AND PLAN (	DF CORRECTION IDENTIFICATION NUMBER	A BUILDING	CON	IPLETED
	ALR-0037	B. VVING	<b>06</b> /	23/202
			TATE, ZIP CODE TS AVENUE, NW	
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(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) COMPLI DATI
R OOC	Initial Comments	R 000		
	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.	1	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.	
	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 074	10108.2 Admissions	R 074		
	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).		<ol> <li>What corrective action(actions) will be accomplished to address the identified deficient practice?</li> <li>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.</li> <li>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?</li> </ol>	
			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.	
	Findings included:			
	1. On 06/21/23 at 3:20 pm, a review of Resident #1's Medical Certification form dated 03/06/2022			
RATORY [	DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR	E .	TITLE	(X6) DATE

PRINTED: 06/28/2023 FORM APPROVED H. Ith Reoulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING **ALR-0037** 06/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE, NW MASS SR CARE, LLC T/A THE RESIDENCES AT WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) How the corrective action will be monitored to ensure R 074 R 074 Continued From page 1. the deficient practice will not recur, i.e. what quality assurance program will be implemented. colonoscopy, Prostate-Specific Antigen, (PSA) test or dentures. 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 2. On 06/22/23 at 12:40 pm. a review of Resident as necessary. The results of this audit and any action plans, #2's Medical Certification form dated 12/22/2022 if needed, will be reported by the ALA to the Quality showed no documented evidence that the physician Assurance Performance Improvement Committee which assessed the resident's temperature. The physician meets at least quarterly. 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

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evaluation, or dentures.

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

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIK (X2) MULTIPLE CONSTRUCTION (XX3) DXATTEE SELURAVEEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WINKS **ALR-0037** 06/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE, NW MASS SR CARE, LLC T/A THE RESIDENCES AT **WASHINGTON, DC 20005** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY cop.5 TE PRÉFIX **PREFIX** OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 074 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 281 10116.15f Staffing Standards R 281 1. What corrective action(actions) will be accomplished to address the identified deficient practice? 10116.15f A healthcare practitioner's written statement as to whether the employee bears any The ALA obtained written statements as to weather communicable diseases, including communicable employees #2, 3, 4, 5, 6, 9, 10, 11,12, 13, HWD and tuberculosis. ED bear any communicable diseases, including Based on observations, interview and record communicable tuberculosis on June 23rd, 2023. reviews, the Assisted Living Residence (ALR) failed to provide evidence that each employee had obtained a written statement from a healthcare 2. What measures will be put into place or what systemic changes will you make to ensure that the deficient practitioner within the past 12 months declaring practice does not occur? them free from communicable diseases, for 12 of the 15 employees (Employees # 2, 3, 4, 5, 6, 9, 10, The ALA or designee will review the written 11, 12, 13, ), the Executive Director (ED) and Health statements for each employee and ensure all and Wellness Director (HWD). employees complete a written statement indicating they are free from communicable diseases, annually. Findings included: On 06/21/2023 beginning at 11:53 am through

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Health Reoulation & Licensing Administration  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
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MASS SF	R CARE, LLC T/A THE	E RESIDENCES AT		SACHUSETTS AVENUE, NW TON, DC 20005					
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R 281	employees (Emplo 13), the Executive Wellness Director throughout the sur activities of daily litalking with resider temperatures, etc.  On 06/22/2023 at a documentation show the employee, the ED statement from a head to be the personnel recovered was no documentation and the personnel recovered was no documentation at the personnel recovered was no documentation. The personnel recovered was no documentation and the personnel recovered was no documentation. The personnel recovered was no documentation and the personnel recovered was no documentation. The personnel recovered was no documentation and the personnel recovered was no documentation. The personnel recovered was no documentation and the personnel recovered was no documentation. The personnel recovered was no documentation and the personnel recovered was no documentation. The personnel recovered was no documentation and the personnel recovered was n	cons showed the follopyees # 2, 3, 4, 5, 6, 9 Director (ED) and He (HWD) providing care vey process. These iving, mealtime, group ints, checking hot wat it.  3:35 pm, the surveyor owing that each obse and HWD had obtain ealthcare practitioner from communicable ginning at 10:24 am, ords provided showed de evidence that Emp ints, 12, 13, the ED and ened by a healthcare process at 11:50 am, the ED above-mentioned em ind HWD did have cur ling communicable of sis (TB) health scree althcare Practitioner. oversight on their par uld receive a health s is from a Healthcare	a, 10, 11, 12, ealth and e services nclude, o bingo, er requested rved led a saying that disease.  a review of that there loyees # 2, HWD had ractitioner for and HWD loployees, rent written disease, nings The ED rand that all creening Practitioner	R 281	deficient practice will not re assurance program will be in Quarterly audits will be co designee to ensure all emp written statements indication communicable disease. Th	mplemented. mpleted by the ALA or loyees have the appropriate ng they are free from e results of this audit will nd presented by the ALA to formance Improvement			

