

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/23/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE RESIDENCES AT THOMAS CIRCLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1330 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20005</b>
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R 000	<p><b>Initial Comments</b></p> <p>An annual licensure survey was conducted on May 23, 2013 to evaluate the facility's compliance with the Assisted Living Law " DC Code § 44-101.01 ". A random sample of five (5) resident records (census of 39) and five (5) staff records (census of 45) were reviewed. The findings of the survey were based on observations, interviews, and review of clinical and administrative records.</p> <p>The outcome of the survey revealed that facility failed to implement sufficient strategies to address a resident's multiple falls. Based on this information, it was concluded that conditions existed that posed an immediate and serious threat to the health and safety of a resident that resided in the facility. On May 24, 2013, the facility's executive director was notified of the concern. At 6:31 p.m. (May 24, 2013), the executive director submitted a plan to remove the urgent concern. The plan included interventions as indicated below :</p> <p>Continue 1 hour checks; With resident's permission, place reminders in the resident's apartment to use pendant in the event assistance is needed; With resident's permission, visit resident's room to organize personal belongings to ensure that "important" personal items are in reach; With resident's permission, provide the resident with a "reacher"; Ordered Bedside Pocket Storage Caddy to help organize stationary, notebook, mail and other personal items (will be implemented upon arrival and approval of resident); Obtained the physician's orders for UA/CS, Vitamin D, Chem 7, CBC with Differential, Occupational Therapy Evaluation and Chest</p>	R 000	<p>The Residences at Thomas Circle files this Plan of Correction for the purposes of regulatory compliance. The facility is submitting this document to comply with applicable law and not as an admission or statement of agreement of deficient practices herein.</p> <p><i>Received 6/25/13 Dott-Hella-ICFIO</i></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

F2HZ11

TITLE

*Exec. Dir. Deoeth*

(X8) DATE

*6/20/13*

If continuation sheet 1 of 12

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R 000	Continued From page 1  X-ray; Contacted physician regarding reduction in resident's coumadin dose however, physician feels the benefits of subtherapeutic Coumadin therapy outweigh the risks; Ordered table clip for drink or other small items (will be implemented upon arrival and approval of resident); Request medical director, or designee, to review medical record during the week of May 27, 2013; Schedule ISP meeting for the week of May 27, 2013 to discuss recurring falls and interventions to date, re-introduce option to provide additional private duty support and evaluate potential for shared risk agreement, if appropriate.  The aforementioned plan was reviewed and at approximately 9:37 p.m. on May 24, 2013, it was determined that the plan substantially addressed the urgent nature of the identified risk to a resident's health and safety. Although the immediacy of the identified concern was addressed, it was determined that the facility failed to be in compliance with the Assisted Living Law as indicated by the deficiencies cited in this report.	R 000		7/31/13
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 ]  Based on record review, interview and observation, the Assisted Living Residence (ALR) failed to provide reasonable and adequate accommodations for a resident's individual needs	R 292	1. Corrective Action for Resident: Resident #5 was identified as being by this practice. Resident had a falls on the following dates:  On <b>May 6, 2013</b> , fell out of bed with no injury. Neurological assessment was done post fall. A significant change ISP was done and reviewed with resident, interdisciplinary team and healthcare practitioner. New interventions were as follows:	

