PRINTED: 11/25/2019
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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 _____	11/08/2019

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 survey was conducted on 11/06/19 to 11/08/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The ALR provided care for 37 residents and employed 77 personnel to include professional and administrative staff. A random sample of 15 resident records and 20 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. Listed below are abbreviations that appear in the body of this report: ALA - Assisted Living Administrator ALR - Assisted Living Residence CNA - Certified Nursing Assistant Degrees - ° DON - Director of Nursing DPO - Director of Plant Operations Fahrenheit - F HR - Human Resources ISP - Individualized Service Plan LPN - Licensed Practical Nurse RN - Registered Nurse	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 practice.	
R 273	Sec. 503.2 Dignity. (2) Control time, space, and lifestyle; Based on interview and record review, the ALR failed to ensure that each resident had the right to access all resident areas of the ALR for two of 26 residents. Findings included:	R 273	**R273 Section 503.2 Dignity** 1. What corrective action(s) will be accomplished to address the identified deficient practice? The ALA and Director of Nurses will review all candidates deemed in need of a Wanderguard to ensure that the least restrictive measures have been tried first so that the resident has access to all areas of the ALR. 2. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Inservice education will be given to all licensed staff by the Director of Nurses to ensure their knowledge of the protocol established for the least restrictive environment. 3. 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.	12/31/19 12/31/19 12/31/19

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	ALR-0037	A. BUILDING: _____ B. WING _____	11/08/2019

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 273	Continued From page 1 On 11/06/19 at 9:50 AM, during the entrance conference, the ALA stated that the ALR provided care for 36 residents, 11 of whom resided in the locked memory care unit of the facility. On 11/07/19 at 10:01 AM, review of Resident #7's clinical chart showed that the resident had a diagnosis of Dementia, however was not admitted to the memory care unit. At 11:14 AM, review of the facility's incident log book showed that Resident #1 eloped from the facility on 07/04/19. The incident log also showed that Resident #7 eloped from the facility on 08/30/19 and 09/02/19. The reports detailed that the facility's actions after the elopement was to implement the wanderguard - a device worn by the resident that disabled the elevators in the facility when the residents were near. The wanderguard inhibited the residents' right to freely visit all areas of the ALR. It should be noted that the ALR's residential units and dining room are on the 3rd floor. There is another dining room, activity rooms, common areas and a bistro for residents and guests on the first floor and basement level. At 11:30 AM, review of Resident #1's clinical record showed that the resident had a diagnosis of Dementia and gait abnormality, however was not admitted to the memory care unit. At 1:25 PM, the ALR manager stated during an interview that the ALR does not obtain signed consent for the wanderguard. The ALR manager further stated doctors' orders were obtained after the residents were screened to be a high risk for elopement, and the family was verbally notified about the wanderguard implementation.	R 273	The Director of Nurses will do monthly audits of any AL resident at risk of elopement to ensure the protocols in the policy has been followed. The Director of Nurses will present the results of these audits, along with any action plans for improvement to the Quality Assurance Performance Improvement Committee which meets at least quarterly. The Committee is chaired by the ALA and is attended by the Executive Director of the community.	12/30/19

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	ALR-0037	A. BUILDING: _____ B. WING _____	11/08/2019

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 273	Continued From page 2 At 2:02 PM, the DON stated that neither resident had a one-to-one aide at the time of their elopements. She further said that the nursing notes would document the details after the residents eloped. At 3:35 PM, review of the elopement policy showed that if a resident was assessed to be a high risk for elopement, the ALR would recommend that the resident receive a personal care aide before implementing the wanderguard. On 11/08/19 at 10:35 AM, review of Residents #1 and 7's nursing notes failed to document that a personal care aide was discussed with the residents or their families prior to applying the wanderguard. At the time of survey, the facility failed to provide evidence that the least restrictive measures were implemented to ensure Residents #1 and 7 had access to all areas of the ALR.	R 273		
R 596	Sec. 701d9 Staffing Standards. (9) Assure that members of the staff appear to be free from apparent signs and symptoms of communicable disease, as documented by a written statement from a healthcare practitioner; Based on interview and record review the ALR failed to ensure that all staff were free from signs and symptoms of communicable disease as documented by a written statement from a healthcare practitioner for twenty of twenty-two personnel records reviewed (Administrator, RNs #1 and 2, LPNs #1, 2, 3, 4, 5 and 6, CNAs #1, 2, 3, 4 and 5, Dietary Aide #1, 2, 3 and 4, and the Social Worker).	R 596	**R 596 Staffing Standards** 1. What corrective action(s) will be accomplished to address the identified deficient practice? The facility has revised its Staff Health Certificate form so that it can be reviewed and signed off by a healthcare practitioner that each employee was free from signs and symptoms of communicable disease. 2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	1/15/20

