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-0028	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME OF DC-FOREST SIDE	2701 MILITARY ROAD NW WASHINGTON, DC 20015

(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 survey was conducted on 09/28/2020, 09/29/2020, 09/30/2020, 10/01/2020, 10/02/2020 and 10/05/2020 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq). The Assisted Living Residence (ALR) provided care for 24 residents and employed 59 personnel to include professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALA - Assisted Living Administrator ALR - Assisted Living Residence COVID-19 - Coronavirus 2019 DON - Director of Nursing F - Fahrenheit ISP - Individualized Service Plan PDA - private duty aide % - percent	R 000	This plan of correction is prepared and/or executed because it is required by the Provisions of State Law. The plan of correction is Forest Hills of DC's credible Allegation of Compliance.	
R 272	Sec. 503.1 Dignity. (1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible; Based on observation, interview and record review, the ALR failed to ensure (I) each kitchen was clean and free of dirty/soiled linens, for one of four kitchens in the ALR; and (II) all chemicals were kept secured at all times when not in use (Kitchen #1, 2 and 3). Findings included:	R 272		

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R 272	Continued From page 1 I. On 09/28/2020 beginning at 10:39 AM, an environmental walk-through of the facility showed there was a white, dirty/soiled linen observed on the floor in front of the refrigerator in Kitchen #1. This observation was brought to the attention of the Director of Assisted Living (Director) and the Administrator who accompanied the surveyors during the walk-through. At 11:01 AM, the dirty/soiled linen remained on the floor in the kitchen in front of the refrigerator. On 09/30/2020 at 3:30 PM, the Director was asked during a telephone interview about why the dirty/soiled linen remained when observed on the kitchen floor. The Director immediately stated, "I should have put on gloves and picked up the linen or had staff to put on gloves and have the dirty/soiled linen taken to the laundry room area right away." The Director added that dirty/soiled linens should be taken to the laundry room when the linens are dirty/soiled. At 3:35 PM, review of the ALR's policy and procedure entitled "Soiled Linen Processing" (undated), via email showed that staff was to put on gloves, collect the dirty/soiled linen, and transport the linen to the laundry room in a covered container. II. On 09/28/2020 at 10:45 AM, an environmental walk-through of the facility was conducted. Observations of the first floor multi-purpose room showed surface cleaning products in unlocked cabinet in Kitchens #1 and 2. It should be noted that at the time of observation, there were five residents and one staff in the multi-purpose room. The unsecured cleaning chemicals were brought to the Director's attention, and they were removed from the cabinet. It should be noted that the all of	R 272	R 272 1) Soiled Linen was removed by staff immediately after being brought to the attention of the Administrator. Chemicals were relocated to a secured storage area. 2) Staff will be educated to include proper removal and disposal of soiled linens and to secure chemicals in a secured storage area. 3) Nursing staff or designee will round 1x day x 6months to make sure that soiled linens are placed in the laundry. Housekeeping staff will round at random weekly x 6 months to ensure that all chemicals remain secured in a secure storage area. Performance will be monitored and reported quarterly to QAPI committee.	09/28/2020 10/30/2020 Ongoing

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R 272	Continued From page 2 the residents had diagnoses which included memory deficits. At 11:43 AM, observation of the second floor multi-purpose room showed surface cleaning products and numerous packets of dishwasher powder in an unlocked cabinet in Kitchen #3. It should be noted that there were nine residents and three staff in the multi-purpose room at the time of the observation. This observation was also brought to the Director's attention, and the chemicals were removed. At 11:45 AM, when asked if the cleaning products were usually kept in the unlocked cabinet, the Director replied "no." She stated that she would ensure that the staff secure all chemicals when not in use, going forward. On 09/29/2020 at 11:22 AM, the Director provided the policies and procedures for "Chemical Usage, via email." Review of the policy Chemical Usage (undated) showed that staff should "never leave chemical bottles unattended." At the time of the survey, the ALR failed to ensure dirty/soiled linen was placed in a covered container and transported to the laundry room; and failed to ensure that caustic chemicals were kept secure to prevent injury.	R 272		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; Based on interview and record review the facility	R 292		

