STATE FORM

PRINTED: 11/25/2019 FORM APPROVED

Health Regulation & Lice STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIENCLIA	(X2) MULTIPI	E CONSTRUCTION (X3	OMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		
	ALR-0037	B. WING		11/08/2019
NAME OF PROVIDER OR SUPP	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
	1330 M/	ASSACHUSET	ITS AVENUE, NW	
MASS SR CARE,LLC T/A	THE RESIDENCES AT WASHIN	NGTON, DC 2	0005	
(EACH DEEK)	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETE ATE DATE
	A.	R 000	The Residences at Thomas Circle fi	es de la
R 000 Initial Commen	ts	11.000	this plan of Correction for the purp	iose
An annual cum	rey was conducted on 11/06/19 to	(A)	of regulatory compliance. The faci	lity
11/08/19 to det	ermine compliance with the	1	submits this document to comply	with
Assisted Living	Law (DC Official Code §	ž.	applicable law and not as an admis	sion
44-101 01 et se	ed) and the Assisted Living	i		3,011
Residence (AL	R) emergency and proposed	į	or statement of agreement of	
regulations. T	he ALR provided care for 37		deficient practice.	t)
residents and	employed 77 personnel to include			
professional ar	nd administrative staff. A random esident records and 20 employee	4	R273 Section 503.2 Dignity	1
sample of 15 f	elected for review. The findings of	ıf (	1. What corrective action(s) will be	
the survey war	e based on observation througho	ut !		Flori
the facility, clin	ical and administrative record		accomplished to address the identi	neu
review, and re-	sident and staff interviews.		deficient practice?	
12		1	The ALA and Director of Nurses will	
Listed below a	re abbreviations that appear in the	B :	review all candidates deemed in ne	
body of this re	port:	1 .	of a Wanderguard to ensure that the	
ALA Accietac	Living Administrator	Į.	least restrictive measures have bee	ען אין יפאיין ח
ALA - ASSISION	Living Residence	E	tried first so that the resident has	1
CNA - Certified	Nursing Assistant	1	access to all areas of the ALR.	
Degrees -		8		
DON - Directo	r of Nursing	1	2. What measures will be put in	4
DPO - Directo	r of Plant Operations	į.	place or what systemic changes you	(g)
Fahrenheit - F		I.	will make to ensure that the deficie	nt I
HR - Human F	Resources alized Service Plan	1	practice does not recur?	
SP - Individua	d Practical Nurse	1	Inservice education will be given to	all
RN - Register		ŝ	licensed staff by the Director of Nur	ses inklin
, and thoughts.			to ensure their knowledge of the	rses 12/31/19
R 273 Sec. 503.2 Di	anity.	R 273	protocol established for the least	1
( 2 / U O O O O O O O O O O O O O O O O O O	g,	1	restrictive environment.	
(2) Control tim	ne, space, and lifestyle;	1	İ	
Resed on inte	rview and record review, the ALR		3. How the corrective action(s) will	be
failed to ensu	re that each resident had the right	26	monitored to ensure the deficient	I
	ident areas of the ALR for two of	1	practice will not recur, i.e. what qu	ality Inlala
residents.		1	assurance program will be	ality 12/31/19
Findings inclu	ded:	į.	implemented.	*
I thinkings more		31	implemented.	
Health Regulation & Licensing	Administration	O COLUMN TURNS	, TITLE	(X6) PATE
ABORATORY DIRECTOR'S OR	PROVIDER/SUPPLIER REPRESENTATIVE'S	SIGNITURE	as too too	2/20/19
( star	1 / 1	Marni	MSTRATEL 10	If continuation sheet 1 or
STATE FORM	71 7	-6000	UGFQ11	ii portilinating i directi 1 O

