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 _____	05/06/2022

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 0000 Initial Comments An annual licensure survey was conducted on 05/04/2022, 05/05/2022 and 05/06/2022, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 41 residents and employed 88 personnel, to include professional and administrative staff. A random sample of 15 resident records, 13 employee records, one companion record and one Private Duty Aide (PDA) record were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, and resident, family, and staff interviews.	R 000	The Residences at Thomas Circle files this Plan of Correction for the purpose of regulatory compliance. The facility submits this document to comply with applicable law and not as an admission or statement of agreement of deficient practices.	
R 330	10122.1 On Site Medication Review 10122.1 The on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued. Based on interview and record review, the Registered Nurse (RN) failed to assess the resident's ability to safely continue to self-administer medications every 45 days for one of one resident in the sample who self-medicated (Resident #5). Findings included: On 05/04/2022 at 10:00 AM, the health and	R 330	***What corrective actions will be accomplished to address the identified deficient practice?*** Health and Wellness Director immediately reviewed resident #5 as well as any other resident who self administers medication to assess their ability to continue to self-administer medications. ***What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur?*** Health and Wellness Director will assess residents ability to safely continue to self-administer medications every 45 days.	

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 _____	05/06/2022

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 330	Continued From page 1 Wellness Director (HWD) identified Resident #5 as being able to self-medicate. A review of the resident's Intermediate Care Facilities Division Admission/Annual Medical Certification form on 05/06/2022 at 1:06 PM indicated that the resident was able to self-medicate. Review of the nurses 45 Days Medication Review forms dated 03/25/2022, 02/09/2022, 12/26/2021, 11/11/2021, and 2/15/2021 failed to show evidence that the nurse documented the resident's ability to continue to self-administer his medications. On 05/06/2022 at 3:40 PM, the HWD said that the nurses assess the resident's ability to self-administer medications every six months, however she acknowledged that they did not do it every 45 days as required. At the time of the survey, the Assisted Living Residences RN failed to assess the resident's ability to continue to self-medicate every 45 days.	R 330	***How will the corrective actions be monitored to ensure the deficient practice will not recur?*** 45 day medication review for residents who self-administer will be audited by the Health and Wellness Director and Administrator quarterly. Audit results will be reviewed in monthly quality assurance meetings. The Executive Director will be responsible to ensure overall compliance is maintained for all of the noted deficiencies.	
R 380	10125.2 Reporting Complaints To The Director 10125.2 An ALR shall immediately notify the Department of Health, the District's Adult Protective Services program, and the District of Columbia Long-Term Care Ombudsman of all suspected or alleged incidents of abuse, neglect, or exploitation. The Department of Health shall be notified by phone immediately, and the ALR shall follow up by written notification to the Department within twenty-four (24) hours or the next business day. Based on interview and record reviews, the Assisted Living Residence (ALR) failed to report immediately an allegation of abuse to the Department of Health (DOH) and follow up with written notification to DOH within 24 hours or the	R 380	***What corrective actions will be accomplished to address the identified deficient practice?*** The allegation of abuse along with the findings were reported to the appropriate entities. There were no findings of abuse. Executive Director and Health and Wellness Director were educated by the Divisional Director of Health and Wellness for Senior Lifestyle on appropriate abuse reporting standards on May 16th 2022. Health and Wellness Director educated staff on appropriate abuse reporting standards by May 20th, 2022.	

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 _____	05/06/2022

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 380	Continued From page 2 next business day, for one of 15 residents in the core sample (Resident #13). Findings included: On 05/04/2022 beginning at 12:28 PM, review of the ALR's incident report log showed that on 09/29/2021, Resident #13 stated a couple weeks ago that [staff name (Certified Nursing Assistant)] brought a cart with snacks to her room door and said to her, "help yourself". Resident #13 said that the Certified Nursing Assistant (CNA) spoke to her in a harsh way, and that this is abuse. Further review showed that the incident was report to DOH on 10/01/2021, two days later. On 05/05/2022 at 2:31 PM, the Assisted Living Administrator (ALA) and Health Wellness Director (HWD) were interviewed regarding their procedure for reporting allegations of abuse to DOH. The ALA stated that allegations of abuse should be reported immediately to DOH, followed by written notification to DOH within 24 hours or the next business day. The HWD said that the allegation of abuse was investigated and completed on 10/04/2021 but could not be substantiated. When asked when DOH was notified of the abuse incident, the HWD stated that DOH was notified on 10/01/2021, which was not immediately. The ALA and HWD stated that moving forward, DOH will be notified immediately of all allegations of abuse incidents and followed with written notifications in accordance with the ALR regulations. At the time of the survey, the ALR failed to provide immediate notification to DOH regarding an allegation of abuse incident, as required.	R 380	***How will the corrective action be monitored to ensure the deficient practice will not recur?*** The education related to abuse reporting will be reviewed in quality assurance meetings to ensure compliance of all education related to the noted deficiencies. The Executive Director will be responsible to ensure overall compliance is maintained for all of the noted deficiencies.	

