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-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 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 000	It is the intention of Ingleside at Rock Creek to comply with all regulations for the ALR.	
R 392	Sec. 509b3 Abuse, Neglect, and Exploitation. (3) An ALR shall thoroughly investigate any allegation of abuse, neglect, or exploitation and shall take appropriate action to prevent further incidents. The ALR shall report the results of its investigation and actions taken, if any, to the Mayor. Based on interview and record review, the Assisted Living Residence (ALR) failed to thoroughly investigate an allegation of verbal abuse, for one of 12 residents in the core sample (Resident #4). Findings included: On 02/09/2021 at 10:46 AM, review of the incidents reports showed that on 09/09/2020, the ALR's Life Enrichment Associate reported that she overheard Resident #4's assigned companion shouting at the resident during care. Resident #4's companion was removed from resident care and sent home pending the outcome of the investigation.	R 392	A review of the ID notes for resident #4 indicate resident was interviewed by licensed staff for evidence of trauma. Based on the interview resident exhibited no signs or symptoms of psychosocial trauma related to the incident. Resident was immediately separated from the companion. Resident was monitored post incident with noted/observed psychosocial trauma. An audit of incidents involving allegations of abuse for a 30 day period will be reviewed by March 31, 2021. The community staff will be re-educated on the policy of abuse and neglect and investigations through an in-service, with a post test by March 31, 2021. Director of Nursing will monitor all investigations involving allegations of abuse to validate notes of investigation findings and validation of post incident notes for monitoring monthly.	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Senior Director of Healthcare Services	3.23.2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 392	Continued From page 1 During a video conference call on 02/12/2021 beginning at 12:30 PM, the Assisted Living Administrator (ALA) was asked about the ALR's internal investigation report regarding Resident #4's verbal abuse that occurred on 09/09/2020. The ALA stated that the incident should have been investigated and that she would check the records to see if the ALR had completed an investigation. At 1:48 PM, review of the ALR's "Abuse Investigation and Reporting" policy revised on May 2019 showed that all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. On 02/16/2021 beginning at 3:00 PM, the ALA confirmed during the exit conference that the ALR did not conduct an internal investigation regarding Resident #4's verbal abuse that occurred on 09/09/2020 in accordance with the facility's policy. At the time of the investigation, there was no evidence that the ALR investigated Resident #4's allegation of verbal abuse.	R 392		
R 403	Sec. 601b Admissions (b) Prior to admission of a resident, the ALA or designee shall determine that the resident is appropriate for admission to the ALR and that the resident's needs can be met in addition to the needs of the other residents. Based on interview and record review, the	R 403	The physicians for Residents #6, #10, and #11 will be contacted for updates to Intermediate Care Facilities Division Admission/Annual Medical Certification form by March 31, 2021. A full audit will be completed of all residents in the ALR to ensure compliance and corrections updated by March 31, 2021. The ALR staff and Marketing team will be reeducated	

