

Received 5/28/13

Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities (ICF) Division

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FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ <b>899 North Capitol St., N.E.</b> <b>Washington, D.C. 20002</b>  B. WING _____	(X3) SURVEY COMPLETED  <b>05/02/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE GEORGETOWN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2512 Q STREET NW WASHINGTON, DC 20008</b>
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R 000	<p><b>Initial Comments</b></p> <p>An annual licensure survey was conducted on May 2, 2013 to determine compliance with the Assisted Living Law " DC Code § 44-101.01 " . A random sample of five (5) resident records (census of 65) and five (5) staff records(census of 72) were reviewed.</p> <p>On May 2, 2013, the facility was notified, via telephone, of the following licensure deficiencies that posed a potential risk to residents' health, safety and rights.</p> <p>The facility failed to make certain that insulin needles were properly disposed;</p> <p>The facility failed to ensure timely response to emergency call bells (via call cord and pendants); and</p> <p>The facility failed to ensure reasonable accomodation of individual needs consistent with their physical capabilities.</p> <p>On May 2, 2013, at 5:05 p.m. the facility submitted a written response to address the aforementioned concerns that included the following:</p> <p>A sharps container was provided immediately upon notification of the deficiency. New medication carts with built-in sharps container were scheduled to be delivered by May 3, 2013;</p> <p>Emergency situations to respond to immediately are fall detection, wander detection and bath pull cord. All other calls from patient pendants are responded to within 10 minutes.</p> <p>It should be noted that the written response did</p>	R 000	<p><b>R 008 - Sec. 102b2: Philosophy of Care</b></p> <p><b>Complete Date: 6/30/13 and Ongoing</b></p> <ol style="list-style-type: none"> <li>To date, there have been no instances of residents with cognitive impairments wandering into building stairwells.</li> <li>The facility has a controlled access and wander management system to proactively protect residents with cognitive impairments. In addition, the facility has a system of interior and exterior cameras to continuously observe the activity of all residents in the perimeter of exit doors.</li> <li>A proposal to install stairwell cameras has been requested from the same company that has installed our interior and exterior cameras. The images from these newly installed cameras will appear in rotating sequence on the current desktop monitoring screens that are located at the Front Desk and the Nursing Office. An appointed staff person continuously views the camera monitors 24 hours each day. These cameras will be used to make staff aware of resident activity in the stairwells. Individual date/time stamped images will be printed of unescorted cognitively impaired residents loitering in stairwells.</li> <li>Additionally, a wandering and cognitive assessment is completed at the time of admission and on an ongoing basis for all residents to determine if they are candidates to wear a "wander-alert" bracelet/anklet. When wandering residents wear an electronic ID tag,</li> </ol>	
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*Sharon L. Sellers*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: *General Manager* (X6) DATE: *5/26/13*

STATE FORM 6899 ZIVT11 If continuation sheet 1 of 9

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R 000	Continued From page 1  not address other life threatening emergencies that could be signaled by the pendant that required immediate response, such as shortness of breath and choking. Furthermore, the facility failed to address the identified concern related to accommodating residents' individual needs.  The deficiencies cited were based on observations, record review and patient and staff interviews.	R 000	<b>R 008 - Sec. 102b2: Philosophy of Care (continued)</b> <b>Complete Date: 6/30/13 and Ongoing</b>  our resident safety wandering system electronically restricts access to all exit doors and notifies staff immediately of residents loitering at exit doors via the following methods: <ul style="list-style-type: none"> <li>▪ A wandering alert page (with the name and apartment number of the wandering resident) is immediately transmitted to the pagers worn by all nurses and certified nursing assistants. This alert will repeat continuously until the resident has moved from the perimeter of an exit door.</li> <li>▪ The resident safety software application immediately flashes an alert on the computer monitor. This alert continues to flash until the wandering residents has been removed from the perimeter of an exit door. All computers in the facility, including the Front Desk and the Nursing Office which are monitored 24 hours a day, have the capability of viewing these alerts.</li> </ul>		
R 008	<b>Sec. 102b2 Philosophy of Care</b>  (2) The design of services and environment should acknowledge that a significant number of residents may have some form of cognitive impairment. Services and environment should offer a balance between choice and safety in the least restrictive setting. Based on observation and interview, the assisted living facility failed to ensure sufficient safeguards to prevent potential harm.  The finding includes:  On May 2, 2013, at approximately 10:30 a.m., a tour of the facility revealed the stair well were unlocked and did not have an alarm system on the doors.  During an interview with the administrator on May 2, 2013, at approximately 2:45 p.m., the administrator was asked if a resident was to go in the stairwell, how would the staff be made aware? The administrator stated, we would not know but we haven't had a problem.	R 008		5. Each wandering alert is responded to immediately. Each wandering event is logged by the resident safety software and added to management reports that are printed daily, and reviewed by nursing and management staff at the daily stand-up meeting and shift change meetings.	