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-0037	A. BUILDING: _____ B. WING _____	05/06/2022

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 licensure survey was conducted on 05/04/2022, 05/05/2022 and 05/06/2022, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 41 residents and employed 88 personnel, to include professional and administrative staff. A random sample of 15 resident records, 13 employee records, one companion record and one Private Duty Aide (PDA) record were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, and resident, family, and staff interviews.	R 000	The Residences at Thomas Circle files this Plan of Correction for the purpose of regulatory compliance. The facility submits this document to comply with applicable law and not as an admission or statement of agreement of deficient practices.	
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 record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure that each resident contract was signed by the resident or surrogate prior to admission, for two or the 15 residents in the sample (Residents #7, and 13). Findings included: 1. On 05/5/2022 at 2:46 PM, a review of Resident #7's clinical record revealed that the resident was admitted on 07/02/2021. The record failed to show documented evidence that the ALR provided the resident with an agreement prior to	R 421	***What corrective actions will be accomplished to address the identified deficient practice?*** Sales team, Health and Wellness Director, Business office Manager and Business office Assistant were educated on the need to have a contract signed prior to day of admission on May 6th, 2022 ***What measures will be put into place to ensure the deficient practice does not recur?*** The Executive Director will review every contract for completion prior to admission.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sena Quist, Executive Director | 5/22/2022

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 _____	05/06/2022

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 421	Continued From page 1 admission to the facility. 2. On 05/06/2022 at 11:51 AM, review of Resident #13's clinical record revealed that the resident was admitted on 06/30/2020. The record failed to show documented evidence that the ALR provided the resident with an agreement prior to admission to the facility. On 05/06/2022 at 3:20 PM, the Assisted Living Administrator (ALA) and Health and Wellness Director (HWD) were made aware of the findings and acknowledged the deficiency. At the time of the survey, the ALR failed to ensure all residents received resident agreements prior to admission.	R 421	***How will the corrective actions be monitored to ensure the deficient practice will not recur.*** The education related to admission agreements will be reviewed in quality assurance meetings to ensure compliance of all education related to the noted deficiencies. The Executive Director will be responsible to ensure overall compliance is maintained for all of the noted deficiencies.	
R 425	Sec. 602a4 Resident Agreements (4) A list of resident rights including grievance procedures. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to show evidence that each resident received a list of the resident rights, for one of the 15 residents in the sample (Residents #13). Findings included: On 05/06/2022 at 11:51 AM, review of Resident #13's Resident Agreement (RA), dated 06/30/2020, failed to include a list of the resident's rights as required by the regulation. At 3:30 PM, the Assisted Living Administrator Reviewed Resident #13's Residential Agreement and confirmed that the resident's rights had not been included in the document.	R 425	***What corrective actions will be accomplished to address the identified deficient practice?*** A copy of the Resident Rights were given to Resident #13 and receipt of the document was recorded in the resident record. Sales team, Health and Wellness Director, Business office Manager and Business office Assistant were educated on the need to have a contract signed prior to day of admission on May 6th, 2022 ***What measures will be put into place to ensure the deficient practice does not recur?*** The Executive Director will review every contract for completion prior to admission.	

