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-0018	A. BUILDING: _____ B. WING _____	C 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCES AT THOMAS CIRCLE	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	Continued From page 1 District of Columbia Metropolitan Police Department Detective - DCMPDD District of Columbia Metropolitan Police Officer-DCMPO Department of Public Works - DPW Executive Director - ED Global Positioning System - GPS Health Center - HC Human Resource Director - RHRD Individual Service Plan - ISP Medical Examiner - ME Metropolitan Police Department - MPD Mini-Mental State Examination - MMSE Personnel Action Form - PAF Physician's Orders Sheet - POS	R 000	**This Plan of Correction is submitted without denying or acknowledging that the cited deficiencies exist. This plan of correction is a requirement of the Department of Health.** **What corrective action(s) will be accomplished to address the identified deficient practice;** All nursing and activities staff will be in-serviced on the elopement policy and procedure, which encompasses appropriate supervision. The outing procedures will be modified so that elopement residents only goon outings with one-to-one supervision. Activities staff will be in-serviced on the outing procedures. **How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;** All dementia residents have the potential to be effected. All nursing and activities staff will be in-serviced.	
R 522	Sec. 607a1 Services To Be Provided 1) Twenty-four hour supervision and oversight to ensure the well-being and safety of its residents; [D.C. Official Code § 44-106.07 (a) (1)] Based on interview, and the review of records and a surveillance tape, the ALR failed to consistently provide supervision and oversight for three (3) of six (6) residents who were on an outing. (Resident #1, #3 and #5) The findings include: 1. The MPD issued a " Silver Alert " seeking the public ' s assistance in locating Resident #1, who was last seen walking towards the 500 block of K Street, NW, on Wednesday, March 11, 2014. On March 12, 2014 Resident #1 was identified as a resident of the ALA. On March 21, 2014, DOH/HRLA received notification that Resident #1	R 522		

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R 522	Continued From page 2 was found deceased. On March 26, 2014, at approximately 3:27 p.m., interview with the AD revealed that on March 11, 2014, six (6) residents were transported on an outing to a restaurant. Accompaning the residents were the AA and three (3) CNAs, two (2) of which were PDAs responsible for providing one-to-one supervision of Resident #3 and Resident #5.) Further interview with the AD, and a review of records, revealed that the six (6) residents were diagnosed with varying degrees of physical and cognitive impairments that required close supervision. 2. a. On May 30, 2014, at approximately 8:20 a.m., a review of Resident #1's Admission/Annual Medical Certification, dated August 20, 2013, revealed that the resident had diagnoses that included Alzheimer's dementia, diabetes mellitus, hypertension, hyperlipemia, and depression. Continued review revealed that the resident had symptoms of poor memory, confusion, and personality changes. b. On May 30, 2014, at approximately 9:32 a.m., Review of Resident #1's Admission Assessment, dated August 20, 2013, revealed that the resident had a medical history of Alzheimer disease that included symptoms of acute confusion, problems with long term memory, severely impaired cognitive skills and aimless wandering. Additionally, under the section entitled "elopement risk," the resident had a score of five (5) which indicated a high risk of elopement and that	R 522	**What measures will be put into place or what systemic changes you will make to ensure that the deficient does not recur.** All nursing and activities staff will be in-serviced. **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.** Residents that are at risk for elopement will only go on outings with one-to-one supervision. The outing records will be submitted to QA for a period of 3 months to ensure compliance. 7/31/14	

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R 522	Continued From page 3 appropriate interventions should be initiated. c. On May 30, 2014, at approximately 11:05 a.m., a review of Resident #1's Service/Functional Assessment, dated August 20, 2013, revealed that in the area of "wandering" and "needing someone to accompany them when leaving the facility to go shopping or on appointments" the resident had a score of three (3) in both areas, which indicated that the resident required extensive assistance from staff. Additional comments revealed that during the assessment the resident was observed to be "wandering about, wants to go out". d. On May 30, 2014, at approximately 6:32 p.m., a review of Resident #1's MMSE, dated September 5, 2013, indicated a score of twelve (12). Review of the Social Services Progress Note, dated September 12, 2013, indicated that a MMSE score of twelve (12) represented severe cognitive impairment. e. On June 4, 2014, at approximately 2:15 p.m., a review of an undated " Elopement Prevention and Behavioral Management Program " policy and procedure document revealed that residents should be assessed for elopement upon admission and interventions for elopement incorporated into the ISP. f. On June 4, 2014, at approximately 3:25 p.m., a review of Resident #1's ISP, dated September 30, 2013, and subsequently reviewed on October 28, 2013 and December 4, 2013, indicated that the resident had memory loss, and detailed	R 522		

