| 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 ____ | 04/06/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| INGLESIDE AT ROCK CREEK | 3050 MILITARY ROAD NW WASHINGTON, DC 20015 |

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| R 000 | Initial Comments<br><br>0000 Initial Comments<br>An annual licensure survey was conducted on 03/30/2022, 03/31/2022, 04/01/2022, 04/04/2022, 04/05/2022, and 04/06/2022 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 42 residents and employed 94 personnel, to include professional and administrative staff. A sample of 15 resident records, 38 employee records and 12 private Duty Aides (PDAs) records were selected for review. Two additional residents were added to the sample, following a review of incident reports. The records of two residents who died and a third resident who was transferred also were reviewed.<br><br>The findings were based on observations, interviews, and the review of resident and administrative records. | R 000 | Ingleside at Rock Creek is filing this Plan of Correction for the purposes of regulatory compliance. This Center is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. | |
| R 074 | 10108.2 Admissions<br><br>10108.2<br>Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all areas on the Intermediate Care Facilities Division Admission/Annual Medical Certification form was addressed by the physician, for 11 of the 15 residents in the core sample (Residents #1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 15).<br><br>Findings included:<br><br>1. On 04/01/2022 at 12:13 PM, review of Resident #1's medical certification form dated 02/04/2020, showed no evidence that the resident | R 074 | Admissions<br>Complete all areas of the Intermediate Care Facilities Division Admission/ Annual Medical Certification Form<br>1) Corrective Actions to Address Deficient Practice:<br>1a. Review/update forms identified as deficient during on site survey<br>1b. Review Intermediate Care Facilities Division Admission/ Annual Medical Certification Forms for all Residents for completeness and accuracy<br>2) Systemic Changes to Ensure Deficient Practice Does not Recur:<br>2a. Train nurses on importance of thoroughly reviewing form for completeness and accuracy<br>2b. Return incomplete forms to provide for completion prior to conducting resident's admission assessment<br>3) Quality Assurance Program to be Implemented:<br>3a. Quarterly audits of Intermediate Care Facilities Division Admission Annual Medical Certification Forms<br>3b. Presentation of findings to QAPI committee for determination of further audits/ action | 5/10/2022<br><br>5/10/2022<br><br>6/23/2022 |

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| R 074 | Continued From page 1 | R 074 | | |

was screened for Tuberculosis. In addition, there was no listing of the resident's medications.

2. On 04/04/2022 at 11:20 AM, review of Resident #2's medical certification form dated 09/17/2021, showed that the physician did not list the resident's medication and failed to indicate if the resident required further medical evaluation or laboratory services.

3. On 04/01/2022 at 10:05 AM, review of Resident #3's medical certification form, dated 10/21/2021, showed that the physician did not indicate if the resident required laboratory services.

4. On 04/01/2022 at 09:40 AM, review of Resident #4's medical certification form, dated 09/14/2021, showed that the physician failed to document the resident's date of birth and present home address. In addition, there was no documented evidence that the resident was screened for Tuberculosis and behavior assessment.

5. On 03/31/2022 at 04:39 PM, review of Resident #5's medical certification form dated 06/18/2021, showed that the physician failed to list the resident's medications.

6. On 03/31/2022 at 4:13 PM, review of Resident #7's medical certification form dated 01/28/2022, showed that the physician failed to indicate the reason for the evaluation.

7. On 03/31/2022 at 4:33 PM, review of Resident #8's medical certification form dated 11/05/2021, showed that the physician failed to indicate the reason for the evaluation, and if the resident was or was not exhibiting any signs or symptoms

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| R 074 | Continued From page 2 | R 074 | | |

suggestive of communicable disease that could be transmitted through casual contact.

8. On 04/01/2022 at 09:40 AM, review of Resident #9's medical certification form, dated 05/05/2021, showed that the physician failed to document the reason for the evaluation, if the resident was in need of or had a mammogram, pap smear, colonoscopy, or a prostate-specific antigen (PSA). In addition, the physician failed to address the resident's behavior and to list the their medications on the form provided.

9. On 04/01/2022 at 8:58 AM, review of Resident #10's medical certification form dated 01/22/2021, showed that the physician failed to list the resident's medication on the form.

10. On 04/01/2022 at 4:34 PM, review of Resident #11's medical certification form dated 11/13/2019, showed that the physician failed to document the reason for evaluation, and if the resident needed or has a PSA.

11. On 04/04/2022 at 11:20 AM, review of Resident #15's medical certification form dated 03/13/2020, showed that the physician did not document the resident's temperature, allergies and the results of a TB test.

On 04/01/2022 at approximately 1:30 PM, the above findings were shared with the Director of Wellness and Infection Control, who acknowledged that the Intermediate Care Facilities Division Admission/Annual Medical Certification form should be filled out.

At the time of the survey the, ALR failed to ensure all sections of the Immediate Care Facilities Division Admission/Annual Medical Certification