Health	Regulation & Licensir	ng Administration			
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDINI	PLE CONSTRUCTION  G:	(X3) DATE SURVEY COMPLETED
		ALR-0037	B. WING _		11/08/2019
	PROVIDER OR SUPPLIER  R CARE, LLC T/A THE  SUMMARY STA	RESIDENCES AT 1330 MAS		, STATE, ZIP CODE TTS AVENUE, NW 20005 PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE COMPLETE
R 273	conference, the ALA care for 36 resident locked memory care. On 11/07/19 at 10:0 clinical chart showed diagnosis of Demento the memory care. At 11:14 AM, review book showed that R facility on 07/04/19, that Resident #7 elo 08/30/19 and 09/02/the facility's actions implement the wand the resident that distacility when the resident wanderguard inhibite visit all areas of the the ALR's residentia the 3rd floor. There activity rooms, commesidents and guests basement level.  At 11:30 AM, review record showed that to of Dementia and gain not admitted to the number of the wanderguard for the wanderguard for the wanderguard showed that to of Dementia and gain not admitted to the number of the wanderguard for the wanderguard	AM, during the entrance a stated that the ALR provided in the equal of the facility.  1 AM, review of Resident #7's dithat the resident had a stia, however was not admitted unit.  1 of the facility's incident log esident #1 eloped from the The incident log also showed ped from the facility on 19. The reports detailed that after the elopement was to derguard - a device worn by abled the elevators in the dents were near. The led the residents' right to freely ALR. It should be noted that I units and dining room are on a sanother dining room, non areas and a bistro for son the first floor and  of Resident #1's clinical the resident had a diagnosis to abnormality, however was nemory care unit.  manager stated during an R does not obtain signed derguard. The ALR manager is orders were obtained after creened to be a high risk for samily was verbally notified	R 273	The Director of Nurses will do moraudits of any AL resident at risk of elopement to ensure the protoco policy has been followed.  The Director of Nurses will present of these audits, along with any act for improvement to the Quality As Performance Improvement Commwhich meets at least quarterly. The Committee is chaired by the A and is attended by the Executive Dof the community.	the results tion plans surance littee
	about the wandergua	ira impiementation.			4

Health Regulation & Licensing Administration STATE FORM

Health Regulation & Licensin	ng Administration			,
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:	COMPLETED
	ALR-0037	B. WING _		11/08/2019
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE	
MASS SR CARE,LLC T/A THE	RESIDENCES AT	SSACHUSE STON, DC	ETTS AVENUE, NW 20005	ž.
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE COMPLETE
R 273 Continued From pa	ge 2	R 273		
had a one-to-one at elopements. She fur notes would docum residents eloped.  At 3:35 PM, review showed that if a reshigh risk for elopem recommend that the care aide before important or their far wanderguard.  At the time of survey evidence that the learn plemented to ens	e resident receive a personal plementing the wanderguard.  5 AM, review of Residents #1 as failed to document that a was discussed with the milies prior to applying the y, the facility failed to provide ast restrictive measures were ure Residents #1 and 7 had			
access to all areas of		D 506	R 596 Staffing Standards	6.4
be free from appare communicable disea written statement from Based on interview a failed to ensure that and symptoms of condocumented by a write healthcare practition personnel records refer to the statement of the statement o	mbers of the staff appear to nt signs and symptoms of ase, as documented by a sm a healthcare practitioner; and record review the ALR all staff were free from signs mmunicable disease as litten statement from a er for twenty of twenty-two eviewed (Administrator, RNs 2, 3, 4, 5 and 6, CNAs #1, 2, ide #1, 2, 3 and 4, and the	R 596	1. What corrective action(s) will be accomplished to address the identice deficient practice?  The facility has revised its Staff Heat Certificate form so that it can be reand signed off by a healthcare practithat each employee was free from and symptoms of communicable decrease.  2. What measures will be put into or what systemic changes you will rensure that the deficient practice of recur?	ified alth eviewed ctitioner signs lisease. place make to

