STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0037	A. BUILDING: _____ B. WING _____	11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASS SR CARE,LLC T/A THE RESIDENCES AT	1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments An annual survey was conducted on 11/05/18 through 11/09/18 to determine compliance with the Assisted Living Law. The Assisted Living Residence provided care for 35 residents and employed 150 personnel to include professional and administrative staff. The findings of the survey were based on observations, record reviews, and interviews. Listed below are abbreviations used throughout the body of this report: ALR - Assisted Living Residence DON- Director of Nursing ISP - Individualized Service Plan HRD - Human Resources Director CNA - Certified Nursing Assistant LPN - Licensed Practical Nurse RN - Registered Nurse	R 000		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; Based on record review, policy review and interview, the facility failed to follow the fall policy for one of two residents in the sample who fell (Resident #5). Findings included: Record review of the facility's revised policy titled, "Fall Policy", dated 04/17/18, showed that following each resident fall, the ALR staff were to complete a fall risk tool, complete a [comprehensive] assessment, update the ISP	R 292		

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R 292	Continued From page 1 with new intervention(s), and discuss interventions with care staff. Record review of the facility's incident reports on 11/08/18 at 9:30 AM showed that Resident #5 fell eight times from 02/08/18 through 10/09/18 (02/08/18, 02/18/18, 06/12/18, 07/02/18, 08/20/18, 08/29/18, and 10/09/18). Three of the falls (02/18/18, 07/02/18, and 10/09/18) resulted in injuries that included a scratch to the forehead, swollen area of the forehead, and swollen left knee. Review of Resident #5's current medical record on 11/09/18 at 9:30 AM revealed the resident had a history of Anoxic Brain Damage, Seizure Disorder, Depression, Gait Disorder, Dizziness, and Hypertension. Further review of the records showed that the resident had seven falls from 02/08/18 through 10/09/18. The record lacked documented evidence the staff followed the fall policy, as evidenced below: - 02/08/18: No fall risk tool completed, ISP not updated to reflect new interventions; - 02/18/18-: No assessment completed, ISP not updated to reflect new interventions; - 06/12/18: No assessment completed, ISP not updated to reflect new interventions; - 07/02/18: Care staff not re-educated on new interventions; - 08/20/18: No fall risk tool completed, ISP not updated to reflect new interventions; -08/29/18: No fall risk tool completed, care staff not re-educated on new interventions; and	R 292	1. The ISP for resident #5 was reviewed to ensure goals and interventions are realistic that are tailored to address residents falls with the necessary interventions. 2. AL Manager was in-serviced to ensure ISP's are updated with new intervention and care staff is educated with all the new intervention. Nursing staff has been in-serviced to ensure the nurses have a full understanding of the facility fall, and assessment policy. 3. AL manager/designee will Audit, and document findings and present to QA committee for review, evaluation and approval.	11/10/19 1/18/19 1/30/19

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R 292	Continued From page 2 - 10/09/18: No fall risk tool completed, care staff not re-educated on new interventions. During an interview on 11/09/18 at 2:00 PM, the DON stated that Resident #5 refused to call for assistance when transferring. At the time of the survey, the ALR failed to ensure the provision of adequate and appropriate services to address the individual needs of Resident #5 and to ensure the resident's health and safety.	R 292	1. Resident #5 history and physical was reviewed by the primary care physician and corrections were made at the time of the survey. 2. To prevent future occurrences and to ensure compliance, AL manager will be in-serviced on how to review of the physician history and physical to ensure proper completion of history and physical by the primary care physician before admission to the facility. 3. Al manger/designee will review monitor resident's history and physical to ensure that they are correctly completed before admission to the facility. AL manager/designee will Audit, and document findings and present to QA committee for review, evaluation and approval.	11/19/18 ongoing ongoing
R 407	Sec. 601d2 Admissions (2) Is at high risk for health or safety complications which cannot be adequately managed by the ALR and requires more than 35 hours per week of skilled nursing and home health aide services combined, provided on less than a daily basis, according to section 2113.1 of HCFA Pub. 75 and 42 CFR, sections 409.32, 409.33, and 409.44. Based on record review, observation, and interview, the ALR admitted a resident who required 24-hour skilled nursing services for one of five residents in the sample (Resident #5). Findings included: Review of Resident #5's clinical record on 11/08/18 at 11:00 AM showed that the resident was admitted on 08/05/17. Further review of the record revealed a history and physical signed by the physician on 07/26/17, which indicated that the resident required 24-hour skilled nursing care.	R 407		