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| R 074 | Continued From page 3<br>forms were completed by the physician, as required. | R 074 | | |
| R 106 | 10110.1 Required Policies and Procedures<br><br>10110.1 An ALR shall develop and implement dated, written policies and procedures concerning its operation which shall be consistent with the Act, this chapter, and all other applicable District or federal law.<br><br>Based on observations, interviews and record reviews, the Assisted Living Residences (ALR) failed to implement its policy titled "COVID-19 Vaccination Policy for Employees" (DC and VA) dated 08/30/2021, to mitigate and prevent the spread of COVID-19, for eight of the eight staff identified as employees of the ALR (Staff #1, 2, 3, 4, 5, 6, 7 and 8).<br><br>Findings included:<br><br>According to District Law 22-B DCMR 11200 at seq every licensed healthcare facility may not employ, contract, or grant privileges or credentials to employees, contractors, or volunteers who are not fully vaccinated. In addition, the healthcare facility must keep documentation of employee vaccination or granted exemption. Following the emergency legislation, the facility adopted a policy titled COVID-19 Vaccination Policy for Employees (DC and VA) dated 08/30/2021. According to the facilities internal policy, employees who had not received an exemption and had not completed their vaccine series by 11/01/2021 would be "placed on an unpaid administrative leave of absence pending receipt of the necessary vaccination or approved exemption. Such employees will receive a written warning and | R 106 | Policy and Procedure<br>Necessary Actions to Comply with DC Laws Regarding COVID Vaccination for Health Care Workers<br><br>1) Corrective Action to Address the Deficient Practice:<br><br>1a. Vaccination and exempt statuses of employees identified during the survey were reviewed. All non-exempt staff were compliant with the vaccination policy. Employees seeking exemption were found not to have requested exemptions through the DC Portal<br><br>1b. An audit will be completed by HR for all current employees to ensure all employees either have COVID vaccinations or have been granted exemptions<br><br>1c. Exempt employees will be required to request an exemption through the DC Portal, and provide evidence of their request to IRC's HR department<br><br>2) Systemic Changes to Ensure Deficient Practice Does Not Recur:<br><br>2a. Sr. VP of Human Resources will train the IRC Human Resources Director and the HR Coordinator on Ingleside's and DC's COVID vaccination and exemption policies<br><br>2b. All new staff will be required to show proof of vaccination upon hire<br><br>2c. Human Resources Director will complete an audit of new employee's COVID vaccination status weekly for 1 month, followed by monthly for 3 months<br><br>3) Quality Assurance Program to be Implemented: Audit findings will be submitted quarterly to the QAPI Committee. At the completion of the audit period (September, 2022) the QAPI Committee will determine if further audits/ actions are indicated | 4/6/2022<br><br>5/9/2022<br><br>6/1/2022<br><br>5/11/2022<br><br>6/23/2022 |

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| R 106 | Continued From page 4<br><br>notification...will be considered a refusal to comply..." The policy also stated that if the employee had not submitted proof that they were fully vaccinated and had not received an approved exemption by 11/29/2021 they would be considered "to have refused to comply with this policy and to have voluntarily resigned. Their employment would be terminated."<br><br>On 04/01/2022 the facility provided a list of 13 employees vaccination status, and on 04/04/2022 at 12:35 PM, the Human resources Director provided a comprehensive list of every employee's vaccination status. The list identified 14 employees who had not completed the vaccination series.<br><br>On 04/04/2022 beginning at 3:21 PM interview with the Human Resources Director revealed that she and the Director of Wellness and infection control had begun updating the facility's employee vaccination data base. Per the human resources director, emails were sent to facility managers beginning on 03/04/2022 in which the managers were given the names of staff still needing vaccination, and informed that an on-site vaccinations would be available. The request for copies of said e-mails was made by the survey team.<br><br>Discussion with the administrators during a meeting on 04/4/2022 at 4:35 PM revealed that a corporate officer (name not disclosed) reportedly granted exemptions to some employees (names not available). The survey team sent a follow-up email on 04/05/2022 requesting the names, titles and the nature of vaccination exemptions requested. On 04/06/2022, the administrator replied, "request had been "forwarded to headquarters for follow-up." | R 106 | | |

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| R 106 | Continued From page 5<br><br>At the time of the survey, the facility failed to take necessary actions to comply with the District of Columbia Laws requiring COVID-19 vaccinations for all healthcare workers. | R 106 | | |
| R 110 | 10110.2c Required Policies and Procedures<br><br>10110.2 (c) Private duty nurses, aides, and other healthcare professionals.<br>10110.2(c)<br><br>Based on observations, interviews and record reviews, there was no evidence that the facility developed and implemented policies and procedures guiding the use of private duty aides (PDAs), for 13 of the 13 PDA's currently working with residents (PDAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13).<br><br>Findings included:<br><br>[Cross-reference to 10118.2 (b) and 10118.4] On 03/30/2022, surveyors observed eight (8) private duty aides (PDA's) providing services to the residents during lunch: PDAs #1, 2, 3, 4, 5, 6, 7, and 8. It was later revealed that there was a total of 13 PDAs currently working in the facility, employed by two nurse staffing agencies (NSAs).<br><br>On 04/01/2022 at 10:22 AM, the Human Resource (HR) Director said there were no personnel files maintained in the facility for the PDAs. On 04/04/2022 beginning at 12:07 PM, the Assisted Living Administrator (ALA) confirmed that there were no PDA personnel files maintained in the Assisted Living Residence (ALR). The ALA said she did not have credentialing information or evidence of PDA | R 110 | REQUIRED POLICIES AND PROCEDURES<br>Policies and Procedures Guiding the Use of Private Duty Aides<br><br>1) Corrective Actions to Address Deficient Practice:<br>1a. Obtain personnel files from nurse staffing agencies employing PDAs during the survey<br>1b. Ensure each file contains credentialing information, background checks, evidence of freedom from communicable diseases including tuberculosis, COVID vaccination/ exempt status, and relevant training<br>1c. Store files electomically at the facility<br><br>2) Systemic Changes to Ensure Deficient Practice Does Not Recur:<br>2a. Educate families to regulatory requirements when selecting staffing agencies/PDAs<br>2b. Develop list of Preferred Nurse Staffing Agencies that meet regulatory requirement and for whom IRC has required documentation<br>2c. Secure written agreements with Preferred Staffing Agencies and required necessary information on PDAs assigned to IRC<br>2d. Develop policies that address use of PDAs at IRC<br><br>3) Quality Assurance Program to be Implemented:<br>3a. Monthly audits<br>3b. Submit findings to QAPI for determination of further audits/ actions | 4/15/2022<br><br>5/31/2022<br><br>6/23/2022 |

