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-0003	A. BUILDING: _____ B. WING _____	08/08/2025

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 was conducted at this facility from 07/31/2025 through 08/08/2025, 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 42 residents and employed 135 personnel, including professional and administrative staff. A sample of 15 resident records and 15 employee records, including Private Duty Aides (PDA)s were selected for review. The findings of the survey were based on observations throughout the facility, including a medication administration pass, clinical and administrative record review, and resident, family, and staff interviews.	R 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	
R 149	10113.3 Individualized Service Plans (ISPs) 10113.3 An ALR shall ensure that the assessments conducted prior to a resident's admission, pursuant to §§ 802 and 803 of the Act (D.C. Official Code §§ 44-108.02 and 44-108.03), are performed by a registered nurse who is licensed to practice in the District, and any other healthcare professional necessary to perform the assessments as required who shall also be licensed or otherwise authorized to practice in the District. Based on record reviews and interviews, the facility failed to ensure a nursing assessment was completed prior to each residents admission to determine the appropriateness of placement, for 11 of the 15 residents in the sample (Resident #1, #2, #5, #6, #7, #8, #10, #11, #13, #14 and #15).	R 149		

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 _____	08/08/2025

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 149	Continued From page 1 Findings included: Review of the facility's undated Individual Service Plan (ISP) Policy listed that: "Pre-admission and post move-in assessments shall be performed by a licensed Registered Nurse (RN) and any other necessary licensed healthcare professionals." a) On 07/31/2025 beginning at 2:15 PM, a review of Resident #5's records showed the resident was admitted to the facility on 11/29/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. b) On 08/01/2025 beginning at 12:00 PM, a review of Resident #2's records showed the resident was admitted to the facility on 08/29/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. c) On 08/01/2025 beginning at 3:30 PM, a review of Resident #1's records showed the resident was admitted to the facility on 03/21/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. d). On 08/03/2025 beginning at 10:45 AM, a review of Resident #7's records showed the resident was admitted to the facility on 03/27/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse.	R 149	1. Retrospectively corrective action could not be accomplished for all 11 residents identified as affected (Residents #1, #2, #5, #6, #7, #8, #10, #11, #13, #14, and #15). 2. On 8/7/2025 a full audit of all 5 resident admissions from the past three months was conducted to identify any additional residents who may not have received a preadmission nursing assessment. The audit revealed that none of the five residents had a completed preadmission nursing assessment. 3. On 8/7/2025 the ISP policy was revised to include a process ensuring all required assessments are completed prior to resident move-in. On 8/15/2025 the licensed nursing staff involved in admissions received refresher training on the requirement for pre-admission assessments and ISP completion. The Nurse Manager will review 100% of new admissions weekly for the next 12 weeks to ensure preadmission assessments are completed. Any issues found will be addressed by the DON upon discovery. 4. The DON will report the results of the audit to the QAPI committee that meets quarterly until August 2026.	10/3/2025

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 _____	08/08/2025

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 149	Continued From page 2 e) On 08/04/2025 beginning at 10:30 AM, a review of Resident #6's records showed the resident was admitted to the facility on 02/28/2025. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. f) On 08/04/2025 beginning at 12:13 PM, a review of Resident #8's records showed that the resident was admitted to the facility on 04/14/2025. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. g) On 08/05/2025 beginning at 09:50 AM, a review of Resident #10's records showed the resident was admitted to the facility on 03/20/2025. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. h) On 08/05/2025 beginning at 2:12 PM, a review of Resident #11's records showed the resident was admitted to the facility on 08/08/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. i) On 08/05/2025 beginning at 3:18 PM, a review of Resident #15's records showed the resident was admitted to the facility on 03/21/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse.	R 149		

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 _____	08/08/2025

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 149	Continued From page 3 j) On 08/06/2025 beginning at 10:30 AM, a review of Resident #13's records showed the resident was admitted to the facility on 11/27/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. k) On 08/07/2025 beginning at 11:00 AM, a review of Resident #14's records showed the resident was admitted to the facility on 08/02/2024. Continued review of the resident's records failed to show any documented evidence that a pre-admission nursing assessment was completed by the facility's registered nurse. On 08/07/2025 at 10:53 AM, the Director of Nursing (DON) acknowledged during interview that the facility did not document the pre-admission nursing assessments of the residents. Per the DON, she believed that the "level of need assessment" was the nursing assessment.	R 149		
R 150	10113.4 Individualized Service Plans (ISPs) 10113.4 In accordance with § 604 of the Act (D.C. Official Code § 44-106.04), the ISP developed following the completion of the "post move-in" assessment shall be based on the following factors: Based on interviews and record reviews, the facility failed to ensure that an Individualized Service Plan (ISP) was developed following completion of the post move-in nursing assessment for 11 of the 15 residents reviewed (Residents #1, #2, #5, #6, #7, #8, #10, #11, #13, #14, and #15).	R 150		

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 _____	08/08/2025

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 150	Continued From page 4 Findings included: Review of the facility's undated Individual Service Plan (ISP) Policy listed under the "Post Move-In ISP Creation": "The completed ISP will be based on the medical, rehabilitation, and psychosocial assessment, the functional assessment, and the reasonable accommodation of the resident's preferences." a) On 07/31/2025 beginning at 2:15 PM, a review of Resident #5's records showed that a post nursing assessment was completed on 11/29/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. b) On 08/01/2025 beginning at 12:00 PM, a review of Resident #2's records showed that a post nursing assessment was completed on 09/12/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. c) On 08/01/2025 beginning at 3:30 PM, a review of Resident #1's records showed that a post nursing assessment was completed on 03/21/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. d) On 08/03/2025 beginning at 10:45 AM, a review of Resident #7's records showed that a post nursing assessment was completed on 03/28/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. e) On 08/04/2025 beginning at 10:30 AM, a	R 150	1.Retrospectively corrective action could not be accomplished for all 11 residents identified as affected (Residents #1, #2, #5, #6, #7, #8, #10, #11, #13, #14, and #15). 2.On 8/7/2025 a full audit of all current residents newly admitted within the last three months was conducted to identify any additional residents who did not have a complete post move-in ISP. None of the 5 newly admitted residents have post move in ISP. 3.On 8/7/2025 the ISP policy was revised to clearly require that all post move-in assessments must be followed by ISP development within 3 days of admission. On 8/15/2025 the licensed nursing staff involved in post move-in assessments received refresher training on the requirement for post move-in assessments and ISP completion. The Clinical Manager will conduct weekly audits of x 3 months for compliance. Any issues found will be addressed by the DON upon discovery. 4.The DON will report the results of the audit to the QAPI committee that meets quarterly until August 2026.	10/3/2025

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 _____	08/08/2025

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 150	Continued From page 5 review of Resident #6's records showed that a post nursing assessment was completed on 02/28/2025. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. f) On 08/04/2025 beginning at 12:13 PM, a review of Resident #8's records showed that a post nursing assessment was completed on 04/14/2025. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. g) On 08/05/2025 beginning at 09:50 AM, a review of Resident #10's records showed that a post nursing assessment was completed on 03/20/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. h) On 08/05/2025 beginning at 2:12 PM, a review of Resident #11's records showed that a post nursing assessment was completed on 08/08/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. i) On 08/05/2025 beginning at 3:18 PM, a review of Resident #15's records showed that a post nursing assessment was completed on 03/21/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. j) On 08/06/2025 beginning at 10:30 AM, a review of Resident #13's records showed that a post nursing assessment was completed on 11/27/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment.	R 150		

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 _____	08/08/2025

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 150	Continued From page 6 k) On 08/07/2025 beginning at 11:00 AM, a review of Resident #14's records showed that a post nursing assessment was completed on 08/02/2024. There was no documented evidence that an ISP was completed following the resident's post move-in assessment. On 08/07/2025 at 10:58 AM, the Director of Nursing (DON) acknowledged the findings during an interview. Per the DON, she was unaware of the requirement to develop an ISP following a resident's post move-in assessment.	R 150		
R 298	10118.2b4 Private Duty Healthcare Professionals 10118.2b4 A healthcare practitioner's written statement as to whether the nurse, aide, or other healthcare professional bears any communicable diseases, including communicable tuberculosis; Based on observations, interviews, and record review, the facility failed to ensure that each employee's personnel file contained a written statement from a healthcare practitioner confirming they were free from communicable disease, including tuberculosis, for one of the two Private Duty Aides (PDA) reviewed (PDA #1). Findings included: During the entrance conference on 07/31/2025 at 11:22 AM, the facility's Administrator stated that some residents received PDA services. The survey team requested the personnel records of the PDAs for review. On 07/31/2025 at 11:00 AM, PDA #1 was observed escorting Resident #9 to the activity	R 298	1. 08/07/2025 The missing documentation for PDA #1 was immediately corrected by obtaining a written clearance statement from a licensed healthcare practitioner verifying the aide is free from communicable disease, including tuberculosis and placed in PDA #1's personnel file on the same day. 2. On 8/7/2025 an audit of all the remaining 7 Private Duty Aides' personnel files was conducted to verify that each contained the required communicable disease clearance. There were no additional missing or outdated clearances. 3. On 8/7/2025 the Director of Human Resources (HR) and Nursing Administration staff were re-educated on the regulatory requirement for written communicable disease clearance, including TB screening. HR will conduct monthly random audits of 10% of employee files (including Private Duty Aides) for the next 6 months to ensure health clearance documentation is present and current. Any issues found will be addressed by the HR Director upon discovery. 4. The Director of HR will report the results of the audit to the QAPI committee that meets quarterly until August 2026.	10/3/2025