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### PRINTED: 06/28/2023 FORM APPROVED Health Reaulntion & Licensina Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:\_ B. WING ALR-0037 06/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE, NW MASS SR CARE, LLC T/A THE RESIDENCES AT WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) GOMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) R 281 Continued From page 4. R 281 free from communicable disease. R 33C 10122.1 On Site Medication Review R 330 What corrective action(actions) will be accomplished to address the identified deficient practice? 10122.1 The on-site medication review by a For Resident # 9 The medication changes were registered nurse that is arranged to occur every documented and shown to the surveyor where it was forty-five (45) days, pursuant to § 903 of the Act located, and we agreed at the time that it was not an (D.C. Official Code § 44-109.03), shall include issue. After receiving this deficiency, the same copy documentation of any changes to the resident's of the 45-day documentation was sent to the surveyor medication profile, including changes in dosing and via email on 6/28/2023. any medications that have been added or discontinued. Based on interviews and record reviews, the For resident #13 The Resident was not harmed by this Assisted Living Residence (ALR) failed to ensure deficient practice. 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). 2. What measures will be put into place or what systemic changes will you make to ensure that the deficient Findings included: practice does not occur? HWD was educated by the ED regarding including 1. On 06/22/2023 at 11:13 am, a review of Resident medication changes on the medication review from #9's record showed a 45-day medication review on 6/23/2023.

for seven (7) days.

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mg.

document dated 10/10/2022. The document indicated that there were no changes to the

resident's medication regimen, however, the review

resident's Seroquel dose was decreased to 12.5

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

of a physician's order dated 09/12/2022 showed the

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How the corrective action will be monitored to ensure

the deficient practice will not recur, i.e. what quality

Quarterly audits will be completed by the HWD or

reported immediately and presented by the ALA to

the Quality Assurance Performance Improvement

Committee which meets at least quarterly.

designee to ensure all 45 day reviews include any medication changes. The results of this audit will be

assurance program will be implemented

FORM APPROVED Health Regulation & Lirensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:\_ B VVING\_ ALR-0037 06/23/2023 STREETADDRESS, GITY, STATE, ZPCODE NAME OF PROVIDER OR SUPPLIER 1330 MASSACHUSETTS AVENUE, NW MASS SR CARE, LLC T/A THE RESIDENCES AT **WASHINGTON, DC 20005** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) R 330 Continued From page 5. R 330 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.

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(X6) DATE

Health Reo «lation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING **ALR-0037** 06/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1330 MASSACHUSETTS AVENUE, NW MASS SR CARE, LLC T/A THE RESIDENCES AT WASHINGTON, DC 20005 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5 COMPLETE DATE ID PREFIX (X4) IO PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 000 Initial Comments R 000 An annual licensure survey was conducted on The Residences at Thomas Circle files this 06/21/2023, 06/22/2023, and 06/23/2023, to Plan of Correction for the purpose of determine compliance with the Assisted Living Law regulatory compliance. The facility (DC Official Code § 44-101.01 et seg) and Assisted submits this document to comply with Living Residence Regulations, Title 22-B DCMR applicable law and not as an admission (Public Health and Medicine) Chapter 101. The or statement of agreement of deficient Assisted Living Residence (ALR) provided care for practices. 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. Please start typing your responses here: 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 602 R 602 Sec. 701f Staffing Standards. 1. What corrective action(actions) will be accomplished (f) Employees shall be required on an annual basis to address the identified deficient practice? to document freedom from tuberculosis in a communicable form. The ALA obtained written statements as to weather employees #2, 3, 4, 5, 6, 9, 10, 11,12, 13, HWD and Based on observations, interview and record ED bear any communicable diseases, including reviews, the Assisted Living Residence (ALR) failed communicable tuberculosis on June 23rd, 2023. to provide evidence that each employee had obtained a written statement from a healthcare practitioner within the past 12 months declaring 2. What measures will be put into place or what systemic them free from communicable diseases, for 12 of changes will you make to ensure that the deficient the 15 employees (Employees # 2, 3, 4, 5, 6, 9, 10, practice does not occur? 11, 12, 13, ), the Executive Director (ED) and Health and Wellness Director (HWD). 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. Findings included: On 06/21/2023 beginning at 11:53 am through 3:15 pm, observations showed the following

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUL
AND PLAN OF CORRECTION IDENTIFICATION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION B. WING \_ ALR-0037 06/23/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
1330 MASSACHUSETTS AVENUE, NW

MASS SR GARE,LLGT/ATHERESIDENGESAT  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 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 Regulation & Licensing Administration STATE FORM

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Health R• ulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	_
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

**ALR-0037** 

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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)	}p PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
R1003	(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	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.			
	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		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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06/23/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
A-BUILDING:	COMPLETED

ALR-0037

STREET ADDRESS, CITY, STATE, ZIP CODE

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## MASS SR CARE, LLC T/A THE RESIDENCES AT

# 1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005

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 3.	R1003				
	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.					

Health Regulation & Licensing Administration STATE FORM

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	ALR-0037	B. VVING		06/23/2023	
NAME OF PROVIDER OR SUPPLIER  MASS SR CARE, LLC T/A THE RESIDENCES AT  STREET ADDRESS, CITY, STATE, ZIP CODE  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 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			

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