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| R 110 | Continued From page 6<br><br>screening for tuberculosis and other communicable diseases readily available. Instead, she obtained the information from their employers after the survey team requested the information. Moments later, the ALA said there were no written agreements or contracts with the two NSAs. When asked if the PDAs received training on the rules and regulations that apply to ALR's, the ALA said that a charge nurse would provide orientation training for the PDA on the unit. When asked if training materials, nursing notes or other documentation was available to verify PDAs were informed of ALR regulations, the ALA said she "doubts the charge nurses keep a record of that training." At 12:25 PM, surveyors requested the facility's policies and procedures regarding PDAs. No additional information was presented for review before the survey ended on 04/06/2022.<br><br>At the time of the survey, the facility failed to provide evidence that it had developed and was implementing policies and procedures that addresses the use of private duty aides. | R 110 | | |
| R 281 | 10116.15f Staffing Standards<br><br>10116.15f. A healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis.<br><br>Based on interviews and record reviews, the Assisted Living Residence failed to show evidence that each employee had obtained a written statement from a healthcare practitioner within the past 12 months declaring them free from communicable diseases, for 11 of the 21 staff whose health screening/ physician's certification was requested (Staff #6, 7, 10, 11, | R 281 | | |

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| R 281 | Continued From page 7 | R 281 | | |

12, 14, 17, 18, and 21, the Assistant Director of Nursing, and the Assisted Living Administrator.

Findings included:

On 03/30/2022 at 9:30 AM, surveyors met the concierge (Staff # 6) and the Director of Wellness and Infection Control (Staff # 2) in the lobby, and at 9:56 AM, met with the management team, including Staff #1, 3, and 5. Observations beginning at 11:53 AM, showed the following employees working with residents on the 2nd and 4th floors: Staff #7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17. On 03/31/2022 at 12:40 PM, surveyors met additional managers: Staff #18, 19, 20, and a maintenance employee (Staff #21) who was observed cleaning the elevator.

On 03/31/2022 at 4:15 PM, the surveyors requested documentation showing that each employee had obtained a statement from a healthcare practitioner saying that he or she was free of communicable disease. A follow-up request was made on 04/01/2022 at 3:31 PM.

On 04/01/2022 beginning at 8:50 AM, review of personnel records revealed the following:

1. There was no documented evidence that Staff #1, 4, 6, 10, 12, 17, and 21 had been screened by a healthcare practitioner for communicable diseases.

2. There was no evidence that Staff #7, 11, 14, and 18 had been screened by a healthcare practitioner within the past 12 months, declaring them free from communicable disease. The most recent healthcare practitioner's signatures were from the years 2017, 2018, 2013, and 2019, respectively.

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| R 281 | Continued From page 8<br><br>During interview on 04/01/2022 beginning at 10:08 AM, the Human Resources Director stated that "everyone" at the time of hire must obtain a purified protein derivative test (PPD) or a chest x-ray. Annually thereafter, the employee would complete a tuberculosis symptoms checklist (self-check) and have their checklist "signed-off by a medical professional" and agreed to forward the policy to the survey team.<br><br>Additional requests were made for employee health certificates on 04/06/2022 at 11:31 AM and 1:41 PM; however, no new Information was made available for review.<br><br>In a follow-up email sent to the Assisted Living Administrator (ALA) on 04/06/2022, surveyors again requested the agency's policies regarding employee health screenings for communicable diseases. The ALA said that she was unable to locate such a policy. The ALA copied the facility's Human Resources Director on her email; however, no additional information was forwarded for review.<br><br>At the time of the survey, there was no evidence that the Assisted Living Residence (ALR) required each employee to obtain a healthcare practitioner's statement at the time of hire and annually thereafter, certifying that he or she is free from communicable disease. In addition, there was no evidence that the ALR developed and implemented written policies and procedures regarding employees being screened for communicable diseases. | R 281 | Staffing Standards<br>Need for Healthcare Practitioner's Statement Upon Hire and Annually to Ensure Freedom from Communicable Disease.<br><br>1) Corrective Action to Address to Deficient Practice:<br><br>1a. Arrangements have been confirmed with health care providers from Bethesda Newtrition and Wellness Center (on site provider) to complete health clearance certifications for employees included in the survey sample<br><br>1b. Monthly reports are currently provided through Ingleside's payroll system that lists employees due for annual PPD. Employees now recieve PPDs at IRC. Additionally, staff will be issued health clearance forms for completion by a health care provider and returned to IRC for filing<br><br>2) Systemic Practice to Prevent Recurrence:<br><br>2a. Require completed health screening form that documents freedom from communicable disease as condition for employment for new staff<br><br>2b. Develop monitoring system to track submission by all staff of annual health screening documentation<br><br>2c. Conduct quarterly audits to determine compliance<br><br>3) Quality Assurance Program to be Implemented:<br>Present audit findings quarterly to QAPI Committee x3 quarters. Committee will determine if additional actions are indicated | 5/23/2022 (1a)<br><br>5/23/2022 (2a)<br><br>6/23/2022 (3) |
| R 282 | 10116.16 Staffing Standards | R 282 | | |