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R 292	Continued From page 3 failed to (I) ensure that each resident received appropriate nursing interventions based on their needs; and (II)provide ongoing monitoring of each resident ' s oxygen saturation levels as required, for two of 12 residents in the sample (Residents # 3 and #7) Findings included: I. The ALR failed to ensure tht each resident received appropriate nursing interventions based on their needs. On 09/30/2020 at 8:35 AM, review of Resident #3's record showed a nurse's notes, dated 09/23/2020. The note documented that the resident presented as "more sleepy", "refused lunch" and was assessed with a blood pressure of 78/48. There was no additional note or physician order from that day to indicate that there was any nursing intervention to address the resident's low blood pressure. It should be noted that the resident received a dialysis treatment earlier that day (09/23/2020), as documented by another nurse. On 09/30/2020 at 11:26 AM, an interview was conducted with the Assisted Living Manager. She stated that she was not aware of the incident. The Assisted Living Manager also acknowledged the deficient practice and the need to ensure that additional nursing intervention should occur when abnormal vital signs are assessed. II. The ALR failed to provide ongoing monitroing of each residents's oxygen saturation levels as required. On 10/01/2020 at 10:30 AM, the DON said during a telephone interview that the nursing staff were	R 292	R292 1) Resident #3 received appropriate nursing interventions based on their needs. Oxygen saturation levels were taken for all residents to include Resident #3 and #7. Physician was notified if residents oxygen saturations was below 93%. 2) Licensed nurses will be educated to include providing appropriate nursing interventions based on the residents' needs and to notify the physician if the residents' oxygen saturation level falls below 93% according to the physician's order. 3) AL Nurse Manager and/or designee will monitor abnormal vital signs to include appropriate nursing interventions were provided, and the oxygen saturation levels weekly x12 and then biweekly x6 to ensure that the physicians are notified when the oxygen saturations fall below 93% according to the physician's order.	09/28/2020 10/30/2020 Ongoing

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R 292	Continued From page 4	R 292		

responsible for completing the COVID-19 screening for each resident. Further interview revealed that each resident had a physician order to have their oxygen saturation levels assessed three times per day. The nursing staff were to document the findings of the checks in the electronic recording system after each check. The DON also said that if a resident's pulse oxygen saturation level fell below 93%, the nursing staff must notify the physician and document it in the resident's record.

On 10/01/2020 at 11:00 AM, a review of the COVID-19 screening documentation for August 2020 and September 2020 evidenced that three residents had low oxygen saturation levels on the following days:

09/06/2020 - Resident #7 had a oxygen saturation level of 92%;
09/06/2020 - Resident #3 had a oxygen saturation level of 92%; and
09/12/2020 - Resident #3 had a oxygen saturation level of 92%.

A follow-up interview with the DON was conducted on 10/04/2020 at 8:32 AM. The DON stated that she reviewed the electronic recording system and found no documented evidence that the nurse notified the physician regarding the three residents low oxygen saturation levels referenced above.

At the time of the survey, the facility nursing staff failed to notify the resident's physician when the resident's oxygen saturation level fell below 93% according to the physician's orders.