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R 292	<p>Continued From page 2</p> <p>consistent with limited physical capabilities for one (1) of five (5) residents. (Resident #5)</p> <p>The finding include:</p> <p>On May 23, 2013, at approximately 1:00 p.m. a review of Resident #5's record revealed a history and physical (H&amp;P) dated April 11, 2013, which documented the resident has a history of lung cancer with metatis to the brain, osteo arthritis, pain syndrome. Additionally, the H&amp;P indicated the resident required intermittent and continual assistance with ambulation.</p> <p>Further review of the record revealed a nurse practitioner (NP) note dated May 10, 2013, at 12:21 p.m., which indicated the resident moved from independent living to assistant living "due to metastatic lung cancer with brain lesions and progressing weakness with syncopal episodes and falls. Wife helps resident with ambulation as he is high risk for falls and should not walk alone. Patient has a bed rail but it is currently in his old apartment. Resident says his PTSD [post traumatic stress disorder] (veteran) causes him to toss and turn at night and that's why he falls out of bed. Both resident and spouse are considering living apart and hiring an aide."</p> <p>The NP note further indicated the resident "walks with a walker" and "needs help getting in and out of bed/chair." Furthermore, the note documented to "continue safety precautions."</p> <p>Continued review of the resident's records revealed an individual service plan (ISP) dated April 11, 2013. The ISP documented in the mobility section that the resident was, "not always reliable, ambulates with supervision, always requires guide or assistance due to physical problems or confusion with adaptive equipment,</p>	R 292	<p>a. Re-education of resident on importance of using pendant.</p> <p>b. Medications Review was done by the healthcare practitioner with no changes made.</p> <p>On <b>May 12, 2013</b> fell from wheelchair in the presence of the son and wife with no injury noted upon assessment. Neurological assessment was done post fall. A significant change ISP was done and reviewed with resident, interdisciplinary team and healthcare practitioner. New interventions were as follows:</p> <p>a. Re-education of resident on importance of using pendant</p> <p>b. Referred to Rehab for consult was sent to the rehab department.</p> <p>c. Rehab recommended 3 in 1 commode to be used at bedside and over the toilet if resident had supervision to go to the bathroom and bed enablers to decrease the risk for falls during supine to sit transfer. The recommendations were initiated immediately and were in place during the time of this survey. The 3 in 1 commode is also used as a raised toilet seat during awake hours which is what was observed by the surveyor on May 23, 2013 at approximately 2:15pm.</p> <p>On <b>May 16, 2013</b>, resident was observed on the floor in his room in a sitting position with the wife present while trying to reach his mail with no injury. Neurological assessment was done post fall. A significant change ISP was done and reviewed with resident,</p>	

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R 292	<p>Continued From page 3</p> <p>dependant- requires assistance with transfers, etc. Resident pretty much uses wheelchair at this time due to weakness." Additionally, in the risk assessment section of the ISP it revealed that the resident was a "fall risk."</p> <p>Review of the incident record revealed Resident #5 fell four times between May 6, 2013 and May 19, 2013 (a 13 day period), as evidenced below:</p> <p>1. An "event report (quality assurance/confidential)" dated May 6, 2013, timed at approximately 3:00 a.m. revealed the nurse documented that Resident #5's wife called the nurse to the room and the resident was "observed on the floor lying on his right side and facing his bed. Resident could not explain what led to his fall." The report indicated that the resident did not sustain any injuries and the physician was made aware, No orders were given.</p> <p>As a result of the incident, the facility implemented the following interventions on May 6, 2013:</p> <ul style="list-style-type: none"> <li>- Re-education about the importance of using the pendant; and</li> <li>- A request was made for the pharmacy to conduct a medication regimen review.</li> </ul> <p>At the time of the survey however, the facility failed to provide evidence that the medication regimen review had been conducted.</p> <p>2. An "event report (quality assurance/confidential)" dated May 12, 2013, timed at 7:00 p.m., documented, that Resident #5 "fell from his wheelchair in the presence of son</p>	R 292	<p>interdisciplinary team and healthcare practitioner. New interventions were as follows:</p> <ul style="list-style-type: none"> <li>a. Re-education of resident on importance of using pendant</li> <li>b. Medications review and reduction was done by the healthcare practitioner</li> <li>c. One hourly check initiated as ordered</li> <li>d. Referral to rehab to address frequent falls, modalities and gait strengthening. Rehab determined that since a screen was done on 5/13/2013, caregiver training was done and rehab was not indicated for resident due to cognitive decline and inability to carry over instructions.</li> </ul> <p>On May 19, 2013, resident was observed on the floor in a sitting position beside the chair with no injury. Neurological assessment was done post fall.</p> <p>A significant change ISP was done and reviewed with resident, interdisciplinary team and healthcare practitioner. New interventions were as follows:</p> <ul style="list-style-type: none"> <li>a. Re-education of resident on importance of using pendant.</li> <li>b. Referred for rehab consult.</li> <li>c. Spouse was re-educated to call for help whenever the resident needs assistance.</li> <li>d. Medication regimen review was sent to the pharmacy.</li> </ul> <p>On June 4, 2013, a wheel chair was ordered and the residents room was rearranged in order to create more space for resident.</p>	