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| R 282 | Continued From page 9 | R 282 | Staffing Standards<br>Employee CPR Certification Status | |
| | 10116.16. Employee records shall be made available for review by the Department of Health upon request during any inspection of an ALR that is authorized by the Act or this chapter. | | 1) Corrective Action to Address Deficient Practice: | 5/12/2022 |
| | Based on observations, interviews and record reviews, the facility failed to make available for review each employee's cardiopulmonary resuscitation (CPR) certification status, for ten (10) of the ten nurses whose CPR certifications were requested for verification (Staff #4, 7, 8, 33, 35, 36, 37, 38, 39, and 40). | | 1a. CPR certifications to be validated for employees 4, 7, 8, 33, 35, 36, 37, 38, 39 and 40 (i.e., employees who may have valid CPR certifications have been requested to submit them to HR) | |
| | | | 1b. An audit will be completed by Human Resources of current employees to determine if additional employees without CPR certification are identified | 5/10/2022 |
| | | | 1c. Once validation is complete, employees identified who need CPR will be provided education by IRC. Plan regarding timeframe for implementation of CPR classes is currently under development in collaboration with the Collective Bargaining Unit. It is anticipated that classes will start June and held weekly until all employees have current certifications | |
| | | | 1d. CPR records will be retained by Human Resources | |
| | Findings included: | | 2) Systemic Changes to Ensure Deficient Practice Does Not Recur: | 5/10/2022 |
| | | | 2a. Sr. VP of Human Resources will educate IRC's Human Resource Director and HR Coordinator on company CPR certification policy | |
| | On 04/01/2022 beginning at 10:08 AM, the Human Resources (HR) Director stated that aides who worked in the Assisted Living Residence were not required to have cardiopulmonary resuscitation (CPR) certification. The HR Director explained that each unit had a nurse on duty around the clock and all nurses were expected to maintain a current CPR certification. The HR Director said that she would consult with their payroll office and submit a list of the nurse's names and their CPR certification status. At 2:21 PM, the HR Director informed the survey team that she was "unable to access that spreadsheet on CPR certifications." The HR Director further indicated that her predecessors had left prior to the day she was hired (in February 2022). She agreed to contact the corporate office in Maryland to request for assistance. | | 2b. Human Resources Director will complete an audit of CPR certification weekly for one month followed by monthly for three months | |
| | | | 3) Quality Assurance Program to be Implemented:<br>Audit findings to be presented to QAPI Committee quarterly. At the end of the audit period (September, 2022), the Committee will determine the need for additional audits/ actions | 6/23/2022 |
| | On 04/04/2022 beginning at 1:55 PM, a review of the staff schedule for the period 04/01/2022 through 04/04/2022 showed the names of ten nurses who had worked at least one shift during the 4-day period. On 04/06/2022 at 11:30 AM, surveyors asked the HR Director to forward | | | |

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|---|---|---|---|
| | ALR-0010 | A. BUILDING: ______<br>B. WING ______ | 04/06/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INGLESIDE AT ROCK CREEK | 3050 MILITARY ROAD NW<br>WASHINGTON, DC 20015 |

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| R 282 | Continued From page 10<br><br>evidence that the 10 nurses identified as having worked on those four days had current CPR certifications. No additional information was provided for verification.<br><br>At the time of the survey, the facility failed to make available for review the records of each nurse in order to verify his or her CPR certification status. | R 282 | | |
| R 296 | 10118.2b2 Private Duty Healthcare Professionals<br><br>10118.2b2 A copy of the registration, certification, license, or other authorization required for the nurse, aide, or other healthcare professional to lawfully practice the healthcare-related services being rendered in the District of Columbia.<br><br>Based on observations, interviews and record reviews, the Assisted Living Residence failed to ensure that each private duty aide (PDA) maintained an accurate and current personnel record with the Assisted Living Residence, to include his or her current credentials, for eight (8) of the 8 PDAs observed on site and the five (5) other PDAs (not observed) as reported by the Assisted Living Administrator (PDAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13).<br><br>Findings included:<br><br>Surveyors observed residents eating lunch on 03/30/2022 beginning at 11:53 AM. Interviews with the Human Resources (HR) Director later revealed that eight (8) of the aides who were observed working with residents during that lunch period were private duty aides (PDAs), and not employed by the Assisted Living Residence (ALR). They were PDAs #1, 2, 3, 4, 5, 6, 7, and 8. | R 296 | Private Duty Healthcare Professionals<br>Maintenance of personnel files in the facility for PDAs that contain current licenses/ certifications.<br><br>1) Corrective Actions to Address Deficient Practice:<br>1a. Obtain personnel files from nursing staff agencies employing PDAs during the survey<br>1b. Ensure each file contains credentialing infomation, background checks, evidence of freedom from communicable diseases including tuberculosis, COVID vaccination/ exempt status, and relevant training.<br>1c. Store files electronically at the facility | 4/15/2022 |
| | | | 2) Systemic Changes to Ensure Deficient Practice Does not Recur<br>2a. Educate families to regulatory requirements when selecting nurse staffing agencies/ PDAs<br>2b. Develop list of Preferred Nurse Staffing Agencies that meet regulatory requirements and for whom IRC has required documentation<br>2c. Secure written agreements with Preferred Staffing Agencies and require necessary information on PDAs assigned to IRC<br>2d. Develop policies that address use of PDAs at IRC | 5/31/2022 |
| | | | 3) Quality Assurance Program to be Implemented:<br>3a. Monthly audits<br>3b. Submit findings to QAPI for determination of further audits/ actions. | 6/23/2022 |

