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 _____	06/09/2023

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 06/06/2023, 06/07/2023, 06/08/2023 and 06/09/2023, 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 48 residents and employed 63 personnel, including professional and administrative staff. A sample of 15 resident records and 16 employee records were selected for review. The findings of the survey were based on observations throughout the facility, including a medication administration pass, clinical and administrative record review, and resident, family, and staff interviews.	R 000	Ingleside at Rock Creek is filing this Plan of Correction for the purposes of regulatory compliance. To remain in compliance with all Federal and State regulations, the Center will take the actions set froth in the following Plan of Correction which 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. **R074: Completion of Admission/Annual Medical Certification Form** 1. Corrective Action to Identify Deficient Practice - Medical Certification forms for all residents were audited to determine if required information had been entered. Seventeen (17) residents were identified as having missing information. Information was updated on forms of these residents. 2. Systemic Changes to Ensure Deficient Practice Does Not Recur. a. Re-trained Delegating Nurse on requirement to complete all sections of Medical Certification forms. b. Developed policy that 1) requires Delegating Nurse to review form for completeness prior to admission clinical assessment. 2) prevents conduct of admission assessment unless form is completed prior to the assessment. 3. Process to Monitor Corrective Action Medical Certification forms will be audited monthly for completeness and findings reported to QAPI Committee quarterly x 4. Threshold: 100%	6/13/23 6/14/23 6/30/23 6/30/23 6/30/23
R 074	10108.2 Admissions 10108.2 Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all required information, for five of the 15 residents in the sample (Residents #10, 12, 13, 14, and 15). Findings included: The ALR failed to ensure each resident's Medical Certification Form was completed with all required assessment areas addressed, as follows: 1. On 06/8/23 at 10:58 am, a review of Resident	R 074		

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 _____	06/09/2023

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 074	Continued From page 1. #10's Medical Certification form dated 02/02/2022 showed no documented evidence that the physician determined the resident's tuberculosis status. The physician also failed to indicate if the resident had or needed dentures. 2. On 06/07/2023 at 3:37 pm, a review of Resident #12's Medical Certification form dated 03/31/2022 showed no documented evidence that the physician assessed the resident's vital signs, including pulse, respirations, height, and weight. Also, the physician failed to document if the resident needed to be screened for dementia or had or needed dentures. 3. On 06/07/2023 at 3:18 pm, a review of Resident #13's Medical Certification form dated 05/01/2023 showed the physician failed to document if the resident had or needed dentures. 4. On 06/07/2023 at 2:41 pm, a review of Resident #14's Medical Certification form dated 04/25/2023 showed no documented evidence that the physician assessed if the resident had or needed a mammogram or Papanicolaou (pap) test or dentures. 5. On 06/07/2023 at 3:18 pm, a review of Resident #15's Medical Certification form dated 04/11/2023 showed the physician failed to document if the resident had or needed dentures. During interview on 06/06/2023 at 2:54 pm, the Delegating Nurse (DN) and Director of Clinical Operations (DCO) both acknowledged the above findings, that the Immediate Care Facilities Division Admission/Annual Medical Certification forms were not filled out completely at the time of the survey. The DN and the DCO stated that the ALR would explore strategies to get the	R 074		

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 _____	06/09/2023

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 074	Continued From page 2. physicians to complete all sections on the Immediate Care Facilities Division Admission/Annual Medical Certification form. At the time of the survey, the ALR failed to ensure all sections of the Immediate Care Facilities Division Admission/Annual Medical Certification forms were completed by the physician.	R 074		

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 _____	06/09/2023

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 06/06/2023, 06/07/2023, 06/08/2023 and 06/09/2023, 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 48 residents and employed 63 personnel, including professional and administrative staff. A sample of 15 resident records and 16 employee records were selected for review. The findings of the survey were based on observations throughout the facility, including a medication administration pass, clinical and administrative record review, and resident, family, and staff interviews.	R 000	**R421: Provision of Signed Written Contract Prior to Admission.** 1. Corrective Action to Identify Deficient Practice. All resident agreements were reviewed to identify any additional contracts signed on or after admission. None were identified. 2. Systemic Changes to Ensure Deficient Practice Does Not Recur. a. Postpone any admission until signature is obtained on contract. b. Update policy to include protocol change. 3. Process to Monitor Corrective Action. All resident agreements will be audited for completeness by Delegating Nurse monthly and findings reported to QAPI Committee quarterly x 4. Threshold: 100%.	6/14/23 6/14/23 6/30/23
R 421	Sec. 602a Resident Agreements (a) A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following: Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident was provided with a written agreement prior to admission, for three of the 15 residents in the sample (Residents #10, 11, and 12). Findings included: 1. On 06/07/2023 at 3:37 pm, a review of Resident #12's records showed that the resident was admitted on 04/04/2022. Continued review of the resident's record showed that the agreement	R 421		

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 _____	06/09/2023

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 421	Continued From page 1. form was signed on the same day, not prior to admission. 2. On 06/08/2023 at 10:58 am, a review of Resident #10's records showed that the resident was admitted on 02/14/2022. Continued review of the resident's record showed that the agreement form was signed on the same day, not prior to the admission. 3. On 06/08/2023 at 10:31 am, a review of Resident #11's record showed that the resident was admitted on 07/28/2022. Continued review of the resident's record showed that the agreement form was signed on the same day, not prior to admission. At 2:30 pm, the above findings were discussed with the Administrator of Health Services and Director of Clinical Operations (DCO), who both acknowledged that the resident agreements were not signed prior to the resident admission, as required. The Administrator of Health Services and the DCO both stated that moving forward, they will ensure that resident agreements will be signed prior to admissions. At the time of the survey, the ALR failed to ensure that each resident agreement was signed prior to the resident's admission.	R 421		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Registered Nurse (RN) developed Individualized Service Plans (ISP's) prior to	R 471		

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 _____	06/09/2023

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 2. admission, for seven of the 15 residents in the sample (Resident #1, 2, 10, 12, 13, 14, and 15). Findings included: A review of the sampled residents' records starting at 9:00 am from 06/06/2023 through 06/09/2023 showed no evidence that the ALR's RN developed an ISP prior to the residents' admission at follows: 1. On 06/07/2023 at 3:00 pm, a review of Resident #1's medical record showed that the resident was admitted on 04/24/2022. There was no documented evidence that an ISP was developed prior to admission. 2. On 06/08/2023 at 10:47 am, a review of Resident #2's medical record showed that the resident was admitted on 11/19/2022. Further review of the record failed to show evidence that an ISP was developed prior to the resident's admission. 3. On 06/08/2023 at 10:58 am, a review of Resident #10's medical record showed that the resident was admitted on 02/14/2022. Continued review of the record showed that the resident's ISP was developed on the same day (02/14/2022). 4. On 06/07/2023 at 3:17 pm, a review of Resident #12's medical record showed that the resident was admitted on 02/14/2022. Continued review of the record showed that the resident's ISP was developed on the same day (02/14/2022). 5. On 06/07/2023 at 3:18 pm, a review of Resident #13's medical record showed that the	R 471	**R471: Development of ISP Prior to Admission by RN** 1. Corrective Action to Identify Deficient Practice. All ISPs for residents admitted within previous 12 months were reviewed to identify residents whose service plans were not developed prior to admission. None had service plans developed prior to admission. Reviewed regulations with Delegating Nurse. 2. Systemic Changes to Ensure Deficient Practice Does Not Recur. a. Trained Delegating Nurse and Charge Nurses on development of pre-admission ISPs. b. Developed ISP documentation competency for nurses. 3. Process to Monitor Corrective Action. ISPs for new admissions will be audited monthly by Delegating Nurse for evidence that RN developed ISP prior to admission. Findings will be reported to QAPI Committee quarterly x4. Threshold: 100%.	6/14/23 6/15/23 6/30/23

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 _____	06/09/2023

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 3. resident was admitted on 04/18/2023. Continued review of the record showed that the resident's ISP was developed one day after the resident's admission. 6. On 06/07/2023 at 2:41 pm, a review of Resident #14's medical record showed that the resident was admitted on 06/10/2022. Continued review of the record showed that the resident's ISP was developed on the same day (06/10/2023). 7. On 06/07/2023 at 1:24 pm, a review of Resident #15's medical record showed that the resident was admitted on 05/04/2023. Continued review of the record showed that the resident's ISP was developed on the same day (05/04/2023). On 06/09/2023 at 12:55 pm, the Administrator of Health Services and Director of Clinical Operations (DCO) acknowledged during an interview that the RN had not developed ISPs for the above residents prior to admission. At the time of the survey, the ALR failed to ensure residents' ISPs were developed prior to admission.	R 471		
R 472	Sec. 604a2 Individualized Service Plans (2) An ISP shall be developed following the completion of the "post move-in" assessment. Based on record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure Individualized Service Plans (ISP's) had been developed after the post move-in assessment, for three of the 15 residents in the sample. (Residents #1, 4 and 11.)	R 472		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		PRINTED: 06/14/2023 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0010	B. WING	06/09/2023 (X5) COMPLETE DATE

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)	
R 472	Continued From page 4 Findings Included: 1. On 06/07/2023 at 3:00 pm, a review of Resident #1's medical record showed that the resident was admitted on 04/24/2022. The record, however, lacked documented evidence that an ISP was developed after the post move-in assessment. 2. On 06/08/2023 at 10:31 am, a review of Resident #11's medical record revealed that the resident was admitted on 07/28/2022. The record, however, lacked documented evidence that an ISP was developed after the post move-in assessment. 3. On 06/08/2023 at 11:19 am, a review of Resident #4's medical record showed that the resident was admitted on 11/10/2022. Continued review of the record failed to show documented evidence that an ISP had been developed after the post move-in assessment. On 06/09/2023 at 1:05 pm, both the Administrator of Health Services and Director of Clinical Operations (DCO) confirmed during an interview that ISPs had not been developed and indicated that they would ensure that an ISP is developed for all residents following their post move-in assessment. At the time of the survey, the ALR failed to ensure ISPs had been developed following the post-move in assessment.	R 472	**R472: Development of ISP after Post Move-In Assessment** 1. <u>Corrective Action to Identify Deficient Practice.</u> Medical records for residents admitted within previous 12 months were reviewed to determine if ISPs were developed after post move-in assessments. Three (3) additional records were found deficient. Reviewed regulations with Delegating Nurse. 2. <u>Systemic Changes to Ensure Deficient Practice Does not Recur.</u> a. Trained Delegating Nurse and Charge Nurses on completing post-admission ISPs. b. Update policy to include documentation changes. c. Develop ISP documentation competency for nurses. 3. <u>Process to Monitor Corrective Action.</u> Medical records of new admissions will be audited for development of ISPs following post move-in assessments by Delegating Nurse monthly. Findings will be reported to QAPI Committee quarterly x4. Threshold: 100%.	6/14/23 6/14/23 6/30/23 6/30/23
R 473	Sec. 604a3 Individualized Service Plans (3) The ISP shall be written by a healthcare	R 473		

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 _____	06/09/2023

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 473	Continued From page 5. practitioner using information from the assessment. Based on record reviews and interview, the Assisted Living Residence (ALR) failed to ensure each resident's Individualized Service Plan (ISP) were written using information from the assessment, for four of the 15 residents in the sample (Resident #3, 6, 8 and 11). Findings included: 1). On 06/08/2023 at 10:25 am, a review of Resident #3's nursing assessment dated 04/26/23 states, "Resident is readmitted after left hip surgical site intact and remain visible, nurse also observed right lower leg/proximal to knee with a rash measuring at 4 x 3 cm." Continued review of Resident #8's ISP (not dated) failed to reflect a focus area on the surgical site care or any goals and interventions to manage the health concern. 2). On 06/08/2023 at 12:16 pm, observations showed Resident #6 lunch meal was served in a puree consistency. At 1:59 pm, a review of Resident #6's medical record showed that the resident was to receive a pureed diet. A review of Resident #6's ISP dated 01/31/2023 failed to reflect a focus area for modified diet or any goals and interventions to manage the resident's nutritional concern. 3). On 06/08/2023 at 10:30 am, a review of Resident #8's medical record showed that the resident was receiving mechanical soft diet, thin consistency. Continued review of the resident's ISP (not dated) failed to reflect a focus area for modified diet or any goals and interventions to manage the resident's nutritional concern.	R 473	**R473: ISP are Based on Information from Assessments** 1. Corrective Action to Identify Deficient Practice. Medical records for residents admitted within previous 12 months were reviewed to determine if assessment information is included in the ISP. Eight (8)records were identified as deficient. 2. Systemic Changes to Ensure Deficient Practice Does Not Recur. a. Train Delegating Nurse and charge nurses to update ISP upon completion of assessments. Review completed b. assessments and corresponding ISPs daily in morning meeting. c. Develop ISP documentation competency for nurses. 3. Process to Monitor Corrective Action. Medical records will be audited monthly for development of ISPs that include interdisciplinary assessments. Findings will be reported to QAPI Committee quarterly x4. Threshold: 100%.	6/14/23 6/30/23 6/30/23 6/30/23

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 _____	06/09/2023

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 473	Continued From page 6. 4). On 06/08/2023 at 10:31 am, a review of Resident #11's Intermediate Care Facilities Admission/Annual Medical Certification form dated 07/28/2023 showed that the resident had skin cancer and the physician documented that he is monitoring the condition. A review of Resident #11's ISP dated 03/16/2023 failed to reflect the diagnosis of skin cancer and any goals and interventions to manage this concern. During the interview on 06/09/2023 at 1:05 pm, the Administrator of Health Services and Director of Clinical Operations (DCO) both acknowledged the findings that the ISP's were not updated using information from the assessments. At the time of the survey, the ALR failed to ensure that all ISP's were completed using information from the assessment.	R 473	wnymY LŘŜyűΛŦΛŎI·ûΛ2y˝ΛY˝ûKŜ L{t 2Ŧ {ŜℕØΛŎŜă tℕ2ØΛŘŜŘΣ CℕŜIjdzŜyŎè 2Ŧ {ŜℕØΛŎŜăΣ I·yŘ I2øκ.è ² K2Y {ŜℕØΛŎŜă ² Λff ōŜ tℕ2ØΛŘŜŘ 1. Corrective Action to Identify Deficient Practice. Medical records for residents admitted within previous 12 months were reviewed to determine if detailed descriptions of services provided were included in the ISP. Twelve service plans did not include details of services provided. 2. Systemic Changes to Ensure Deficient Practice Does Not Recur. a. Train Delegating Nurse and Charge Nurses to include detailed service descriptions in ISPs. b. ¦ LJŘI·ûŜ policy t2 ΛyŎfdzŘŜ ăLJŜŎΛŦΛŎŎ2yűŜyű ℕŜIjdzℕŜY˝Ŝyűă Ŧ2ℕ L{tăΦ c. Develop ISP documentation competency for nurses. 3. Process to Monitor Corrective Action ISPs will be monitored monthly by the Delegating Nurse for ŘŜăŎℕΛLJûΛ2yã ΛY˝ûKŜ L{t 2Ŧ serviceă provided to the resident. Findings will be reported to QAPI Committee quarterly x4. Threshold: 100%.	6/14/23 6/14/23 6/30/23 6/30/23
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Individualized Service Plans (ISP's) contained all services, to include when, how often, and by whom the services will be provided, for five of the 15 residents in the sample (Residents #2, 6, 7, 8 and 11). Findings included 1. On 06/07/2023 at 9:15 am, a female staff was observed retrieving linen from a closet. When asked, the female staff said that she provided?	R 481		

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 _____	06/09/2023

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 481	Continued From page 7. private duty aide (PDA) services daily for Resident #2. A review of Resident #2's record failed to show documented evidence that an ISP was developed to include the use of PDA services by the resident. 2. On 06/09/2023 at 10:30 am, Resident #6 was observed in his motorized wheelchair outside the facility with a male staff walking closely behind him. At 11:53 am, an interview with the male staff revealed that he was Resident #6's Companion/Home Health Aide. A review of Resident #6's ISP dated 01/31/2023 failed to reflect that the residents utilize the help of a Companion, including when, how often, and by whom the services were being provided. 3. On 06/07/2023 at 2:47 pm, a review of Resident #7's medical record showed that the resident was receiving hospice care under Capital Caring Hospice. Continued review of Resident #7's ISP dated 02/23/2023 failed to reflect a focus area on hospice care, including when, how often, and by whom the services were being provided. 4. On 06/08/2023 at 10:26 am, a review of Resident #8's medical record showed that the resident was receiving hospice care under Capital Caring Hospice. However, a review of Resident #8's ISP (not dated) did not reflect a focus area on hospice care to include when, how often, and by whom the services will be provided. 5. A review of Resident #11's medical record revealed a physical therapy (PT) referral for right knee pain. Continued review of the residents ISP dated 03/16/2023 failed to reflect PT services, including when, how often, and by whom the services will be provided.	R 481		

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 _____	06/09/2023

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 481	Continued From page 8. During an interview on 06/09/2023 at 1:05 pm, the Administrator of Health Services and Director of Clinical Operations (DCO) acknowledged the findings that the ISP's did not include all services provided to its residents. At the time of the survey, the ALR failed to ensure that all ISP's contained all services provided to its residents.	R 481	wnyoY {ŜNØΛÖŜ tfl·yã l·NŜ ú2 ōŜ wŜØΛŜøŜŘ l·ú wŜljdzNNŜŘ LyúŜNØÍ·fă ōè l ŜI·fúKÖÍ·NŜ tNl·ÖúΛúΛ2yŜN l·yŘ wŜăΛŘŜyú 2N wŜăΛŘŜyú¶ă {dzNN23Il·úŜΣ l·yŘ ¦ LJŘl·úŜŘ øΛúK {λ3yΛŦΛÖl·yú /Kl·y3ŜăΦ MΦ /2NNŜÖúΛØŜ ! ÖúΛ2y´ú2 LŘŜyúΛŦè 5ŜŦΛÖΛŜyú tNl·ÖúΛÖŜΦ {ŜNØΛÖŜ tfl·yã øŜNŜ l·dzŘΛúŜŘ ú2 ΛŘŜyúΛŦè NŜØΛŜó ŦNŜljdzŜyÖΛŜăT dzLJŘl·úŜăT l·yŘ ăΛ3yl·údzNŜă ōè l / tΣ NŜăΛŘŜyú Σ 2N úKŜ NŜăΛŘŜyú¶ă ădzNN23Il·úŜΦ C2dzN ónú l·ŘŘΛúΛ2yl·f L{tă øŜNŜ ΛŘŜyúΛŦΛŜŘ l·ă ŘŜŦΛÖΛŜyúΦ wŜ3dzfl·úΛ2yã øŜNŜ NŜØΛŜøŜŘ øΛúK úKŜ 5ŜfŜ3l·úΛy3 bdzNăŜΦ HΦ {ëăúŜY´ΛÖ /Kl·y3ŜăúΛ2 9yãdzNŜ 5ŜŦΛÖΛŜyú tNl·ÖúΛÖŜ 52Ŝă b2ú wŜÖdzNΦ a. Develop and implement automated ISP scheduling process within EHR. b. Train Delegating Nurse and Charge Nurses on scheduling system and documentation protocols for ISPs. 3. Process to Monitor Corrective Action. Delegating Nurse will review schedules monthly for accuracy, timeliness, and compliance with documentation protocols. Findings will be reported to QAPI Committee quarterly x4. Threshold: 100%.	CKMΠKHO TKMHKHO TKMpKHO TKHyKHO
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 interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Individual Support Plan (ISP) was reviewed 30 days after admission, at least every six months, updated with significant changes, and that the ISP's had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate, for 12 of the 33 residents sampled (Residents #2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 14 and 15). Findings included: I). The ALR failed to review each resident's ISP 30 days after admission, as follows:	R 483		

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 _____	06/09/2023

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. a. On 06/08/2022 at 11:19 am, a review of Resident #4's medical record showed that the resident was admitted on 11/10/2022. Continued review of the residents ISP failed to show documented evidence that an ISP was completed 30 days after the resident was admitted. b. On 06/08/2023 at 10:47 am, a review of Resident #2's medical record showed that the resident was admitted on 11/19/2022. Continued review of the resident's record failed to show documented evidence that an ISP was completed 30 days after the resident was admitted. c. On 06/07/2023 at 3:18 pm, a review of Resident #13's medical record showed that the resident was admitted on 04/18/2023. Continued review of the residents ISP failed to show documented evidence that the ISP was reviewed 30 days after the resident was admitted. d. On 06/07/2023 at 2:41 pm, a review of Resident #14's medical record showed that the resident was admitted on 06/01/2022. Continued review of the resident's record failed to show documented evidence that the ISP was reviewed 30 days after the resident was admitted. e. On 06/07/2023 at 1:24 pm, a review of Resident #15's medical record showed that the resident was admitted on 05/04/2023. Continued review of the residents ISP failed to show documented evidence that the ISP was reviewed 30 days after the resident was admitted. II). The ALR failed to update each resident's ISP every six months, as follows: a. On 06/08/2023 at 10:47 am, a review of Resident #2's medical record showed that the	R 483		