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R 421	Continued From page 5	R 421		
R 421	Sec. 602a Resident Agreements (a) A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following: Based on record review and interview, the facility failed to ensure that each resident contract was signed by the resident or surrogate prior to admission, for four or 12 residents in the sample (Residents #1, 8, 9 and 12). Findings included: On 09/30/2020 and 10/01/2020, starting at 9:20 AM, review of the records for Residents #1, 8, 9 and 12 showed the following admission dates: Resident #1 - 06/18/2020 Resident #8 - 02/13/2020 Resident #9 - 06/08/2020 Resident #12 - 06/14/2020 Further review of records for Residents #1, 8, 9 and 12 the failed to evidence that the resident or their surrogate signed a written contract. On 09/30/2020 at 11:26 AM, the Director was informed that the resident contracts were not signed. The Director stated that all resident records would be audited to ensure that all contracts were signed. At the time of the survey, the facility failed to ensure that the resident contracts were signed prior to admission.	R 421	R421 1) Contracts for Residents #1, #8, #9, and #12 were reviewed and completed. 2) Admissions staff will be educated to include that resident contracts are to be completed and signed prior to admission. 3) Director of Marketing and/or designee will audit all admission contracts to ensure all are signed and completed. Director of Marketing and Admissions/or designee will monitor new admissions quarterly to ensure that residents contracts are completed and signed prior to admission. Performance will be monitored and reported quarterly to QAPI committee.	10/31/2020 10/31/2020 Ongoing

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R 475	Continued From page 6	R 475		
R 475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR Based on record review and interview, the facility failed to ensure that each ISP was signed by the resident or their surrogate, for ten of 12 residents (Residents #1, 2, 3, 4, 5, 7, 8, 10, 11 and 12). Findings included: On 09/30/2020 and 10/01/2020 starting at 8:30 AM, a review of resident records was conducted. The review showed the following ISP dates: Resident #1 - 06/28/2020 Resident #2 - 07/01/2020 Resident #3 - 06/01/2020 Resident #4 - 05/19/2020 Resident #5 - 07/14/2020 Resident #7 - 06/16/2020 Resident #8 - 09/22/2020 Resident #10 - 04/15/2020 Resident #11 - 04/14/2020 Resident #12 - 07/15/2020 The review showed that the ISPs for Residents #1, 2, 3, 4, 5, 7, 8, 10, 11 and 12 lacked a signature from the resident or their surrogate. On 09/30/2020 at 11:26 AM, the Director and Nurse Manager were informed that the ISPs were not signed. The Nurse Manager stated that all resident records were in the process of being audited. Additionally, the Director stated that the facility would ensure that the ISPs would be signed, going forward. At the time of the survey, the facility failed to ensure that each resident's ISP was signed by	R 475	R475 1) Due to COVID-19, the IDT team will review the ISPs for Residents #1, #2, #3, #4, #5, #6, #7, #8, #10, #11, and #12 with the resident and/ or their surrogate and document that resident and/or surrogate participated in the ISP. 2) IDT team will be educated to include that all ISPs must be signed by the resident and/or their surrogate and that due to COVID-19 all ISPs must be documented that the resident and/or surrogate participated in the ISP if they cannot attend in person. 3) Director of Assisted Living and/or designee will audit all ISP to ensure that the ISPs are signed by the resident and/or their surrogate and/or documented that the resident and/or surrogate participated in the ISP due to precaution of COVID-19. 6 ISPs will be audited quarterly to ensure that the ISPs are signed by the resident or surrogate.	09/28/2020 10/30/2020 Ongoing

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R 475	Continued From page 7 the resident or their surrogate.	R 475	R479	
R 479	Sec. 604a7b Individualized Service Plans (B) The functional assessment of the resident; and Based on record review and interview, the facility failed to ensure that each service provided to the resident was documented on their ISP, for three of 12 residents (Residents #4, 6 and 7). Findings included: On 09/28/2020 at 10:30 AM, the DON provided the surveyor with a document that listed the facility's residents, identified the services each resident received. 1. Review of the list showed that Resident #4 was provided a companion (sitter) from 11:00 AM to 6:00 PM. However, review of the resident's ISP on 09/30/2020 at 8:48 AM, failed to indicate companion services. 2. Review of the list showed that Resident #6 was provided a private duty aide (PDA) from 08:00 AM to 08:00 PM. However, review of the resident's ISP on 09/30/2020 at 10:26 AM, failed to indicate PDA services. 3. Review of the list showed that Resident #7 was provided a private duty aide (PDA) from 07:00 AM to 07:00 PM. However, review of the resident's ISP on 09/30/2020 at 2:35 PM, failed to indicate PDA services. On 09/30/2020 at 8:48 AM, review of Resident #4's ISP was conducted. The ISP failed to indicate that the resident received sitter services.	R 479	1) The ISPs for Residents #4, #5, and #6 were updated to include documentation of all services that the residents are receiving. 2) IDT team will be educated to include that all services that residents are receiving are to be documented on their ISP. 3) AL Nurse Manager and/or designee will audit 6 ISPs monthly x6 to ensure that all services are documented in the residents' ISP. Performance will be monitored and reported quarterly to QAPI committee.	09/28/2020 09/30/2020 Ongoing