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| R 296 | Continued From page 11<br><br>On 04/01/2022 at 10:22 AM, when asked for the personnel folders, the HR Director said there were no personnel files maintained in the facility for PDAs. At 2:09 PM, the HR Director said the Assisted Living Administrator (ALA) had "reached out to the vendors," adding "this HR office does not do anything with PDAs," and directed the surveyors to the ALA for any additional information.<br><br>On 04/04/2022 beginning at 12:07 PM, interview with the ALA revealed that there were 17 Personal Care Aides (PCA's) working in the ALR. The ALA confirmed that there were no personnel files for PDAs maintained in the ALR. The personnel information, including current credentials, that was given to surveyors for review that morning (04/04/2022) was received from the PDA's employers (two nurse staffing agencies) following a request made by the ALA during the survey.<br><br>At the time of the survey, the facility failed to ensure that a personnel file was maintained in the facility for each private duty aide, to include the aide's current license or certification. | R 296 | | |
| R 298 | 10118.2b4 Private Duty Healthcare Professionals<br><br>10118.2b4 A healthcare practitioner's written statement as to whether the nurse, aide, or other healthcare professional bears any communicable diseases, including communicable tuberculosis; and<br><br>Based on observations, interviews and record reviews, the Assisted Living Residence failed to ensure each private duty aide (PDA) maintained an accurate and current personnel record with the | R 298 | | |

Health Regulation & Licensing Adminis' on

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| R 298 | Continued From page 12<br><br>Assisted Living Residence, to include a healthcare practitioner's written statement declaring each aide free of communicable disease, for eight (8) of the 8 PDAs observed on site and the five (5) other PDAs (not observed) as reported by the Assisted Living Administrator (PDAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13).<br><br>Findings included:<br><br>[Cross-reference to 10118.2(b)(2)]. On 03/30/2022 beginning at 11:53 AM, the surveyor team observed eight private duty aides (PDAs #1, 2, 3, 4, 5, 6, 7, and 8) assisting the residents with their lunch.<br><br>On 04/01/2022 at 10:22 AM, when asked for the personnel folders of the private duty aides, the HR Director said there were no personnel files maintained in the facility for PDAs. At 2:09 PM, the HR Director said the Assisted Living Administrator (ALA) had "reached out to the vendors," adding "this HR office does not do anything with PDAs," and directed the surveyors to the ALA for any additional information.<br><br>On 04/04/2022 beginning at 12:07 PM, interview with the ALA revealed that there were 17 Personal Care Aides (PCA's) working in the ALR. The ALA confirmed that there were no personnel files for PDAs maintained in the ALR. The personnel information, including current credentials, that was given to surveyors for review that morning (04/04/2022) was received from the PDA's employers (two nurse staffing agencies) following a request made by the ALA during the survey.<br><br>At the time of the survey, the facility failed to | R 298 | Private Duty Healthcare Professionals<br>Need for Healthcare Practitioner's Statement Upon Hire and Annually to Ensure Freedom from Communicable Disease<br><br>1) Corrective Action to Address the Deficient Practice:<br><br>1a. Obtain personnel files for those PDAs Included in the survey sample<br><br>1b. Ensure each file contains credentialing information, background checks, evidence of freedom from communicable dieases including tuberculosis, COVID vaccination/ exempt status, and relevant training<br><br>1c. If PDA is exempt from COVID Vaccinations, require evidence that exemption status has been applied for through DC portal, require evidence of routine testing as required by DC Health (i.e., weekly) for inclusion in PDAs file, require statement from healthcare practitioner, updated annually, that clears PDA from TB and other communicable disease. If PDA is exempt from standard TB testing due to BCG vaccine or other reasons, require statement from healthcare practitioner, updated annually, that clears PDA from TB and other communicable diseases. Absence of any of the above documentation will disqualify a PDA from working at IRC<br><br>1d. Store files electronically at the facility<br><br>2) Systemic Changes to Ensure Deficient Practice Does not Recur:<br><br>2a. Educate families to regulatory requirements when selecting nurse staffing agencies/ PDAs<br><br>2b. Develop list of Preferred Nurse Staffing Agencies that meet regulatory requirements and for whom IRC has required documentation<br><br>2c. Secure written agreements with Preferred Staffing Agencies and require necessary information on PDAs assigned to IRC<br><br>2d. Develop operational protocols that address the use of PDAs at IRC<br><br>3) Quality Assurance Program to be Implemented:<br><br>3a. Monthly audits of new PDAs files<br><br>3b. Submit audit reports to QAPI committee quarterly | 4/15/22022<br><br>5/31/2022<br><br>6/23/2022 |

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| R 298 | Continued From page 13<br><br>ensure that a personnel file was maintained in the facility for each private duty aide, to include a statement written by a healthcare practitioner saying the aide is free of communicable diseases. | R 298 | | |
| R 301 | 10118.2b5b Private Duty Healthcare Professionals<br><br>10118.2b5b. (B) The name and telephone number of the private nurse, aide, or other healthcare professional's immediate supervisor; and<br><br>Based on observations, interviews and record reviews, the Assisted Living Residence failed to ensure that each private duty aide (PDA) maintained an accurate and current personnel record with the Assisted Living Residence, to include the name of his or her immediate supervisor, for eight (8) of the 8 PDAs observed on site and the five (5) other PDAs (not observed) as reported by the Assisted Living Administrator (PDAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13).<br><br>Findings included:<br><br>[Cross-reference to 10118.2(b)(2)] On 03/30/2022 beginning at 11:53 AM, the surveyor team observed eight private duty aides (PDAs #1, 2, 3, 4, 5, 6, 7, and 8) assisting some of the residents with their lunch.<br><br>On 04/01/2022 at 10:22 AM, when asked for the personnel folders of the private duty aides, the HR Director said there were no personnel files maintained in the facility for PDAs. At 2:09 PM, the HR Director said the Assisted Living Administrator (ALA) had "reached out to the | R 301 | Private Duty Healthcare Professionals<br>Maintenance of PDA personnel files on site that contain name of PDAs immediate supervisor<br><br>1) Corrective Actions to Address the Identified Deficient Practice:<br>1a. Current files on have been obtained from agencies employing PDAs identified during the survey<br>1b. Files are current and contain credentialing information, background checks, evidence of freedom from communicable disease including tuberculosis, COVID vaccination status, relevant training, and name of immediate supervisor<br>1c. Files are stored electronically in the facility for each individual<br><br>2) Systemic Changes to Ensure Deficient Practice Does not Recur:<br>2a. Educate families regarding regulatory requirements<br>2b. Develop list of Preferred Staffing Agencies that address regulations and provide requested information<br>2c. Secure agreements with Preferred Staffing Agencies that address regulations and required information<br>2d. Develop policies regarding use of PDAs at IRC<br><br>3) Quality Assurance Program to be Implemented:<br>3a. Monthly audits with findings presented to QAPI Committee for review and determination if further audits/ actions are required | 4/15/2022<br><br>5/31/2022<br><br>6/23/2022 |

