitted a Plan of Correction dated October 13, 2013 which was not accepted by HRLA, and the deficiencies remained uncorrected.  On September 16, 2013, a review of Employee #9's personnel record starting at 11:00 a.m., failed to evidence a health clearance.  During an interview with the ALA on September 16, 2013, starting at approximately 11:30 a.m., the ALA stated, "I don't remember the exact date Employee #9 was hired, but I think it was early August. I will make sure Employee #9 gets a health clearance."  During an interview on April 12, 2013 with the general manager (GM) it was revealed that Employee #4 had been working in the facility for a few months without a personnel folder. There was no health and criminal background clearances, and no evidence of any training. Further interview with the GM revealed that the employee was a home health aide from a licensed home care agency. Credentialing records were not received upon the conclusion of the survey/investigation.	{R 601}	Q) What measure will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?  A) All newly hired employees will have health clearances prior to starting employment with the facility.  Q) How will the corrective actions be monitored to ensure the deficient practice will not reoccur?  A) The administrator will monitor all newly employed staff files prior to start date to ensure the health clearance is included I the file.	Ongoing
R 660	Sec. 702a4e Staff Training.  (E) Managing difficult aggressive behavior;	R 660		

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R 660	<p>Continued From page 15</p> <p>Based on interview and record review, the facility failed to ensure staff were properly trained and able to demonstrate proficiency in the skills required to effectively manage Resident #5's aggressive behavior.</p> <p>The finding includes:</p> <p>On December 27, 2013, the ALA informed the surveyor that a resident (Resident #5) was verbally abusive and "intimidating" to the ALA and housemates on several occasions. Attempts to redirect the aggressive behavior were unsuccessful. The ALA also expressed "fear" of Resident #5 and concern for the other residents' safety. The ALA stated the family, case manager, and facilities nurse were notified; however, the facility was not equipped to manage difficult behaviors and that staff were not trained.</p>	R 660		