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R 407	Continued From page 3 Observation of Resident #5 on 11/08/18 at 12:00 PM showed that the resident was alert, oriented to name, time, place, and situation. Continued observation showed that the resident's gait was unsteady and uncoordinated. During an interview on 11/08/18 starting at 12:50 PM, the DON stated that she had spoken with the resident's physician, who acknowledged that the resident did not require 24-hour skilled nursing. Continued interview revealed that the physician incorrectly completed the history and physical.	R 407		
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 review and interview, the ALR failed to ensure an ISP had been developed after the post move-in assessment for one of one newly admitted residents in the sample (Resident #2). Findings included: Review of Resident #2's clinical record on 11/06/18 at 11:30 AM showed that the resident was admitted on 10/07/18. A post move-in assessment was conducted by the facility's nurse on 10/07/18. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post move-in assessment. During an interview on 11/06/18 at 11:50 AM, the DON stated that she would ensure a post move-in ISP was developed no later than 48 hours after the completion of the post move-in assessment.	R 472	1. The ISP for resident #2 was revised to include goals and approaches for the resident following the residents post-move in assessment with in 48hrs. 2. To prevent future occurrences, the nursing staffs were re-educated on the post move in assessment procedures. 3. AL manager/designee will monitor all new admissions; Post-move in assessments are completed within 48hrs of admission. Audit, and document findings and present to QA committee for review, evaluation and approval.	11/10/18 11/10/18 ongoing

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R 472	Continued From page 4 At the time of the survey, the ALR failed to ensure Resident #2 had an ISP developed following the completion of the post move-in assessment.	R 472		
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 record review and interview, the ALR failed to document in ISPs how often services would be provided for one of one resident in the sample who had frequent falls (Resident #1). Findings included: Review of the Resident #1's current medical record on 11/07/18 at 10:00 AM revealed an ISP dated 11/06/18 which lacked documented evidence of the frequency that staff was to assist the resident with dressing, feeding, and transferring. During an interview on 11/07/18 at 10:30 AM, the DON stated that she would ensure the frequency for all services was included on residents' ISPs going forward. At the time of the survey, the ALR failed to include the frequency for services on the ISP for Resident #1.	R 481	1. The record of resident #1 was reviewed with the evidence of the frequency of dressing, feeding, and transferring at the time of the survey and presented to the surveyor. 2. To prevent future occurrences and to ensure compliance, nursing staff will be educated to include the frequency of services provided on the ISP assessments. 3. The AL manager/ designee will document findings and report to QA committee monthly for review, evaluation, and approval.	11/9/18 ongoing ongoing
R 598	Sec. 701d11 Staffing Standards. (11) Maintain personnel records for each employee that include documentation of criminal background checks, statements of health status,	R 598		

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R 598	Continued From page 5 and documentation of the employee's communicable disease status; Based on record review and interview, the ALR failed to document the communicable disease status for two of six employees (ALR Staff Administrator and CNA #4). Findings included: Review of the facility's personnel records for the Administrator and CNA #4 on 11/08/18, at 2:48 PM and 3:23 PM, respectively, showed no documented evidence of their communicable disease status. This information was brought to the attention of the HRD on 11/08/18 at 3:06 PM. During the interview, the HRD stated that the Administrator was out of the country and the HRD did not have access to his office. The HRD also stated that she would be sure to get documented evidence of the communicable disease status for the Administrator and CNA #4, and she would send it to the surveyor via email. It should be noted that there was no documented evidence received from the facility via email. At the time of the survey, the ALR failed to maintain personnel records for the Administrator and CNA #4 that included the communicable disease status.	R 598	1. HR has completed an audit of all employee files to 1. Ensure all current employees have an annual Tb screen on record 2. Identify individuals with a history of positive PPD TB skin test and ensure a physician certifies these individuals free of communicable disease. Audit effective completion date is 11/20/2018. 2. HR director or designee will audit all employee health records no later than date 11/25/2018 to ensure 100% compliance with this plan of correction. 3. Following the initial compliance audit, HR director or designee will complete an audit of all new hire, document findings and present it to QA committee for review evaluation and approval.	11/20/18 11/25/18 ongoing
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record review and interview, the ALR failed to ensure an RN conducted a review of the residents' response to medications every 45 days	R 802		

