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-0013	A. BUILDING: _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINS PLACE	4917 FOOTE STREET, NE WASHINGTON, DC 20018

(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 On April 1, 2013, the Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received written notification via email, of an incident regarding an allegation of physical abuse involving Resident #1 on March 21, 2013. The complainant alleged that an assistive living residence employee (Employee #1) slapped Resident #1 across his eyes for failure to follow a directive. An onsite investigation was initiated at the facility on April 4, 2013, to ascertain compliance with Assisted Living Law "DC Code § 44-503 (11)." . Interviews were conducted with the assisted living administrators (ALA #1 and ALA#2), nine residents, 4 employees, one attorney (five of the nine residents) and review of ALR administrative and resident records. Findings of the investigation revealed that the assisted living residence (ALR) was in compliance with the Assisted Living Law DC Code § 44-504 (6). Allegation #1: Employee #1 allegedly slapped Resident #1 across his eyes for failure to follow a directive. Findings: The assistant living residence (ALR) initiated an investigation into the allegation of abuse and Employee #1 was placed on administrative leave pending the outcome of the internal investigation. According to the ALA #1 and ALA #2, Employee #1 did not work on the day in question. Interview with Employee #1 (alleged perpetrator) also stated she was not on duty on March 21, 2013, at 8:00 a.m. as alleged, which was verified through the review of the ALR employee schedule for March 21, 2013. The schedule did not reflect Employee #1 was on duty at 8:00 a.m. as alleged. Additionally, interviews	R 000		

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R 000	Continued From page 1 were conducted with Resident #1 (alleged victim), the witness/complainant (Resident #2), the attorney representative for both residents (victim and complainant). The attorney stated that he participated in the ALR investigation, and neither resident stated that the abuse had occurred. Interviews conducted with both the victim and complainant on April 4, 2013, revealed events of the day in question, could not be recalled. Both were oriented x3; however it should be noted that both Resident #1 and Resident #2 had dementia as part of their diagnoses. All residents and employees (overnight, day and evening shifts) were interviewed and none witnessed Resident #1 being slapped by Employee #1 as alleged. It should be noted that on the day of the investigation, at approximately 7:45 a.m., Resident #2 (complainant) was observed up, dressed, eating breakfast in the den/dining area and ready to leave for his perspective day program. Resident #1 was observed sleeping in his bedroom down the hallway from the dining area and did not awaken and come into the den/dining area until 11:00 a.m. According to staff, Resident #1 does not attend a day program and likes to sleep in and will get up when ready, usually around 10:30 a.m. to 11:00 a.m., stating " He does this on a daily basis", which was verified through morning observations. Staff indicated on the day in question, Resident #2 had already left for the day program and did not see Resident #1 until that evening. Conclusion: This allegation could be substantiated. No deficiencies were identified.	R 000		