

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2018
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NAME OF PROVIDER OR SUPPLIER THE METHODIST HOME OF DC- FOREST HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE NW WASHINGTON, DC 20008
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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) COMPLETE DATE
R 483	<p>Continued From page 1</p> <p>Review of Resident #2's medical record on 01/31/18 at 12:00 PM showed that the resident had thirteen falls from March 2, 2017 through November 11, 2017. The resident sustained minor injuries including an abrasion, a bruise, and two skin tears from four of the thirteen falls. Continued review of the record showed that the resident received physical therapy services after each fall. However, the ISP dated 08/ 23/17 showed that the Physical Therapist did not review it.</p> <p>During an interview with the Physical Therapist on 01/31/18 at 2:00 PM, she stated that she did not review the resident's ISP.</p> <p>At the time of the survey, the ALR failed to ensure all members of the interdisciplinary team (physical therapist) reviewed Resident #2's ISP.</p>	R 483	<p>3. Systemic change to ensure deficient practice does not recur.</p> <p>Rehab Director will be included on monthly emails for residents who are scheduled for ISP review and also inform of date and time of meetings when scheduled.</p> <p>4. Performance monitoring to make the solution is sustained.</p> <p>Assisted Living Nurse Manager will monitor ISP meeting attendance to verify therapy representation at meetings for resident currently on rehab services.</p>	