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R 479	Continued From page 8	R 479		

On 09/30/2020 at 11:26 AM, the Director and Nurse Manager were informed that the ISP lacked documentation of the services each resident received. The Nurse Manager acknowledged the deficient practice and the need to ensure complete and accurate information was captured on the ISPs.

At the time of the survey, the facility failed to ensure that all services for Residents #4, 6 and 7 were documented on their ISP.

R1003 Sec. 1006c Bathrooms. R1003

(c) An ALR shall insure 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 ALR failed to ensure that the hot water temperature did not exceed 110° F, for six of six hand sinks inspected (multi-purpose bathrooms #1 and 2, apartments #101, 103 and 202, and hallway common bathrooms on floors 1 and 2).

Findings included:

On 09/28/2020 beginning at 10:39 AM, an environmental walk-through of the facility was conducted and revealed the following water temperatures that exceeded 110 °F:

First floor multi-purpose bathroom #1 - 114.4 °F ;
First floor multi-purpose bathroom #2 - 114.1 °F;

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R1003	Continued From page 9	R1003	R1003	

Apartment #101 ' s bathroom - 113 5 °F;
Apartment #103 ' s bathroom - 111.7 °F;
Apartment #202 ' s bathroom - 114.8 °F; and
Second floor common bathroom - 113.4 °F.

At 11:19 AM, the Environmental Services Director arrived to the facility. The Environmental Services Director indicated that he adjusted the water temperatures and that the water temperatures needed time to adjust. At 12:20 PM, when asked what the maximum water temperature should be, he stated 110 °F. When asked if staff reported high water temperatures, the Environmental Services Director said, no. Additionally, the Environmental Services Director stated that water temperatures were recorded one time a week on the computer.

At 11:44 AM, a follow-up of the water temperatures showed hot water was within normal range as follows:

First floor multi-purpose room #1 - 103.5 °F ;
First floor multi-purpose room #2 - 102.4 °F;
Apartment #101 ' s bathroom - 101.5 °F;
Apartment #103 ' s bathroom - 104.4 °F;
Apartment #202 ' s bathroom - 104.4 °F; and
Second common bathroom - 104.7 °F.

On 09/29/2020 at 11:22 AM, the Director of Assisted Living provided the surveyor with weekly water temperature logs from September 2020 through July 2020 via email. Review of the temperature logs showed that water temperatures for apartment #216 was above 110 °F on 08/24/2020 (110.4 °F) and 09/14/2020 (113.4 °F).

On 09/30/2020 at 1:41 PM, review of the Water Temperature Testing policy revised on 09/10/2015

1) Water temperatures at the facility were adjusted immediately to within normal range. — 09/28/2020

2) Environmental services staff will be educated to include that the water temperatures must be within in normal range. — 09/28/2020

3) Environmental services staff will check water temperatures daily x30, and then weekly to ensure that the water temperatures are within normal range. Performance will be monitored and reported quarterly to QAPI committee. — Ongoing

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R1003	Continued From page 10 showed that hot water at fixtures accessible to patient/residents shall not exceed 110 degrees Fahrenheit at any time. At the time of the inspection, the ALR failed to ensure hot water temperatures were within normal ranges at all times.	R1003		

