STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0003	A. BUILDING: _____ B. WING _____	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE METHODIST HOME OF DC- FOREST HILLS	4901 CONNECTICUT AVENUE NW WASHINGTON, DC 20008

(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
R 000	Initial Comments An annual licensure survey and complaint investigation [DC00012516] was conducted on 01/04/2024, 01/05/2024 and 01/08/2024, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 31 residents and employed 34 personnel, including professional and administrative staff. A random sample of 15 resident records, 17 employee records, and two Private Duty Aides (PDAs) records were selected for review. The findings of the survey were based on observations made throughout the ALR, interviews with staff and residents, and reviews of clinical and administrative records, to include incident reports. During the survey process on 01/08/2024 at 2:05 pm, the Assisted Living Administrator (ALA) and the Director of Nursing (DON) both informed the State Survey Agency (SSA) team that Resident #15 complained that she was verbally abused by the agency nurse during medication administration on 01/06/2024. According to the ALA, Resident #15 stated that the agency nurse spoke to her in a very loud tone by directing her to turn her head when she coughed and stated to the resident, don't talk, I'll do all the talking. At 2:07 pm, the ALA stated that the agency nurse had just arrived for duty and was told to wait in the lobby. The ALA stated that she informed Human Resources (HR) of the alleged allegation and that the agency nurse was sent home by HR. The SSA team initiated an investigation into the	R 000		

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R 000	Continued From page 1 alleged complaint at 2:30 pm to determine compliance with the ALR Regulatory Act of 2000, "DC Code § 44-101.01" and Title 22-B DCMR (Public Health and Medicine) Chapter 101 attendant regulations. The investigative findings were based on interviews with the residents (including Resident #15), the agency nurse (alleged abuser), professional staff and management staff, and a review of administrative records, including facility nursing notes, personnel files, incidents reports, and time sheets. Based on the information obtained during the investigation, the alleged allegation that the agency nurse verbally abused Resident #15 was found to be undetermined There were no deficiencies cited.	R 000		