| 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 ______ | 12/04/2017 |

| 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<br><br>An annual survey was conducted from November 29, 2017, through December 4, 2017, to determine compliance with the Assisted Living Law "DC Code § 44-101.01." The Assisted Living Residence (ALR) provides care for thirty-nine (39) residents and employs thirty-nine (39) employees to include professional and administrative staff. Four (4) resident records and eleven (11) employee records were reviewed. The findings of the survey were based on observations, record reviews, and interviews with residents and employees.<br><br>Note: Listed below are abbreviations used throughout the body of the report.<br><br>ALA -- Assisted Living Administrator<br>ALR -- Assisted Living Residence<br>CNA -- Certified Nursing Assistant<br>° -- degrees<br>DON -- Director of Nursing<br>F -- Fahrenheit<br>ISP -- Individualized Service Plan<br>LPN -- Licensed Practical Nurse<br>PT -- Physical Therapist<br>OT-- Occupational Therapy | R 000 | Rec'd 1/2/2018 SBdugger | |
| R 272 | Sec. 503.1 Dignity.<br><br>(1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible;<br>Based on observation and interview, the ALR staff failed to ensure hand sanitizer and liquid soap was stored safely away from (14) of fourteen (14) residents with dementia (Residents #1,2, 3, 4, 5, 6, 7,8, 9, 10, 11, 12, 13, | R 272 | | |

| 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 ______ | 12/04/2017 |

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 |
|---|---|---|---|---|
| R 272 | Continued From page 1 and 14).<br><br>Findings included:<br><br>Observation on 11/29/17, at 11:00 AM, showed that hand sanitizer and liquid soap for staff use was unsecured in the dining area of the memory care unit.<br><br>During an interview on 11/29/17, at 11:30 AM, the DON stated that all residents on the memory care unit have some form of dementia. Additionally, the DON stated that she would ensure hand sanitizer and liquid soap is secured at all times.<br><br>At the time of the survey, the provider corrected this deficient practice by removing the hand sanitizer and liquid soap from the reach of residents. | R 272 | R272<br>1. Hand Sanitizer and liquid soap were immediately removed and stored safely away from residents. | 11/29/17 |
| | | | 2. DON/LNHA conducted rounds to ensure that there hand sanitizers and liquid soap were securely stored or mounted. | 11/29/17 |
| | | | 3. DON/LNHA in-serviced staff as to the need to maintain liquid hand sanitizers securely stored away from residents. Liquid soap was mounted on the wall receptacle. AL Manager or designee will conduct safety rounds on a monthly basis. | 1/15/18 |
| R 292 | Sec. 504.1 Accommodation Of Needs.<br><br>(1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents;<br>Based on record review and interview, the ALR failed: (1) to ensure a physician's order was followed, as prescribed; and (2) to follow its Fall Prevention and Management policy for two (2) of four (4) residents in the sample (Residents #2 and 3).<br><br>Findings included:<br><br>1. Review of Resident #2's medical record on 11/29/17, at 10:50 AM, showed a physician order for a PT/OT evaluation and plan, dated 04/27/17. | R 292 | 4. AL Manager will document findings and report to the QA Committee monthly for review, evaluation, and approval. | 1/25/18 |

| 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 ______ | 12/04/2017 |

| 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 292 | Continued From page 2<br>The record, however, lacked documented evidence of the PT/OT evaluation and plan.<br><br>During an interview on 11/29/17, at 11:10 AM, the OT director stated that the PT/OT evaluation and plan was not completed.<br><br>At the time of the survey, the ALR failed to follow Resident 2's physician's order for PT/OT evaluation and plan.<br><br>2. Record review of the facility's undated policy titled, "Fall Prevention and Management," showed the following:<br><br>- Post fall [nursing staff] to ensure appropriate documentation during a 72-hour period of observation; and<br>- A referral to therapy for evaluation will be done following the second fall occurring within 90 days of previous fall.<br><br>The facility failed to follow the policy, as evidenced by:<br><br>Review of Resident #3's medical record on 12/04/17, at 3:00 PM, showed that the resident fell six times from 06/12/17 to 10/14/17. The record lacked evidence that the nursing staff observed and documented on the resident for 72 hours after each fall. Additionally, the record showed that there was no documented evidence of a rehabilitation referral after the second fall on 06/13/17, which was within 90 days of the previous fall on 06/12/17.<br><br>During an interview on 12/04/17, at 3:45 PM, the DON stated that the nurses should have observed and documented on the resident after each fall. Also, a referral should have been sent | R 292 | R292<br>1. Resident #2 was evaluated by physician assistant and she provided no new order for PT/OT. Resident #3 eventually did receive PT but it was discontinued due to resident refusal.<br>2. AL Manager conducted audit to identify residents with outstanding PT/OT orders, needing documentation post falls, and needing rehab order.<br>3. DON has re-in-serviced nurses on facility's fall policy. AL Manager will conduct monthly chart audits.<br>4. AL Manager will document findings and report to the QA Committee monthly for review, evaluation, and approval. | 12/08/17<br><br>12/15/17<br><br>12/21/17<br><br>1/25/18 |