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-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 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 11/24/2019, 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 need of continual acute or long term medical or nursing care or supervision. 2. On 02/09/2021 at 3:31 PM, review of Resident #10's medical certification form dated 01/28/2021, showed that the physician did not indicate that Resident #10 was not in need of 24-hour skilled nursing care and was not in need of continual acute or long term medical or nursing care or supervision. 3. At 4:30 PM, review of Resident #11's medical certification form, dated 01/28/2021, showed that the physician did not indicate that Resident #10 was not in need of 24-hour skilled nursing care and was not in need of continual acute or long term medical or nursing care or supervision. During a video conference call on 02/12/2021 beginning at 12:30 PM, the Assisted Living Administrator (ALA) confirmed that all sections on the Intermediate Care Facilities Division Admission/Annual Medical Certification form was not completed by the Physician. The ALA stated that she would ensure that all sections are	R 403	on the required Admission documents through and in-service and will complete a post-test by March 31, 2021. Director of Nursing will review all Intermediate Care Facilities Division Admission/Annual Medical Certification forms prior to any new Admission for accuracy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	ALR-0010		02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 403	Continued From page 3 completed going forward. At the time of the survey the, ALR failed to ensure all sections of the Immediate Care Facilities Division Admission/Annual Medical Certification forms was completed by the physician, as required.	R 403		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interview and record review the Assisted Living Residence (ALR) failed to develop an Individual Service Plans (ISPs) for all resident prior to their admission, for five (5) of 12 residents in the core sample (Residents #1, 2, 5, 8, and 9). Findings included: 1. On 02/05/2021 at 10:18 AM, review of Resident #1's medical record showed that the resident was admitted to the ALR on 04/10/2020. Further medical record review failed to show documented evidence that a pre-admission ISP was conducted to determine the residents service needs. 2. At 1:30 PM, review of Resident #8's medical record showed that the resident was admitted to the ALR on 10/28/2019. Further medical record review failed to show documented evidence that a pre-admission ISP was conducted to determine the residents service needs. 3. At 2:30 PM, review of Resident #5's medical record showed that the resident was admitted to the ALR on 05/15/2020. Further medical record	R 471	An audit was completed of all ALR admissions for the last 60 days and pre-ISP's were found to be in compliance as of March 31, 2021. The ALR clinical staff will be re-educated on the pre-ISP requirement through an in-service and will complete a post-test by March 31, 2021. ISP meetings will be held weekly to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ____ B. WING ____	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 471	Continued From page 4 review failed to show documented evidence that a pre-admission ISP was conducted to determine the residents service needs. 4. On 02/08/2021 at 4:30 PM, review of Resident #9's medical record showed that the resident was admitted to the ALR on 11/27/2019. Further medical record review failed to show documented evidence that a pre-admission ISP was conducted to determine the residents service needs. 5. On 02/10/2021 at 1:22 PM, review of Resident #2's medical record showed that the resident was admitted to the ALR on 11/05/2019. Further medical record review failed to show documented evidence that a pre-admission ISP was conducted to determine the residents service needs. On 02/12/2021 beginning at 12:30 PM, the Assisted Living Administrator said during a video conference call that she would try to find the missing documents. However, ALA was unable to provide any pre-admission ISPs for the aforementioned residents prior to the exit on 02/16/2021. At the time of the survey, the ALR failed to ensure that pre-admission ISPs were conducted for all residents.	R 471		
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 interview and record review, the Assisted Living Residence (ALR) failed to ensure that all Individual Service Plans (ISPs) were	R 475	The ISP's for Resident #1, #5, #6, #7, #8, #9, #10, #11 and #12 will be provided to the resident, surrogate for signature by March 31, 2021. All ISP's for all the residents in the ALR will be audited for signature compliance by March 31, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 475	Continued From page 5 signed consistently by the resident or a surrogate and a representative of the ALR, as required, for nine of 12 residents in the core sample (Residents #1, 5, 6, 7, 8, 9, 10, 11 and 12). Findings included: 1. On 02/05/2021 at 10:18 AM, review of Resident #1's medical record showed that ISPs were conducted on 12/22/2020 and 01/16/2021. The medical record failed to show documented evidence that the ISPs were signed by the resident or a surrogate and a representative of the ALR. 2. At 10:34 AM, review of Resident #7's medical record showed that an ISP was conducted on 05/01/2020. Further medical review failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR. 3. At 1:30 PM, review of Resident #8's medical record showed that an ISP was conducted on 02/07/2021. Further medical record review failed to show documented evidence that the ISP were signed by the resident or a surrogate and a representative of the ALR. 4. At 2:30 PM, review of Resident #5's medical record showed that ISPs were conducted on 07/15/2020 and 01/15/2021. Further medical record review failed to show documented evidence that the ISPs were signed by the resident or a surrogate and a representative of the ALR. 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.	R 475	After each virtual care conferences - the ISP will be emailed within 48 hours to the responsible party for signature. ALR clinical staff will be re-educated on the requirement of signatures on the ISP through an in-service and will complete a post test by March 31, 2021. ISP meetings will be held weekly to ensure compliance.	

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-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 475	Continued From page 6	R 475		

Further medical record review failed to show documented evidence that the ISPs were signed by the resident or a surrogate and a representative of the ALR.

6. At 4:30 PM, review of Resident #9's medical record showed that an ISP was conducted on 12/27/2019. Further medical records review failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR.

7. At 5:23 PM, review of Resident #6's medical record showed that an ISP was conducted on 06/15/2020. Further medical record review failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR.

8. On 02/09/2021 at 3:31 PM, review of Resident #10's medical record showed that an ISP was conducted on 02/05/2021. Further medical record review failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR.

9. At 4:30 PM, Resident #11's medical record showed that an ISP was conducted on 02/05/2021. Further medical record review failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR.

On 02/12/2021 at 12:20 PM, the Assisted Living Administrator said during a video conference call that the ISPs were not conducted in person and that the ALR had not developed a system to show documented evidence of the resident or surrogate and a representative of the ALR participated in the development of the ISP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 475	Continued From page 7 At the time of the survey the ALR failed to ensure all ISPs were signed by a resident or surrogate and a representative of the ALR.	R 475		
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on interview and record review, the Assisted Living Residence (ALR) failed to address significant changes in the resident's condition on the Individual Service Plan (ISP), for three of 12 residents in the core sample (Residents #1, 8, and 9). Findings included: 1. On 02/09/2021 at 2:15 PM, review of the ALR's incident reports showed that Resident #1 eloped from the memory unit on 07/20/2020, and was found in the parking garage located on the first level of the facility. On 02/16/2021 beginning at 3:00 PM, the Assisted Living Administrator (ALA) said during a telephone interview that Resident #1 left the memory unit and walked into the service elevator located near the staff lounge. The ALA stated that the resident was found in the facility's parking	R 483	The ISP's for Residents #8 and #9 were updated. Resident #1 is no longer in the facility. An audit of all residents in the ALR ISP's will be completed by March 31, 2021 to ensure compliance Any necessary corrections will be made. ALR clinical staff will be educated regarding change in condition and updates to the ISP through an in-service and will complete a post-test by March 31 2021. Weekly ISP meetings will be held to ensure that any changes in conditions are updated and compliance with ISP requirements of 30 days after admission and at least 6 months thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 483 Continued From page 8 R 483

garage on the first level. The ALA also stated the client was missing for about one hour. When asked if the incident of elopement should have been updated on Resident #1's ISP, the ALA responded by saying, "Yes".