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| R 301 | Continued From page 14<br><br>vendors," adding "this HR office does not do anything with PDAs," and directed the surveyors to the ALA for any additional information.<br><br>On 04/04/2022 beginning at 12:07 PM, interview with the ALA revealed that there were 17 PCA's working in the ALR. The ALA confirmed that there were no personnel files maintained in the ALR for PDAs. The personnel information that was given to surveyors for review that morning (04/04/2022) was received by email from the PDAs' employers (two nurse staffing agencies) after surveyors requested the information. When asked about contact information for the PDAs' immediate supervisors, the ALA replied: "we have a contact at the company, but I don't know if it's their immediate supervisor."<br><br>At the time of the survey, the facility failed to ensure that a personnel file was maintained in the facility for each private duty aide, to include the name of the aide's immediate supervisor. | R 301 | | |
| R 302 | 10118.2b5c Private Duty Healthcare Professionals<br><br>10118.2b5c. (C) A copy of the agency's license or other authorization to operate in the District.<br><br>Based on observations, interviews and record reviews, the Assisted Living Residence failed to ensure that each private duty aide (PDA) maintained an accurate and current personnel record with the Assisted Living Residence, to include a copy of their employer's license to operate in the District of Columbia, for eight (8) of the 8 PDAs observed on site and the five (5) other PDAs (not observed) as reported by the Assisted Living Administrator (PDAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13). | R 302 | | |

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| R 302 | Continued From page 15<br><br>Findings included:<br><br>[Cross-refer to 10118.2(b)(2)] On 03/30/2022 beginning at 11:53 AM, the surveyor team observed eight private duty aides (PDAs #1, 2, 3, 4, 5, 6, 7, and 8) assisting some of the residents with their lunch.<br><br>On 04/01/2022 at 10:22 AM, the Human Resources Director said there were no personnel files maintained in the Assisted Living Residence (ALR) for the PDAs and directed surveyors to the Assisted Living Administrator (ALA) for any additional information regarding PDAs.<br><br>During interview on 04/04/2022 beginning at 12:07 PM, the ALA revealed that there were 17 PCA's working in the ALR and confirmed that there were no personnel files for private duty aides maintained in the ALR. The personnel information that was given to surveyors for review that morning (04/04/2022) was received by email from the PDAs' employers (two nurse staffing agencies) after surveyors requested the information. When asked if the two nurse staffing agencies were licensed in the District of Columbia, the ALA replied: "I haven't seen their license."<br><br>At the time of the survey, the facility failed to ensure that a personnel file was maintained in the facility for each private duty aide, to include evidence showing that their employer is currently licensed as a nurse staffing agency in the District of Columbia. | R 302 | Private Duty Healthcare Professionals<br>Maintenance of PDA personnel files at the facility that include evidence that employer is licensed in the District of Columbia<br><br>1) Corrective Actions to Address the Identified Deficient Practice:<br>1a. Business licenses have been obtained from agencies employing PDAs identified during the survey<br>1b. PDA files have been updated to include agency business licenses<br>1c. Files are stored on site electronically<br>2) Systemic Changes to Ensure Deficient Practice Does not Recur:<br>2a. Develop list of Preferred Staffing Agencies that, among other requirements, are licensed in DC<br>2b. Secure agreements with these agencies that include copies of current business licenses<br>3) Quality Assurance Program to be Implemented<br>3a. Monthly file audits with findings presented to the QAPI Committee for review. The Committee will determine if further audits/ actions are required | 4/15/2022<br><br>5/31/2022<br><br>6/23/2022 |
| R 306 | 10118.4 Private Duty Healthcare Professionals | R 306 | | |

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| R 306 | Continued From page 16 | R 306 | Private Duty Healthcare Professionals<br>Written agreements that include requirements for compliance with regulations on reporting | |

10118.4. An ALR shall have a written agreement with each private duty healthcare professional providing healthcare services on the ALR's premises, or the agency that employs him or her, if applicable, requiring the private duty healthcare professional to report the following events to the ALR and describing the procedure by which such reporting shall occur:

Based on observations, interviews and record reviews, the Assisted Living Residence failed to have a written agreement or contract with two (2) of the 2 nurse staffing agencies that provided private duty aides, for eight (8) of the 8 PDAs observed on site and the five (5) other PDAs (not observed) as reported by the Assisted Living Administrator (PDAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13).

Findings included:

Surveyors observed residents eating lunch on 03/30/2022 beginning at 11:55 AM. Interviews with the Human Resources (HR) Director later revealed that the eight (8) aides who were observed working with residents during the lunch time were private duty aides (PDAs), and not employed by the Assisted Living Residence (ALR).

On 04/04/2022 at 12:32 PM, the Assisted Living Administrator (ALA) said the facility did not have written agreements or contracts with the two nurse staffing agencies (NSAs) that deployed PDAs to the facility. No additional information was shared before the survey ended on 04/06/2022.

