

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>FOREST HILLS OF DC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008</b>		
(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) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced Recertification Survey was conducted at Forest Hills of DC August 7, 2018, through August 14, 2018, and consisted of a review of 16 resident clinical records. Based on observations, record reviews, and staff interviews, an analysis of the findings determined the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p><b>Abbreviations</b>  AMS - Altered Mental Status  ARD - assessment reference date  BID - Twice- a-day  B/P - Blood Pressure  cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide  CRF - Community Residential Facility  D.C. - District of Columbia  DCMR- District of Columbia Municipal Regulations  D/C Discontinue  DI - deciliter  DMH - Department of Mental Health  EKG - 12 lead Electrocardiogram  EMS - Emergency Medical Services (911)  G-tube Gastrostomy tube  HSC Health Service Center  HVAC - Heating ventilation/Air conditioning</p>	F 000			

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

TITLE

(X6) DATE

*Mary Fawcett*

*Executive Director*

*10/16/18*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.