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R 292 R 292	Continued From page 2 Sec. 504.1 Accommodation Of Needs.  (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; [ D.C. Official Code § 44-105.04 (1) ]  I. Based on observation, interview, and record review, the Assistant Living Residence (ALR) failed to provide reasonable accommodation for an individual with a disability. (Resident #5)  The finding includes:  During an interview with Resident #5 on May 2, 2013, at approximately 12:15 p.m., the resident complained of not having a shower or a bath since her admission to the ALR, and not being able to gain access to her telephone and refrigerator. The resident stated "I haven't had a shower or bath since I came to this place. . . .I'm in a wheelchair it's not safe for them to give me a shower. . . .I can't get in the bathroom in my room because my wheelchair can't get through the door. . . . They gave me a portable toilet and I have to call them for help when I need to use the bathroom. . . .I can't even get to my refrigerator or telephone. . . . I fell once trying to get to my telephone."  Observation on May 2, 2013, at approximately 2:15 p.m., confirmed that the resident's wheelchair could not go through the bathroom door. A portable toilet was observed near the residents bed for her use. Interview with the administrator confirmed that the resident was receiving bed-baths due to lack of wheelchair	R 292 R 292	R 008 - Sec. 102b2: Philosophy of Care (continued) Complete Date: 6/30/13 and Ongoing  6. The quarterly Safety Committee meeting will monitor response times to all wandering alerts, as well as documentation of cognitively impaired residents wandering in stairwells. The safety committee will make recommendations for further action(s) needed to ensure the safety of all residents.  R 292 - Sec. 504.1 - I: Accommodation of Needs Complete Date: 6/15/13 and Ongoing  1. The facility ordered a wheeled shower/commode chair in which the resident will sit and be wheeled into the walk-in shower for bathing. This chair can also be positioned on top of the toilet as an elevated toilet seat. Resident satisfaction with the wheeled shower chair will be monitored by the Director of Nursing, and additional actions will be taken if needed.  2. The refrigerator and the telephone were moved on the date of the inspection to a location requested by the resident and deemed accessible. Resident satisfaction with the apartment layout will be monitored by the Director of Social Services, and additional actions will be taken if needed.	

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R 292	<p>Continued From page 3</p> <p>access to the bathroom.</p> <p>Further observation on May 2, 2013, confirmed that the resident had difficulty accessing her telephone, which was located on a nightstand; and she had difficulty accessing the refrigerator that was located in a small hallway beside the bathroom.</p> <p>II. Based on observations during an environmental walk through, the facility failed to ensure the security and safety of the residents of the facility.</p> <p>The finding includes:</p> <p>During the environmental walk through on May 2, 2013, beginning at approximately 10:05 a.m. at approximately 10:28 a.m., the medical alarm was pulled in a residents room. There was no staff response to the alarm. While in this same residents room at 10:32 a.m., after another emergency cord was pulled on the second floor at approximately 10:45 a.m. no response was received when surveyors left the apartment at 10:55 a.m.</p> <p>Again on the afternoon of May 2, 2013, at approximately 2:45 p.m., a resident on the third floor gave the surveyor permission in the presence of the facility's director of nursing (DON) to test her personal life alert system. At approximately 2:45 p.m. the resident's personal pendent was placed on the floor not being activated. At 2:50 p.m. the pendent was actually pushed and placed back on the floor. And there was no response at 2:55 p.m. At approximately 3:02 p.m. on the second floor, another resident was in the hallway, I introduced myself to him and</p>	R 292	<p><b>R 292 - Sec. 504.1 - I:</b> <b>Accommodation of Needs (continued)</b> <b>Complete Date: 6/15/13 and Ongoing</b></p> <p>3. All concerns regarding resident accommodation inside the community will be reviewed quarterly by a multidisciplinary team during the Safety Committee Meeting. The effectiveness of actions taken to improve accessibility will be reviewed, and recommendations will be made regarding additional steps needed to improve accommodation for all residents.</p> <p>4. The General Manager will develop new policies as required for accommodation of the toileting and bathing needs of new residents moving into the community.</p> <p><b>R 292 - Sec. 504.1 - II:</b> <b>Accommodation of Needs</b> <b>Complete Date: 6/1/13 and Ongoing</b></p> <p>Each resident that moves into The Georgetown is offered a Lifeline Emergency Pendant. Residents are instructed to press their pendant when they have an emergency, when they feel ill, or need direct assistance from a certified nursing assistant or a nurse. Each of these emergency pendants is an "auto-alert help button" that automatically detects resident falls without the resident having to press the pendant.</p> <p>The Georgetown's policy is to respond to all pendant alerts within ten (10) minutes. Emergency</p>	