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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899 North Capitol St., NE
Washington DC 20002
2nd Floor (2224)
202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Forest Side Memory Care ALR	2701 Military Road, NW Washington, DC 20015	9/28/2020 - 10/05/2020 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
0000	A licensure survey was conducted on 09/28/2020, 09/29/2020, 09/30/2020, 10/01/2020, 10/02/2020 and 10/05/2020 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq). The Assisted Living Residence (ALR) provided care for 24 residents and employed 59 personnel to include professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALR – Assisted Living Residence COVID-19 – Coronavirus 2019 LPN – Licensed Practical Nurse			

C. McKew for Caryn Strongfield — Name of Inspector
10/23/2020 — Date Issued

Facility Director/Designee
Oct 29, 2020 — Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	SSA – State Surveying Agency The ALR was notified on 03/06/2020 of their responsibility to monitor the coronavirus.dc.gov website for guidance and preventing the spread of infection related to COVID-19. On 03/13/2020, the website included guidance on *DC Health Infection Control Recommendations for Preparedness and Management of Coronavirus 2019 in Skilled Nursing Facilities and Assisted Living Residencies.* **Mayor's Order 2020-063** **SUBJECT: Extensions of Public Emergency and Public Health and Measures to Protect Vulnerable Populations During the COVID-19 Public Health Emergency**				
V(1)(k)	**Mayor's Order 2020-063 V(1)(k)** **Implement regular disinfection procedures for cleaning high-touch surfaces and any shared equipment.** The order is not met as evidenced by: Based on observation, interview and record review, the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	ALR failed to implement their policies and procedures for cleaning and disinfecting frequently shared equipment to prevent the spread of COVID-19. Findings included: On 09/28/2020 at 9:35 AM, the surveyors arrived to the facility and was greeted at the foyer by LPN #1. The LPN asked the surveyors and another staff member to perform hand hygiene. The LPN was observed to retrieve a tympanic thermometer from the nursing cart, took the staff's temperature, then place the thermometer on a table in the foyer. The LPN asked the surveyors to complete a COVID-19 screening form and then picked up a tympanic thermometer from the table to assess the surveyors' temperature. The surveyors declined to have their temperature checked using the tympanic thermometer as there was no observed evidence that it has been sanitized. The surveyors used their government-issued infrared thermometer to verify that their temperatures were within normal range. At 9:55 AM, another staff member arrived to the facility. The Director instructed the staff to screen himself. The staff was observed to walk into the common hallway bathroom to perform hand hygiene. Moments later, staff was observed to check his own temperature with the tympanic thermometer. After use, staff placed the thermometer back on the table without sanitizing or disinfecting the thermometer.	V (I) (k) 1) Tympanic thermometer was removed immediately. It was replaced with a non-contact thermometer with alcohol pads for cleaning/disinfecting to include instructions on how to clean/disinfect the thermometer. 2) Staff will be educated to include that the thermometer is to be cleaned and/or disinfected after each use to prevent the spread of COVID-19. 3) Infection Preventionist and/or designee will monitor the staff to ensure that the thermometer is cleaned/disinfected after every use. Performance will be monitored and reported quarterly to QAPI committee	09/28/2020 09/28/2020 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

At 11:38 AM, LPN #1 said during an interview that their tympanic thermometer should be disinfectant after each use with an alcohol pad. When asked why was the thermometer not disinfected after she checked the staff's temperature, LPN #1 stated that she should have cleaned the thermometer.

At 12: 33 PM, the surveyor asked if there were written policies and procedures in place on how and when shared PPE (i.e. thermometer) should be disinfected, the Director of Assisted Living said, "Yes".

On 10/01/2020 at 9:58 AM, review of the ALR's policies and procedures for Coronavirus Disease 2019 showed a policy entitled, "Cleaning and Disinfecting of Residents – Care Items and Equipment" dated 08/31/2020. The policy stated that non-critical reusable items are cleaned and disinfected or sterilized between each use.

At the time of the survey, the ALR failed to ensure the frequently used tympanic thermometer was cleaned and/or disinfected after each use to prevent to spread of COVID-19.