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R 522	Continued From page 4 conversations revealed problems of withdrawal, depression, and isolation. The ISP also indicated that strong reminders were required; however, the interventions were not specified. Further review revealed that the resident required supervision due to a high risk for wandering and elopement when in and out of the facility; however, no specific interventions were identified. g. On June 2, 2014, at approximately 10:25 a.m., a review of Resident #1's available POS dated March 1, 2013, revealed that the resident's "where abouts [sic] was to be monitored at all times" and the resident was to wear a "wanderguard" which was to be checked on every shift. 3. On March 26, 2014, at approximately at 3:27 p.m., interview with the AD revealed that they were not provided instruction on that day for resident care precautions while on an outing. 4. On March 26, 2014, at approximately 2:50 p.m., interview with the CNA revealed that Resident #1 was not provided adequate supervision during the community outing on March 11, 2014. The staff stated, " [Resident #1] stood up and stated that [s/he] was going to the bathroom. " The staff did not observe Resident #1 to go into the bathroom because s/he was having a conversation with another resident. Additionally, the staff stated that the bathroom was not visible from where s/he was seated. Approximately 5 minutes later, Resident #1 could not be located in the bathroom.	R 522		

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R 522	Continued From page 5 5. On March 31, 2014, beginning at 12:30 p.m., interview with the restaurant ' s manager revealed that the elopement was captured by a surveillance camera. The review of the camera ' s video, dated March 11, 2014, revealed the following:	R 522		
	a. At 2:53 p.m., observations revealed Resident #1 got up from the table, walked over to the window and began looking out the window. The AA, who was directly responsible for Resident #1, was observed standing directly beside the resident as they both looked out the window. The CNA who was also responsible for Resident #1 was observed sitting at the table talking with Resident #6. b. At 2:54 p.m., Resident #1 was observed to walk toward the elevator and stand waiting for it to open. Resident #1 was immediately redirected to come back to the table by PDA #2. The AA was observed with his/her back turned toward the elevator. The CNA was engaged in conversation with Resident #6 and was also observed with his/her back turned toward the elevator. c. At 2:55 p.m., Resident #1 was observed again to walk toward the bathroom which was near the elevator. At this time, PDA #2, who had been seated with Resident #5 next to the elevator, left the area with resident #5 to join the AA, who was looking out of the window. It should be noted that both PDA #2 and the AA ' s backs were turned towards the bathroom, and Resident #1 and Resident #3 were not in their line of sight.			

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R 522	Continued From page 6 d. At 2:56 p.m., the elevator opened, and Resident #1 walked into the elevator with an unaffiliated person. Resident #5 was observed to walk to the elevator door as Resident #1 walked into the elevator. The elevator door began to close, but reopened as Resident #5 stood in front of the elevator. Resident #5 did not enter the elevator; however, the elevator door reopened for a second time. Again, Resident #5 did not get on the elevator and returned back to the table on his/her own. During this time, the AA and PDA #2 were observed standing at the window with their backs turned toward the elevator. The CNA remained engaged in conversation with Resident #6 and was also observed with his/her back turned toward the elevator. e. Approximately five (5) minutes later, at 3:01 p.m., both the AA and PDA #2 were observed to move away from the window and return back to the table. Resident #1 was not observed to be with the group.	R 522	**R562** **What corrective action(s) will be accomplished to address the identified deficient practice;** The identified deficient practices are the result of a misrepresentation of the Executive Director's quote. A copy of the PDA policy is attached. **How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with PDA's have the potential to be affected by the PDA policy. The PDA policy is attached.	
R 562	Sec. 701a Staffing Standards. (a) An ALR shall be supervised by an ALA who shall be responsible for all personnel and services within the ALR. Based on record review and interview, it was determined that the ALA failed to be responsible for PDA services being provided within the ALR for two (2) of 2 PDA's in the sample. (PDA #1 and PDA #2) The finding includes: On April 3, 2014, starting at approximately 10:30 a.m., review of	R 562	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** No changes will be put into place, however, a full review of all PDA's will be done to ensure compliance with the policy.	

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R 562	Continued From page 7 PDA #1's personnel record revealed that PDA #1 was a current live-in aide who provides PDA services for Resident #3, 24 hours a day, 7 days a week. Further review of the record revealed a hire date of March 7, 2012. On April 3, 2014, starting at approximately 10:50 a.m., review of PDA #2's personnel record revealed that PDA #2 provides PDA services, Monday through Friday, eight (8) hours a day for Resident #5. Further review of the record revealed a hire date September 9, 2009. During an interview with the ED, on April 3, 2014, at approximately 11:55 a.m., the ED stated, "The [ALR] is not responsible for PDA services because they [PDA's] are hired by the resident's families and not the [ALR]." Please Note : The ED is the ALA's supervisor.	R 562	**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 audit of the PDA policy will be submitted to the QA committee for a period of 3 months to ensure compliance. Completion Date 7/31/14	
R 682	Sec. 702c3 Staff Training. (3) Four hours covering cognitive impairments in an in-service training approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association; and Based on record review and interview, the ALR failed to ensure that all staff had four (4) hours of annual training covering cognitive impairments approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association for two (2) of 2 non-newly hired employees in the investigation. (CNA and AA) The findings include:	R 682	R682 **What corrective action(s) will be accomplished to address the identified deficient practice;** Dementia training is currently on-going at Thomas Circle to ensure 100% compliance with the program. A copy of the trainer's resumes are attached to this POC.	

