H •lth Rgor lation & Licensina 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. VVING_____	06/23/2023

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)	Jp PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(Xs) COMPLETE DATE
R 000	Initial Comments 0000 Initial Comments An annual licensure survey was conducted on 06/21/2023, 06/22/2023, and 06/23/2023, 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 40 residents and employed 107 personnel, to include professional and administrative staff. A sample of 15 resident records, 15 employee record 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	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 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 properly completed with all required information, for seven of the 15 residents in the sample (Residents #1, 2, 4, 6, 11, 12 and 13). Findings included: 1. On 06/21/23 at 3:20 pm, a review of Resident #1's Medical Certification form dated 03/06/2022	R 074	1**. What corrective action(actions) will be accomplished to address the identified deficient practice?** The Medical Certification form for residents #1, 2, 4, 6, 11, 12, and 13 were reviewed by the Primary Care Physician and Health and Wellness Director. **2. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?** To prevent future occurrences and to verify compliance, the ALA will provide training for the Health and Wellness Director and sales and marketing team on how to review and verify proper completion of the medical certification form before admission to the facility.	

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

H• lth Reoulation & 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 _____	06/23/2023

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

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R 074	Continued From page 1. colonoscopy, Prostate-Specific Antigen, (PSA) test or dentures. 2. On 06/22/23 at 12:40 pm, a review of Resident #2's Medical Certification form dated 12/22/2022 showed no documented evidence that the physician assessed the resident's temperature. The physician also failed to document if the resident had non-prescription drugs or assessed if the resident had or needed a mammogram or Papanicolaou (pap) test. 3. On 06/23/2023 at 11:39 am, a review of Resident #4's annual Medical Certification form dated 12/12/2022 showed no documented evidence that the physician determined if the resident had or needed a mammogram or Papanicolaou (pap) test or needed a speech evaluation. 4. On 06/07/2023 at 3:18 pm, a review of Resident #6's annual Medical Certification form dated 06/05/2023 showed the physician failed to document if the resident had or needed a mammogram, Papanicolaou (pap) test or dentures. 5. On 06/23/2023 at 9:35 am, a review of Resident #11's annual Medical Certification form dated 06/22/2023 showed no documented evidence that the physician assessed if the resident had or needed a hearing evaluation or dentures. 6. On 06/22/2023 at 10:10 am, a review of Resident #12's annual Medical Certification form dated 04/11/2023 showed the physician failed to document if the resident had or needed a Prostate-Specific Antigen, (PSA) test, a speech evaluation, or dentures.	R 074	**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented.** Audits prior to admission will be completed by the ALA to verify that all resident's medical certification forms are completed before admission and action plans implemented as necessary. The results of this audit and any action plans, if needed, will be reported by the ALA to the Quality Assurance Performance Improvement Committee which meets at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-00077	A. BUILDING: _____ B. WING _____	06/23/2023

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**

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R 074	Continued From page 2. 7. On 06/22/2023 at 2:43 pm, a review of Resident #13's annual Medical Certification form dated 04/11/2023 showed the physician failed to document if the resident had or needed a mammogram or Papanicolaou (pap) test. During an interview on 06/23/2023 at 1:00 pm, the Health and Wellness Director confirmed that the Immediate Care Facilities Division Admission/Annual Medical Certification forms were not properly completed with all the required information. At the time of the survey, the ALR failed to ensure the physician completed the Intermediate Care Facilities Division Admission/Annual Medical Certification forms with all required information.	R 074		
R 281	10116.15f Staffing Standards 10116.15f A healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis. Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed to provide evidence that each employee had obtained a written statement from a healthcare practitioner within the past 12 months declaring them free from communicable diseases, for 12 of the 15 employees (Employees # 2, 3, 4, 5, 6, 9, 10, 11, 12, 13,), the Executive Director (ED) and Health and Wellness Director (HWD). Findings included: On 06/21/2023 beginning at 11:53 am through	R 281	1. **What corrective action(actions) will be accomplished to address the identified deficient practice?** The ALA obtained written statements as to weather employees #2, 3, 4, 5, 6, 9, 10, 11,12, 13, HWD and ED bear any communicable diseases, including communicable tuberculosis on June 23rd, 2023. **2. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?** The ALA or designee will review the written statements for each employee and ensure all employees complete a written statement indicating they are free from communicable diseases, annually.	