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R 292	<p>Continued From page 4</p> <p>and wife." The report further indicated that the resident did not sustain any injuries and the physician was notified. No new orders were given.</p> <p>As a result of the incident, the facility implemented the following interventions on May 12, 2013:</p> <ul style="list-style-type: none"> <li>- Re-education on using the pendant at all times when help is needed; and</li> <li>- A written rehabilitation referral was developed for rehab services to address improper positioning in bed or wheelchair, risk for skin breakdown, and needs assistance for transfers and unsteady gait. The referral indicated that the evaluation was assigned to physical therapy.</li> </ul> <p>At the time of this survey (11 days after the referral) however, the facility failed to provide evidence that the physical therapy evaluation had been performed.</p> <p>It should be further noted that an occupational therapy screening note dated May 13, 2013, documented that therapist spoke with the facility staff and family regarding patient's recent fall. The therapist recommended bed enablers as well as a 3 in 1 commode chair (bedside commode) to minimize Resident #5's fall risk.</p> <p>Observation of the Resident #5's apartment on May 23, 2013, at approximately 2:15 p.m., revealed two bed enablers (half side rails) and a raised toilet seat on the toilet in the bathroom. The recommendation for a 3 in 1 commode chair (bedside commode) however, had not been implemented.</p>	R 292	<p>Note: In addition to all the above intervention that were put in place immediately after each fall, and on Friday, May 24, an ISP meeting was held on June 6, 2013 with resident, resident's wife, son/POA, Executive Director/ALA, AL Director, AL Manager, Hospice team, Charge nurse, Nurse Practitioner, CNA, activities staff and the Ombudsman.</p>	

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R 292	<p>Continued From page 5</p> <p>It should be noted that when the assistant living manager was asked about the resident's 3 in 1 commode ( bedside commode), the assistant living manager escorted the surveyor to the resident's bathroom and pointed to the raised toilet seat.</p> <p>3. An "event report (quality assurance/confidential)" dated May 16, 2013, timed at 7:00 p.m., revealed the nurse documented that Resident #5 was "observed on the floor in his room in a sitting position, he was trying to reach for his mail. Wife present during fall." The report further indicated that the resident had no injuries.</p> <p>As a result of the incident, the facility implemented the following interventions on May 16, 2013:</p> <ul style="list-style-type: none"> <li>- "Resident was re-educated with his spouse to call for help at any time when help is needed";</li> <li>- Obtained referral to occupational and physical therapy for transfer modalities and gait strengthening. Additionally, there was a reduction to the resident's Metoprolol Tartrate to 25 milligrams, one tab by mouth twice a day, for atrial fibrillation because of hypotension. Staff should check on the resident hourly to anticipate his needs to avoid falls; and</li> <li>- Referral to rehab services to address frequent falls. Occupational and physical therapy evaluation for transfer modalities and gait strengthening.</li> </ul> <p>At the time of this survey (7 days after the fall) however, the facility failed to provide evidence that the physical and occupational therapy</p>	R 292		
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R 292	<p>Continued From page 6</p> <p>evaluation for transfer modalities and gait strengthening and hourly monitoring of the resident had been conducted.</p> <p>During an interview with the assistant living manager (ALM) on May 23, 2013, at approximately 2:00 p.m., the ALM stated that "the physical and occupational therapy evaluation had been discontinued by the physician on today because of recommendations made by the occupational therapist during the screening on May 13, 2013."</p> <p>During a telephone conversation with the ALM on May 24, 2013, a request was made to forward to the Department of Health any documentation that substantiated hourly monitoring had been implemented. The ALM was further requested to forward the facility's fall policy. The ALM stated, "we are no longer doing the hourly monitoring, we are just monitoring the resident every two hours as a nursing intervention." The ALM was then asked to fax the new order that documented the discontinuance of the hourly monitoring and any documentation of the hourly monitoring provided. It should be noted however, that the documents were not received.</p> <p>4. An "event report (quality assurance/confidential)" dated May 19, 2013, timed 5:00 p.m., revealed the nurse documented that Resident #5 was "observed on the floor in a sitting position beside the chair. No apparent injuries, and denies pain or discomfort..." The nurse indicated no new physician orders were given.</p> <p>As a result of the incident, the facility implemented the following interventions on May 19, 2013:</p>	R 292		