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	ALR-0037	A. BUILDING: _____ B. WING _____	11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASS SR CARE,LLC T/A THE RESIDENCES A1	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 596	Continued From page 3 Findings included: On 11/07/19 at 2:18 PM, review of the personnel records for (Administrator, RNs #1 and 2, LPNs #1, 2, 3, 4, 5 and 6, CNAs #1, 2, 3, 4 and 5, Dietary Aide #1, 2, 3 and 4, and the Social Worker), showed that the records did not contain written statements from a healthcare practitioner indicating that the employees were free from signs and symptoms of communicable disease. On 11/08/19 at 1:40 PM, the HR Director stated during an interview that she was not aware of the new ALR regulations. At the time of survey, the personnel records failed to evidence a signed statement from a healthcare practitioner that each employee was free from signs and symptoms of a communicable disease.	R 596	The Director of Human Resources will review the health certificates of each new hire and then annually thereafter during the month of December to ensure that the employee was deemed free of signs and symptoms of communicable disease by virtue of a signature of a healthcare practitioner. 1/15/20 3. 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? Quarterly audits will be done to ensure that all employees have the appropriately signed health certificate. The results of this audit, and any action plans for improvement if needed, will be presented by the Director of Human Resources to the Quality Assurance Performance Improvement Committee which meets at least quarterly. The Committee is chaired by the ALA and is attended by the Executive Director of the Community. 1/31/20	
R 605	Sec. 701g2 Staffing Standards. (2) Possess current and appropriate licensure and certifications as required by law; Based on interview and record review, the ALR failed to ensure that all staff possessed appropriate certification for CNAs #4 and 5, and a Social Worker. Findings included: On 11/08/19 at 10:55 AM, review of ALR's personnel records showed that there were no current certifications available for review for CNAs #4 and 5. Additionally, there was no current license available for a Social Worker. On 11/08/19 at 11:20 AM, the HR representative stated during an interview that she would contact	R 605	**R605 Sec. 701g2 Staffing Standards** 1. What corrective action(s) will be accomplished to address the identified deficient practice? The identified CNAs were removed from the schedule until their DC license could be secured. The updated license for the Social Worker was placed in her file. The Human Resources Director will ensure that no licensed individual	

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	ALR-0037	A. BUILDING: _____ B. WING _____	11/08/2019

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 605	Continued From page 4 the staff to obtain their proper licenses. She further stated that the staff in question would not be permitted to work until they provided a current licensure. At the conclusion of the survey no additional information was provided the surveyor. At the time of survey, the personnel records failed to evidence	R 605	is placed on the schedule after hire until a current D.C. license is in place.	12/31/19
R 821	Sec. 904e8 Medication Storage (8) Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure that only residents who self-administered kept medications in their units, for one of 15 residents in the sample (Resident #6). Findings included: On 11/06/19 at 11:05 AM, observation of Resident #6's apartment showed the resident holding an opened bottle of medication (fiber supplement). The resident then retrieved two capsules from the bottle and self-administered them. Further observation showed there was a bottle of Advil on a cart in the resident's living area, a pack of Immodium and another bottle of Advil in the resident's bathroom. The surveyor asked if the resident locked the door when leaving the apartment. Resident #6 responded that the door remains unlocked at all times. At 12:30 PM, the DON presented the surveyor with the ALR's resident list. The DON identified on the list which residents were capable of	R 821	2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An audit will be conducted each quarter by the Director of Human Resources to ensure that the CNAs and other licensed staff (Social Workers, Nurses, Dieticians, etc.) have current D.C. licenses on file. The results of this audit will be sent to the ALA and the Executive Director for review. 12/31/19 3. 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? The Director of Human Resources will present the results of these audit to the Quality Assurance and Improvement Committee along with any action plans for improvement to ensure the facility's compliance in this area. The Committee is chaired by the ALA and is attended by the Executive Director of the community. 1/31/19 **R 821 Sec. 904e8 Medication Storage** 1. What corrective action(s) will be accomplished to address the identified deficient practice?	