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 _____	05/06/2022

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 425	Continued From page 2 At the time of the survey, there was no evidence that the ALR ensured that each Resident Agreement included a list of resident rights.	R 425	***How will the corrective actions be monitored to ensure the deficient practice will not recur.*** The education related to resident rights will be reviewed in quality assurance meetings to ensure compliance of all education related to the noted deficiencies. The Executive Director will be responsible to ensure overall compliance is maintained for all of the noted deficiencies.	
R 704	Sec. 802a Medical, Rehabilitation, Psychosocial Assess. (a) A medical, rehabilitation, and psychosocial assessment of the resident shall be completed within 30 days prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all areas of the Intermediate Care Facilities Division Admission/Annual Medical Certification form were addressed by the physician, for 12 of the 15 residents in the core sample (Residents #1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, and 15). Findings included: 1. On 05/04/2022 at 2:24 PM, review of Resident #1's medical certification form dated 08/15/2020, showed no evidence that the physician documented if the resident needed or had a mammogram, pap smear, colonoscopy, or a prostate-specific antigen (PSA). The physician also failed to indicate if there was a need for the resident to be tested for dementia and list the resident's medications. 2. On 05/05/2022 at 10:12 AM, review of Resident #8's medical certification form dated 11/18/2021, showed that the physician failed to document the resident's respirations or temperature or if the resident took nonprescription medications. In addition, the resident's medication was not listed on the form.	R 704	***What corrective actions will be accomplished to address the identified deficient practice?*** All intermediate Care Facilities Division Admission/Annual Medical Certification forms for the identified residents were corrected by a physician. Sales team, Health and Wellness Director, Business office Manager and Business office Assistant were educated on the need to have all areas of the intermediate Care Facilities Division Admission/Annual Medical Certification complete. ***What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not occur?*** All intermediate Care Facilities Division Admission/Annual Medical Certifications will be audited prior to admission by the Health and Wellness Director and Executive Director. ***How will the corrective actions be monitored to ensure the deficient practice will not recur?*** The education related to the intermediate Care Facilities Division Admission/Annual Medical Certifications will be reviewed in quality assurance meetings to ensure compliance of all education related to the noted deficiencies. The Executive Director will be responsible to ensure overall compliance is maintained for all of the noted deficiencies.	

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 _____	05/06/2022

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 704	Continued From page 3 3. On 05/05/2022 at 10:53 AM, review of Resident #4's medical certification form, dated 11/19/2021, showed that the physician failed to document the resident's vital signs, and to indicate if the resident was taking non-prescription medications. The physician also failed to list the resident's medication or indicate that the resident was not in need of continued acute or long term medical or nursing care or 24-hour skilled nursing care. 4. On 05/05/2022 at 12:08 AM, review of Resident #15's medical certification form dated 03/28/2022, showed that the physician failed to document the reason for the evaluation. 5. On 05/05/2022 at 12:51 PM, review of Resident #11's medical certification form dated 02/03/2022, showed that the physician did not indicate if the resident needed to be screened or tested for dementia or cognitive impairment and failed to list the resident's medications. 6. On 05/05/2022 at 2:46 PM, review of Resident #7's medical certification form dated 06/29/2021, showed that the physician failed to document the resident's immunizations and test i.e., influenza and tetanus. The physician also failed to indicate if the resident needed to be screened/tested for dementia or cognitive impairment. 7. On 05/06/2022 at 9:33 AM, review of Resident #3's medical certification form dated 06/21/2020, showed that the physician failed to document the resident's present address and respiration rate. 8. On 05/06/2022 at 09:40 AM, review of Resident #9's medical certification form, dated 12/30/2020 showed that the physician failed to document the date, facility name, present	R 704		

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 _____	05/06/2022

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 704	Continued From page 4 address and the reason for the evaluation. The physician also failed to indicate if there was a need for the resident to be tested for dementia. 9. On 05/06/2022 at 11:00 AM, review of Resident #14's medical certification form dated 08/25/2021, showed that the physician did not indicate if the resident needed or had a mammogram, pap smear, colonoscopy, or a prostate-specific antigen (PSA). In addition, the physician did not indicate if the resident needed to be screened or tested for dementia or cognitive impairment the reason for the evaluation. 10. On 05/06/2022 at 1:06 PM, review of Resident #5's medical certification form, dated 02/12/2021, showed that the physician failed to list the resident's medications and did not indicate if the resident needed any other services. 11. On 05/06/2022 at 12:34 PM, review of Resident #6's medical certification form dated 03/16/2022, showed that the physician failed to indicate if the resident needed or had a pap smear or colonoscopy. 12. On 05/06/2022 at 2:00 PM, review of Resident #10's medical certification form dated 06/22/2021, showed that the physician failed document the resident's present address on the form. On 05/06/2022 at approximately 3:30 PM, the above findings were shared with the Director of Wellness and Infection Control, who acknowledged that the Intermediate Care Facilities Division Admission/Annual Medical Certification form should be completely filled out. At the time of the survey the, ALR failed to ensure	R 704		