Health Regulation & Licensing Administration

STATE FORM

NAME OF PROVIDER OR SUPPLIER  ALR-0037  NAME OF PROVIDER OR SUPPLIER  ALR-0037  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JP CODE  1330 MASSACHUSETTS AVENUE, NW  WASHINGTON, DC 20005  130 MASSACHUSETTS AVENUE, NW  WASHINGTON, DC 20005  R 596 Continued From page 3  Findings included:  On 11/07/19 at 27:18 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 Aids #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.  At the time of survey, the personnel records falled to evidence a signed statement from a healthcare practitioner that each employee was free from signs and symptoms of a communicable disease.  R 805  Sec. 701g2 Staffing Standards.  R 805  R 805  R 805  R 806  R 805  R 806  R 805  R 806  R 806  R 805  R 807  R 806  R 807  R 807  R 807  R 807  R 807  R 806  R 807  R 807  R 807  R 808  R 808  R 808  R 808  R 808  R 809  R		Health R	legulation & Licensin	g Administration			· · · · · · · · · · · · · · · · · · ·
MASS SR CARE,LLC T/A THE RESIDENCES AT  MASS SR CARE,LLC T/A THE MASS MASS AND ANABACHUSETTS AVENUE, THE  MASS SR CARE,LLC T/A THE MASS MASS AND ANABACHUSE TIAN OF COMPRETE  MASS SR CARE,LLC T/A THE MASS MASS AND ANABACHUSE TIAN OF COMPRETE  PREPTX  TAG  TROOF PROVIDENCE AT AN OF COMPRETON  CROOF CORRECTION  MASS SR CARE,LLC T/A THE MASS MASS AND ANABACHUSE TIAN OF COMPRETON  TAG  THE MASS AND ANABACHUSE TIAN OF COMPRETON  TAG  THE MASS AND ANABACHUSE TIAN OF COMPRETON  TAG  THE DIRECTOR SPAIN OF CHARM TO COMPRISE  THE DIRECTOR AND THE APPROPRIATE  ON THE MASS AND ANABACHUSE TO MA		STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED
MASS SR CARE,LLC T/A THE RESIDENCES AT 1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005    PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   TACK   PROVIDER'S PLAN OF CORRECTION   PREFIX TACK   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PREFIX TACK   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PL		_		ALR-0037	B. WING		11/08/2019
MASS R CARE,LLC T/A THE RESIDENCES AT  WASHINGTON, DC 20005    PROPRIETY TAG   SUMMARY STATEMENT OF EDEFORENCES PER PRODUCED BY FILL RESULATIONY ON LGC DENTIFIANG INFORMATION)   PREFIX TAG   PROPRIETY PLAN OF CORRECTION GOVERNMENT OF PROCESSED BY FILL RESULATIONY ON LGC DENTIFIANG INFORMATION)   PREFIX TAG   PROPRIETY PLAN OF CORRECTION GOVERNMENT OF PROCESSED BY FILL RESULATIONY ON LGC DENTIFIANG INFORMATION)   PREFIX TAG   PROPRIETY PLAN OF CORRECTION GOVERNMENT OF PROCESSED BY FILL RESULATIONY ON LGC DENTIFIANG INFORMATION)   PREFIX TAG   PROPRIETY PLAN OF CORRECTION GOVERNMENT OF CONTROL OF PROPRIETY PLAN OF CORRECTION GOVERNMENT OF PROPRIETY PLAN OF CORRECTION GOVERNMENT OF PROPRIETY PLAN OF CORRECTION (EACH CORRECTION COLOR OF PREFIX TAG   PROPRIETY PLAN OF CORRECTION (EACH CORRECTION COLOR OF PREFIX TAG   PROPRIETY PLAN OF CORRECTION OF CROSS-REFERENCE OF OTHER APPROPRIATE CORRECTION (EACH CORRECTION OF THE APPROPRIATE CORRECTION OF THE APPROPRIATE CONTROL OF THE PROPRIETY CARD OF THE APPROPRIATE CORRECTION OF THE APPROPRIATE CONTROL OF THE APPROPRIATE CORRECTION OF THE APPROPRIATE WHEN THE APPR	Ī	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
R 596 Continued From page 3 Findings included:  On 11/07/18 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 practitioner that each employee was free from signs and symptoms of a communicable disease.  R 805 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 certifications as required by law, Based on interview and record review, the ALR failed to ensure that all staff possessed appropriate records showed that there were no current certifications as valiable for review for CNAs #4 and 5, Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications as valiable for review for CNAs #4 and 5. Additionally, there were no current certifications for CNAs #4 and 5. Additionally, there were no		MASS SF	R CARE,LLC T/A THE	DECIDENCES AT		0005	
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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 statement from a healthcare practitioner that each employee was free from signs and symptoms of a communicable disease.  R 605  Sec. 701g2 Staffing Standards.  R 605  Sec. 701g2 Staffing Standards.  R 605  C2) 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			written statements	from a healthcare practitioner			•
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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 605 Sec. 701g2 Staffing Standards.  R 605 (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		ė	signs and symptom	s of communicable disease.	1		
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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.  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		8	during an interview	that she was not aware of the	:		nsure .
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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  could be secured. The updated license for the Social Worker was placed in her file. The Human Resources Director			personnel records s	showed that there were no	į.	r.	
license available for a Social Worker.  On 11/08/19 at 11:20 AM, the HR representative  for the Social Worker was placed in her file. The Human Resources Director						1	
On 11/08/19 at 11:20 AM, the HR representative her file. The Human Resources Director		į			Š.		
On 11/06/19 at 11:20 Aivi, the fix representative		9					
stated during an interview that she would contact		13	On 11/08/19 at 11:2	O AM, the HR representative	!		
			stated during an int	erview that she would contact	Ē.	Grade tractio neeriaed many	IGGAI