| 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 ______ | 12/04/2017 |

| 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 292 | Continued From page 3<br>to rehab after the second fall on 06/13/17.<br><br>At the time of the survey, the ALR failed to follow its Fall Prevention and Management policy. | R 292 | | |
| R 481 | Sec. 604b Individualized Service Plans<br><br>(b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed.<br>Based on record review and interview, the ALR failed to include in the ISP who was responsible for providing services for four (4) of four (4) residents in the sample (Residents #1, 2, 3, and 4).<br><br>Findings included:<br><br>1. Review of Resident #1's medical record on 11/29/17, at 11:30 AM, showed an ISP dated 07/07/17, and a physician order for OT services three times a week, dated 07/10/17. The ISP, however, lacked documented evidence it was updated with when, how often, and who was responsible for providing OT services. Further review of the ISP showed that the resident also required assistance in the areas of dressing, mobility, and eating, but there was no documented evidence of who would assist the resident in the identified areas.<br><br>2. Review of Resident #2's medical record on 11/30/17, at 11:30 AM, showed an ISP, dated 08/23/17. The ISP indicated that the resident required assistance in the areas of bathing, hygiene, and mobility. Further review of the ISP showed that it failed to identify who would assist the resident in the identified areas. | R 481 | R481<br><br>1. Resident #1's, #2's, #3's, and 4's ISPs have been updated to include services provided and who would provide those services.<br>2. AL Manager has conducted an audit to identify ISPs needing updates and updated them as needed.<br>3. AL Manager will audit ISPs monthly to ensure they include services provided and who will provide those services.<br>4. AL Manager will document findings and report to the QA Committee monthly for review, evaluation, and approval. | 12/08/17<br><br>12/15/17<br><br>12/21/17<br><br>1/25/18 |

| 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 ______ | 12/04/2017 |

| 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 481 | Continued From page 4<br><br>3. Review of Resident #3's medical record on 12/04/17, at 3:30 PM, showed an ISP dated 09/14/17. The ISP indicated that the resident required assistance in the areas of mobility, eating, and continence. Further review of the ISP showed it failed to identify who would assist the resident in the identified areas.<br><br>4. Review of Resident #4's medical record on 12/04/17, at 4:00 PM, showed an ISP, dated 11/01/17. The ISP indicated that the resident required assistance in the areas of bathing, dressing, and mobility. Further review of the ISP showed that it failed to identify who would assist the resident in the identified areas.<br><br>During an interview on 11/29/17, at 11:10 AM, the DON stated that the rehabilitation department provided the OT services as ordered. The DON also stated that she would ensure that going forward all residents ISPs included services provided and personnel responsible for providing the service.<br><br>At the time of the survey, the ALR failed to include in the ISPs for Residents #1, 2, 3, and 4 all services provided and who would provide those services. | R 481 | | |
| R 679 | Sec. 702c Staff Training.<br><br>(c) After the first year of employment, and at least annually thereafter, a staff member shall complete a minimum total of 12 hours of in-service training in the following:<br>Based on record review and interview, the ALR failed to ensure that six (6) of six (6) employees completed a minimum of twelve hours of annual | R 679 | | |