At the time of the survey, there was no evidence that the facility entered into written agreements with agencies employing PDAs requiring compliance with regulations on reporting

**Provider's Plan of Correction (R 306):**

1) Corrective Action to Address Identified Deficient Practice: — 4/15/2022

1a. Obtained written agreements from staffing agencies

1b. Incorporate requirements that address PDAs reporting responsibilities (med errors, abuse/ neglect allegations) and any changes in PDAs credentials

1c. File agreements electronically at the facility

2) Systemic Changes to Ensure Deficient Practice Does not Recur: — 5/10/2022

2a. Require from staffing agency evidence of PDA training on reporting requirements

2b. Require staffing agency to report to IRC any changes in staff's credentials as part of written agreement

3) Quality Assurance Program to be Implemented: — 6/23/2022

3a. Monthly file audits

3b. Findings presented to QAPI Commitee for review. The Committee will determine if further audits/ actions are required.

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| R 306 | Continued From page 17<br><br>medication errors, reporting abuse, neglect, incidents such as changes in the resident's condition, and reporting changes in the PDA's credentialing. [Also see 10118.2(b)] | R 306 | | |
| R 319 | 10119.4a Companions<br><br>10119.4a A completed criminal background check for unlicensed professionals performed in accordance with D.C. Official Code §§ 44-551 et seq. and 22-B DCMR §§ 4700 et seq., which shall be free from conviction of an offense listed in 22-B DCMR § 4705.1, or their equivalents, within seven (7) years prior to the criminal background check unless permitted under § 22-B DCMR § 4705.2.<br><br>Based on Interviews, the Assisted Living Residence failed to show evidence that it obtained a criminal background check that meets the standards and requirements as prescribed by 22B DCMR §§ 4700 et seq. from each companion, (number unknown) currently visiting facility residents.<br><br>Findings included:<br><br>During an interview with the Assisted Living Administrator (ALA) on 04/04/2022 at 12:21 PM, the ALA stated that some residents had companions who came into the facility on a regular basis to play cards and socialize. Typically, the companion was someone the family had known prior to the resident being admitted, and that the role played by the companions was important and such relationships is usually encouraged by the facility.<br><br>At 12:25 PM, the ALA said she was unaware of any facility policies and procedures that would | R 319 | Companions<br>Criminal Background Checks<br><br>1) Corrective Actions to Address Deficient Practice:<br>1a. Require companions identified during survey to obtain criminal background checks according to DC Code 44-551, 22-b DCMR 4700 et seq. and 22-B DCMR, 10119.<br>1b. Determine that companions identified during survey comprise the total number of companions servicing residents at IRC<br>1c. Inform any companion unable to meet regulatory requirements of their inability to serve as companions at IRC<br>1d. Educate families, residents, guardians, and other surrogates of the of the requirement to obtain criminal background checks prior to the individual's accepting role of companion<br><br>2) Systemic Changes to Ensure Deficient Practice Does not Recur:<br>2a. Develop operating policy that includes requirement for criminal background checks for companions<br>2b. Educate staff, residents, families, guardians, and other surrogates on policy<br>2c. Maintain electronic files on site for all companions that include evidence of criminal background checks<br><br>3) Quality Assurance Program to be Implemented:<br>3a. Audit companion files before service is initiated to ensure criminal background checks have been completed<br>3b. Report audit findings to QAPI Committee quarterly | 8/1/2022<br><br>6/1/2022<br><br>6/23/2022 |

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| R 319 | Continued From page 18<br><br>provide guidance regarding the companion services, and currently does not have an exact number of companions currently visiting the Assisted Living Residence (ALR). She said she would look for applicable policies and procedures.<br><br>At 12:30 PM, when asked if the companions obtained criminal background checks when they first presented themselves to the ALR, the ALA replied "no." The ALA described companion arrangements as "informal," adding that companions were asked to show evidence of their COVID-19 vaccination status and are required to go through the COVID-19 screening process each time they entered the facility.<br><br>On 04/04/2022 at 1:21 PM, the Director of Wellness and Infection Control, who was facilitating the survey, agreed to get the number of companions currently visiting facility residents. No additional information was made available before the survey ended on 04/06/2022.<br><br>At the time of the survey, the facility failed to ensure that companions obtained a criminal background check that met the standards and requirements as prescribed by 22B DCMR §§ 4700 et seq. | R 319 | | |
| R 326 | 10120.1 & 2 *Unlicensed Personnel Criminal Background Che<br><br>10120.1 No ALR shall employ or contract an unlicensed person for work on the ALR's premises until a criminal background check has been conducted for that person.<br><br>10120.2 An ALR shall implement and comply with the criminal background check standards and | R 326 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **INGLESIDE AT ROCK CREEK** | **3050 MILITARY ROAD NW<br>WASHINGTON, DC 20015** |