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 _____	05/06/2022

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 704	Continued From page 5 all sections of the Immediate Care Facilities Division Admission/Annual Medical Certification forms was completed by the physician, as required.	R 704		
R 803	Sec. 903 3 On-Site Review. (3) Assess the resident's ability to continue to self-administer his or her medications. Based on interview and record review, the Registered Nurse (RN) failed to assess the resident's ability to safely continue to self-administer medications every 45 days for one of one resident in the sample who self-medicated (Resident #5). Findings included: On 05/04/2022 at 10:00 AM, the Health and Wellness Director (HWD) identified Resident #5 as being able to self-medicate. A review of the resident's Intermediate Care Facilities Division Admission/Annual Medical Certification form on 05/06/2022 at 1:06 PM indicated that the resident was able to self-medicate. Review of the nurses 45 Days Medication Review forms dated 03/25/2022, 02/09/2022, 12/26/2021, 11/11/2021, and 2/15/2021 failed to show evidence that the nurse documented the resident's ability to continue to self-administer his medications. On 05/06/2022 at 3:40 PM, the HWD said that the nurses assess the residents ability to self-administer medications every six months, however she acknowledged that they did not do it every 45 days as required. At the time of the survey, the Assisted Living Residences RN failed to assess the resident's	R 803	***What corrective actions will be accomplished to address the identified deficient practice?*** Health and Wellness Director immediately reviewed resident #5 as well as any other resident who self administers medication to assess their ability to continue to self-administer medications. ***What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur?*** Health and Wellness Director will assess residents ability to safely continue to self-administer medications every 45 days. **How will the corrective actions be monitored to ensure the deficient practice will not recur?** 45 day medication review for residents who self-administer will be audited by the Health and Wellness Director and Administrator quarterly. Audit results will be reviewed in monthly quality assurance meetings. The Executive Director will be responsible to ensure overall compliance is maintained for all of the noted deficiencies.	

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 _____	05/06/2022

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 803	Continued From page 6 ability to continue to self-medicate every 45 days.	R 803		
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 observations and interview, the Assisted Living Residence (ALR) failed to ensure all equipment was maintained in good repair, for one of two Hot Wells used to keep the resident's food warm/hot. Findings included: On 05/05/2022 at 11:10 AM, observations during the tour of the facility showed the Hot Well located on the third-floor main kitchen was missing three knobs. The Plant Director, who accompanied the surveyor during the tour, stated that the missing knobs were used to keep the residents' meals warm/hot. The Plant director said he was not informed that the Hot Well knobs were missing, and that he would order new knobs as soon as possible. At 12:30 PM, the Plant Director presented the surveyor with a work order document and indicated that the knobs for the Hot Well had been ordered and expected to be installed next week. On 05/06/2022 at 2:37 PM, the Assisted Living Administrator (ALA) was interviewed to ascertain how staff operated the Hot Well without the three knobs. The ALA stated that staff were using pliers to operate the Hot Well. At the time of the survey, the ALR failed to ensure the Hot Well was maintained in good repair.	R 981	***What corrective actions will be accomplished to addressed the identified deficient practice?*** On 5/5 the water temperature was corrected to meet standards. On 5/5 replacement knobs were ordered and replaced on 5/13. ***What measures will be put into place to ensure the deficient practice does not recur?*** The Director of Plant Services or designee will audit water temperatures every week and rectify any variances immediately. The Director of Dining Services or designee will audit the knobs weekly for the first 4 weeks, then monthly thereafter. The results of the audits will be presented in monthly Quality Assurance meetings. ***How the corrective actions will be monitored to ensure the deficient practice will not recur.*** The Executive Director will be responsible to ensure overall compliance maintained for all of the noted deficiencies.	

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 _____	05/06/2022

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
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled using thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observations, interview, and record reviews, the ALR failed to ensure water temperatures did not exceed 110 degrees Fahrenheit, for one of one bar sink located on the third floor near apartment #318. Findings included: On 05/05/2022 beginning at 9:50 AM, a walk-thru of the facility with the Plant Director showed that the bar sink located on the third floor near apartment #318 showed a water temperature that measured 120.0 degrees Fahrenheit. When asked about the parameters for the hot water temperatures, the Plant Director stated that the hot water temperatures should not exceed 110 degrees Fahrenheit. The Plant Director said that he had to retrieve a special tool from his office to adjust the valves below the bar sink. At 12:30 PM, the Plant Director stated that the hot water temperatures had been adjusted. When asked how hot water temperatures are monitored, the Plant Director said that water temperatures checks are conducted daily throughout the facility and documented in the water temperature log electronic system. At 1:03 PM, a follow-up observation showed that the bar sink water temperature located on the third floor had been adjusted which measured 103.8 degrees Fahrenheit.	R1003		

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 _____	05/06/2022

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
R1003	Continued From page 8 On 05/06/2022 at 11:05 AM, review of the water temperature logs from May 2022 through February 2022 showed the temperatures remained within the normal range in accordance with local requirements. At 11:11 AM, review of the Water Temperature Testing Policy last reviewed on 04/06/2019, showed the facility staff was to test five random locations per week, and document all results on the water temperature log within the electronic system. Water temperatures results must fall within the temperature range specified by the local Department of Health. At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110 degrees Fahrenheit on the third-floor bar sink.	R1003		