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 _____	08/08/2025

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 298	Continued From page 7 room for a trivia game. PDA #1 positioned the resident near the television so the resident could hear and see the trivia questions, and when asked, the PDA staff member confirmed that she was the PDA assigned to Resident #9. On 08/06/2025 at 2:25 PM, review of PDA #1's personnel record revealed no documented evidence of a written statement from a healthcare practitioner confirming that the employee was free from communicable disease, including tuberculosis. During an interview on 08/06/2025 at 3:03 PM, the facility's Human Resources (HR) staff member, who was responsible for all the personnel files, stated that the facility recently hired an Assisted Living Manager who would be responsible for ensuring all PDA files were up to date. After reviewing PDA #1's file with the surveyor, the HR staff confirmed there was no current written statement from a physician or healthcare practitioner declaring the PDA free from communicable diseases. The HR staff acknowledged responsibility for the file not being up to date.	R 298		
R 383	10125.4a Reporting Complaints To The Director 10125.4a. An ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day; and Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to promptly notify the Department of Health (DOH)	R 383		

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 _____	08/08/2025

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 383	Continued From page 8 by telephone of incidents-including falls with injuries involving potential for significant harm to the residents-followed by written notification within 24 hours or the next business day, for five residents (Residents #1, #13, #15, #16, and #17). Findings included: A review of the facility's undated Incident Reporting Policy stated: "It is the policy of ALR to promptly identify, investigate, document and report all incidents that may affect the health, safety, or welfare of residents, in accordance with applicable District of Columbia and federal regulations. This includes timely reporting to DC Health as required." Reportable incidents meeting DC Health's criteria for mandatory reporting include, but are not limited to serious injury, fractures, elopement, or unauthorized absence of a resident. A review of the facility's incident/fall/complaint report binder from March 2024 through July 2025 revealed: 1) A report revealed that on 07/25/2024, Resident #16 was found on the floor in the day room with a hematoma on the left side of the forehead and an abrasion. The resident was alert but confused. There was no documented evidence that the incident was reported to DC Health. 2) A report revealed that on 11/08/2024, Resident #17 was found on the floor in front of his recliner and TV stand after staff heard a loud noise. The resident sustained bruising on the left side of the back of the head. There was no documented evidence that the incident was reported to DC Health. 3) A report revealed that on 03/17/2025, Resident #1 was readmitted to the facility at 4:00 PM.	R 383	1. All delayed incident reports for the identified residents (#1, #13, #15, #16, and #17) found no adverse effects related to the fall. 2. On 8/8/2025 a review of all three incidents with injury from the past three months was conducted to ensure timely reporting requirements were met. There are no additional findings. 3. On 8/15/2025 Nursing Supervisor, Clinical Manager, and Charge Nurses received refresher training on DC Health reporting requirements, documentation standards, and accountability. The Clinical Manager will audit all incident reports weekly times 3 months and then monthly to confirm timely DC Health notification and proper documentation. Any issues found will be addressed by the DON upon discovery. 4. The DON will report the results of the audit to the QAPI committee that meets quarterly until August 2026.	10/3/2025

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 _____	08/08/2025

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 383	Continued From page 9 During rounds, staff found the resident on the floor near his bed. The resident was assisted up and taken to the dining room where he fell again, sustaining an abrasion to the left side of the forehead. The resident was alert and confused. There was no documented evidence that the incident was reported to DC Health. 4) Per a report dated 03/24/2025, Resident #15 experienced decreased oral intake, increased lethargy, and altered mental status. The physician ordered a hospital transfer. The incident was reported to DC Health nine days later on 04/02/2025. 5) A report revealed that on 05/03/2025, Resident #13 leaned back as he sat on the chair dining room, and it tipped backward, causing him to strike his head on the table behind. The resident sustained a hematoma to the back right side of the head. EMS was called and the resident was transported to the hospital. There was no documented evidence that the incident was reported to DC Health. During an interview on 08/08/2025, the Director of Nursing (DON) acknowledged, after reviewing the incident reports, that the above events were not reported promptly to DOH by telephone followed by written notification, as required by regulation and facility policy.	R 383		