PRINTED: 03/28/2017 **FORM APPROVED** Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED ALR-0003 B. WING 03/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4901 CONNECTICUT AVENUE NW** THE METHODIST HOME OF DC-FOREST HILL WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) R 000 Initial Comments R 000 CORRECTIVE ACTION FOR IDENTIFIED PRACTICE: Lack of documented evidence An annual survey was conducted on March 21. that employees received four (4) hours 2017, to determine compliance with the Assisted annual training covering cognitive Living Law "DC Code § 44-101.01." The ALR impairment for the year 2016. provides care for twenty five (25) residents and 1. An EXCEL Spreadsheet was developed to record employee participation in thirty-five (35) employees that include professional and administrative staff. A sample training sessions on cognitive impairment. 3/30/17 size of three (3) resident records and three (3) 2. Employee sign-in sheets for training employee records were selected for review. The sessions on cognitive impairment were reviewed and compared to documentation findings of the survey were based on in employee files. observations, record reviews, and interviews. 3/30/17 3. Information from employee sign-in The following abbreviation is used throughout the sheets was entered into EXCEL Spreadsheet to document evidence of employee body of this report: participation in training sessions. 3/30/17 4. Spreadsheets were then reviewed to ALR - Assisted Living Residence identify any employee who had not received training on cognitive impairment R 682 Sec. 702c3 Staff Training. R 682 in 2016. 3/30/17 5. A training plan was developed by which (3) Four hours covering cognitive impairments in training will be scheduled for any an in-service training approved by a nationally staff who did not have four (4) hours of recognized and creditable expert such as the cognitive impairment training in 2016. 4/5/17 Alzheimer's Disease and Related Disorder SYSTEMIC CHANGES TO ENSURE Association: and DEFICIENT PRACTICE DOES NOT Based on staff interview and record review, the RECUR. ALR failed to ensure all staff had four (4) hours of 1. All required education (including annual training covering cognitive impairments cognitive impairment) will be listed on a approved by a nationally recognized and master EXCEL Spreadsheet. Each employee's name will also be included creditable expert such as the Alzheimer's Disease on the Spreadsheet (vertical axis). and Related Disorder Association for two (2) of 4/7/17

The findings include:

#1 and #2)

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On March 21, 2017, at approximately 1:31 p.m., review of Employee #1's personnel record revealed he was hired May 15, 2006. Further review of the employee's record revealed no documented evidence of 4 hours of annual

the three (3) personnel records reviewed. (LPN

2. The Master Spreadsheet will be

3. Education policy will be updated to

sessions are presented.

include 1 and 2 above.

updated by the Nurse Educator as training

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

Mary Saroy

executive Director
81PW11

(X6) DATE

If continuation sheet 1 of 2

initiate

4/7/17

4/15/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			A. BUILDING:			COMPLETED	
		ALR-0003	B. WING		03/21/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 03/21/2017		
THE ME	THODIST HOME OF	DC- FOREST HILL 4901 CON	NECTICUT	FAVENUE NW			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		TON, DC 20008			
PRÉFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
R 682	Continued From pa	age 1	R 682	QA PROGRAM TO BE IMPLEME		)	
	training covering cognitive impairment for Employee #1.			MONITOR DEFICIENT PRACTIC			
				1. Spreadsheet entries will be review	ved		
	Interview date of the	Ver .		monthly by QA Manager.  2. QA findings will be presented quality.	arterly to	initiate 4/7/17	
	Interview with the ALR's educator on March 21, 2017, at 3:43 p.m., revealed that she was responsible for conducting all of agency's training.			QA Committee for compliance with	nolicy.	4/27/17	
					1		
	The agency's education	ator proceeded to provide					
	evidence of two in-	service trainings that she					
	conducted on March 2, 2017 and March 20, 2017. The trainings were entitled Dementia and						
	Nutrition and Psych	o-Social Aspects of Aging,					
	respectively. Further interview with the educator						
	revealed each of the	e aforementioned trainings					
	were one hour long	Continued discussion with					
	#1 and #2 probably	ed that she knew Employees had more hours, but she was					
	not able to provide t	he evidence of four (4) hours					
	of annual training co	overing cognitive impairment					
	approved by a natio expert for 2016.	nally recognized and credible					
1)	On March 21, 2017,	at approximately at 1:45					
	p.m., review of Emp	loyee #2's personnel record					
	revealed she was hi	red on November 9, 2005.				)	
	nere was no docun	nented evidence of 4 hours of ring cognitive impairment for					
Ì	Employee #2. At 3:1	15 p.m., the ALR's educator					
	provided sign-in she	ets for the aforementioned					
t	training (Dementia and Nutrition)conducted on						
4	March 2, 2017 and F	Sycho-Social Aspects of 17. It should be noted that					
E	here was no docum	ented evidence that					
	mployee #2 attende	ed those trainings or any					
	vidence of four (4) h	nours of annual training					
	overing cognitive im	pairment for the year 2016.	1				
			1			1	

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FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ALR-0003 03/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4901 CONNECTICUT AVENUE NW** THE METHODIST HOME OF DC-FOREST HILL WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R 000 Initial Comments R 000 An annual survey was conducted on March 21, 2017, to determine compliance with the Assisted Living Law "DC Code § 44-101.01." The ALR provides care for twenty five (25) residents and thirty-five (35) employees that include professional and administrative staff. A sample size included three (3) resident records and three (3) employee records were selected for review. The findings of the survey were based on observations, record reviews, and interviews. The following abbreviation is used throughout the body of this report: ALR - Assisted Living Residence R 682 Sec. 702c3 Staff Training. R 682 (3) Four hours covering cognitive impairments in an in-service training approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association: and Based on staff interview and record review, the ALR failed to ensure all staff had four (4) hours of annual training covering cognitive impairments approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association for two (2) of the three (3) records reviewed. (Employees #1 and #2) The findings include: On March 21, 2017, at approximately 1:31 p.m., review of Employee #1's personnel record revealed he was hired May 15, 2006. Further

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

review of the employee's record revealed no documented evidence of 4 hours of annual

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED 03/21/2017	
		ALR-0003	B, WING		03/		
	PROVIDER OR SUPPLIER THODIST HOME OF D	C- FOREST HILL 4901 COI		STATE, ZIP CODE AVENUE NW 0008			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE		
	training covering co- Employee #1.  Interview with the AI day at 3:43 p.m., revresponsible for conducted on M 2017. The trainings Nutrition and Psychorespectively. Further revealed each of the were one hour long, the educator revealed #1 and #2 probably I not able to provide the of annual training co approved by a nation expert for 2016.  On March 21, 2017, p.m., review of Employee #2. At 3:1 provided sign-in sheet training conducted on 20, 2017. It should be documented evidence those trainings or any	gnitive impairment for _R's educator on the same	R 682				

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