Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: **B. WING** ALR-0010 02/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW INGLESIDE AT ROCK CREEK WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) R 000 Initial Comments R 000 It is the intention of Ingleside at Rock Creek to comply with all regulations for the ALR. An annual licensure survey was conducted on 02/02/2021, 02/03/2021, 02/05/2021, 02/08/2021, 02/09/2021, 02/10/2021, 02/11/2021, 02/12/2021 and 02/16/2021, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq). The Assisted Living Residence (ALR) provided care for 28 residents and employed 24 personnel, to include professional and administrative staff. A random sample of 12 resident records and 14 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident, family, and staff interviews. R 392 Sec. 509b3 Abuse, Neglect, and Exploitation. R 392 A review of the ID notes for resident #4 indicate resident was interviewed by licensed staff for evi-(3) An ALR shall thoroughly investigate any dence of trauma. Based on the interview resident allegation of abuse, neglect, or exploitation and shall take appropriate action to prevent further exhibited no signs or symptoms of psychosocial incidents. The ALR shall report the results of its trauma related to the incident. Resident was investigation and actions taken, if any, to the immediately separated from the companion. Res-Mayor. ident was monitored post incident with noted/ob-Based on interview and record review, the served psychosocial trauma. Assisted Living Residence (ALR) failed to thoroughly investigate an allegation of verbal An audit of incidents involving allegations of abuse abuse, for one of 12 residents in the core sample for a 30 day period will be reviewed by March 31, (Resident #4). 2021. The community staff will be re-educated on the pol-Findings included: icy of abuse and neglect and investigations through On 02/09/2021 at 10:46 AM, review of the an in-service, with a post test by March 31, 2021. incidents reports showed that on 09/09/2020, the Director of Nursing will monitor all investigations ALR's Life Enrichment Associate reported that involving allegations of abuse to validate notes of she overheard Resident #4's assigned investigation findings and validation of post incident companion shouting at the resident during care. notes for monitoring monthly. Resident #4's companion was removed from resident care and sent home pending the

Health Regulation & Licensing Administration

outcome of the investigation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Senior Director of Healthcare Services

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		ALR-0010	B. WING	***	02/16/2021
NAME OF	PROVIDER OR SUPPLIER	STREETAL	DRESS, CITY,	STATE, ZIP CODE	
INCLES	DE AT ROCK CREEK	3050 MIL	ITARY ROA	D NW	
IIIGEE	DE AT ROOK CREEK	WASHING	STON, DC 2	20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
R 392	Continued From page	ge 1	R 392		
	beginning at 12:30 F Administrator (ALA) internal investigation #4's verbal abuse th The ALA stated that been investigated ar records to see if the investigation. At 1:48 PM, review of	erence call on 02/12/2021 PM, the Assisted Living was asked about the ALR's report regarding Resident eat occurred on 09/09/2020. the incident should have nd that she would check the ALR had completed an of the ALR's "Abuse eporting" policy revised on			
!	May 2019 showed the abuse, neglect, exploresident property, minunknown source ("al reported to local, sta	nat all reports of resident oitation, misappropriation of istreatment and/or injuries of buse") shall be promptly te and federal agencies (as egulations) and thoroughly			
	confirmed during the did not conduct an in Resident #4's verbal	nning at 3:00 PM, the ALA exit conference that the ALR ternal investigation regarding abuse that occurred on lance with the facility's policy.			
1	At the time of the investigation of the ALI allegation of verbal a	estigation, there was no R investigated Resident #4's buse.			
R 403	Sec. 601b Admission	s	R 403	The physicians for Residents #6, # contacted for updates to Intermedia	
(designee shall detern	of a resident, the ALA or nine that the resident is sion to the ALR and that the		Division Admission/Annual Medica March 31, 2021.	1
,	esident's needs can	be met in addition to the	1	A full audit will be completed of all	
	needs of the other re		İ	ALR to ensure compliance and cor	rections updated
		nd record review, the		by March 31, 2021.	580 St. C. III
				The ALR staff and Marketing team	will be reeducated