Health Reoulation & 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. VVING_____	06/23/2023

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

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R 281	Continued From page 3. 3:15 pm, observations showed the following employees (Employees # 2, 3, 4, 5, 6, 9, 10, 11, 12, 13), the Executive Director (ED) and Health and Wellness Director (HWD) providing care services throughout the survey process. These include, activities of daily living, mealtime, group bingo, talking with residents, checking hot water temperatures, etc. On 06/22/2023 at 3:35 pm, the surveyor requested documentation showing that each observed employee, the ED and HWD had obtained a statement from a healthcare practitioner saying that he or she was free from communicable disease. On 06/23/2023 beginning at 10:24 am, a review of the personnel records provided showed that there was no documented evidence that Employees # 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, the ED and HWD had been currently screened by a healthcare practitioner for communicable diseases. During an interview at 11:50 am, the ED and HWD confirmed that the above-mentioned employees, including the ED and HWD did have current written statements regarding communicable disease, including tuberculosis (TB) health screenings completed by a Healthcare Practitioner. The ED said that it was an oversight on their part and that all the employees would receive a health screening including tuberculosis from a Healthcare Practitioner as soon as possible. At the time of the survey, there was no documented evidence that the ALR ensured each employee obtained a current healthcare practitioner's statement certifying that he or she is	R 281	**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented.** Quarterly audits will be completed by the ALA or designee to ensure all employees have the appropriate written statements indicating they are free from communicable disease. The results of this audit will be reported immediately and presented by the ALA to the Quality Assurance Performance Improvement Committee which meets at least quarterly.	

Health Reaulntion & Licensina 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 _____	06/23/2023

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

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R 281	Continued From page 4. free from communicable disease.	R 281		
R 33C	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 interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's 45-day medication profile included or reflected added or discontinued medications, for two of the 15 residents in the sample (Residents # 9 and 13). Findings included: 1. On 06/22/2023 at 11:13 am, a review of Resident #9's record showed a 45-day medication review document dated 10/10/2022. The document indicated that there were no changes to the resident's medication regimen, however, the review of a physician's order dated 09/12/2022 showed the resident's Seroquel dose was decreased to 12.5 mg. 2. On 06/22/2023 at 2:43 pm, a review of Resident #13's record showed a 45-day medication review document dated 06/21/2023. The document indicated that there were no changes to the resident's medication regimen, however, the review of a physician's order dated 06/14/2023 showed the resident was started on Keflex 250 mg twice a day for seven (7) days.	R 330	**What corrective action(actions) will be accomplished to address the identified deficient practice?** For Resident # 9 The medication changes were documented and shown to the surveyor where it was located, and we agreed at the time that it was not an issue. After receiving this deficiency, the same copy of the 45-day documentation was sent to the surveyor via email on 6/28/2023. For resident #13 The Resident was not harmed by this deficient practice. **2. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?** HWD was educated by the ED regarding including medication changes on the medication review from on 6/23/2023. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented** Quarterly audits will be completed by the HWD or designee to ensure all 45 day reviews include any medication changes. The results of this audit will be reported immediately and presented by the ALA to the Quality Assurance Performance Improvement Committee which meets at least quarterly.	

Health Regulation & Lir•nsinq Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	ALR-0037	A. BUILDING:_____ B VVING_____	06/23/2023

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MASS SR CARE, LLC T/A THE RESIDENCES AT	1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005

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R 330	Continued From page 5. During an interview on 06/23/2022 at 1:00 pm, the Health and Wellness Director confirmed that the residents #9 and 13 45-day medication profiles were not updated to included medications started or decreased. At the time of the survey, the ALR failed to ensure the nurse included new/decreased or discontinued medications to the resident's 45-day medication.	R 330		

Health Reo«lation & 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 _____	06/23/2023

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

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R 000	Initial Comments An annual licensure survey was conducted on 06/21/2023, 06/22/2023, and 06/23/2023, 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 40 residents and employed 107 personnel, to include professional and administrative staff. A sample of 15 resident records, 15 employee record 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	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. Please start typing your responses here:	
R 602	Sec. 701f Staffing Standards. (f} Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed to provide evidence that each employee had obtained a written statement from a healthcare practitioner within the past 12 months declaring them free from communicable diseases, for 12 of the 15 employees (Employees # 2, 3, 4, 5, 6, 9, 10, 11, 12, 13,), the Executive Director (ED) and Health and Wellness Director (HWD). Findings included: On 06/21/2023 beginning at 11:53 am through 3:15 pm, observations showed the following	R 602	1**. What corrective action(actions) will be accomplished to address the identified deficient practice?** The ALA obtained written statements as to weather employees #2, 3, 4, 5, 6, 9, 10, 11,12, 13, HWD and ED bear any communicable diseases, including communicable tuberculosis on June 23rd, 2023. **2. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?** The ALA or designee will review the written statements for each employee and ensure all employees complete a written statement indicating they are free from communicable diseases, annually.	