UGFQ11

Health Regulation & Licensi	ng Administration			. 4.44
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	f	PLE CONSTRUCTION  G:	(X3) DATE SURVEY COMPLETED
	ALR-0037	B. WING_		11/08/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE		
	1330 MAS		ETTS AVENUE, NW	
MASS SR CARE,LLC T/A THE	WASHING	STON, DC	-	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPRIESE  DEFICIENCY)	D BE COMPLETE
R 605 Continued From pa	ige 4	R 605	is placed on the schedule after hire	euntil , ,
the staff to obtain the	neir proper licenses. She		a current D.C. license is in place.	12/3/19
further stated that to be permitted to wor licensure. At the conadditional information	the staff in question would not the staff in question would not the until they provided a current inclusion of the survey no on was provided the surveyor.  By, the personnel records failed		2. What measures will be put into what systemic changes you will me ensure that the deficient practice on ot recur?  An audit will be conducted each questions and the conducted each questions.	ake to does uarter
R 821 Sec. 904e8 Medica	tion Storage	R 821	by the Director of Human Resource to ensure that the CNAs and other	
use prescription and in their units as long from other residents Based on observation review, the facility faresidents who self-a in their units, for one sample (Resident #Findings included:  On 11/06/19 at 11:0 #6's apartment show opened bottle of me The resident then resident then resident in the resident limmodium and another sample (Resident then resident and self-admit observation showed a cart in the resident limmodium and another samples (Resident then resident limmodium and another samples)	on, interview and record ailed to ensure that only administered kept medications at of 15 residents in the 65).  5 AM, observation of Resident wed the resident holding an dication (fiber supplement), strieved two capsules from the nistered them. Further there was a bottle of Advil on its living area, a pack of ther bottle of Advil in the		staff (Social Workers, Nurses, Dieti have current D.C. licenses on file. The results of this audit will be ser ALA and the Executive Director for 3. How the corrective action(s) will monitored to ensure the deficient will not recur, i.e. what quality ass program will be implemented? The Director of Human Resources with present the results of these audit to Quality Assurance and Improvement Committee along with any action program for improvement to ensure the factoristic compliance in this area. The Commits chaired by the ALA and is attended.	cians, etc.)  Int to the review. 12/1/9  I be practice urance  will o the ent clans sility's sittee
resident locked the capartment. Resident remains unlocked at At 12:30 PM, the DC	ON presented the surveyor ent list. The DON identified on		the Executive Director of the comm  R 821 Sec. 904e8 Medication Stora  1. What corrective action(s) will be accomplished to address the identideficient practice?	ge
	6.0		acholetic bi actice?	

