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PRINTED: 09/23/2013
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CRF-000744	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/19/2013
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NAME OF PROVIDER OR SUPPLIER
ALVETTA HOSE

STREET ADDRESS, CITY, STATE, ZIP CODE
**5201 BANKS PLACE, NE
WASHINGTON, DC 20019**

(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
{D 000}	Initial Comments A follow-up survey was conducted on September 19, 2013, based on the deficiencies cited on July 31, 2013. The survey findings was based on observations in the home, interviews with administrative management, and direct care staff, and a review of resident and administrative records, including incident reports.	{D 000}	<p>USE AS ORIGINAL</p> <p><i>Received 10/3/13</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
{D 840}	3406.4(a) Transfer and Discharge Policies (a) A written statement signed by the Residence Director or the supervising agency (if any), describing the reasons for the transfer or departure, and providing timely (at least two (2) weeks) notice to the resident and sponsor, if any; and This CONDITION is not met as evidenced by: Based on interview, the residence director (RD) failed to ensure a written statement was provided to describe the reasons for the transfer of one of one residents who had been transferred. (Resident #5) The finding includes: A follow-up survey was conducted on September 19, 2013, to verify compliance with the transfer discharge requirement. Interview with a personal care aide (PCA) at approximately 10:00 a.m. revealed one of the residents (Resident #6) injured his leg at his day program. Further interview with the PCA revealed the resident was transferred to a rehabilitation center. The PCA was not aware of the details surrounding the resident's injury, and she did not know when the resident was transferred to the rehabilitation	{D 840}		

Health Regulation & Licensing Administration

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

TITLE

(X6) DATE

Alveta D. Hose

Director

10/3/13

STATE FORM

7HZ12

If continuation sheet 1 of 4

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(D 840)	<p>Continued From page 1 center.</p> <p>Review of the resident's medication administration record (MAR) on September 19, 2013, at 10:10 a.m. revealed Resident #5 had been out of the facility since August 1, 2013.</p> <p>At the time of the follow-up survey, the PCA contacted the administrator, however, the administrator failed to return the call before the surveyor left the premises. The surveyor attempted to contact the administrator on September 19, 2013, to ascertain information regarding Resident #5's injury and his transfer, but was not successful in making contact.</p> <p>[This is a repeat deficiency that was cited on July 31, 2013.]</p> <hr/> <p>Based on interview, the residence director (RD) failed to ensure a written statement was provided to describe the reasons for the transfer of one of one residents who had been transferred. (Resident #7)</p> <p>The findings include:</p> <p>Interview with the RD on July 30, 2013, at 11:15 a.m. revealed that Resident #5 had been transferred to an assistant living residence in the state of Maryland. Further interview with the RD revealed the resident was transferred in January 2013 due to a change in his level of care.</p> <p>Continued discussion with the RD verified that she had not documented a written statement to describe the reasons why the resident was</p>	(D 840)		

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(D 840)	<p>Continued From page 2</p> <p>discharged from the community resident facility (CRF).</p> <p>At the time of the survey, the RD failed to provide evidence of documentation of one of the residents discharged from the facility.</p> <hr/> <p>A follow-up survey was conducted on September 19, 2013. Interview with the personal care aide (PCA) on the same day at approximately 10:00 a.m. revealed one of the residents (Resident #5) injured his leg at his day program. Further interview with the PCA revealed the resident was transferred to a rehabilitation center. The PCA was not aware of the details surrounding the resident's injury, and she did not know when the resident was transferred to the rehabilitation center.</p> <p>Review of the resident's Medication Administration Record (MAR) on September 19, 2013, at 10:10 a.m. revealed Resident #6 had been out of the facility since August 1, 2013.</p> <p>At the time of the follow-up survey, the PCA contacted the administrator, however, the administrator failed to return the call before the surveyor left the premises. The surveyor attempted to contact the administrator on September 19, 2013, to ascertain information regarding Resident #5's injury and his transfer, but was not successful in making contact. [This is a repeat deficiency that was cited on July 31, 2013.]</p> <p>Interview with the administrator post survey on September 20, 2013, at approximately 10:15 a.m.</p>	(D 840)		

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NAME OF PROVIDER OR SUPPLIER ALVETTA MOSE	STREET ADDRESS, CITY, STATE, ZIP CODE 6201 BANKS PLACE, NE WASHINGTON, DC 20019
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{D 840}	Continued From page 3 revealed Resident #5 had been experiencing back pain. The administrator also revealed the resident had back surgery, but was unable to recall the date. Further discussion with the administrator, verified that the resident was transferred from the hospital post back surgery to a local nursing/rehabilitation center. The surveyor asked the administrator if she knew how long Resident #5 is expected to be in rehabilitation. The administrator had no knowledge of how long the resident would be in rehabilitation.	{D 840}	Patient was out of the facility due to back surgery and rehab services. Patient was to return to facility however the level of care changed before discharge. After discussions with the guardian it was decided that pt go to an Assisted Living Facility. Will ensure that documentation be provided upon patient's discharge/transfer for future clients in accordance with 3405.4(a).	10/7/13