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R 292	<p>Continued From page 7</p> <p>- Spouse was re-educated to call for help whenever the Resident #5 needs help; and</p> <p>- A written request was made for a medication regimen review by the pharmacy.</p> <p>At the time of this survey however, the facility failed to provide evidence that the medication regimen review had been conducted.</p> <p>A telephone discussion with the Executive Director (ED) and director of nursing (DON) on May 24, 2013, at approximately 3:00 p.m., revealed that although the resident had a 24 hour private duty aide prior to moving to assistant living, the resident and the resident's son refused to continue private duty aide services. When the ED and DON was asked by the surveyor why was the hourly monitoring discontinued, they indicated that they had spoken with the resident about the hourly monitoring and the resident informed them that he did not want people looking over his shoulder all the time. Further conversation revealed the resident was evaluated by therapy on May 20, 2013. The DON agreed to e-mail the May 20, 2013 therapy evaluation to the surveyor, however, the evaluation has not been received.</p>	R 292		
R 483	<p>Sec. 604d Individualized Service Plans</p> <p>(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</p>	R 483	<p>1. Corrective Action for Resident: Residents #2, 3, 4 and 5 were identified as being affected by this practice. Upon discovery, the ISP for each of the above residents was reviewed and signed by the healthcare practitioner.</p> <p>2. Identify Other Residents: All residents have the potential of being affected by this practice. An audit of ISPs was conducted by the ALR Manager and all records were found to be in compliance.</p>	7/31/13

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R 483	<p>Continued From page 8</p> <p>resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. [ D.C. Official Code § 44-106.04 (d) ]</p> <p>Based on record review and interview, the Assisted Living Residence (ALR) failed to ensure four (4) of five (5) residents' Individualized Services Plans (ISP's) were reviewed by the residents' healthcare practitioner and updated for significant changes. (Residents' #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>1. On May 23, 2013, at approximately 12:10 p.m., review of Resident #2's record revealed an ISP dated April 25, 2013. The ISP failed to provide evidence that it had been reviewed by a healthcare practitioner .</p> <p>An interview on May 23, 2013, at approximately 2:25 p.m. with the ALR manager, revealed that, the resident's healthcare practitioner had not reviewed the ISP and the ISP is a on a new form which does not include a signature line for the resident's healthcare practitioner.</p> <p>2. On May 23, 2013, starting at approximately 12:30 p.m., a review of Resident #3's record revealed an ISP dated January 3, 2013. The ISP failed to evidence that it had been reviewed by a healthcare practitioner.</p> <p>An interview on May 23, 2013, at approximately 2:25 p.m. with the ALR manager, revealed that the resident's healthcare practitioner had not reviewed the ISP. Additionally, the interview revealed that the new ISP form does not include a signature line for the resident's healthcare</p>	R 483	<p>3. Systemic Changes: All ISPs shall be review during the ISP meeting with the interdisciplinary team, the healthcare practitioner, and the resident's surrogate (if appropriate) in the ALR. If the healthcare practitioner is not present, then he/she shall review the ISP within three days post the ISP meeting and sign the ISP with a copy given to the resident/POA.</p> <p>4. Monitor Corrective Actions: The ALR Manager or designee will conduct a monthly chart audit to ensure that all ISPs are reviewed by the healthcare practitioner. Any finding of non-compliance shall be corrected immediately and reported to DON and NHA. The AL Manager or designee will report all non-compliance issues during the quarterly QA meeting</p>	

