Health	Regulation & Licensii	ng Administration			FORM	APPROVED
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		ALR-0037	B. WING		11/0	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY.	, STATE, ZIP CODE	1 170	9/2018
MASS	SR CARE,LLC T/A THE	RESIDENCES AT 1330 MA		TTS AVENUE, NW		į
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DIBE	(X5) COMPLETE DATE
R 000	Initial Comments		R 000-		- //50	
R 292	An annual survey we through 11/09/18 to the Assisted Living I Residence provided employed 150 person and administrative is survey were based or reviews, and interview. Listed below are able the body of this reportant the body of the Individualized Start PN - Individualized Start PN - Licensed Pract RN - Registered Nursel LPN - Licensed Pract RN - Registered Nursel PN	g Residence rsing Service Plan urces Director ing Assistant tical Nurse se odation Of Needs ate and appropriate services easonable accommodation of preferences consistent with ical and mental capabilities ety of other residents; ew, policy review and failed to follow the fall policy ints in the sample who fell  facility's revised policy titled, 4/17/18, showed that int fall, the ALR staff were to ol, complete a essment, update the ISP	R 292			
BORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	0	(6) DATE

STATE FORM

Stephen Grane. Administrator

STATEME	Regulation & Licensin	d Administration			FORM	APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATI	SURVEY
	Å	22	A BUILDING	3:	COM	PLETED
		ALR-0037	B. WING		ľ	
NAME OF	PROVIDER OR SUPPLIER				11/	09/2018
				STATE, ZIP CODE		
MASS S	R CARE,LLC T/A THE	RESIDENCES AT WASHING	SSACHUSE GTON, DC 2	TTS AVENUE, NW		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	1			
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CORRECTIVE ACTION SHOULD CORRECT OF ACTION SHOULD CORRECT OR	) PC	(X5)
		O IDENTIFICATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE	COMPLETE DATE
R 292	Continued From pag	pe 1	D 000	BET ICIENCY)		
			R 292			
j	with new intervention interventions with ca	1(S), and discuss		ł.		
1				Į.		
4	Record review of the	facility's incident reports on				
1	11/08/18 at 9:30 AM	Showed that Resident #5 fell		•		
- 1	(02/08/18, 02/19/19	08/18 through 10/09/18				
- 1	(02/08/18, 02/18/18, 08/20/18, 08/29/18, 8	and 10/09/18). Three of the	(			
	ralls (02/18/18, 07/02	1/18, and 10/09/18) resulted		1. The ISP for resident #5 was		
1	in injuries that include	ed a scratch to the forebead		reviewed to ensure goals and		11/10/13
- 1	swollen area of the fo	orehead, and swollen left		interventions are realistic that a	ire l	,,,,,,,
1	knee.			tailored to address residents fal		
1	Review of Resident #	5's current medical record		with the necessary intervention		
- 19	on 11/09/18 at 9:30 A	M revealed the resident had		I I I I I I I I I I I I I I I I I I I	is.	
1.3	a history of Anoxic Br	ain Damage, Seizure		Į I.		
1) 1	Disorder, Depression	. Gait Disorder Dizziness		2. AL Manager was in-serviced	1 to	1/18/19
116	and Hypertension. Fu	rther review of the records		ensure ISP's are updated with a		1 10 11
ľ	02/08/18 through 10/0	ent had seven falls from 09/18. The record lacked		intervention and care staff is	ICM	
10	documented evidence	e the staff followed the fall	Ü	educated with all the new		
t	policy, as evidenced b	pelow:	ill	intervention. Nursing staff has	haan	
li li	00/00/40 N 5 !!	i	9	in-serviced to ensure the nurses	have	
11.	pdated to reflect new	tool completed, ISP not		a full understanding of the faci		
1	paged to reflect new	interventions;	1)	fall, and assessment policy.	iity	1
]-	02/18/18-: No assess	sment completed, ISP not		and acceptancial poricy:		
Ju	ipdated to reflect new	interventions;	• #	3. AL manager/designee will A	ndit	1 30 119
30	06/40/40. N		1	and document findings and pre	cent	וריוו ייכון
	pdated to reflect new	ment completed, ISP not	- 1	to QA committee for review.	SCIIL	
-	paded to reliect new	interventions;	T T	evaluation and approval.		
1 -	07/02/18: Care staff	not re-educated on new	4	Transactor and approvar.		1
ir	nterventions;		- 1			1
1	09/20/40-31-4-4-4-4					
1.	pdated to reflect new	tool completed, ISP not				
<b>4</b> 4	Paged to relieur New	interventions;	4		1	
<b>∦</b> -0	08/29/18: No fall risk t	tool completed, care staff	1		3	
∥ ne	ot re-educated on nev	w interventions; and	1		][	- [
in Regulation	on & Licensing Administrat	lon		Company of the Compan	1	
TE FORM		Ges	N NIL	IFG11		-

