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 _____	03/30/2012

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	Initial Comments An annual licensure survey was conducted on March 27, 2012 through March 30, 2012 to determine compliance with Assisted Living Law " DC Code § 44-101.01." The survey was based on clinical and administrative record reviews, staff and patient interviews. The sample size were four (4) resident records based on a census of one hundred thirty-nine (39) residents and six (6)employees records based on a census of sixty (60) employees.	R 000	The Residences at Thomas Circle is filing this Plan of Correction for the purposes of regulatory compliance. The facility is submitting this Plan of Correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein.	
R 292	Sec. 504.1 Accommodation Of Needs. (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; [D.C. Official Code § 44-105.04 (1)] Based on observation, interview and record review, the Assistant Living Residence (ALR) failed to isolate Resident #4 who had drainage from both eyes. Subsequently, the resident was diagnosed with conjunctivitis. The finding include: On March 27, 2012, an observation on the second floor (memory and dementia unit) at approximately 10:00 a.m., revealed Resident #4 sitting at the dining table. Both of her eyes appeared with red, with clear drainage. Also observed was an uncovered lesion on the right side of the neck that was draining blood. Interview with the Licensed Practical Nurse on March 27, 2012 at approximately 10:10 a.m., she stated "The resident does not have conjunctivitis."	R 292	1. **Corrective Action for Resident** Resident #4 was being treated with eye ointment as ordered by the physician. There was no physician order for contact isolation. Staff utilized standard precautions as stated in the Infection Control Policy. The DON reviewed regulations and CDC guidelines for proper isolation procedures with the diagnosis of conjunctivitis. The DON confirmed that contact isolation was unnecessary. The resident was not observed touching their eyes and therefore not at risk of spreading infection. There was no need for contact isolation as stated by the physician. 2. **Identify Other Residents** All other residents in the Memory Care Unit were assessed on March 27, 2012. No other resident showed signs or symptoms of conjunctivitis.	

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R 292	Continued From page 1 He/She also indicated the resident would see a dermatologist during the week about the cancerous neck lesion. Additionally, the surveyor asked the director of nursing (DON) if there was any orders to address the uncovered bleeding lesion. He/She stated "I will call the doctor and get an order." On March 27, 2012, a record review of Resident #4's record revealed a physician order dated March 22, 2012 as follows " Dermatology appointment at GW for skin lesion to right neck. Sulfacetamide opthahalmide ophthalmic sol. 10 % two drops four (4) times a day for two (2) days then twice a day for seven (7) days for conjunctivitis." The DON was asked if he/she could have used contact isolation as a nursing precaution for the safety of the other resident's. The DON indicated the staff uses standard precautions and the physician did not order contact isolation. The DON also indicated the residents neck lesion was cleansed and covered after it was identified the resident was bleeding.	R 292	3 **Systemic Changes** 04.25.2012 The nursing staff was in-serviced to request a physician to evaluate whether contact isolation is appropriate with a diagnosis of conjunctivitis. 4. **Monitor Corrective Actions** The AL Manager or designee will review residents within 8 hours of a diagnosis of conjunctivitis. S/he will ensure appropriate infection control measures are in place. All infections will be reported at quarterly QA.	
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. [D.C. Official Code § 44-106.04 (a) (1)] Based on record review and interview, the Assistant Living Residence (ALR) failed to develop a Individualized Service Plans (ISP) for one (1) of four (4) resident's included in the sample prior to admission. (Resident's #2) The finding Includes:	R 471	1. **Corrective Action for Resident** No corrective action could be taken retrospectively. 05.03.2012 2. **Identify Other Residents** All new admissions within the last 60 days were reviewed. Pre-admission ISPs existed for each record reviewed. 3. **Systemic Changes** The Health Services Marketing Director or designee will communicate all upcoming	