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| R 326 | Continued From page 19 | R 326 | Unlicensed Personnel Criminal Background Check | |
| | requirements for unlicensed personnel prescribed by D.C. Official Code §§ 44-551 et seq. and 22-B DCMR §§ 4700 et seq.<br>Based on interviews and record reviews, the Assisted Living Residence failed to show evidence that procedures were developed and implemented to ensure compliance with the criminal background check requirements prescribed by 22B DCMR §§ 4700 et seq., for five of the seven non-licensed employees whose records were reviewed (Staff #3, 12, 18, 19, and 20). | | 1) Corrective Action to Address Deficient Practice:<br>1a. Background checks have been scheduled or completed for staff identified during the survey. Eligibility check completed for staff #20 DC Health received email on 5/6/2022. Currently awaiting Eligibility Statement. Outstanding Items will be added to employees personne files. | 5/13/2022 |
| | | | 1b. An audit will be completed by Human Resources of current employees to ensure current background checks, licenses and finger prints are recorded in the HR file. | 5/10/2022 |
| | | | 2) Systemic Changes to Ensure Deficient Practice Does Not Recur:<br>2a. Sr. VP of Human Resources will educate IRC's Human Resources Director and Coordinator to ensure licenses, background checks & finger prints are in the employee's file prior to starting employment; and retained in the employees HR file throughout employment | 5/11/2022 |
| | Findings included:<br>On 04/01/2022 at 8:50 AM, a review of the facility's personnel records was conducted. Seven employees were identified who did not possess a professional license issued through DC Health. Of those seven employees, there was no evidence that the facility had obtained "eligibility statements" issued by DC Health for five of the unlicensed employees, verifying that they were cleared to work in a healthcare facility. | | 3) Quality Assumace Program to be implemented:<br>3a. Human Resources Director will complete an audit of employee files for one month followed by monthly for three months<br>3b. Findings will be submitted to the QAPI Committee for review. The Committee will be determine if further audits and/or actions are required. | 6/23/2022 |
| | Records showed the following:<br>1. Staff #3's personnel record lacked evidence of a DC Health "eligibility statement" clearing her for employment, although the record contained a report dated 09/29/2021, showing that Staff #3 passed a background check that was obtained through a private company.<br>2. Staff #12's personnel record showed the employee received orientation training in August 2019. The record lacked evidence of an "eligibility statement" issued by DC Health, nor was there evidence that the facility sought another background check at the time Staff #12 was hired. | | | |

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| R 326 | Continued From page 20<br>3. Staff #18's personnel record showed that on 05/22/2018, DC Health informed the applicant that he must be fingerprinted. There was no "eligibility statement" in the record and no evidence that Staff #18 was fingerprinted and completed the process through DC Health.<br>4. Staff #19's personnel record contained a series of emailed communications with DC Health, with the most recent email dated 01/30/2020 in which DC Health granted the applicant's request for a 15-day extension to get fingerprinted. There was no evidence that he followed through with fingerprinting, nor was there evidence that the facility obtained a background check that was obtained through a private company.<br>5. Staff #20's record showed no evidence that the ALR received an "eligibility statement" issued by DC Health, nor was there evidence that the facility had another background check performed.<br><br>On 04/04/2022 at 4:35 PM, the findings were discussed the facility management. The Assisted Living Administrator and the Human Resources Director acknowledged an "eligibility statement" issued by DC Health, and that there was no evidence that the facility had another background check performed.<br><br>At the time of the survey, the Assisted Living Residence failed to ensure all staff had background checks as required. | R 326 | | |
| R 330 | 10122.1 On Site Medication Review<br><br>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 | R 330 | | |

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| R 330 | Continued From page 21<br><br>medication profile, including changes in dosing and any medications that have been added or discontinued.<br>Based on record reviews and interviews, the facility failed to ensure that the Registered Nurses consistently assessed each resident's response to their medication for 11 of the 15 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15).<br><br>Findings included:<br><br>1. Review of Resident #1's record on 04/01/2022 at 12:13 PM revealed that the nursing staff reviewed the resident's medication regimen monthly, however there was no evidence that the resident's response to her medications was assessed.<br><br>2. Review of Resident #2's record on 04/01/2022 at 11:20 AM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.<br><br>3. Review of Rosidont #3's record on 04/01/2022 at 10:05 AM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.<br><br>3. Review of Resident #4's record on 04/01/2022 at 9:40 AM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed. | R 330 | On Site Med Review<br>Assessment of Resident's Reponse to Medication<br><br>1) Corrective Actions to Address Deficient Practice:<br>1a. 45-day medication reviews for residents included in the survey were updated to reflect resident's responses to meds<br>1b. 45-day reviews for all residents were reviewed and updated to include medication changes during the review period (dosage changes, discontinued meds, etc.) and resident responses to these changes. Where indicated, additional assessment information was documented in progress notes<br><br>2) Systemic Changes to Ensure Deficient Practice Does Not Recur:<br>2a. Train RNs to document resident responses to meds during 45-day med reviews<br>2b. Assign consistent RNs to complete 45-day reviews<br><br>3) Quality Assurance Program to be Implemented:<br>3a. Audit medication review documentation quarterly x3 quarters to determine compliance<br>3b. Present audit findings to QAPI Committee. The Committee will determine if further audits/ actions are required | 5/1/2022<br><br>5/15/2022<br><br>6/23/2022 |

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| R 330 | Continued From page 22 | R 330 | | |

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4. Review of Resident #5's record on 03/31/2022 at 4:39 PM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.

5. Review of Resident #9's record on 04/01/2022 at 9:49 AM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.

6. Review of Resident #10's record on 04/01/2022 at 8:58 AM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.

7. Review of Resident #11's record on 04/01/2022 at 4:34 PM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.

8. Review of Resident #12's record on 04/01/2022 at 2:54 PM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.

9. Review of Resident #13's record on 04/01/2022 at 1:20 PM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications

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| R 330 | Continued From page 23<br>was assessed.<br><br>10. Review of Resident #14's record on 04/01/2022 at 3:40 PM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.<br><br>11. Review of Resident #15's record on 04/01/2022 at 1:42 PM, revealed that the nursing staff reviewed the resident's medication regimen every 45 days, however there was no evidence that the resident's response to the medications was assessed.<br><br>During interview on 04/01/2022, the Director of Wellness and Infection Control acknowledged the findings. The Director stated that she identified the deficient practice when she joined the ALR and had put a document in place for the nurses, that captures the assessment of the resident's response to their medications.<br><br>At the time of the survey, the ALR failed to ensure the nurses consistently assessed each resident's reaction to their medications. | R 330 | | |