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

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASS SR GARE,LLGT/ATHERESIDENGESAT	1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005

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R 602	Continued From page 1. employees (Employees # 2, 3, 4, 5, 6, 9, 10, 11, 12, 13), the Executive Director (ED) and Health and Wellness Director (HWD) providing care services throughout the survey process. These include, activities of daily living, mealtime, group bingo, talking with residents, checking hot water temperatures, etc. On 06/22/2023 at 3:35 pm, the surveyor requested documentation showing that each observed employee, the ED and HWD had obtained a statement from a healthcare practitioner saying that he or she was free from communicable disease. On 06/23/2023 beginning at 10:24 am, a review of the personnel records provided showed that there was no documented evidence that Employees # 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, the ED and HWD had been currently screened by a healthcare practitioner for communicable diseases. During an interview at 11:50 am, the ED and HWD confirmed that the above-mentioned employees, including the ED and HWD did have current written statements regarding communicable disease, including tuberculosis (TB) health screenings completed by a Healthcare Practitioner. The ED said that it was an oversight on their part and that all the employees would receive a health screening including tuberculosis from a Healthcare Practitioner as soon as possible. At the time of the survey, there was no documented evidence that the ALR ensured each employee obtained a current healthcare practitioner's statement certifying that he or she is free from communicable disease.	R 602	Quarterly audits will be completed by the ALA or designee to ensure all employees have the appropriate written statements indicating they are free from communicable disease. The results of this audit will be reported immediately and presented by the ALA to the Quality Assurance Performance Improvement Committee which meets at least quarterly.	

Health R• ulation & 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 \MNG _____	06/23/2023

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**

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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 by the use of 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 (°F), for four of the five-bathroom sinks (Third Floor) and one of the three-bathroom sinks (Second Floor), (Apartments #317, 315, 316, 321 and 208). Findings included: On 06/21/2023 beginning at 12:11 pm, an environmental walk-through of the facility with the ALR's Health and Wellness Director (HWD) showed the following: - At 12:13 pm, water temperature in the bathroom sink located in an empty apartment (#317) measured 135.5 °F. When asked about the parameters for the hot water temperatures, the HWD and the maintenance staff, who were present while the surveyor checked the water temperatures on the third floor, said the hot water temperatures should not exceed 110 degrees Fahrenheit. The maintenance staff said that apartments 315, 316 and 317 were newly renovated including the bathrooms, and that may have something to do with the high-water temperatures. - At 12:16 pm, the bathroom sink located in the model apartment #315 showed a water	R1003	**What corrective action(actions) will be accomplished to address the identified deficient practice?** The was an immediate diagnosis by the Maintenance Director and the water temperatures identified were adjusted to ensure temperatures did not exceed 110 degrees Fahrenheit. **2. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?** The Maintenance Director or designee will perform weekly water temperature checks on 100% of sinks in the community and document each on a water temperature log. All discrepancies will be immediately reported to the ALA. If there are any adjustments, there will be a follow up in 24 hours to ensure systemic compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented** The Director of Plant Operations or designee will present the results of the temperature logs to the Quality Assurance Performance Improvement Committee, along with any action plans for improvement, quarterly.	

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R1003	Continued From page 3. temperature that measured 137.1 °F. - At 12:17 pm, the bathroom sink located in the resident apartment #316 showed a water temperature that measured 120.0 °F. - At 12:22 pm, the bathroom sink located in the resident apartment #321 showed a water temperature that measured 116.2 °F. At 12:52 pm, the HWD said she would reach out to the maintenance director regarding the hot water temperatures. On 06/23/2023 at 9:30 am, the maintenance staff stated that the hot water temperatures in the apartments on the second and third floors had been adjusted. Beginning at 9:58 am, a follow-up observation showed that the maintenance staff adjusted the hot water temperatures on the second and third floor, and that the readjusted water temperatures measured the following: - Apartment #317, bathroom sink water temperature reading was 109.9 °F. - Apartment #315, bathroom sink water temperature reading was 104.3 °F. -Apartment #316, bathroom sink water temperature reading was 105.4 °F. -Apartment #321, bathroom sink water temperature reading was 106.2 °F. -Apartment #208, bathroom sink water temperature reading was 107.4 °F.	R1003		

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R1003	Continued From page 4. At 10:04 am, a review of the water temperature logs from June 2022 through March 2023 showed the temperatures remained within the normal range in accordance with local requirements. At 10:15 am, a review of the Water Temperature Testing Policy last reviewed April 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. The 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 hot water temperature did not exceed 110 degrees Fahrenheil throughout the facility as required.	R1003		