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If continuation sheet 2 of 10

STATEM	ENT OF DEFICIENCIES		MALES A.	Hart and the second	. •	APPROVED
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0037	B: WING		4411	20/2040
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS CITY	STATE, ZIP CODE	11/(	09/2018
MASSS	SR CARE,LLC T/A THE			TTS AVENUE, NW		
IIIAGG C	SK CARE, LLC I/A I THE	WASHIN	GTON, DC 2	20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	pr.	(X5) COMPLETE DATE
R 292	Continued From pag	e 2	R 292			
	During an interview of DON stated that Res assistance when tran	on 11/09/18 at 2:00 PM, the ident #5 refused to call for asferring.		•		
R 407	the provision of adeq services to address to	ne individual needs of nsure the resident's health	R 407	1. Resident #5 history and phys was reviewed by the primary caphysician and corrections were made at the time of the survey.	ire	11/19/18
	(2) Is at high risk for complications which complications which commanaged by the ALR hours per week of ski health aide services of than a daily basis, accord FCFA Pub. 75 and 42 409.33, and 409.44. Based on record revie	health or safety cannot be adequately and requires more than 35 led nursing and home ombined, provided on less cording to section 2113.1 of CFR, sections 409.32, w, observation, and	R 407	2. To prevent future occurrences to ensure compliance, AL mana will be in-serviced on how to resof the physician history and phy to ensure proper completion of history and physical by the prim care physician before admission the facility.	ger view sical arv	DNSDing
F F 1 v r	of five residents in the Findings included: Review of Resident #5 11/08/18 at 11:00 AM sivas admitted on 08/05 ecord revealed a histohe physician on 07/26	d nursing services for one sample (Resident #5).  's clinical record on showed that the resident /17. Further review of the bry and physical signed by /17, which indicated that 4-hour skilled nursing care.		3. Al manger/designee will revie 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 prese to QA committee for review, evaluation and approval.		ongoing