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R 682	Continued From page 8 1. On May 30, 2014, review of the CNA's personnel record at approximately 5:15 p.m., revealed that the employee's date of hire was October 8, 2012. Further review of the record revealed an in-service training document entitled Alzheimer's Disease, Common forms of Dementia and Picks Disease dated October 23, 2012. However, the record failed to show documented evidence that the employee had four (4) hours of training on cognitive impairments from a creditable expert such as the Alzheimer's Disease and Related Disorder Association in 2012 or 2013. 2. On May 30, 2014, review of the AA's personnel record at approximately 5:20 p.m., revealed that the employee's date of hire was February 5, 2013. Further review of the record revealed an in-service training document entitled Alzheimer's Disease, Common forms of Dementia and Picks Disease dated February 7, 2013. However, the record failed to show documented evidence that the employee had four (4) hours of training on cognitive impairments from an approved nationally recognized creditable expert such as the Alzheimer's Disease and Related Disorder Association on February 7, 2013. During an interview with the ALA on April 3, 2014 at approximately 12:30 p.m., regarding the aforementioned training the ALA stated, "I will email the training to you." It should be noted the documents were e-mailed; however, they failed to evidence the number of training hours provided and that the training was from a "creditable expert".	R 682	**How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected. Therefore, all staff will be trained. **What measures will be put into place or what systemic changes you will make to ensure that the deficient** Dementia training is currently on-going at Thomas Circle to ensure 100% compliance with the education program. A copy of the trainer's resumes are attached to this POC. **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.**	

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R 000	INITIAL COMMENTS On March 12, 2014, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received verbal and written notification that Resident #1 was reported missing after attending a community outing. On March 21, 2014, the DOH/HRLA received notification from the assisted living that Resident #1 had been located, however, the resident had expired, and the incident was under investigation by the Metropolitan Police Department, (MPD). Based on the nature of the incident, an investigation was initiated on March 26, 2014 to determine if the ALR provided adequate supervision and oversight to ensure Resident #1's well-being and safety as required by the "Assisted Living Law." Additionally, incidental findings were noted during this investigation and the deficiencies are cited in the report. The below are abbreviations that may appear throughout the body of this report. Activities Assistant - AA Assistant Living Administration - ALA Assistant Living Residence - ALR Activities Director - AD Certified Nursing Assistant - CNA Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) District of Columbia Fire Department Emergency Medical Services - DCFDEMS District of Columbia Office of the Chief Medical Examiner-DCOCME District of Columbia Metropolitan Police Department - DCMPD	R 000	Audits will be submitted to Quality Assurance until 100% compliance is obtained. The training will occur annually at Thomas Circle. Completion Date 7/31/14	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R 000	Continued From page 1 District of Columbia Metropolitan Police Department Detective - DCMPDD District of Columbia Metropolitan Police Officer-DCMPO Department of Public Works - DPW Executive Director - ED Global Positioning System - GPS Health Center - HC Human Resource Director - RHRD Individual Service Plan - ISP Medical Examiner - ME Metropolitan Police Department - MPD Mini-Mental State Examination - MMSE Personnel Action Form - PAF Physician's Orders Sheet - POS	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the Assistant Living Residence (ALR) failed to ensure a criminal background check for all jurisdictions in which the employee had worked or resided within 7 years for one (1) of nine (9) staff reviewed. (AD) The finding includes: Review of the personnel records on April 2, 2014, beginning at 1:35 p.m., revealed the ALR failed to provide evidence of a criminal background check	R 125	**What corrective action(s) will be accomplished to address the identified deficient practice;** A background check was completed on the AD and came back with no issues. **How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be effected. Therefore, all staff files will be audited to make sure they have a background check on file. If they do not, a background check will be ordered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient** A background check will be verified for all current employees. Going forward, the Executive Director or their delegate will verify all employee files on the first day of employment to verify a background check has been completed.	

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R 125	Continued From page 2 that disclosed a seven year history of all jurisdictions where one staff worked and/or resided at the time of the survey. The AD was on hired September 3, 2013. No criminal background check was conducted according to record information where he/she lived and previously worked. On April 3, 2014, at approximately 12:45 p.m. during an interview with the residence human resource director (RHRD) he/she acknowledged the aforementioned findings and indicated they spoke with the employee about getting a criminal; background check done. There were no additional documents given to the surveyor for review by the end of the interview.	R 125	**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.** 10 employee files will be audited each month for the next 3 months and audit results will be reported to HR to ensure compliance. An analysis will be conducted about whether or not to continue the audits at the conclusion of 90 days. Completion Date 7/31/14	