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R 483	<p>Continued From page 9</p> <p>practitioner.</p> <p>3. On May 23 , 2013, at approximately 1:15 p.m., review of Resident #4's record revealed a physician order dated May 6, 2013 which ordered "resident to ambulate with a rolling walker...." Further review of the record, revealed an ISP dated June 29, 2012. The ISP failed to provide evidence that the significant change in ambulation which required the use of a rolling walker as ordered on June 29, 2012.</p> <p>The ALR manager was made aware of the finding on May 23, 2013, at approximately 2:00 p.m. The director stated, "I will update the ISP to include the use the rolling walker."</p> <p>4. On May 23, 2013, starting at approximately 1:45 p.m., a review of Resident #5's record revealed an ISP dated April 11, 2013. The ISP failed to evidence that it had been reviewed by a healthcare practitioner.</p> <p>An interview on May 23, 2013, at approximately 2:25 p.m., with the ALR manager revealed that the resident's healthcare practitioner had not reviewed the ISP. Additionally, the interview revealed that the new ISP form does not include a signature line for the resident's healthcare practitioner.</p>	R 483		
R 600	<p>Sec. 701d13 Staffing Standards.</p> <p>(13) Complete the training required by section 702 and 12 additional hours of training, annually, conducted by a nationally recognized organization that possesses experience in training staff in dementia care, such as the Alzheimer's Disease and Related Disorders Association, on managing residents who are living with cognitive</p>	R 600	<p>1. Corrective Action: No action could be taken retrospectively. The ALA has identified 12 CEUs to complete that are approved by the Alzheimer's Association. The ALA will complete the 12 hours of CEU training by 7/15/13.</p>	7/31/13

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(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
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R 600	<p>Continued From page 10</p> <p>impairments. Based on record review and interview, it was revealed that the Assistant Living Residence (ALR) failed to provide documentation that the Assistant Living Administrator (ALA) had the required annual 12 hour in-service training on managing residents.</p> <p>The finding includes:</p> <p>On May 23, 2013, at approximately 1:05 p.m., review of the ALA personnel record failed to provide evidence that all required training had been received.</p> <p>During a face to face interview with the ALA on May 23, 2013, at approximately 2:00 p.m., it was acknowledged that the required training was not in the personnel file at the time of the survey.</p> <p>On May 30, 2013, post survey, a second request was made via telephone and e-mail to obtain 2012 training requirement for the administrator. The facility responded by sending the administrator's training for 2006 and 2013.</p> <p>The facility failed to provide evidence of the 12 hours required training conducted by a nationally recognized organization in dementia care for the administrator. It should be noted that a follow-up phone call was made on May 31, 2013 to obtain the required training records, but was unsuccessful.</p>	R 600	<p>2. Identify residents affected: All residents have the potential of being affected by this practice.</p> <p>3. Systemic Changes: The ALA will complete 12 hours of Dementia training on an annual basis.</p> <p>4. Monitor Corrective Actions: The ALA will report the status of CEU completion and compliance at the Quarterly QA meeting to ensure that 12 Dementia CEUs are completed annually per regulation.</p>	
R 981	<p>Sec. 1004a General Building Interior</p> <p>(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.</p>	R 981	<p>1. Corrective Action: The resident in room #301 was identified as being affected by this practice. Upon discovery, the bathroom ceiling identified as having chipping and peeling paint in room #301 was repaired.</p>	7/31/13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/23/2013</b>
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R 981	<p>Continued From page 11</p> <p>Based on observation and staff interview, the facility failed to ensure that the interior of the Assisted Living Residence (ALR) was maintained in a structurally sound manner and in good repair.</p> <p>The finding includes:</p> <p>During an environmental inspection on May 23, 2013, at approximately 10:25 a.m., Apartment # 301 was observed to have chipping and peeling paint on the bathroom ceiling.</p> <p>During a face to face interview with the facility's maintenance staff at approximately 12:30 p.m., it was acknowledged that the bathroom ceiling had chipping paint. Further interview revealed that the facility would repair the bathroom ceiling.</p>	R 981	<p>2. Identify residents affected: No other were identified by this practice. All rooms and bathroom ceilings were evaluated and found to be in good condition and not in need of repair.</p> <p>3. Systemic Changes: A Monthly Room Inspection of all resident rooms has been implemented to ensure that walls, ceilings, floors, doors, windows, fixtures and equipment are maintained in good order and that any needed repairs are documented and completed in a timely manner, or completed immediately, depending on nature of the deficiency at that time. In addition, in-service given to key staff to report any deficiencies observed and or, reported via Residents, Guests, Visitors and or Private Aides as a work order.</p> <p>4. Monitor Corrective Actions: Monthly Room Inspections will be documented and reviewed by the Plant Operations Director and records of inspections will be kept in a location that can be reviewed as a part of Thomas Circle's PM Program. Any deficiencies noted will be resolved immediately and reported via the quarterly QA meeting.</p>	
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