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A	_Hea	alth Regulation & Licensia	ng Administration			FURM APPROVED
NAME OF PROVIDER OR SUPPLIER INGLESIDE AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL TARK PROAD NW MASHINGTON, DC 20015 R 403 CONTINUED From page 2 Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed, for three of 12 residents in the core sample (Residents #6, 10, and 11). Findings included: 1. On 02/08/2021, at 5:23 PM, review of Resident #6's medical certification form dated 11/28/2019, showed a section entitled 'Behavior' which was not addressed by the physician. Further review of the form revealed the physician did not indicate that Resident #6 was not in need of 24-hour skilled nursing care and was not in meed of 24-hour skilled nursing care and was not in meed of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursing care and was not in need of 24-hour skilled nursin	STAT	EMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			
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INGLI	ESIDE AT ROCK CREEK	2050 MIL	TARY ROA	•	
		WASHING	STON, DC 2	20015	
(X4) I PREF TAG	IX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTICIENCY)	D BE COMPLETE
R 4	03 Continued From pa	ge 3	R 403		
	completed going for	ward.		K	
	all sections of the In Division Admission/	urvey the, ALR failed to ensure nmediate Care Facilities Annual Medical Certification ed by the physician, as			*
R 4	71 Sec. 604a1 Individu	alized Service Plans	R 471	An audit was completed of all Al	LR admissions for
	resident prior to adm Based on interview a Assisted Living Resi develop an Individua resident prior to their	oe developed for each nission. and record review the dence (ALR) failed to al Service Plans (ISPs) for all r admission, for five (5) of 12 sample (Residents #1, 2, 5,		the last 60 days and pre-ISP's we compliance as of March 31, 202. The ALR clinical staff will be re-e ISP requirement through an in-splete a post-test by March 31, 20 ISP meetings will be held weekly ance.	vere found to be in 1. educated on the pre- ervice and will com- 021.
	Findings included:				
	resident was admitte Further medical reco documented evidence	10:18 AM, review of al record showed that the d to the ALR on 04/10/2020. rd review failed to show e that a pre-admission ISP termine the residents service			
	record showed that the the ALR on 10/28/20 review failed to show	of Resident #8's medical ne resident was admitted to 19. Further medical record documented evidence that was conducted to determine needs.			
	record showed that the	of Resident #5's medical ne resident was admitted to 20. Further medical record			ĺ

Health	Regulation & Licensir				101411111111111111111111111111111111111
	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
1					
	···	ALR-0010	B. WING	4,	02/16/2021
NAME O	F PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	24 - ANAMARA 250
INGLE	SIDE AT ROCK CREEK		ITARY ROA		
			GTON, DC 2	0015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETE
R 47	Continued From page	ge 4	R 471	1998	
		w documented evidence that was conducted to determine e needs.			
	#9's medical record admitted to the ALR medical record revie evidence that a pre-	4:30 PM, review of Resident showed that the resident was on 11/27/2019. Further we failed to show documented admission ISP was nine the residents service			
	#2's medical record admitted to the ALR medical record revie evidence that a pre-a	1:22 PM, review of Resident showed that the resident was on 11/05/2019. Further w failed to show documented admission ISP was ine the residents service		=	
	Assisted Living Admi conference call that s missing documents. provide any pre-adm	nning at 12:30 PM, the inistrator said during a video she would try to find the However, ALA was unable to ission ISPs for the dents prior to the exit on			
	At the time of the sur that pre-admission IS residents.	vey, the ALR failed to ensure Ps were conducted for all			
R 475	Sec. 604a5 Individua	lized Service Plans	R 475	The ISP's for Resident #1, #5, #6	
		signed by the resident, or		#11 and #12 will be provided to the	
	surrogate, and a repri	esentative of the ALR.		gate for signature by March 31, 2	
	Based on interview ar Assisted Living Resid that all Individual Sen	nd record review, the ence (ALR) failed to ensure vice Plans (ISPs) were		All ISP's for all the residents in th audited for signature compliance	