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R 471	Continued From page 2 On March 27, 2012, a review of Resident #2's record revealed an admission dated of March 3, 2011. Further review of the record revealed there no evidence a pre-admission ISP had been developed. During a face to face interview with the director of nursing on March 27, 2012 at approximately 2:30 p.m., he/she indicated there was some ISP's in his/her office. It should be noted the pre-admission ISP was not provided to the surveyor at the time of this survey.	R 471	admissions to AL Manager or designee within 72 hours prior to admission. 4. **Monitor Corrective Actions** At least 48 hours prior to admission the ISP will be reviewed by the DON or designee. Any issues of non-compliance will be reported via quarterly QA.	
R 481	Sec. 604b Individualized Service Plans (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. [D.C. Official Code § 44-106.04 (b)] Based on interview and record review, the facility failed to document on the individual service plan (ISP) for two (2) of four (4) resident's when and how often services will be provided. (Resident #1 and #3). The findings include: 1. During a face to face interview with the director of nursing (DON) on March 27, 2012 at approximately 10:30 a.m., it was revealed Resident #1 had been receiving private duty aide services, 24 hours a day daily, since transfer from in-house skilled unit on January 18, 2011. On March 27, 2012, a review of Resident #1's record at approximately 11:30 a.m., revealed ISP's with date of January 18, 2011 and November 8, 2011 that failed to evidence when ,	R 481	1. **Corrective Action for Resident** For resident #1 the use of a 24-hour a day private aide is now included in the ISP. 05.03.2012 Resident #2 was offered therapy services. Therapy Services attempted to asses resident #2 but the resident refused. 2. **Identify Other Residents** The ISPs of all residents with private duty service were reviewed. The ISPs confirm that residents with private duty service are documented in the ISP. 05.03.2012 Review of records indicated that no other resident was affected by this practice.	

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R 481	Continued From page 3 how often and by whom private duty aide services were to be provided. 2. On March 27, 2012, a review of Resident #3's record revealed a physician order dated March 2, 2012. The physician ordered physical therapy (PT) and occupation therapy (OT) services after the resident had a fall and shoulder sprain. Further review of the record revealed ISP's dated November 23, 2011 and December 23, 2011, that failed to documented when , how often and by whom PT and OT services were to be provided. During a face to face interview with the DON on March 27, 2012 at approximately 2:00 p.m., he/she stated "I will find out when services were provided and fax that info to you. On March 28, 2012, the ALR staff faxed a note which indicated PT and OT was not aware of order for services.	R 481	3. **Systemic Changes** All intervention provided by staff or private duty aide will be documented on the ISP and reviewed during the ISP meeting. All physician orders written for therapy will be communicated to the Therapy Department by utilizing the communication form. The form(s) will be reviewed during the following interdisciplinary team update meeting. 04.25.2012 All nursing staff was in-serviced on proper documentation of the ISP and utilization of the Therapy Communication Form. 4. **Monitor Corrective Actions** The AL Manager or designee will report all non-compliance issues during the quarterly QA meeting.	
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. [D.C. Official Code § 44-106.04 (d)] Based on record reviews and interview, the Assisted Living Residence (ALR) failed to ensure one (1) of four (4) resident's Individualized Services Plan's (ISP's) were reviewed by the	R 483	1. **Corrective Action for Resident** An ISP was reviewed on resident #1 on 04.10.2012 date. An ISP will be reviewed for resident #2 on 05.10.2012 date. A current ISP is in place for both residents. An ISP will be reviewed by the healthcare provider for each resident every 6 months or more frequently if there is a change in condition.	

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R 483	Continued From page 4 interdisciplinary team that includes the resident's healthcare practitioner, thirty days after admission and at least every six (6) months. (Resident #1 and #2) The findings include: 1. On March 27, 2012, a review of Resident #1's record at approximately 11:30 a.m., revealed ISP's with dates of January 18, 2011 and November 8, 2011. Review of the ISP's failed to evidence the resident's health practitioner had reviewed the aforementioned ISP's. Further review of the record revealed there was no documented evidence the ISP was updated in six months (July 2011). 2. On March 27, 2012, a review of Resident #2's record at approximately 12:00 p.m., revealed the resident was admitted on March 3, 2011. Further review of the record revealed an ISP dated December 16, 2011. There was no documented evidence the aforementioned ISP was reviewed in 30 days (April 3, 2011) or in six months (September 2011). During a face to face interview with the Associate Administrator and the Director of Nursing on March 27, 2012 at approximately 2:30 p.m., they were informed of the aforementioned findings.	R 483	An audit of ISPs was conducted by the Social Worker and an ISP schedule created. Going forward ISPs will be reviewed prior to admission, within the 1st 30 days, and every 60 days thereafter unless there is a change in condition. 2. **Identify Other Residents** All other records were reviewed and found to be in compliance. No other residents were found to be affected by this practice. 05.03.2012 3. **Systemic Changes** An ISP meeting will be held within 30-days of admission and at least every 6 months thereafter or sooner if there is a change in condition. The review will include, but not be limited to, the interdisciplinary team, the healthcare practitioner, and the resident's surrogate if necessary in the ALR. 05.03.2012 The nursing staff will be in-serviced on updating and reviewing the ISP as required by healthcare guidelines. 4. **Monitor Corrective Actions** The AL Manager or designee will review all charts monthly to ensure all ISPs are reviewed and up-to-date. The AL Manager or designee will report all non-compliance issues during the quarterly QA meeting.	
R 602	Sec. 701f Staffing Standards. (f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. [44-107.01 (f) Employees shall be required on and annual basis to document freedom from	R 602		