Health Regulation & Licensi	ng Administration			p.,,
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	1			
	ALR-0037	B. WING		11/08/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	
	1330 MAS		TS AVENUE, NW	
MASS SR CARE,LLC T/A THE		TON, DC 2	0005	
CEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 85 PRECEDED BY FIII I SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	
R 821 Continued From pa	200 5	R 821	An immediate inspection was done in	The state of the s
T .	_		ALR units to ensure that any resident	who his lan
self-administering	medication. Resident #6 was	İ	self-medicates has their medication se	
not identified on the	e list. When questioned about		in their rooms. There were no other in	icidents
not able to self-adr	onfirmed that the resident was minister medications. The DON	:	noted.	8
	there were unsecured	!		3
	sident #6's apartment. The	4	2. What measures will be put into place	
DON responded th	at the medications would be	!	or what systemic changes you will ma	
removed immediat	ely.		ensure that the deficient practice does Staff on the ALR was inserviced by the	
. At the time of our	the feelity foiled to opeur		of Nurses to ensure their knowledge of	
	ey, the facility failed to ensure who self-administer kept their		who self-medicate must have their me	
medications securi		;	secured at all times in their rooms. Th	
i i i i i i i i i i i i i i i i i i i	od III dieli diila.	3	of Nurses/designee will inspect and m	
R1003 Sec. 1006c Bathro	ome.	R1003	the residents' room at least monthly to	
K1003 Sec. 10000 Datillo	oms.		compliance	sensore property
(c) An ALR shall ir	sure that the temperature of	i	in this area.	
	taps to which residents have			
	d by the use of thermostatically		3. How the corrective action(s) will be	
controlled mixing v	alves or by other means, the source, so that the water	1	monitored to ensure the deficient prac	tice
temperature does i	not exceed 110 degrees	Ì	will not recur, i.e. what quality assuran	ice
Fahrenheit	not expose 110 degrees	1	program will be implemented?	.9
Based on observat	tion and interview, the ALR	1	The Director of Nurses will present the	
	at hot water temperatures did		findings of these inspections, along with	
	grees Fahrenheit (°F) in two of		any action plans for improvement, to the	
	spected (apartments #302 and		Quality Assurance Performance Improv	rement 12/31/19
311).			Committee for their review and	3
Findings included:		Į	recommendations. The Committee is cliby the ALA and is attended by the Exec	
1			Director.	utive
	ning at 11:05 AM, the ALA and	5		-5
	nied the surveyors during an	(f) 1	R1003 Sec. 1006c. Bathrooms	
	k-through of the facility. 29 AM showed that the hot	)	Parabanta and Parabanta	
	in the bathroom of apartment		What corrective action(s) will be	8
	4 °F. At 11:38 AM, the hot	6	accomplished to address the identified	1
	measured 117 °F in the	į	deficient practice?	13
bathroom of apartr	ment #311.	§.	There was an immediate diagnosis by	2
			the Director of Plant Operations of the	e .