112.00	D			, ,	FORM APPROVED
STATEME	Regulation & Licensir ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		ALR-0010	B WING	J	
		ALK-0010			02/16/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
INGLES	IDE AT ROCK CREEK		ITARY ROA GTON, DC		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
R 475	Continued From page	ge 5	R 475	After each virtual care conferer	nces - the ISP will be
		by the resident or a surrogate		emailed within 48 hours to the	responsible party for
	and a representative nine of 12 residents	e of the ALR, as required, for		signature.	
		7, 8, 9, 10, 11 and 12).		ALR clinical staff will be re-edu	
	(7, 0, 0, 10, 11 and 12).		requirement of signatures on th	
	Findings included:			service and will complete a pos	st test by March 31,
	1 On 02/05/2021 at	: 10:18 AM, review of		2021.	
	Resident #1's medic	cal record showed that ISPs		ISP meetings will be held week	lly to ensure
	were conducted on	12/22/2020 and 01/16/2021.		compliance.	
		failed to show documented			
		Ps were signed by the attempt at and a representative of			
	the ALR.	ate and a representative of			
;	2. At 10:34 AM, revie	ew of Resident #7's medical		*	
		an ISP was conducted on medical review failed to show			
;		ce that the ISP was signed by			
	the resident or a suri	rogate and a representative			
	of the ALR.				
	3 At 1:30 PM review	v of Resident #8's medical			
		an ISP was conducted on			
		medical record review failed			
		evidence that the ISP were			
	representative of the	nt or a surrogate and a ALR.			
		v of Resident #5's medical			
		SPs were conducted on			
	07/15/2020 and 01/1: record review failed to	5/2021. Further medical			
		o snow documented Ps were signed by the			
		te and a representative of			
	the ALR.	p: - 35.118111			1

5. On 02/08/2021 at 4:20 PM, review of Resident #12's medical record showed that an ISP was

conducted on 07/21/2020 and 10/22/2020.

Health Regulation & Licensi	ng Administration			FORIVI APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	B. WING		02/16/2021
NAME OF PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, S	STATE, ZIP CODE	1 02/10/2021
INGLESIDE AT ROCK CREEK		ITARY ROAD		
PRÉFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
R 475 Continued From pa	ge 6	R 475	10100-1	
documented evider by the resident or a representative of the 6. At 4:30 PM, revier record showed that 12/27/2019. Further to show documente signed by the resider representative of the 7. At 5:23 PM, revier record showed that 06/15/2020. Further to show documenter signed by the resider representative of the 8. On 02/09/2021 at #10's medical record conducted on 02/05/2021 review failed to show the ISP was signed I and a representative 9. At 4:30 PM, Resides howed that an ISP to 02/05/2021. Further to show documented signed by the resider representative of the On 02/12/2021 at 12 Administrator said duthat the ISPs were not signed by signed of the ISPs were not signed to the ISPs were not signed t	ew of Resident #9's medical an ISP was conducted on medical records review failed devidence that the ISP was ent or a surrogate and a e ALR. w of Resident #6's medical an ISP was conducted on medical record review failed devidence that the ISP was ent or a surrogate and a e ALR. 3:31 PM, review of Resident devidence that an ISP was ent or a surrogate and a e ALR. 3:31 PM, review of Resident devidence that an ISP was ent or a surrogate end of the ALR. In the resident or a surrogate end the ALR. In the resident or a surrogate end the ALR. In the resident or a surrogate end the ALR. In the resident or a surrogate end the ALR. In the resident or a surrogate end and a surrogate and a ALR. In the residence that the ISP was ent or a surrogate and a ALR. In the residence of the ALR. In the residence of the ALR. In the residence of the ISP was ent or a surrogate and a ALR.			
documented evidence surrogate and a representation				