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R 602	Continued From page 5 tuberculosis in a communicable form] Based on record review and interview, it was determined that the Assistant Living Residence failed to ensure that employees documented that they were free from tuberculosis in a communicable form for five (5) of six (6) of employees in the sample. (Employee #2, #3, #4, #5 and #6) The finding includes: Review of the facility's current personnel records on March 30, 2012, at approximately 1:30 p.m., revealed that employees #2, #3, #4, #5, and #6 did not have current health certificates to ensure that the employees were free of tuberculosis. Interview with the facility's new Human Resources Director, at approximately 2:45 p.m., revealed that he was unaware of the annual requirement for a tuberculosis clearance.	R 602	1. **Corrective Action for Resident** The Human Resource Director reviewed all employee files. All employee files had evidence of up to date Tuberculosis testing and/or proof of freedom from Tuberculosis. 2. **Identify Other Residents** No resident was affected by this practice. 3. **Systemic Changes** The Human Resource Director in-serviced all Department Directors that when the list of employees whose PPD/chest x-ray is close to expiration, the Director will ensure that the employee will complete the PPD/chest x-ray prior to the expiration of the employee's current PPD/chest x-ray. 4. **Monitor Corrective Actions** The Human Resource Director or designee will review all employees' files on a monthly basis. The HR Director or designee will report all non-compliance issues during the quarterly QA meeting.	04.20.2012 04.20.2012
R 704	Sec. 802a Medical, Rehabilitation, Psychosocial Assess. (a) A medical, rehabilitation, and psychosocial assessment of the resident shall be completed within 30 days prior to admission. [D.C. Official Code § 44-108.02 (a)] Based on record review and interview, it was determined the Assistant Living Residence (ALR) failed to ensure that a medical, rehabilitation, and psychosocial assessment had been completed within 30 days prior to admission for one (1) of four (4) resident's included in the sample. (Resident #3)	R 704	1. **Corrective Action for Resident** Resident #3's medical, rehabilitation, and psychosocial was completed by the healthcare practitioner on May 3, 2012. 2. **Identify Other Residents** All admissions in the past 60 days have been reviewed for a complete medical, rehabilitation, psychosocial assessment by the healthcare practitioner and no resident records were found to be out of compliance.	05.03.2012 04.25.2012

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R 704	Continued From page 6 The finding includes: On March 27, 2012, a review of Resident #3's record at approximately 1:00 p.m. revealed an incomplete medical, rehabilitation and psychosocial assessment dated November 22, 2011. During a face to face interview with the director of nursing on March 27, 2012 at approximately 2:00 p.m., he/she was informed of the aforementioned finding.	R 704	3. **Systemic Changes** The healthcare practitioner, admission coordinator, and social worker were in-serviced by the Associate Administrator that a medical, rehabilitation, psychosocial assessment has to be completed within 30-days prior to admission to the facility. 05.03.2012 4. **Monitor Corrective Actions** Not later than 48 hours prior to scheduled admission, the DON will ensure that the medical, rehabilitation, psychosocial assessment has been completed. All issues of non-compliance issues during the quarterly QA meeting.	
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so indicated during the medical assessment. [D.C. Official Code § 44-108.02 (b)] Based on record review and interview, the Assisted Living Residence (ALR) failed to a physician assessment of resident's health status for one (1)of three (4) residents living in the facility. (Resident #1) The finding includes: On March 27, 2012, a review of Resident #1's record at approximately 11:30 a.m. revealed there was no evidence a physician assessment had been obtained that includes a description of the residents physical, medical and psychological and cognitive status.	R 705	1. **Corrective Action for Resident** Resident #1. The medical assessment form (the Mayor's form) was used to complete the physical assessment of the resident's health status by the physician. 05.03.2012 2. **Identify Other Residents** All resident records were reviewed to ensure presence and completion of The Mayor's Form. No additional resident records were found to be out of compliance. 05.03.2012 3. **Systemic Changes** The healthcare practitioner and social worker were in-serviced by the Associate Administrator that a medical assessment form (the Mayor's form) has to be completed by a physician at least 7-days prior to their scheduled AL admission date. 05.03.2012	