In an earlier record review on 02/02/2021 at 11:30 AM, Resident #1's ISP dated 12/22/2020 showed no documented evidence that the 07/20/2020 elopement incident had been updated on the ISP. Further review revealed the ISP did not address specific elopement strategies for staff to ensure the resident's safety.

At 11:50 AM, review of the "Assisted Living Elopement/Missing Resident" policy revised in July 2019 showed that the ALR should update Service Plans and resident summaries to reflect potential elopement and that the service plans would reflect interventions for resident safety.

At the time of the survey, the ALR failed to address significant changes in the resident's condition (elopement) on the ISP.

2. On 02/06/2021 at 5:30 PM, review of the ALR's incident reports showed that on 05/24/2020, staff observed Resident #9 lying on her back on the bedroom floor. The resident complained of right side pain. The resident's physician gave an order to send the resident to the Emergency Room (ER). It was determined that Resident #9 sustained rib fractures with associated lung bruising.

Review of Resident #9's ISP dated 07/16/2020 showed no documented evidence that 05/24/2020 emergency room visit where the resident sustained rib fractures with bruising to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ____ B. WING ____	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 483	Continued From page 9	R 483		

the lung was updated on the ISP.

On 02/12/2021 beginning at 12:30 PM, the Assisted Living Administrator along with the Director of Nursing (DON) said during a video conference call that the ISP should have been updated to address the resident's fall that resulted in rib fractures and bruised lungs.

At the time of the survey, the ALR failed to address significant changes in the resident's condition (fractured ribs and bruised lung) on the ISP.

3. On 02/02/2021 at 11:04 AM, during the facility walk-thru, Resident #8 was observed not wearing any clothing, while seated in the dining area. The DON, who was present at the time of the observation, was asked if Resident #8 disrobed often. The DON said that the resident disrobed occasionally.

On 02/09/2021 at 3:30 PM, review of Resident #8's ISP dated 02/07/2021, failed to show documented evidence that the resident's disrobing behavior and interventions for staff had been updated on the ISP.

At the time of the survey the ALR failed to ensure Resident #8's disrobing behavior was reflected on the ISP.

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-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 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 000		
R 330	10122.1 On Site Medication Review 10122.1 The on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that the Registered Nurse (RN) assessed each resident's response to their medication at least 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	R 330	Resident #1 is no longer in the facility. Residents #2, #4, #6, #8, #9 and #12 medications will be reviewed by a RN by March 31 2021. All residents in the ALR medications will be reviewed by a RN by March 31, 2021 and again by May 15th, 2021 and every 45 days thereafter. The ALR staff were re-educated on the medication review regulation through an in-service and will complete a post-test by March 31, 2021. Residents due for a medication review will be discussed in the weekly ALR meeting to ensure continued compliance.	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Senior Director of HealthCare Services	3.23.2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 330	Continued From page 1	R 330		

assessed the resident's response to her medications every 45 days.

2. At 1:30 PM, review of Resident #8's medical record failed to show documented evidence that the ALR's RN assessed the resident's response to her medications every 45 days.

3. On 02/08/2021 at 4:20 PM, Review of Resident #12's medical record failed to show documented evidence that the ALR's RN assessed the resident's response to his medications every 45 days.

4. At 4:30 PM, review of Resident #9's medical record failed to show documented evidence that the ALR's RN assessed the resident's response to her medications every 45 days.

5. At 5:23 PM, review of Resident #6's medical record failed to show documented evidence that the ALR's RN assessed the resident's response to her medications every 45 days.

6. On 02/09/2021 at 5:46 PM, review of Resident #4's medical record failed to show documented evidence that the ALR's RN assessed the resident's response to her medications every 45 days.

7. On 02/10/2021 at 10:18 PM, review of Resident #2's medical record failed to show documented evidence that the ALR's RN assessed the resident's response to her medications every 45 days.

On 02/12/2021 beginning at 12:30 PM, the Assisted Living Administrator said during a video conference call that the ALR Registered Nurse (RN) had not been consistently assessing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	A. BUILDING: ______ B. WING ______	02/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 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 330	Continued From page 2 residents' responses to their medication every 45 days. At the time of the survey, the ALR's RNs failed to consistently assess the residents' response to their medications every 45 days.	R 330		

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

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:	Survey Date:
Ingleside at Rock Creek	3050 Military Road, N.W. Washington, DC 20015	02/02/2021 – 02/16/2021 **Follow-up Dates(s):**

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
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. The Assisted Living Residence (ALR) was in substantial compliance with the requirements of Emergency Preparedness. No deficiencies were cited.			

C. McGee for Michael Walker — **Name of Inspector**

2/16/2021 — **Date Issued**

Facility Director/Designee

Date