Healt	h Regulation & Licensi		-4_		FORM	1 APPROVED
AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	SURVEY
1	consumptive	INCLUSION TO HOMBEK!	A <sub>k</sub> BUILDIN		COM	PLETED
l	ì		1 - 120/01/25		1	
		ALR-0037	B. WING		11/0	09/2018
NAME	F PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE		
MASS	SR CARE,LLC T/A THE			TTS AVENUE, NW		
		WASHIN	GTON, DC	20005		
(X4) IC PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
TAG	REGULATORY OR L	C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP	DRE	COMPLETE
	-			DEFICIENCY)	NATE	DAIE
R 40	7 Continued From page	ge 3	R 407		·	
1	Observation of Resi	dent #5 on 11/08/18 at 12:00	<b>'</b>			
į.	PM showed that the	resident was alert, oriented	1			1
	to name, time, place	and situation. Continued			i	! 1
i	observation showed	that the resident's gait was	1	<u> </u>		l l
į	unsteady and uncoo	rdinated.	t.			
	During an interview	on 11/08/18 starting at 12:50				
	PM, the DON stated	that she had spoken with the		li de la companya de		1
	🚽 resident's physician.	who acknowledged that the				1
	resident did not requ	ire 24-hour skilled nursing	1	1		
	incorrectly complete	revealed that the physician			- 1	
	incorrectly completed	the history and physical.			1	1
R 47	Sec. 604a2 Individua	dized Service Blanc	0.470			į.
100	Oec. 004az majvidua	inzed Service Plans	R 472	1 The ISD C	1	
	(2) An ISP shall be	developed following the	- 1	1. The ISP for resident #2 was		1110118
	completion of the "po	st move-in" assessment		revised to include goals and	1	' '
	Based on record revi	ew and interview, the ALR		approaches for the resident	4	
	the post move in one	P had been developed after		following the residents post-mo	ve	1
	newly admitted reside	essment for one of one ents in the sample (Resident	1	in assessment with in 48hrs.	IŲ.	1
	#2).	and in the sample (Nesident		2 7	1	- 1
		}	t d	2. To prevent future occurrence		
	Findings included:			the nursing staffs were re-educa		11/10/18
3	Review of Resident#	Ola aliniant consul	1	on the post move in assessment		
1	11/06/18 at 11:30 AM	showed that the resident		procedures.	1	
j	was admitted on 10/0	7/18. A post move-in		2.45	1	1
	assessment was con-	ducted by the facility's nurse		3. AL manager/designee will	ĵ	1
i	on 10/07/18. Further	review of the record	1	monitor all new admissions; Po		1
1	revealed there was no	documented evidence that		move in assessments are comple		
9	an ISP had been deve- resident's post move-	in assessment	ł	within 48hrs of admission.		ongoing
(	. Joid office post Hove-	iii dosessiiielit.	1	Audit, and document findings a	and	<i>' J</i>
Į.	During an interview or	n 11/06/18 at 11:50 AM, the	ľ	present to QA committee for		
	DON stated that she v	vould ensure a post	\$	review, evaluation and approval	1.	l l
Y	move-in ISP was deve	eloped no later than 48	1			, 1
	hours after the complete assessment.	etion of the post move-in	ĺ		1	
	099699111G[]["	Į.	ļ		ij	
Mr. Doggi	ation & Licensing Administra	0.41	To Assess			

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Heal	th Regulation & Licensi	ng Administration		F	DRM APPROVED
AND P	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A₌;BUILDIN	PLE CONSTRUCTION  G , (X3)	DATE SURVEY COMPLETED
o o		ALR-0037	B. WING		11/09/2018
NAME	OF PROVIDER OR SUPPLIER			, STATE, ZIP CODE	
MASS	SR CARE,LLC T/A THE	RESIDENCES AT 1330 MA	ISSACHUSE IGTON, DC	TTS AVENUE, NW	
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC 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 47	2 Continued From pa	ge 4	R 472		
D 41	completion of the po	urvey, the ALR failed to ensure ISP developed following the ost move-in assessment.		•	
K:40	Sec. 604b Individua	lized Service Plans	R 481		
	provided, when and provided, and how a be provided and acc Based on record rev failed to document in would be provided for	clude the services to be how often the services will be nd by whom all services will essed. iew and interview, the ALR ISPs how often services or one of one resident #1).		1. The record of resident #1 was reviewed with the evidence of the frequency of dressing, feeding, and transferring at the time of the surve and presented to the surveyor.	11/4/18
	record on 11/07/18 a dated 11/06/18 which evidence of the frequithe resident with drestransferring.	ency that staff was to assist ssing, feeding, and		<ul> <li>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.</li> <li>3. The AL manager/ designee will document findings and report to QA</li> </ul>	owgāing
	DON stated that she	n 11/07/18 at 10:30 AM, the would ensure the frequency cluded on residents' ISPs	,	committee monthly for review, evaluation, and approval.	orgoing
	At the time of the sunthe frequency for servent.	vey, the ALR failed to include rices on the ISP for Resident			
R 598	Sec. 701d11 Staffing	Standards.	R 598		1
	background checks, s	documentation of criminal tatements of health status,			
un Regul	ation & Licensing Administra	tion			

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if continuation sheet 5 of 10

ř	Health	Regulation & Licensii	g Administration			FOR	MAPPROVED
I	AND PLA	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		TE SURVEY
l				į.	NG (	CON	MPLETED
F	NAME OF		ALR-0037	B. WING		11/	/09/2018
		PROVIDER OR SUPPLIER			Y, STATE, ZIP CODE		
L	MASS	SR CARE,LLC T/A THE	RESIDENCES AT WASHI	ASSACHUS NGTON, DC	ETTS AVENUE, NW		
	(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	)N	T
	TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DRE	(X5) COMPLETE DATE
Γ	R 598	Continued From pag	10.5		DEFICIENCY)		
	We arrive at	and documentation		R 598	1. HR has completed an audit of al	1	
		communicable disea	ise status:	1	employee files to 1. Ensure all curr	ent	1.
ll.		Based on record rev	iew and interview, the ALR ne communicable disease	ii	employees have an annual Tb scree	en on	11/20/18
		status for two of six e	employees (ALR Staff	Æ	record 2. Identify individuals with history of positive PPD TB skin tes	a t and	
		Administrator and CN	NA #4).	1	ensure a physician certifies these	it atter	
		Findings included:		1	individuals free of communicable		
				1	disease. Audit effective completion is 11/20/2018.	date	
		Administrator and CN	s personnel records for the IA #4 on 11/08/18, at 2:48		10.00.2010.		
		PM and 3:23 PM, res	pectively, showed no	j			1
		documented evidence disease status.	e of their communicable		2. HR director or designee will audi	it all	1
		uisease status.			employee health records no later that date 11/25/2018 to ensure 100%	an	
		This information was	brought to the attention of	1	compliance with this plan of correct	tion.	11 25 18
	ŀ	interview the HRD st	at 3:06 PM. During the ated that the Administrator				
	1.	was out of the country	and the HRD did not have	1	3. Following the initial compliance a		
	- 1	access to his office. T	he HRD also stated that		HR director or designee will comple	audit,	
	11	the communicable dis	get documented evidence of ease status for the	1	audit of all new hire, document find	ings	
	- 3	Administrator and CN,	A#4, and she would send it.		and present it to QA committee for		ongoing
		to the surveyor via em there was no docume	ail. It should be noted that noted evidence received		review evaluation and approval.		, ,
	1	from the facility via em	ail.			J	
		At the time of the surv	By the ALD felled to				
	4.1	maintain personnel rec	cords for the Administrator	1		J	
	1 3	and CNA #4 that includ disease status.	ded the communicable			1	
	1	disease status.			1		1
	R 802	Sec. 903 2 On-Site Re	view <u>.</u>	R 802			
	1.	(2) Assess the reside	nt's response to	1		ľ	Į,
		nedication; and Based on record reviev	v and interview, the ALR			1	1
	Ti Ti	alled to ensure an RN	conducted a review of the				
	ľ	esidents' response to	medications every 45 days				į.
illi	h Regulati	on & Licensing Administrati	AN .				10

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If continuation sheet 6 of 10

STALEME	Regulation & Licensii NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	TORK	APPROVE
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G <sub>k</sub>	(X3) DAT	E SURVEY PLETED
		NI BOSSEC	1		1	
114147.00		ALR-0037	BWING		41/	09/2018
	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY	, STATE, ZIP CODE	11/	03/2018
MASS S	R CARE,LLC T/A THE	RESIDENCES AT 1330 MA	SSACHUSE	TTS AVENUE, NW		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	GTON, DC	20005		
PREFIX TAG	REAUTH DEFICIENCY	MUST BE PRECEDED BY CITY	PREFIX	PROVIDER'S PLAN OF CORRECTION	N.	(Y5)
1/10	NEGODATORY OR ES	C IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	DBE	(X5) COMPLETE DATE
R 802	Continued From page	10.6		DEFICIENCY)		
	The state of the s		R 802	-		
- 1	for three of five residents #3, #4, a	dents in the sample		1		ř
1	(Modidents #5, #4, a	na #5).		ľ		10
	Findings included	. <del>19</del>	i)	l.		(
9	4 B	and the same	1			ļ
	1. Review of Resider	nt #3's clinical record on			1	
1	was admitted on 04/	A showed that the resident 29/14, and the nursing staff		§	Sk	
11	was responsible for a	administering the resident's		1. The residents were not harm	ed by	
- 1	medications. Further	review of the clinical record	1	this deficient practice. Resident	s#3	M
- 1	revealed medication	reviews dated 06/25/18		#4 and #5 were assessed based	on i	11/10/1
1	07/25/18, and 10/25/	18 that were conducted by		the current medication	-	till it
	the medication review	N, as required. Additionally, vs lacked documented		administration procedures and I	nave	
1	evidence of the reside	ent's response to the		a current assessment conducted	by	į.
4,	medications.	inc and		RN.	·	*
1.	Poviou of Docide-				1	
11	1/07/18 at 12:00 PM	t #4's clinical record on showed that the resident		2. In- service training was provi	ded	,
v	vas admitted on 07/2	8/16, and the nursing staff	1.	to the AL manager regarding th	e II	1 1
Į. v	vas responsible for a	dministering the resident's	ij	assessment and documentation	of	0/10/1
10	nedications. Further i	review of the clinical record	1	residents response to medication	ns 📗	
Į r	evealed medication r	eviews dated 08/24/18	d	every 45 days in the residents		
10	9/25/18, and 10/25/1	8 that were conducted by		medical record.	10	
th	ne medication review	N, as required. Additionally, s lacked documented			li li	
e	vidence of the reside	nt's response to the	1	3. AL manager/designee will		
n	nedications.		. 1	Audit, and document findings a	nd	525 10
	Daview of D			present to QA committee for rev	iew.	onegoine
1.3	Review of Resident	#5's clinical record on	9	evaluation and approval.	,	
w	as admitted on 08/05	showed that the resident 5/17, and the nursing staff	ı	P. ************************************	1	
I W	as responsible for ac	ministering the resident's	į.			
3HLO	edications. Further re	eview of the clinical record				
re	vealed medication re	eviews dated 07/25/18			1	
08	5/24/18, 09/25/18, an	d 10/25/18 that were				
A	ddionally the media	and not an RN, as required.	1		- 1	
do	ddtionally, the medica	of the resident's response	ı			
1 10	the medications.				1	
Danilalia	n & Licensing Administrat			<u> </u>	-	

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AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION (X3)	DATE SURVEY
THE FERNI	. O. GORRECHON	IDENTIFICATION NUMBER:	A. BUILDING	G: <sub>(A3)</sub>	COMPLETED
		ALR-0037	B. WING		· marine
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE	11/09/2018
	R CARE,LLC T/A THE	4000		TTS AVENUE, NW	
WACC C		WASHIN	GTON, DC 2	20005	
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETE DATE
R 802	Continued From	7		DEFICIENCY)	
1. 002	Continued From pa	ge /	R 802,	1	- 2
	During an interview	on 11/08/18 at 1:00 PM, the		ĺ	1
	DON stated that go	ing forward she would ensure	4 1	l l	1
	that RNs assessed medications.	residents' response to			
			1		
ľ	At the time of the su	rvey, the ALR failed to ensure		19.50	
ı	their medications ev	essessed for a response to very 45 days.			
				Apartment 312 No.1	
R 981	Sec. 1004a General	Building Interior	R 981		
	(a) An ALR shall en	sure that the interior of its		1. The bathroom faucet to	1
į,	facility including wall	s, ceilings, doors, windows.	i	apartment 312 noted at the time of	11/9/18
	equipment, and fixtu structurally sound, sa	res are maintained anitary, and in good repair.	l l	the survey was repaired. The walls throughout the apartment that were	
ľ,	Based on observatio	n and interview, the ALR		soiled at the time of the survey was	
	talled to ensure the f in sanitary condition	acility interior was maintained and all equipment was in	1	repaired and painted.	
	good repair.	and an equipment was in			
	Findings included:		1	2. Plant operations Director/design	ee
				will conduct an environmental rounds to identify maintenance and	
19	Observations on 11/0	05/18 at 10:53 AM during an	1	environmental issues monthly. In	10 1
	environmental walk-t apartments revealed			service will be done with the	113019
1				maintenance staff regarding	
Į,	<ol> <li>Apartment #312's stationary and mover</li> </ol>	bathroom faucet was not when the hot water was	1	replacement, inspecting the	
l t	urned on. Further ob	servation in Apartment #312	1	bathroom faucet and walls on a routine basis to ensure their proper	
// 8	showed that the walls	s throughout the apartment be noted that the facility's	1	repair.	i i
1 1	Naintenance Supervi	sor accompanied the	1	_	
S	surveyors during the	walk-through and indicated	ľ	3. Plant operations	
a	and the walls would b	that the faucet was repaired be painted.	j.	Director/designee will	
1		i i	ï	Audit, and document findings and	Paraparo
12	. Apartment #316's	ceiling showed a large water view on 11/05/18 at 10:59	1	present to QA committee monthly for review, evaluation and approval	
11.0					110

seems makes

Health I	Regulation & Licensin	g Administration	-		FORM	APPROVED
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY PLETED
		ALR-0037	B. WING		117	09/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY.	STATE, ZIP CODE		19/2018
MASS S	R CARE,LLC T/A THE	RESIDENCES AT 1330 MAS	SSACHUSE	TTS AVENUE, NW		
-		WASHING	STON, DC 2	20005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	AM, the Maintenand water stain was the the apartment just a further stated that the would paint the ceiling.  3. Apartment #302's for the shower. The peeling and chipped according to a review reports, Resident #5 10/20/18. The incide the resident sustained contusion.  4. Apartment #323's observed to be soiled the space.  5. The carpet locate the facility's elevator hazard. During an intended the maintenance entire carpet would be spaint, and the bathroominges. A roach was the bathroom floor.  On 11/05/18 at 1:30 If Supervisor presented from the exterminato	ce Supervisor stated that the result of a convector leak in above Apartment #316. He are contractor was on-site and ang.  Is bathroom lacked a slip guard shower also contained paint. It should be noted that, w of the ALR's incident afell on the bathroom floor on an treport also indicated that are a left-sided head  living room carpet was a living room carpet was d in large areas throughout d on the second floor near was ripped and was a trip terview on 11/05/18 at 11:48 as Supervisor stated that the pereplaced.  Cathroom door and walls and a large patch of peeling om door was not set on its also observed crawling on PM, the Maintenance d a service inspection report or, dated 10/31/17, which	R 981	Ceiling showed a large APT 316 No.2  1. Resident in Apt 316 v harmed by the deficient The ceiling in APT 316 replaced.  2. To prevent future occ building services and cli will be educated on safe requirement of functions Staff will be educated or request process on ensur repairs.  3. Plant operations Director/designee will Audit, and document fir present to QA committee for review, evaluation ar No3. Apartment #302 bath lack a slip guard for the noted at the time of the been placed. The show contain peeling and chi	water stain  vas not practice.  was  urrences, nical staff ty issues and al convector. In repair re timely  addings and e monthly and approval  room that e shower survey has er that also	11/20/18
5 6 8	showed that the kitch been treated, howeve evidence that any of t serviced.	en and the second floor had er, there was no documented the apartments had been vey, the ALR failed to be		that were noted at the ti survey has been painted	me of the	
E FORM	- Andrews Research		199 NI	HEG11	lf continuatio	

	Regulation & Licensin				FORM	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY
			*		ń	
		ALR-0037	B, WING		11/0	9/2018
NAME OF	PRÖVIDER ÖR SUPFLIER		DORESS, CITY, ST			
MASS S	R CARE,LLC T/A THE		SSACHUSETT: GTON, DC 200	S AVENUE, NW 05		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE
R 981	Continued From page	ge 9	R 981			
		ry condition and good repair,	4	2.Plant operations Director/designee will conduct environmental rounds to ider maintenance and environmental issues monthly. In service with the maintenance with the maintenance staff regarding replacement inspecting the bathroom slip guand walls on a routine base to ensure their proper repair.	ntify ntal ill ance	ongoing
				3.Plant operations Director/designee will Audit, and document finding and present to QA committee monthly for review, evaluation and approval.	ė	ongoine
			a	No-4 Apartment #323  1. Resident in # 323 was not harmed by the deficient practice apartment #323 living room car were replaced.	e ¦	11/50/18
				2. No other resident was affected the deficient practice. The Direct of housekeeping/designee with conduct environmental round monthly to identify and ensure that a sanitary, orderly and comfortable carpet without soil. In service was provided with housekeeping and nursing statement their findings of lines.	ector	1/18/19 ONG DING
	ion & Licensing Administr	allón).		report their findings of dirty/stail carpet in the rooms.	ned	
TATE FORM	-		6899 NHF		ation	sheet 10 of 10
1	·	Ŧ.		3. Housekeeping Director/designee will Audit, and document findings	3 3	

and present to QA committee monthly for review, evaluation

and approval

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

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

11/25/18

1/30/10

ougoing

11/9/18

1/30/19

ongoin g

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

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1/18/19

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