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 _____	06/09/2023

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 10. resident was admitted on 1/19/2022. Further review of the medical record revealed there were no ISP's available for review. b. On 06/08/2023 at 10:58 am, a review of Resident #10's medical record showed that the resident was admitted on 02/14/2022. Further review of the medical record showed that an ISP dated 03/30/2023. There was no documented evidence that the ISP was reviewed six months prior to 03/30/2023. c. On 06/07/2023 at 3:37 pm, a review of Resident #12's medical record showed that the resident was admitted on 04/04/2022. Further review of the medical record showed that an ISP dated 05/11/2023. There was no evidence that the ISP was reviewed six months prior to 05/11/2023. d. On 06/07/2023 at 2:41 pm, a review of Resident #14's medical record showed that the resident was admitted on 06/01/2022. Further review of the medical record showed no documented evidence that ISPs were reviewed every six months after the resident's admission. III). The facility failed to update the resident's ISP with significant changes, as follows: a. On 06/09/2023 at 12:04 pm, a review of the facility's complaint/incident reports showed an incident dated 02/18/2023. According to the incident, Resident #4 was observed having tremors with altered mental status and was transferred to the nearest emergency room (ER) via 911 for an evaluation secondary to tachycardia, tremors, and low oxygen saturation. The above ER visit was not reflected on Resident #4's current ISP.	R 483		

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 _____	06/09/2023

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 11. b. On 06/08/2023 at 12:04 pm, a review of Resident #12's nursing progress notes showed that the resident tested positive for the COVID-19 virus on 09/15/2022. Continued review of the residents ISP dated 05/11/2023 failed to show documented evidence that the resident's COVID status was addressed, and preventive measures implemented. c. On 06/08/2023 at 10:25 am, a review of Resident #3's nursing assessment dated 04/26/23 states, "Resident is readmitted after left hip surgical site intact and remain visible, nurse also observed right lower leg/proximal to knee with a rash measuring at 4 x 3 cm." Further review of Resident #8's ISP (not dated) failed to reflect a focus area on the surgical site care or any goals and interventions to manage this concern. d. Observations on 06/08/2023 at 12:16 pm, showed Resident #6 lunch meal was served in a puree consistency. At 1:59 pm, a review of Resident #6's medical record showed that the resident was to receive a pureed diet. Continued review of Resident #6's ISP dated 01/31/2023 failed to reflect a focus area for modified diet or any goals and interventions to manage the resident's nutritional concern. e. On 06/09/2023 at 10:30 am, Resident #6 was observed in a motorized wheelchair outside the facility accompanied by a male staff. During an interview at 11:53 pm, the male staff revealed that he was Resident #6's Companion/Home Health Aide. A review of Resident #6's ISP dated 01/31/2023 failed to reflect that the resident utilizes a Companion, including, when, how often, and by whom the services were provided.	R 483		

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 _____	06/09/2023

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 12. f. On 06/07/2023 at 2:47 pm, a review of Resident #7's medical record showed that the resident was receiving hospice care under Capital Caring Hospice. Continued review of Resident #7's ISP 02/23/2023 failed to reflect a focus area on hospice care or any goals and interventions to manage the resident's hospice care. g. On 06/08/2023 at 10:26 am, a review of Resident #8's medical record showed that the resident was receiving hospice care under Capital Caring Hospice. Continued review of the resident's ISP (not dated) failed to reflect a focus area on hospice care or any goals and interventions to manage the resident's hospice care. h. On 06/08/2023 at 10:30 am, a review of Resident #8's medical record showed that the resident was receiving mechanical soft diet, thin consistency. Continued review of the resident's ISP (not dated) failed to reflect a focus area for modified diet or any goals and interventions to manage the residents nutritional concern. i. On 06/08/2023 at 10:31 am, a review of Resident #11's medical record showed a physical therapy (PT) referral for right knee pain. Continued review of the resident's ISP dated 03/16/2023 failed to reflect the diagnosis of skin cancer and PT services or any goals and interventions to manage the resident's health concerns. j. On 06/08/2023 at 10:31 am, a review of Resident #11's Intermediate Care Facilities Admission/Annual Medical Certification form dated 07/28/2023 showed that the resident had skin cancer and the physician documented that	R 483		

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 _____	06/09/2023

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 13. he is monitoring the condition. Continued review of the resident's medical record revealed a physical therapy (PT) referral for right knee pain. Further review of Resident #11's ISP dated 03/16/2023 failed to reflect the diagnosis of skin cancer and PT services or any goals and interventions to manage these concerns. On 06/09/2023 at 12:53 pm, the Administrator of Health Services and Director of Clinical Operations both confirmed during the exit conference that the ISP's were not completed and/or reviewed 30 days after the residents were admitted to the ALR. The Administrator and Director of Clinical Operations also confirmed during an interview that the ISP's were not updated at least every six months and updated to reflect significant changes in the resident's health status. At the time of the survey, the ISP's lacked documented evidence that they were reviewed either 30 days after admission, at least every six months, and/or updated to address significant changes.	R 483		