| 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 ______ | 12/04/2017 |

| 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 679 | Continued From page 5<br>in-service training (LPNs #1 and 2, and CNAs #1, 2, 3, and 4).<br><br>Findings included:<br><br>Review of personnel records for LPN #1, LPN #2, CNA #1, CNA #2, CNA #3, and CNA #4 on 11/30/17, at approximately 2:00 PM, showed that the employees received three hours of in-service training in resident rights and emergency and disaster response for 2016. There was no evidence that the aformentioned staff received a total minimum of twelve hours of training in the topics of cognitive training, resident rights, emergency and disaster response.<br><br>During an interview on 12/4/17, at 12:00 PM, the ALA stated that the staff did not receive the required twelve total hours of minimum in-service training across all required topics in 2016.<br><br>At the time of the survey, the ALR failed to ensure employees received the minimum twelve hours of annual in-service training. | R 679 | R679<br><br>1. LPN #1, LPN #2, CNA #1, CNA #2, CNA #3, and CNA #4 will attend monthly one hour training sessions to ensure completion of 12 hours of in-service training.<br>2. ED/NHA or designee will conduct a review of in-service training schedule/<br>3. ED/NHA or designee will develop a monthly training program to ensure completion of annual 12 hours of in-service training by Thomas Circle personnel. ED or designee will audit training records monthly.<br>4. ED/NHA or designee will report findings to the QA Committee monthly for review, evaluation, and approval. | 1/15/18<br><br>1/15/18<br><br>1/15/18<br><br>1/25/18 |
| R 981 | Sec. 1004a General Building Interior<br><br>(a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair. Based on observation and interview, the ALR failed to ensure that the facility was maintained in good repair and in sanitary condition.<br><br>Findings included:<br><br>I. Observation of the memory care unit on 11/29/17, at 10:27 AM., showed the following: | R 981 | | |

| 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 ____ | 12/04/2017 |

| 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 981 | Continued From page 6<br><br>A. Black stains on the handrail;<br><br>B. Baseboards marred and scarred; and<br><br>C. The handle on the entrance/exit door was broken.<br><br>During an interview on 11/29/17, at 10:00 AM, the director of environmental services stated that she would have the identified areas repaired.<br><br>At the time of the survey, the ALR failed to ensure the facility was maintained in good repair.<br><br>II. Observation of the kitchen on 12/01/17, at 11:30 AM, showed a roach inside the juice machine.<br><br>During an interview on 12/01/17, at 11:40 AM, the food and beverage director stated that he would remove the juice, clean the machine, and request an exterminator to treat the kitchen.<br><br>On 12/4/17, at 3:30 PM, the food and beverage director presented a service inspection report from the exterminator which showed that the kitchen was treated on 12/04/17.<br><br>At the time of the survey, the ALR failed to ensure the juice machine was maintained in sanitary condition. | R 981 | R981<br><br>1. I. Handrails and Baseboards will be painted. The handle on the entrance/exit door was fixed.<br>II. The Kitchen was treated by pest control company.<br>2. I. Plant Operations Director or designee will conduct an environmental rounds to identify maintenance and environmental issues.<br>II. F&B Director or designee has conducted a kitchen environmental round to identify pest control issues.<br>3. I. Plant Operations Director or designee will conduct environmental rounds monthly.<br>II. F&B Director will conduct kitchen environmental rounds monthly. | 1/15/18<br><br>1/15/18<br><br>1/15/18 |
| R1003 | Sec. 1006c Bathrooms.<br><br>(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 | R1003 | | |

Health Regulation & Licensing Admini...ion

| 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 ______ | 12/04/2017 |

NAME OF PROVIDER OR SUPPLIER: MASS SR CARE,LLC T/A THE RESIDENCES AT

STREET ADDRESS, CITY, STATE, Z...: 1330 MASSACHUSETTS AVE, 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 | (...) CR... ...TION ...ULD BE ...ROPRIATE | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R1003 | Continued From page 7<br>controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit.<br>Based on observation and interview, the ALR failed to ensure that the hot water temperature did not exceed 110° F in one (1) of eleven (11) bathrooms inspected (Apartment #317).<br><br>Findings included:<br><br>Observation on 12/01/17, at 10:59 AM, showed that the hot water temperature measured at 112.2°F in Apartment 317.<br><br>During an interview on 12/01/17, at 11:00 AM, the maintenance director stated that he would adjust the mixing valve to decrease the water temperature down to 110°F.<br><br>Follow-up observation on 12/01/17, at 3:56 p.m., showed that the hot water temperature was 109°F.<br><br>At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110°F in Apartment 317. | R1003 | 4. I. Plant Operations Director will document findings and report to the QA Committee monthly for review, evaluation, and approval.<br>II. F&B Director will document findings and report to the QA Committee monthly for review, evaluation, and approval. | 01/25/18 |
| | | R1003 | 1. Plant Operations Director took immediate corrective action by adjusting the mixing valve under the sink in Apartment 317. | 12/01/17 |
| | | | 2. Plant Operations Director or designee has conducted room inspections to identify other temperature issues | 12/08/17 |
| | | | 3. Plant Operations Director or designee will continue weekly room inspections. Plant Operations Director educated maintenance staff on inspecting temperatures. | 12/08/17 |
| | | | 4. Plant Operations Director will document findings and report to the QA Committee monthly for review, evaluation, and approval. | 1/25/18 |