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

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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 472	Sec. 604a2 Individualized Service Plans (2) An ISP shall be developed following the completion of the "post move-in" assessment. Based on interviews and record reviews, the facility failed to ensure that an Individualized Service Plan (ISP) was developed for each resident 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). Findings included: Review of the facility's undated Individual Service Plan (ISP) Policy listed under the "Post Move-In ISP Creation" stated: "The completed ISP will be based on the medical, rehabilitation, the psychosocial assessment, the functional assessment, and the	R 472		

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R 472	Continued From page 1 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 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	R 472	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

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R 472	Continued From page 2 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. 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.	R 472		

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R 472	Continued From page 3 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 residents post move-in assessment.	R 472		
R1003	Sec. 1006c Bathrooms. (c) An ALR shall ensure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation, interview, and record review, the Assisted Living Residence (ALR) failed to ensure that hot water temperatures did not exceed 110 degrees Fahrenheit, as required by [insert applicable state/local regulation], for the two hallway bathrooms (Bathrooms #1 and #2) located on the first floor across from the Assembly Hall (Activity Room). Findings include: The ALR's policy and local regulations require that resident-accessible hot water temperatures remain at or below 110°F to prevent injury. On 07/31/2025 at 10:58 AM, while performing hand hygiene in Bathroom #1, the hot water felt very hot to the touch. A temperature check of the water showed a reading of 125.8°F. Bathroom #2, located beside Bathroom #1, measured 124.3°F. At 11:32 AM, a recheck of the temperatures showed that Bathroom #1 measured 125.2°F and Bathroom #2 measured 128.2°F.	R1003	1. Immediately upon discovery, hot water temperatures in Bathrooms #1 and #2 were measured and were in compliance with the required range (not exceeding 110°F). 2. Starting 7/31/2025 a facility-wide check of the resident-accessible sinks and showers was conducted to measure hot water temperatures not exceeding 110 degrees. There were no additional findings. However, random check by surveyor on 8/4/25 measured 131.5F degrees. This was immediately addressed in the presence of the surveyor. 3. On 7/31/2025 the Director of Maintenance re-educated the staff to reinforce the regulatory requirement of the water temperature ≤110°F. The Maintenance Director or designee will test hot water temperatures at a minimum of 10 random resident-accessible outlets weekly for 12 weeks, then monthly x 9 months for compliance. Any issues found will be addressed by the Director of Maintenance upon discovery. 4.The Director of Maintenace will report the results of the audit to the QAPI committee that meets quarterly until August 2026.	10/3/2025

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R1003	Continued From page 4 Observations on 08/01/2025 at 10:46 AM showed a resident being assisted to Bathroom #2 by a staff member. The staff member remained outside the bathroom door while the resident used the bathroom. At 11:03 AM, Bathroom #1 measured 124°F and Bathroom #2 measured 126.9°F. On 08/04/2025 at 10:44 AM, a recheck of Bathroom #1 revealed that it measured 131.5°F. At approximately 10:50 AM, the concern was brought to ALR's management staff. A few minutes later, maintenance was observed checking Bathroom #1's hot water. Shortly afterwards, the surveyor rechecked both bathrooms and found that the temperatures were within normal limits. On 08/05/2025 at 11:00 AM, during an interview, the maintenance staff stated that an outside company had been working on the facility's boiler since July 29, 2025, which had affected hot water temperatures in both Bathrooms #1 and #2. When asked if the residents or staff had been alerted to the elevated temperatures, the maintenance staff replied, "No, I should have." On 08/05/2025 at12:06 PM, a review of the facility's water temperature logs from July 2025 through August 5, 2025, showed temperatures documented that were within normal limits.	R1003		