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R 292	Continued From page 4  asked if he had a pendent. I asked permission to borrow it and explained to him why it was needed. I received his permission to place it on the floor without activating it, 2 minutes later I received a response from one of the facilities Health aide. She indicated she had just come from the alarm activated on the third floor. I asked why it took so long to respond to the third floor alarm, she indicated she thought there was an aide on the third floor, and when the alarm went off for the third time she responded.  Prior to leaving the facility Staff #2 provided information concerning the Auto Alert Help Button System for Senior Living. She also provided prior alerts that are received electronically through the he Georgetown Assist Living computer system.  It should be noted that interview with the assisted living administrator on May 2, 2013, revealed that the facility had a policy that addressed two types of responses for emergency. The first type requires a response within 10 minutes and the second type requires an immediate response. The immediate response was activate when the patient falls.	R 292	R 292 - Sec. 504.1 - II: Accommodation of Needs (continued) Complete Date: 6/1/13 and Ongoing  alerts that have the following system designation are to be responded to immediately: a) Fall Detection b) Wander Detection c) Bathroom Pull Cord Alerts  1. Pendant response times are monitored daily by the General Manager and Director of Health Services. All untimely responses are flagged, and the staff persons responsible for responding to the alerts are identified. Staff are counseled and disciplined for failures to respond to pendant alerts in a timely manner.  2. The shift Charge Nurse is accountable for supervising the CNAs and ensuring timely response to all alerts. In the absence of an available CNA, Charge Nurses have been instructed that they have the responsibility to respond to pendant alerts.  3. Disciplinary actions in the form of verbal and written warnings have been implemented when alert response times have not been reduced to within 10 minutes for routine alerts and "immediately" for alerts from the bathroom, resident falls and residents loitering near an exit door. (See attached discipline forms)  4. The quarterly Safety Committee meeting will monitor pendant response time trends. The	
R 481	Sec. 604b Individualized Service Plans  (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 § 44-106.04 (b) ]  Based on record review and interview, the Assistant Living Residence (ALR) failed to include on the individual service plan (ISP) when and how often services will be provided for one (1) of five (5) residents . (Residents #1).	R 481		

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R 481	Continued From page 5  The findings include:  1. On May 2, 2013, at approximately 12:00 p.m., a review of Resident #1's record revealed that the resident was receiving hospice and wound care services which was initiated on February 22, 2013. The resident's ISP, dated March 13, 2013, however, failed to reflect when and how often hospice and wound care services were to be provided.  During a interview with the director of nursing (DON) on May 2, 2013, at approximately 12:30 p.m., the DON acknowledged the failure to update the ISP and stated, that the ISP will be updated to include the needed information.  2. On May 2, 2013, at approximately 1:00 p.m., a review of Resident #2's record revealed the resident was receiving hospice services. Further review of the record revealed an ISP, dated December 2, 2013. The ISP, however, failed to include information concerning the provisions of hospice services.  During a interview with the director of nursing (DON) on May 2, 2013, at approximately 12:30 p.m., the DON stated, the resident receives hospice service twice a week.	R 481	R 292 - Sec. 504.1 - II: <b>Accommodation of Needs (continued)</b> safety committee will make recommendations for further action(s) needed to ensure the timely response to all pendant and wandering alerts.  5. An Employee Town Hall Meeting was held on May 8, 2013 to train staff in the in the procedures to ensure timely response to resident pendant alerts. Pendant Response Training will be offered quarterly to all staff.  R 481 – Sec. 604b: <b>Individualized Service Plans</b> <b>Complete Date: 5/20/13 and Ongoing</b>  1. The Individualized Service Plans (ISPs) for Resident #1 and Resident #2 was addressed and immediately revised to reflect the provision of hospice and wound care services, as well as the frequency of these services. The Hospice Nurse and the Physician reviewed and signed the revised ISPs on 5/20/13.  2. The ISP Team has been instructed on proper documentation of ISPs. The Director of Health Services will monitor all ISPs on a monthly basis for proper documentation and implementation of appropriate follow-up.  3. The Director of Health Services will ensure that the daily 24-hour Report highlights the initiation of new services and treatments to include hospice, wound care, and physical, occupational and speech therapy.	
R 575	Sec. 701c3i Staffing Standards.  (I) Infection control, including standard precautions to prevent infection; [ D.C. Official Code § 44-701 (c) (3) (i) ]  Based on an observation and interview, it was revealed the assistant living facility failed to follow standard precautions as related to the proper	R 575		