Health Regulation & Licensing Administration

Health F	Regulation & Licensin	g Administration		Kills - William	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		ALR-0037	B. WING		11/08/2019
	PROVIDER OR SUPPLIER	RESIDENCES AT 1330 MAS		STATE, ZIP CODE ITS AVENUE, NW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE
R1003	DPO revealed that it residents' apartment at any time. He the staff to adjust the wind on 11/06/19 at 3:58 of the water temperature in apart At the time of the su	1 AM, an interview with the the water temperatures in the its should not exceed 110 °F in requested a maintenance ater temperatures.  9 PM, a follow-up observation ature in apartment #302 sured 106.3 °F. At 3:58 PM, a ment of the hot water timent #302 was 109 °F.  Invey, the ALR failed to ensure imperature did not exceed 110	R1003	failure of the single cartridge water faucet in room #302. An adjustment be the temperature within an acceptable of the faucet was replaced within 24 hour of the faucet failure. In room #311, the mixing valve located under the sink was adjusted which immediately brought to temperature within range. All other far were tested on the ALR and there were further temperature issues.  2. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice do not recur?  The Maintenance Department will perform weekly water temperature checks and document each on a Water Temperature if there are any adjustments, there will follow up in 24 hours to ensure system temperature compliance.  3. How the corrective action(s) will be monitored to ensure the deficient practivill not recur, i.e. what quality assurant program will be implemented?  The Director of Plant Operations will	range.  Irs  III6 19  he nucets  no  e e e es  orm  re Log. 12/31/9 be a ic
The second secon	ધ્ક	The second secon		present the results of the Temperature Logs to the Quality Assurance Performa Improvement Committee, along with a action plans for improvement, which me at least quarterly. The Committee is chaired by the ALA and is attended by the Executive Director of the community.	eets [2]3) 9

Name of Inspector

Date Issued 11/25/11

Facility Director/Designer

Vate /

IT. LOWAR (B. Teckasing 5/14, Torbit



Rev. 9/02

GOVERNMENT OF THE DISTRICT OF COLUMBIA

### HEALTH REGULATION & LICENSING DEPARTMENT OF HEALTH

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

202-442-5888

# ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:		Street Address, City, State, ZIP Code:	tate, Z	IP Code:	Survey Date:	
					11/06/19-11/08/19	11/08/19
Mass Sr. Care, L	Mass Sr. Care, LLC T/a Residences at Thomas Circle ALR -0037	1330 Mas Wasi	sachus: hingtor	1330 Massachusetts Avenue, NW Washington, DC 20005	Follow-up Dates(s):	s(s):
Regulation Citation	Statement of Deficiencies		Ref.	Plan of Correction	0n	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:	11/06/19 through th the Assisted 101.01 et seq) and the lergency and wided care for 37 I to include f. A random sample yee records were he survey were based ty, clinical and v of the emergency and staff interviews.		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 lay and not as an admission or statement of agreement of deficient practice.	de files this Plan of regulatory ts this document and not as an eement of	
	Listed below are abbreviations used of this report:	throughout the body				
	ALA – Assisted Living Administrator ALR – Assistant Living Residence CNA – Certified Nursing Aide DPO – Director of Plant Operations	Dr.			5	

**Procedures** Policies and Required 10110



Rev. 9/02

**GOVERNMENT OF** THE DISTRICT OF

#### HEALTH REGULATION & LICENSING DEPARTMENT OF HEALTH ADMINISTRATION

2

COLUMBIA

## HHA - Home Health Aide

HR - Human Resources

LPN - Licensed Practical Nurse Medicare and Medicaid Services, at 42 CFR & 483.73; set for long term care facilities by the Centers for the same standards for emergency preparedness as those 10110.01 (k) Emergency preparedness, which shall meet

This regulation is not met as evidenced by

needs (specifically sewage and waste disposal) during develop written policies and procedures to ensure subsistence Based on record review and interview, the ALR failed to emergencies, for 37 of 37 residents in the facility.

