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-0018	A. BUILDING: _____ B. WING _____	06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES AT THOMAS CIRCLE	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 from June 10, 2015 through June 11, 2015, to determine compliance with the Assisted Living Law "DC Code § 44-101.01." The Assisted Living Residence (ALR) provides care for forty-three (43) residents and employs thirty-three (33) employees to include professional and administrative staff. The findings of the survey were based on observations, record reviews, and interviews. Please note: Listed below are the abbreviations used in this report Assisted Living Residence (ALR) Director of Nursing (DON) Registered Nurse (RN)	R 000	**This Plan of Correction is submitted without denying or acknowledging that the cited deficiencies exist. This plan of correction is a requirement of the Department of Health.** **What corrective action(s) will be accomplished to address the identified deficient practice;** Residents #1, 2, and 4 have suffered no adverse effects as a result of this alleged deficient practice. All residents currently receiving medication have the potential to be affected by the alleged deficient	
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's RN failed to assess the resident's response to medications every forty-five days for three (3) of three (3) residents in the sample. (Residents' #1, #2 and #4) The findings include: On June 11, 2015, starting at approximately 11:00 a.m., a review of Residents #1, #2 and #4 clinical record failed to evidence that the RN assessed each resident to determine the effectiveness of his/her medications. During an interview with the DON on June 11, 2015, at approximately 2:00 p.m., the DON	R 802	practice. All residents will be assessed by 7/31/15 by a Registered Nurse to determine the effectiveness and responsiveness to his/her medications. These assessments will be documented and stored in each resident chart. Additionally, each resident will have a medication review completed no less than every 45 days which includes resident responses to prescribed medications. This POC will be completed by the Registered Nurse, DON or her delegate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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R 802	Continued From page 1 indicated that the aforementioned resident's medications were checked monthly, however, their response to the prescribed medications were not assessed.	R 802	**practices does not recur; and** Each resident will have a medication review completed no less than 45 days which includes resident responses to prescribed medications, if necessary. This POC will be completed by the Registered Nurse, DON or her delegate. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented?** Results of the 7/31/15 audit and first 2 months monthly audits will be submitted to QA to monitor for compliance. **Date of Compliance** 7/31/15 **R961** Last year, this deficiency was questioned by community staff. However, no appeal was possible as no Monetary Penalty was assessed. Upon discussion with the department of health a monetary penalty will be issued, thus allowing the community to appeal per dc regulation and the issue to be resolved unlike last year.	
R 961	Sec. 1002.1 Fire Safety. (1) An ALR shall be in compliance with Chapter 22, New Residential Board and Care Occupancies, Life Safety Code of the National Fire Protection Association; and Based on observation and interview, it was revealed that the ALR failed to follow the Life Safety Code of the National Fire Protection Association [Section 18.7.8. Portable Space Heating Devices. Portable space-heating devices shall be prohibited in all healthcare occupancies] for one resident residing in the facility. (Resident #5) The finding includes: On June 10, 2015, at approximately 11:30 a.m., observation of Resident #5's bedroom revealed a portable operating space heater in the closet. During an interview with Resident #5 on June 10, 2015, at approximately 11:45 a.m. s/he stated, "The nurse just put my heater in the closet go and ask her why she did it." Further interview with Resident #5 revealed that s/he uses the space heater starting at night through early mornings daily. During an interview with the DON on June 10, 2015, at approximately 12:15 p.m., the DON indicated that the family was suppose to pick up the heater.	R 961		

DON

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R 961	Continued From page 2 Note: This is a repeat deficiency [in regards to the same resident using a space heater] from the November 2014 survey. The Plan of Correction (POC) dated December 27, 2014 indicated that, pending legal appeal, no space heaters will be used in the assisted living neighborhoods. To date, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) have not been informed of any legal decision made in the appeal regarding the use of space heaters in assisted living residences.	R 961	**What corrective action(s) will be accomplished to address the identified deficient practice;** **The space heater was immediately removed from the resident's room.** Pending the outcome of the appeal, the space heater may or may not be allowed to go back into the room. The space heater will not be allowed in the room until the appeal process is complete. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur; and** Pending the outcome of the appeal, if space heaters are not allowed in Assisted Living, all staff and residents will be in-serviced regarding the decision. Rooms will be swept once a month for three months to monitor for compliance. Results will be reported to QA. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented?** Rooms will be swept once a month for three months to monitor for compliance. Results will be reported to QA. **Date of Compliance** 7/31/15 (or later, depending on the scheduled appeal)	

H-CTGWRU DOH