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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 821	Continued From page 5 self-administering medication. Resident #6 was not identified on the list. When questioned about the list, the DON confirmed that the resident was not able to self-administer medications. The DON was informed that there were unsecured medications in Resident #6's apartment. The DON responded that the medications would be removed immediately. At the time of survey, the facility failed to ensure that only residents who self-administer kept their medications secured in their units.	R 821	An immediate inspection was done in all ALR units to ensure that any resident who self-medicates has their medication secured in their rooms. There were no other incidents noted. 2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Staff on the ALR was inserviced by the Director of Nurses to ensure their knowledge of residents who self-medicate must have their medications secured at all times in their rooms. The Director of Nurses/designee will inspect and monitor the residents' room at least monthly to ensure compliance in this area. 3. 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? The Director of Nurses will present the findings of these inspections, along with any action plans for improvement, to the Quality Assurance Performance Improvement Committee for their review and recommendations. The Committee is chaired by the ALA and is attended by the Executive Director.	11/6/19 12/31/19 12/31/19
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 observation and interview, the ALR failed to ensure that hot water temperatures did not exceed 110 degrees Fahrenheit (°F) in two of eight bathrooms inspected (apartments #302 and 311). Findings included: On 11/06/19 beginning at 11:05 AM, the ALA and the DPO accompanied the surveyors during an environmental walk-through of the facility. Observation at 11:29 AM showed that the hot water temperature in the bathroom of apartment #302 measured 114 °F. At 11:38 AM, the hot water temperature measured 117 °F in the bathroom of apartment #311.	R1003	**R1003 Sec. 1006c. Bathrooms** 1. What corrective action(s) will be accomplished to address the identified deficient practice? There was an immediate diagnosis by the Director of Plant Operations of the	

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	ALR-0037	A. BUILDING: _____ B. WING _____	11/08/2019

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	Continued From page 6 On 11/06/19 at 11:31 AM, an interview with the DPO revealed that the water temperatures in the residents' apartments should not exceed 110 °F at any time. He then requested a maintenance staff to adjust the water temperatures. On 11/06/19 at 3:58 PM, a follow-up observation of the water temperature in apartment #302 showed that it measured 106.3 °F. At 3:58 PM, a follow-up measurement of the hot water temperature in apartment #302 was 109 °F. At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110 °F in residents' apartments at all times.	R1003	failure of the single cartridge water faucet in room #302. An adjustment brought the temperature within an acceptable range. The faucet was replaced within 24 hours of the faucet failure. In room #311, the mixing valve located under the sink was adjusted which immediately brought the temperature within range. All other faucets were tested on the ALR and there were no further temperature issues. 2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Department will perform weekly water temperature checks and document each on a Water Temperature Log. If there are any adjustments, there will be a follow up in 24 hours to ensure systemic temperature compliance. 3. 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? The Director of Plant Operations will present the results of the Temperature Logs to the Quality Assurance Performance Improvement Committee, along with any action plans for improvement, which meets at least quarterly. The Committee is chaired by the ALA and is attended by the Executive Director of the community.	11/6/19 12/31/19 12/31/19

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
899 North Capitol St., NE
Washington DC 20002
2nd Floor (2224)
202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Mass Sr. Care, LLC T/a Residences at Thomas Circle ALR -0037	1330 Massachusetts Avenue, NW Washington, DC 20005	11/06/19-11/08/19 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An annual survey was conducted on 11/06/19 through 11/08/19, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The ALR provided care for 37 residents and employed 77 personnel to include professional and administrative staff. A random sample of 15 resident records and 20 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, review of the emergency preparedness program and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALA – Assisted Living Administrator ALR –Assistant Living Residence CNA – Certified Nursing Aide DPO – Director of Plant Operations		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 practice.	

C. Stringfield/T. Lomax/S. Teekasingh/M. Torbit — 11/08/19
Name of Inspector — Date Issued

Facility Director/Designee — 12/20/19
Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA

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Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

HHA – Home Health Aide
HR – Human Resources
LPN – Licensed Practical Nurse

10110 Required Policies and Procedures	**10110.01 (k) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR & 483.73;** This regulation is not met as evidenced by: Based on record review and interview, the ALR failed to develop written policies and procedures to ensure subsistence needs (specifically sewage and waste disposal) during emergencies, for 37 of 37 residents in the facility. Findings included: On 11/08/19 beginning at 11:32 AM, review of the facility's Resources for Disaster Planning showed the facility was connected to the local sewer system. The facility's Emergency Plan, last reviewed on 07/22/19 did not include written policies and procedures to address sewage and waste disposal during potential service interruptions. During an interview on 11/08/19 at 2:22 PM, the DPO and the ALA indicated that the written policies and procedures did not address sewage management during an emergency. The DPO confirmed the facility was connected to the city	**10110.01 (k) Emergency Preparedness:** 1. What corrective action(s) will be accomplished to address the identified deficient practice? The facility has developed a policy for Sewer Disruption which includes the initiation of a Red Bag program which wil be implemented in each toilet for the collection of waste several time per day and disposed of as biohazardous waste removal. 2. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The new policy has been present to the Safety Committee for their review and inclusion in the facility's Emergency Management Plan. The staff will be educated by the Director of Plant Operations and the ALA about the Sewer Disruption policy to ensure the staff's understanding. 3. 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. The Director of Plant Operation will include the implementation, education and review of the Sewer Disruption policy in his Quality Assurance/ Performance Improvement program which will be reviewed at least quarterly by this Quality Assurance Performance Improvement Committee which is chaired by the ALA and attended by the Executive Director of the Community.	12/31/19 1/31/19 12/31/19