Findings included

during potential service interruptions. Plan, last reviewed on 07/22/19 did not include written connected to the local sewer system. The facility's Emergency Resources for Disaster Planning showed the facility was policies and procedures to address sewage and waste disposal On 11/08/19 beginning at 11:32 AM, review of the facility's

did not address sewage management during an emergency the ALA indicated that the written policies and procedures The DPO confirmed the facility was connected to the city During an interview on 11/08/19 at 2:22 PM, the DPO and

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 10110.01 (k) Emergency Preparedness:

- 1. What corrective action(s) will be accomplished to and disposed of as piohazardous waste removal Disruption which includes the initiation of a Red Bag The facility has developed a policy for Sewer address the identified deficient practice? for the collection of waste several time per day program which wil be implemented in each toilet
- Committee for their review and inclusion in the The new policy has been present to the Safety the deficient practice does not recur? systemic changes you will make to ensure that 2. What measures will be put in place or what Operations and the ALA about the Sewer The staff will be educated by the Director of Plant facility's Emergency Management Plan. Disruption policy to ensure the staff's understanding.
- Performance Improvement Committee which is How the corrective action(s) will be reviewed at least cuarterly by this Quality Assurance Performance Improvement program which will be chaired by the ALA and attended by the Executive The Director of Plant Operation will include the program will be implemented. monitored to ensure the deficient practice Director of the Community. Sewer Disruption policy in his Quality Assurance/ implementation, education and review of the will not recur, i.e. what quality assurance

Staffing Standard

10116

Rev. 9/02

COLUMBIA

#### HEALTH REGULATION & LICENSING DEPARTMENT OF HEALTH **ADMINISTRATION**

#### THE DISTRICT OF GOVERNMENT OF

about four hours if there was a major interruption in he backup waste management system that would be adequate for water and sewer system. The DPO said the facility hida sewage and waste disposal system. STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

emergencies. At the time of the survey, there was no evidence that the needs, such as sewage and waste disposal during facility's policies and procedures addressed all subsistence

each employee pursuant to Section 701(d)(11) of the Act including communicable tuberculosis. and current and shall contain the following: 10116.15 Personnel records maintained by the ALA for whether the employee bears any communicable diseases, (f) A healthcare practitioner's written statement as to (D.C Official Code § 44-107.01(d)(11)) shall be accurate

This regulation is not met, as evidenced by:

ensure that all staff were free from signs and symptoms of Based on interview and record review the ALR failed to communicable disease as documented by a written statement personnel records reviewed (Administrator, RNs #1 and 2. from a healthcare practitioner for twenty of twenty-two Aide #1, 2, 3 and 4, and the Social Worker). PNs #1, 2, 3, 4, 5 and 6, CNAs #1, 2, 3, 4 and 5, Dietary

### 10116.15 Staffing Standards

### 1. What corrective action(s) will be

- and signed off by a healthcare practitioner deficient practice? accomplished to address the identified Certificate form so that it can be reviewed The facility has revised its Staff Health
- or what systemic changes you will make to ensure that the deficient practice does not 2. What measures will be put into place

of a healthcare practitioner. deemed free of signs and symptoms of December to ensure that the employee was The Director of Human Resources will review communicable disease by virtue of a signature then annually thereafter during the month of the health certificates of each new hire and

Performance Improvement Committee which meets at least quarterly. The Committee of Human Resources to the Quality Assurance audit, and any action plans for improvement signed health certificate. The results of this that all employees have the appropriately will not recur, i.e. what quality assurance program How the corrective action(s) will be Executive Director of the Community. is chaired by the ALA and is attended by the if needed, will be presented by the Director Quarterly audits will be done to ensure will be implemented? monitored to ensure the deficient practice

and symptoms of communicable disease.

that each employee was free from signs



GOVERNMENT OF THE DISTRICT OF COLUMBIA

## DEPARTMENT OF HEALTH HEALTHREGULATION & LICENSING ADMINISTRATION

### HEALTHI

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 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:

Reporting
Abuse, Neglect,
Exploitation,
and Unusual
Incidents

## 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 perpolicy and protocol.
- 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.
- 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.

12/21/19

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

## DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

# 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.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **HEALTH REGULATION & LICENSING** ADMINISTRATION