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R 802	Continued From page 6 for three of five residents in the sample (Residents #3, #4, and #5). Findings included: 1. Review of Resident #3's clinical record on 11/07/18 at 10:00 AM showed that the resident was admitted on 04/29/14, and the nursing staff was responsible for administering the resident's medications. Further review of the clinical record revealed medication reviews dated 06/25/18, 07/25/18, and 10/25/18 that were conducted by an LPN and not an RN, as required. Additionally, the medication reviews lacked documented evidence of the resident's response to the medications. 2. Review of Resident #4's clinical record on 11/07/18 at 12:00 PM showed that the resident was admitted on 07/28/16, and the nursing staff was responsible for administering the resident's medications. Further review of the clinical record revealed medication reviews dated 08/24/18, 09/25/18, and 10/25/18 that were conducted by an LPN and not an RN, as required. Additionally, the medication reviews lacked documented evidence of the resident's response to the medications. 3. Review of Resident #5's clinical record on 11/08/18 at 11:00 AM showed that the resident was admitted on 08/05/17, and the nursing staff was responsible for administering the resident's medications. Further review of the clinical record revealed medication reviews dated 07/25/18, 08/24/18, 09/25/18, and 10/25/18 that were conducted by an LPN and not an RN, as required. Addtionally, the medication reviews lacked documented evidence of the resident's response to the medications.	R 802	1. The residents were not harmed by this deficient practice. Residents #3, #4 and #5 were assessed based on the current medication administration procedures and have a current assessment conducted by RN. 2. In- service training was provided to the AL manager regarding the assessment and documentation of residents response to medications every 45 days in the residents medical record. 3. AL manager/designee will Audit, and document findings and present to QA committee for review, evaluation and approval.	11/10/18 01/10/19 ongoing

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R 802	Continued From page 7 During an interview on 11/08/18 at 1:00 PM, the DON stated that going forward she would ensure that RNs assessed residents' response to medications. At the time of the survey, the ALR failed to ensure each resident was assessed for a response to their medications every 45 days.	R 802		
R 981	Sec. 1004a General Building Interior (a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair. Based on observation and interview, the ALR failed to ensure the facility interior was maintained in sanitary condition and all equipment was in good repair. Findings included: Observations on 11/05/18 at 10:53 AM during an environmental walk-through of the ALR's apartments revealed the following: 1. Apartment #312's bathroom faucet was not stationary and moved when the hot water was turned on. Further observation in Apartment #312 showed that the walls throughout the apartment were soiled. It should be noted that the facility's Maintenance Supervisor accompanied the surveyors during the walk-through and indicated that he would ensure that the faucet was repaired and the walls would be painted. 2. Apartment #316's ceiling showed a large water stain. During an interview on 11/05/18 at 10:59	R 981	**Apartment 312 No.1** 1. The bathroom faucet to apartment 312 noted at the time of the survey was repaired. The walls throughout the apartment that were soiled at the time of the survey was repaired and painted. 2. Plant operations Director/designee will conduct an environmental rounds to identify maintenance and environmental issues monthly. In service will be done with the maintenance staff regarding replacement, inspecting the bathroom faucet and walls on a routine basis to ensure their proper repair. 3. Plant operations Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval.	11/9/18 1/30/19 Ongoing