GOVERNMENT OF THE DISTRICT OF COLUMBIA

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DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	water and sewer system. The DPO said the facility had a backup waste management system that would be adequate for about four hours if there was a major interruption in the sewage and waste disposal system. At the time of the survey, there was no evidence that the facility's policies and procedures addressed all subsistence needs, such as sewage and waste disposal during emergencies.	**10116.15 Staffing Standards** 1. What corrective action(s) will be accomplished to address the identified deficient practice? The facility has revised its Staff Health Certificate form so that it can be reviewed and signed off by a healthcare practitioner that each employee was free from signs and symptoms of communicable disease.
10116 Staffing Standard	**10116.15 Personnel records maintained by the ALA for each employee pursuant to Section 701(d)(11) of the Act (D.C Official Code § 44-107.01(d)(11)) shall be accurate and current and shall contain the following:** **(f) A healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis.** This regulation is not met, as evidenced by: Based on interview and record review the ALR failed to ensure that all staff were free from signs and symptoms of communicable disease as documented by a written statement from a healthcare practitioner for twenty of twenty-two personnel records reviewed (Administrator, RNs #1 and 2, LPNs #1, 2, 3, 4, 5 and 6, CNAs #1, 2, 3, 4 and 5, Dietary Aide #1, 2, 3 and 4, and the Social Worker).	2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Director of Human Resources will review the health certificates of each new hire and then annually thereafter during the month of December to ensure that the employee was deemed free of signs and symptoms of communicable disease by virtue of a signature of a healthcare practitioner. 3. 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? Quarterly audits will be done to ensure that all employees have the appropriately signed health certificate. The results of this audit, and any action plans for improvement if needed, will be presented by the Director of Human Resources to the Quality Assurance Performance Improvement Committee which meets at least quarterly. The Committee is chaired by the ALA and is attended by the Executive Director of the Community.

1/15/20

1/15/20

1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	Findings included: On 11/07/19 at 2:18 PM, review of the personnel records for (Administrator, RNs #1 and 2, LPNs #1, 2, 3, 4, 5 and 6, CNAs #1, 2, 3, 4 and 5, Dietary Aide #1, 2, 3 and 4, and the Social Worker), showed that the records did not contain written statements from a healthcare practitioner indicating that the employees were free from signs and symptoms of communicable disease. On 11/08/19 at 1:40 PM, the HR Director stated during an interview that she was not aware of the new ALR regulations. At the time of survey, the personnel records failed to evidence a signed statement from a healthcare practitioner that each employee was free from signs and symptoms of a communicable disease.	**10125.02: Reporting Abuse, Neglect, Exploitation and Unusual Incidents** 1. What corrective action(s) will be accomplished to address the identified deficient practice? The Director and Assistance Director of Nursing will review the 24 hour report each day and ensure that any unusual incidents have been reported per policy and protocol. 12/31/19 2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The licensed nursing staff will be inserviced by the Director of Nurses to make sure that all unusual incidents are reported to the Department of Health per AL regulations and that evidence of this report are kept as a permanent record in the resident's medical record. 12/31/19 3. 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? The Director of Nursing will conduct an audit of all unusual incidents with any action plans for improvement to the Quality Assurance Performance Improvement Committee which meets at least quarterly. The Committee is chaired by the ALA and is attended by the Executive Director of the Community.. The Committee will review the results of the audits and offer any recommendations. 12/31/19
10125 Reporting Abuse, Neglect, Exploitation, and Unusual Incidents	**10125.02 In addition to the requirements to abuse, neglect, and exploitation of a resident provided in Section 509 of the Act (D.C. Official Code § 44-105-09), each ALR shall notify the Director of any unusual incident that substantially affect the resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone immediately, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

This regulation is not met, as evidenced by:

a. On 11/06/19 at 9:50 AM, the surveyors requested a list of the resident discharges and deaths since the last survey (11/09/18). The ALA provided the surveyor with a list which included 12 resident deaths. When asked if the deaths were reported to the Department of Health, the ALA stated that she had not reported them. It should be noted that the ALA's hire date was 03/06/19.

There was no other documentation provided that showed that the deaths had been reported to the Department of Health.

b. On 11/07/19, at 11:14 AM, a review of the facility's incident log showed that Resident #1 eloped from the facility on 07/04/19. Further review showed that Resident #7 eloped on 08/30/19 and 09/02/19. When asked if the elopements had been reported to the Department of Health, the ALA stated that she had not reported them.

There was no other documentation provided that showed that the elopement had been reported to the Department of Health.

At the time of the survey, the ALR failed to ensure that all unusual incidents were reported to the Department of Health.

GOVERNMENT OF
THE DISTRICT OF
COLUMBIA

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DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION