Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0018	A. BUILDING: _____ B. WING _____ JAN 18 2015	C 12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005

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R 000	Initial Comments On August 15, 2014, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received information alleging fraud, dignity concerns, falsifying documents and a broken shower. Due to the nature of the information presented, on November 12, 2014, DOH/HRLA initiated an onsite investigation, to verify compliance with the Assisted Living Law " DC Code § 44-101.01. " Please Note. Listed Below are abbreviations used in this report: Activities of Daily Living (ADL) Certified Nursing Assistant (CNA) Individualized Service Plan (ISP) Instrumental Activities of Daily Living (IADL) Assisted Living Administrator (ALA) She/He (s/he) Allegation #1- Resident #1 alleged that his/her Individualized Service Plan (ISP) dated July 30, 2014, was prepared without his/her consultation and prior to the meeting. In addition, the administrator refused to change his/her Level of Care status from Level 1 (which he/she does not receive) to Basic and is being charged for services he/she is not receiving. Findings- Record review and interviews starting on November 13, 2014 at approximately 11:30 a.m. through December 9, 2014, at approximately 12:30 p.m., revealed the following: Record Reviews - Review of a " History and Physical" dated	R 000	**This Plan of Correction is submitted without denying or acknowledging that the cited deficiencies exist. This plan of correction is a requirement of the District of Columbia Department of Health.** **R 000** **What corrective action(s) will be accomplished to address the identified deficient practice;** For Allegation #4, "that there were inaccurate information in his/her medical record" the staff that documents in the resident's resident record will be In-serviced regarding accurate documentation. The documentation has already been corrected going forward. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The nursing staff will be in-serviced regarding accurate documentation.	

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R 000	Continued From page 1 December 2, 2008, documented that Resident #1 required hands on assistance with ADL's; - Review of a " Resident Agreement" signed and dated December 2, 2009 documented Resident #1 had a Level 2 care status; - Review of a "Level of Care Charge Form" dated July 30, 2014, documented Resident #1 had a Level 1 care status. - Review of the "ISP" dated July 30, 2014, documented Resident #1 needed additional assistance with bathing, hygiene, dressing and meals. - Review of the "Facility Care Information Form" for Genworth Life Company dated November 6, 2014, completed by the facilities medical director and Resident #, documented that Resident #1 required additional (hands on) assistance with bathing, dressing, and personal hygiene. - Review of multiple "Assisted Living Daily Assignment Sheets" dated from July 1, 2014 through October 31, 2014, documented that CNA's provided Resident #1 assistance with showers and/or ADL's. - Review of multiple "ADL Verification Worksheets" dated from November 2, 2014 through November 14, 2014, documented that CNA's provided supervision or limited supervision with eating, personal hygiene, locomotion and/or bathing. Interviews - Interview with the ALA on November 12, 2014, starting at approximately 1:00 p.m. revealed	R 000	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.** The resident's record will be reviewed once a month for three months and the findings will be reported to QA to ensure accurate documentation. **Completion Date** 1/31/15	

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R 000	Continued From page 2 Resident #1 required Level 1 assistance with ADL's- intermittent hands on assistance with shower, dressing, hygiene and meals. - Interview with Resident #1 on November 13, 2014 starting at approximately 11:30 a.m., revealed that s/he needed intermittent assistance with bathing, personal hygiene and dressing. However, Resident #1 stated, "I know I need assistance but I refuse to ask for assistance until this complaint is resolved". -Interview with the ALR manager on November 13, 2014, at approximately 10:00 a.m., revealed Resident #1 required hands on assistance with bathing, personal hygiene and dressing. Additionally, the ALR manager indicated s/he provided Resident #1 with the ISP and s/he was allowed to make changes to the ISP prior to ISP meeting on July 30, 2014. -Interview with the facility's medical director on November 20, 2014, at approximately 9:50 a.m., revealed that s/he completed the "Facility Care Information Form" in conjunction with Resident #1. Per his/her observation and the professional opinion of the nursing staff, Resident agrees that Resident #1 required hands on assistance with bathing, dressing and personal hygiene. -Interview with CNA #1 on November 20, 2014, at approximately 9:50 a.m., revealed that s/he had provided hands on assistance with IADL's for Resident #1 following July 31, 2014 ISP meeting. - Interview with CNA #2 on November 20, 2014, at approximately 10:15 a.m., revealed that s/he only provided assistance with IADL's;	R 000		

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R 000	Continued From page 3 - Interview with CNA #3 on November 20, 2014, at approximately 10:25 a.m., revealed that s/he had provided hands on assistance with ADL's following July 31, 2014 ISP meeting. Conclusion- This allegation could not be substantiated. Allegation #2- Resident #1 alleged that the facility would not pay for transportation for his/her individual activity. And, the facility charged a fee if nurses attended group activities. Findings- Record review and interviews starting on November 13, 2014 at approximately 11:30 a.m. through December 9, 2014, at approximately 12:30 p.m., revealed the following: Record Review - On November 21, 2014, at approximately review of the "Offsite Program" policy revealed that "transportation/trips will be provided according to community's standards for minimums". Interviews - Interview with Resident #1 on November 13, 2014, starting at approximately 11:30 a.m., revealed that the facility paid for an individual resident (from independent living) to go to the casino. - Interview with the administrator on November 13, 2014, at approximately 2:00 p.m., the administrator indicated that the facility will not pay for an individual resident transportation to an activity, however they will pay for transportation for a group activity. Additionally, the administrator	R 000		

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R 000	Continued From page 4 indicated that although the facility will not pay for resident's individual activities; they will assist with coordination of transportation. Conclusion: This allegation could not be substantiated. Allegation #3- Resident #1 alleged that management approached him/her with complaints from unnamed resident about his/her unsafe operation of a motorized wheelchair. Findings- Record review and interviews starting on November 13, 2014 at approximately 11:30 a.m. through December 9, 2014, at approximately 12:30 p.m., revealed the following: Record Review - On November 20, 2014, at approximately 1:30 p.m., review of the "Outcome Referral" dated July 9, 2014, signed by the occupational therapist indicated that s/he and the administrator had met with Resident #1 to discuss that facility's motorized wheelchair policy. - On November 20, 2014, at approximately 2:00 p.m., review of an email dated July 16, 2014, from the administrator to the family member who made the complaint indicated that he had "'anonymously" discussed the concern with the operation of the motorized wheelchair with the "resident in question". Interviews - Interview with Resident #1 on November 19, 2014, at approximately 12:00 p.m., revealed that	R 000		

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R 000	Continued From page 5 a social worker accused him/her of operating his/her wheel chair "swiftly". Additionally, Resident #1 indicated that in the past s/he had bumped another resident's chair by accident. -Interview with the administrator on November 19, 2014, at approximately 2:00 p.m., revealed that a resident's family member had spoken with him/her in reference to Resident #1 operating his/her motorized wheelchair unsafely around other residents. Additionally, the administrator indicated that s/he didn't think it was a good idea to reveal the resident's name and he just wanted to meet with Resident #1 and discuss the facilities motorized wheelchair policy. Conclusion- This allegation was partially substantied but there were no deficient practices. Allegation #4 - Resident #1 alleged that there were inaccurate information in his/her medical record. Findings- Record review and interviews starting on November 13, 2014 at approximately 11:30 a.m. through December 9, 2014, at approximately 12:30 p.m., revealed the following: Record Review On November 13, 2014, starting at approximately 2:00 p.m., review of Resident #1's clinical record revealed a Physician Order Sheet (POS) signed by the facilities physician on November 13, 2014. The POS contained the following orders: "1. 10/31/14 - Head-to-toe assessment every Wednesday 3-11 shift by charge nurse. 2. Monitor pain level every shift with 0-10 scale	R 000		

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R 000	Continued From page 6 notify physician for unmanageable [unmanageable] pain. 3. 05/25/14- Tap water enema per rectal as needed if no bowel movement for 5 days, as needed." - The record failed to evidence that the above listed orders had been conducted. - Review of multiple "Assisted Living Daily Assignment Sheets" dated from July 1, 2014 through October 31, 2014, documented that CNA's provided Resident #1 assistance with showers and/or ADL's. - Review of multiple "ADL Verification Worksheets" dated from November 2, 2014 through November 14, 2014, documented that CNA's provided supervision or limited supervision with eating, personal hygiene, locomotion and/or bathing. Interviews - Interview with Resident #1 on November 13, 2014, starting at approximately 11:30 a.m., Resident #1 stated, "CNA records are false and there are doctors orders that are not from my doctor. The orders were never done." - Interview with the ALR manager on November 13, 2014, starting at approximately 12:30 p.m., the ALR manager indicated, "All physician orders that [Resident #1] questioned after reviewing his/her record were discontinued. The physician orders had not been carried out by the staff." - Interview with administrator on December 9, 2014, at approximately 2:00 p.m., the	R 000		

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R 000	Continued From page 7 administrator Indicated that the physician orders that Resident #1 questioned were general orders and were not carried out by staff. -Interview with CNA #1 on November 20, 2014, at approximately 9:50 a.m., revealed that s/he had provided hands on assistance with IADL's for Resident #1 following July 31, 2014 ISP meeting. - Interview with CNA #2 on November 20, 2014, at approximately 10:15 a.m., revealed that s/he only provided assistance with IADL's; - Interview with CNA #3 on November 20, 2014, at approximately 10:25 a.m., revealed that s/he had provided hands on assistance with IADL's following July 31, 2014 ISP meeting. This allegation was partially substantiated. Allegation #5- Resident #1 alleged that his/her shower curtain is to small which causes water to be on the floor during showering. Observation On November 19, 2014, at approximately 1:50 p.m., observation of Resident #1's bathroom revealed that the shower curtains width was shorter than the shower rod. Additionally, there was no evidence of water damage to the bathroom floor or carpet in front of the bathroom door. Interview - On November 19, 2014, at approximately 1:35 p.m., Interview with Resident #1 revealed that	R 000		

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R 000	Continued From page 8 when s/he is taking a shower the water runs off of him/her and onto the floor. - On November 19, 2014, at approximately 2:50 p.m., interview with the administrator and the director of plant operation revealed that Resident #1 made the same complaint previously and they attempted to mitigate the problem by installing a new shower rod and curtain on November 29, 2013. The administrator then stated, "We will install a new shower curtain". Record Review - On November 19, 2014, at approximately 1:30 p.m. review of a work order sheet revealed a new curtain rod and shower curtain had been installed. - On November 21, 2014, at approximately 1:30 p.m. an email was sent to the surveyor from the administrator that indicated the new shower curtain had been installed and Resident #1 was satisfied with the new curtain. Conclusion- This allegation was substantiated but there were no deficient practices. Additionally, incidental findings were noted during this investigation and the deficiency is cited in the report below.	R 000		
R 293	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	R 293	**R293** **What corrective action(s) will be accomplished to address the identified deficient practice;** The orders will be re-written to appropriately reflect that they are standing FYI orders or they will be discontinued per the physician and resident's preference.	

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R 293	Continued From page 9 practicable physical, mental and psychosocial well-being; Based on record review and interview, it was determined that the ALR failed to ensure one (1) of (1) residents in the sample had access to appropriate nursing services. (Residents #1) The finding includes: On November 13, 2014, starting at approximately 2:00 p.m., review of Resident #1's clinical record revealed a Physician Order Sheet (POS) signed by the facilities physician on November 13, 2014. The POS contained the following orders: "1. 10/31/14 - Head-to-toe assessment every Wednesday 3-11 shift by charge nurse. 2. Monitor pain level every shift with 0-10 scale notify physician for unmanageable [unmanageable] pain. 3. 05/25/14- Tap water enema per rectal as needed if no bowel movement for 5 days, as needed. " There was no document evidence that the above listed orders had been done. During an interview with Resident #1 on November 13, 2014, at approximately 11:30 a.m., Resident #1 stated, " There are doctors orders that are not from my doctor. The orders were never done." During an interview with the ALR manager on November 13, 2014, starting at approximately 12:30 p.m., the ALR manager indicated, "all physician orders that [Resident #1] questioned after reviewing his/her record were discontinued."	R 293	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The resident's record will be reviewed once a month for three months and the findings will be reported to QA to ensure accurate documentation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.** The resident's record will be reviewed once a month for three months and the findings will be reported to QA to ensure accurate documentation. **Completion Date** 1/31/15	

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R 293	Continued From page 10 Then the ALR manager then stated, "The physician orders had not been carried out by the staff'. During an interview with administrator on December 9, 2014, at approximately 2:00 p.m., the administrator indicated that the physician orders that Resident #1 questioned were general orders and were not carried out by staff.	R 293		