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R 981	Continued From page 8 AM, the Maintenance Supervisor stated that the water stain was the result of a convector leak in the apartment just above Apartment #316. He further stated that the contractor was on-site and would paint the ceiling. 3. Apartment #302's bathroom lacked a slip guard for the shower. The shower also contained peeling and chipped paint. It should be noted that, according to a review of the ALR's incident reports, Resident #5 fell on the bathroom floor on 10/20/18. The incident report also indicated that the resident sustained a left-sided head contusion. 4. Apartment #323's living room carpet was observed to be soiled in large areas throughout the space. 5. The carpet located on the second floor near the facility's elevator was ripped and was a trip hazard. During an interview on 11/05/18 at 11:48 AM, the Maintenance Supervisor stated that the entire carpet would be replaced. 6. Apartment #12's bathroom door and walls were dirty, the wall had a large patch of peeling paint, and the bathroom door was not set on its hinges. A roach was also observed crawling on the bathroom floor. On 11/05/18 at 1:30 PM, the Maintenance Supervisor presented a service inspection report from the exterminator, dated 10/31/17, which showed that the kitchen and the second floor had been treated, however, there was no documented evidence that any of the apartments had been serviced. At the time of the survey, the ALR failed to be	R 981	**Ceiling showed a large water stain APT 316 No.2** 1. Resident in Apt 316 was not harmed by the deficient practice. The ceiling in APT 316 was replaced. 2. To prevent future occurrences, building services and clinical staff will be educated on safety issues and requirement of functional convector. Staff will be educated on repair request process on ensure timely repairs. 3. Plant operations Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval **No3. Apartment #302** 1.Apartment #302 bathroom that lack a slip guard for the shower noted at the time of the survey has been placed. The shower that also contain peeling and chipped paint that were noted at the time of the survey has been painted.	11/20/18 1/30/19 Ongoing 11/9/18

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R 981	Continued From page 9 maintained in sanitary condition and good repair.	R 981	2.Plant operations Director/designee will conduct environmental rounds to identify maintenance and environmental issues monthly. In service will be provided with the maintenance staff regarding replacement inspecting the bathroom slip guards and walls on a routine base to ensure their proper repair. 3.Plant operations Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval. **No-4 Apartment #323** 1. Resident in # 323 was not harmed by the deficient practice apartment #323 living room carpet were replaced. 2. No other resident was affected by the deficient practice. The Director of housekeeping/designee will conduct environmental rounds monthly to identify and ensure that a sanitary, orderly and comfortable carpet without soiling . In service was provided with the housekeeping and nursing staff to report their findings of dirty/stained carpet in the rooms. 3. Housekeeping Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval	ONGOING ONGOING 11/20/18 1/18/19 ONGOING

R-981 No -5

1. No resident was harmed by the deficient practice. The carpet located on the second floor near the facility elevator has been replaced. 11/25/18

2. In –service will be provided with the Maintenance, housekeeping and nursing staff to report ripped carpets and any a trip hazard issues regarding replacement inspecting the carpet on a routine basis to ensure their proper repair. 1/30/19

3. Plant operations Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval. ongoing.

R-981 No 6

1. The bathroom door and walls noted at the time of the survey has been cleaned. The wall that had a large patch of peeling paint that was noted at the time of the survey has been painted. The bathroom door that was not set on its hinges noted at the time of the survey was required. 11/9/18

2. In service will be done with the maintenance staff regarding replacement inspecting the bathroom doors, bathroom door hinges and wall on routine basis to ensure their proper repair. 1/30/19

3. Plant operations Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval ongoing

Roach was also observed crawling on the bathroom floor

1. Pest control contractor was contacted immediately upon report of sighting on 11/10/18. The past control contractor followed up and treated the area on 11/10/18 in Apt 12. 11/10/18

2. Nursing and housekeeping Staff was educated regarding the proper protocol and follow up for a pest control sighting/reporting which includes logging in to the blinder and contacting the environmental service director who will in turn contact the pest control contractor for follow-up. 1/18/19

3. Housekeeping Director/designee will Audit, and document findings and present to QA committee monthly for review, evaluation and approval ongoing