

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2020
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NAME OF PROVIDER OR SUPPLIER HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005
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(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) COMPLETION DATE
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E 000	Initial Comments An Emergency Preparedness Survey was conducted on November 10, 2020, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 483.73. The survey found that the facility was not in substantial compliance with Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility's bed capacity is 27; the census was five (5).	E 000	The Residences at Thomas Circle files this Plan of Correction for the purpose of regulatory compliance. The facility submits this document to comply with applicable law and not as an admission or statement of agreement of deficient practices.	
E 007 SS=E	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC,	E 007	EP Program Patient Population. 1. The Facility Assessment does address the type of residents that the skilled unit has and what type of risk present. Additional information was added to the Emergency Plan upon discovery at the time of the survey. 2. Once the additional information was added, there were no other corrections needed. 3. Inservices were given throughout 2020 noting the care needs of residents at risk including the care of residents who were COVID positive, supports needed for those at risk due to hearing/vision/ambulation/transfer/contractures; bathing, showers, oral/denture care.	11/15/20 11/15/20 11/20/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005		
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E 007	<p>Continued From page 1 hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, facility staff failed to establish an emergency plan to address the specific population served with the facility.</p> <p>Findings included...</p> <p>A review of the facility's Emergency Preparedness plan on November 10, 2020, lacked evidence that the plan included the facility's patient populations that would be at risk in an emergency, and how the facility would address their specific needs and their unique vulnerability in the event of an emergency or disaster.</p> <p>Employee #1 acknowledged the findings during a face-to-face interview on November 10, 2020, at approximately 12:30 PM.</p>	E 007	<p>3. (continue) The final skilled resident was discharged from the facility; and, the skilled unit was closed.</p> <p>4. The skilled unit was closed.</p>	<p>11/20/20</p> <p>1/13/21</p> <p>1/13/21</p>