Health Regulation & Licensin	ng Administration		1	FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	B. WING		02/16/2021
NAME OF PROVIDER OR SUPPLIER INGLESIDE AT ROCK CREEK	3050 MIL	DRESS, CITY, STARY ROAD		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
R 475 Continued From page At the time of the sulf all ISPs were signed and a representative R 483 Sec. 604d Individua	rvey the ALR failed to ensure d by a resident or surrogate e of the ALR.	R 475	The ISP's for Residents #8 and	#9 wore undated
admission and at lea The ISP shall be up is a significant chang. The resident and, if shall be invited to pa reassessment. The an interdisciplinary to resident's healthcare the resident's surrog ALR. Based on interview a Assisted Living Resident's significant of condition on the Indit three of 12 residents (Residents #1, 8, and Findings included: 1. On 02/09/2021 at a incident reports show from the memory uni found in the parking a level of the facility. On 02/16/2021 begin Assisted Living Admit telephone interview the memory unit and wall located near the staff	review shall be conducted by earn that includes the e practitioner, the resident, ate, if necessary, and the and record review, the dence (ALR) failed to hanges in the resident's vidual Service Plan (ISP), for in the core sample d 9). 2:15 PM, review of the ALR's yed that Resident #1 eloped to n 07/20/2020, and was garage located on the first		Resident #1 is no longer in the five An audit of all residents in the A completed by March 31, 2021 to Any necessary corrections will be ALR clinical staff will be educated in condition and updates to the lin-service and will complete a portion of the portion o	acility. LR ISP's will be on ensure compliance of regarding change isP through an ost-test by March 31 died to ensure that any ed and compliance is after admission

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A BUILDING;	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	B. WING		02/16/2021
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
INGLESIDE AT ROCK CREEK		JITARY ROAD		
		GTON, DC 20	015	
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLE
R 483; Continued From pag	ge 8	R 483		
client was missing for asked if the incident	evel. The ALA also stated the or about one hour. When to felopement should have esident #1's ISP, the ALA g, "Yes".			
AM, Resident #1's IS no documented evid elopement incident h Further review revea	review on 02/02/2021 at 11:30 SP dated 12/22/2020 showed lence that the 07/20/2020 and been updated on the ISP. aled the ISP did not address strategies for staff to ensure			
Elopement/Missing F July 2019 showed the Service Plans and re potential elopement a	of the "Assisted Living Resident" policy revised in at the ALR should update esident summaries to reflect and that the service plans ntions for resident safety.			
At the time of the sur address significant cl condition (elopement	vey, the ALR failed to hanges in the resident's on the ISP.			
incident reports show observed Resident #5 bedroom floor. The resident to send the resident to (ER). It was determin	5:30 PM, review of the ALR's red that on 05/24/2020, staff 9 lying on her back on the esident complained of right nt's physician gave an order o the Emergency Room ed that Resident #9 s with associated lung			
showed no document 05/24/2020 emergend resident sustained rib	cy room visit where the fractures with bruising to			ii.
n Regulation & Licensing Administra E FORM		BZN	C11 If	continuation sheet 9 or

		ia.

	Health Regulation & Licensin	ng Administration			
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
L		ALR-0010	B. WING		02/16/2021
	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	INGLESIDE AT ROCK CREEK		ITARY ROAD GTON, DC 2		W = 2.400
	PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (CROSS-REFERENCE)	D BE COMPLETE
	R 483 Continued From page	ge 9	R 483		
	the lung was update	ed on the ISP.			
	Assisted Living Adm Director of Nursing (conference call that updated to address resulted in rib fractu At the time of the su address significant of	nning at 12:30 PM, the inistrator along with the (DON) said during a video the ISP should have been the resident's fall that res and bruised lungs. rvey, the ALR failed to changes in the resident's ribs and bruised lung) on the			
	walk-thru, Resident any clothing, while so DON, who was preso observation, was ask often. The DON said occasionally. On 02/09/2021 at 3:3 #8's ISP dated 02/07 documented evidence disrobing behavior are been updated on the	that the resident #8 disrobed that the resident disrobed 30 PM, review of Resident //2021, failed to show e that the resident's and interventions for staff had			