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R 705	Continued From page 7 During a face to face interview with the Associate Administrator and the Director of Nursing on March 27, 2012 at approximately 2:30 p.m., they were informed of the aforementioned finding.	R 705	**4. Monitor Corrective Actions** The DON will review all files at least 48 hours prior to scheduled admission to ensure the medical assessment form (the Mayor's form) is completed by a physician. The DON or designee will report all non-compliance issues during the quarterly QA meeting.	
R 782	Sec. 901 1 Responsibilities Of The ALR - Personnel (1) Is capable of self-administering his or her own medications; [D.C. Official Code § 44-109.01 (1)] Based on staff interview and record review, the ALA failed to ensure all residents were provided an initial assessment which identified their ability to self-medicate for one of one sampled residents. (Resident #2) The finding includes: On March 27, 2012, a review of Resident #2's record at approximately 12:30 p.m. revealed the resident was admitted on March 3, 2011. There was no evidence of an initial self-medication assessment in the resident's record at the time of this survey. During a face to face interview with Resident #2 on March 27, 2012 at approximately 1:50 p.m., he/she stated "I take two medications and just like I told the other nurse I'm not letting you see them. My medicines are fine."	R 782	**1. Corrective Action for Resident** Resident #2. A self-medication assessment was completed with the resident during which the resident was determined appropriate to self-administer medications. 03.28.2012 **2. Identify Other Residents** All residents who self-administer their medications were assessed and determined appropriate to self-administer their medication. 03.28.2012 **3. Systemic Changes** The nursing staff was in-serviced on assessing all residents who wish to self-administer their medication prior to residents self-administering their medication. 04.25.2012 **4. Monitor Corrective Actions** A standard form has been identified and will be utilized for all new admissions and reviewed by the AL Manager or designee every 45 days or sooner if there is a change in condition. 03.28.2012 The AL Manager or designee will reevaluate residents who self-administer their medication on a monthly basis. The AL Manager or designee will report all non-compliance issues during the quarterly QA meeting.	

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R 821	Continued From page 8	R 821		
R 821	Sec. 904e8 Medication Storage (8) Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep them secured from other residents. [D.C. Official Code § 44-109.04 (8)] Based on observation and interview, the Assistant Living Residence (ALR) failed to ensure one (1) of one (1) resident's included in the sample secured her medication from other residents. (Resident #2) The finding Includes: On March 27, 2012, an observation of resident #2's room on March 27, 2012 at approximately 1:50 p.m. revealed there was no lock on room door. During a face to face interview with Resident #2 on March 27, 2012 at approximately 1:50 p.m., she stated "I take two medications and just like I told the other nurse I'm not letting you see them. My medicines are fine." When this surveyor asked the resident if he/she locks his/her medication up when he/she leaves his/her room. He/She stated "I can't do that because there is no lock on my door."	R 821	1. **Corrective Action for Resident** Resident #2. A lock was placed on the apartment door and the lock was approved by the resident. 03.31.2012 2. **Identify Other Residents** All residents who self-administer their medication have a locked door or other means to secure their medication in their apartment. 3. **Systemic Changes** The AL Manager and the Maintenance Director were in-serviced on ensuring that residents who self-administer their medication have a locked door. 03.31.2012 4. **Monitor Corrective Actions** The AL Manager or designee will check doors of residents who self-administer their medication to ensure doors or other secure means utilized lock appropriately. Doors or other secure means utilized will be checked on a weekly basis and issues of non-compliance will be addressed immediately and reported during the weekly Risk Meeting and quarterly QA.	