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R 575	Continued From page 6  disposal of insulin syringes and use of Iodoform gauze.  The findings include:  1. On May 2, 2013, at approximately 10:00 a.m., an observation of the activity room, revealed an uncapped insulin syringe with a bent needle in plastic drinking cup on top of a medication cart.  During a interview with a licensed practical nurse (LPN) on May 2, 2013, at approximately 10:05 a.m., the LPN stated we have new carts and they don't have a sharps container so I put the needle in the cup.  2. On May 2, 2013, at approximately 11:10 a.m., while observing wound care it was noted that Iodoform gauze was open and undated.  During an interview with the LPN on May 2, 2013, at approximately 11:15 a.m., the LPN stated, the Iodoform gauze was opened on March 14, 2013. It should be noted at the time of this survey there was no date on the bottle of Iodoform gauze being used during the observed wound care.	R 575	<b>R 481 – Sec. 604b: Individualized Service Plans (continued)</b> 4. The quarterly Safety Committee meeting will monitor a sample of resident ISPs where deficiencies have previously been identified. The safety committee will make recommendations for further action(s) needed to ensure the accuracy of all documentation.  <b>R 575 – Sec. 701c3i: Staffing Standards – Infection Control Complete Date: 5/3/13 and Ongoing</b>  1. A Sharps container was immediately supplied to the interim Medication Cart upon notification of the deficiency.  2. The Georgetown received new permanent medication carts on 5/3/13, the day after our survey. The new carts contain built in sharps containers on the side of the cart. The Charge Nurse is responsible for visually scanning the carts daily for any infection control issues. None have been observed.  3. All containers of saline, ointments, sprays, will be dated accordingly. An instruction poster has been placed in the medication room as a reminder to the staff to date supplies when first opened. The Director of Health Services will check resident's supplies weekly to determine if opened supplies used for wound care have been dated.  4. The Director of Health Services will audit the medication carts weekly.	
R 784	Sec. 901 3 Responsibilities Of The ALR Personnel  (3) Requires that medications be administered by a TME or a licensed nurse. [ D.C. Official Code § 44- 109. 01(1) ]  Based on record review and interview, it was determined the assistant living residence (ALR) failed to conduct an initial medication assessment for one (1) of (1) newly admitted resident. (Resident #3)	R 784		

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R 784	Continued From page 7 The finding includes:  During a record review of Resident #3's record at approximately 2:00 p.m., revealed the resident was admitted on April 23, 2013. Further review of the record revealed an individualized service plan (ISP), dated April 29, 2013. The ISP indicated the resident required medication administration from staff. There was no evidence of an initial medication assessment in the record at the time of this survey.  During an interview with a licensed practical nurse (LPN) on May 2, 2013, at approximately 2:50 p.m., the LPN stated, we only do assessments on the self-medicated residents.	R 784	<b>R 784 Sec. 901 3:</b> <b>Responsibilities of the ALR Personnel</b> <b>Complete Date: 5/30/13 and Ongoing</b>  1. The Initial Medication Assessment will be performed as a portion of the Resident Admission process along with the completion of the ISP. (See attached forms: "Initial Move-in Nursing Assessment" and the "Assessment for Self-administration of Medications")  2. The Director of Health Services will conduct a New Admission chart review one week after each new admission to determine the performance of the Initial Medication Assessment.  3. All resident records of newly admitted residents were audited and found to be in compliance with the initial medication assessment.  4. The quarterly Safety Committee meeting will monitor a sample of resident charts where deficiencies have previously been identified. The safety committee will make recommendations for further action(s) needed to ensure the completion of the initial medication assessment.	
R 803	Sec. 903 3 On-Site Review.  (3) Assess the resident's ability to continue to self-administer his or her medications. [ D.C. Official Code § 44- 109.03 (3) ]  Based on record review and interview, the Assisted Living Residence (ALR) failed to assess the resident's ability to self-administer every forty-five days. (Resident #4)  The finding includes:  On May 2, 2013, at approximately 1:45 p.m., a review of Resident #4's record revealed that the resident administered his own medications, and has been doing so since his admission on March 12, 2012. Further review of the record revealed an Individual Service Plan (ISP), dated December 3, 2012. Additionally, the only self-medicate assessment in the record was dated April 10, 2013.	R 803		

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R 803	Continued From page 8  During an interview with the director of nursing (DON) on May 2, 2013, at approximately 2:00 p.m., the DON stated, I know the assessments had been done but the record might have been reduced.	R 803	R 803 – Sec. 903 3: On-Site Review Complete Date: 5/28/13 and Ongoing  1. An assessment of the ability of Resident #4 to self-administer her medication was completed on May 28, 2013.  2. All resident records of residents that self-administer their medications were audited and found to be in compliance with the forty-five (45) day medication assessment. The Director of Health Services initiated corrective actions when necessary.  3. The Director of Health Services has developed a spreadsheet of the review dates for assessments of residents that self administer their medications.  4. The Director of Health Services will monitor the timely completion of all medication assessments by conducting quarterly chart audits.	