d			
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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ALR-0010 B. WING 02/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW **INGLESIDE AT ROCK CREEK** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) R 000 Initial Comments R 000 0000 Initial Comments An annual licensure survey was conducted on 02/02/2021, 02/03/2021, 02/05/2021, 02/08/2021, 02/09/2021, 02/10/2021, 02/11/2021, 02/12/2021 and 02/16/2021, to determine compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 28 residents and employed 24 personnel, to include professional and administrative staff. A random sample of 12 resident records and 14 employee records were selected for review. The findings of the survey were based on observation throughout the facility. clinical and administrative record review, and resident, family, and staff interviews. R 330 10122.1 On Site Medication Review R 330 Resident #1 is no longer in the facility. Residents #2, #4, #6, #8, #9 and #12 medications will be 10122.1 The on-site medication review by a reviewed by a RN by March 31 2021. registered nurse that is arranged to occur every All residents in the ALR medications will be forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include reviewed by a RN by March 31, 2021 and again documentation of any changes to the resident's by May 15th, 2021 and every 45 days thereafter. medication profile, including changes in dosing The ALR staff were re-educated on the medication and any medications that have been added or review regulation through an in-service and will discontinued. Based on interview and record review, the complete a post-test by March 31, 2021. Assisted Living Residence (ALR) failed to ensure Residents due for a medication review will be that the Registered Nurse (RN) assessed each discussed in the weekly ALR meeting to ensure resident's response to their medication at least continued compliance. every 45 days, for seven of 12 residents in the core sample (Residents #1, 2, 4, 6, 8, 9, and 12). Findings included: 1. On 02/05/2021 at 10:18 AM, review of Resident #1's medical record failed to show documented evidence that the ALR's RN

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

benior Director of HealthCare Sorvices

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	Health Regulation & Licensi	ng Administration	- 111		
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED
L		ALR-0010	B. WING		02/16/2021
l	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
l	INGLESIDE AT ROCK CREEK		ITARY ROAD		
ŀ			GTON, DC 2		
	PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
	R 330 Continued From pa	ige 1	R 330		
	assessed the residence medications every	ent's response to her 45 days.			
	record failed to sho	ew of Resident #8's medical w documented evidence that ssed the resident's response every 45 days.			
	#12's medical recor evidence that the Al	t 4:20 PM, Review of Resident rd failed to show documented LR's RN assessed the to his medications every 45			
	record failed to show	w of Resident #9's medical w documented evidence that used the resident's response every 45 days.			ŀ
	record failed to show	w of Resident #6's medical w documented evidence that used the resident's response every 45 days.			
	#4's medical record evidence that the AL	5:46 PM, review of Resident failed to show documented .R's RN assessed the to her medications every 45			
		nt's response to her			
	Assisted Living Admi	nning at 12:30 PM, the inistrator said during a video the ALR Registered Nurse			

nealth	Regulation & Licensin	ig Administration			
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		ALR-0010	B WING		02/16/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
INGLES	DE AT ROCK CREEK	3050 MIL	ITARY ROAD) NW	
MGLESI	DE AT ROCK CREEK	WASHING	STON, DC 2	0015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETE
R 330	Continued From page	ge 2	R 330		
	residents' response days.	s to their medication every 45			1
	At the time of the su consistently assess their medications ev	rvey, the ALR's RNs failed to the residents' response to ery 45 days.			
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GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address 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:	State, Z	.IP Code:	Survey Date:	
II	Ingleside at Rock Creek	3020	0 Milita	3050 Military Road, N.W.	02/02/2021	02/02/2021 - 02/16/2021
		Was	shingto	Washington, DC 20015	Follow-up Dates(s):	s(s):
Regulation Citation	Statement of Deficiencies	ncies	Ref.	Plan of Correction	a	Completion
EP 0000	An emergency preparedness survey was conducted on 02/02/2021, 02/03/2021, 02/05/2021, 02/08/2021, 02/09/2021, 02/10/2021, 02/11/2021, 02/12/2021 and 02/16/2021.	was conducted on , 02/08/2021, , 02/12/2021 and				Pate
	The Assisted Living Residence (ALR) was in substantial compliance with the requirements of Emergency Preparedness.	R) was in substantial Emergency				
	No deficiencies were cited.					
		_				

C. Mebu for Muchae Welker

2/16/2021 Date Issued

Facility Director/Designee

Date

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