

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2026
NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, 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
R 000	Initial Comments On February 23, 2026, through March 27, 2026, the Office of Health Facilities, Intermediate Care Facilities Division, conducted an unannounced complaint investigation survey to determine compliance with the Assisted Living Residence (ALR) Regulations, Title 22 B DCMR, Chapter 101, and the Assisted Living Residence Act, D.C. Code § 44 101.01 et seq. Complaints #DC00014138, #DC00014139, and #DC00014181 were investigated during the survey, and deficiencies were identified in relation to them. The survey activity's included onsite visits from 02/23/2026 through 03/05/2026; 03/10/2026; 03/18/2026 through 03/19/2026; and 03/25/2026 through 03/27/2026, with additional offsite investigative reviews on 03/09/2026 and 03/11/2026 through 03/13/2026. The findings of the survey were based on observations, interviews, records and video surveillance reviews, and medication pass observations.	R 000	Please start typing your responses here:	
R 202	Sec. 501a Standard Of Care (a) An ALR must care for its residents in a manner and in an environment that promotes maintenance and enhancement of the residents' quality of life and independence. Based on observation (including video surveillance), record reviews, and staff and resident interviews, the Assisted Living Residence (ALR) failed to 1. ensure residents were free from neglect, 2. to implement and follow their policies and procedures for emergency response, monitoring of changes in condition, and required	R 202		

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

TITLE

(X6) DATE

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STREET ADDRESS, CITY, STATE, ZIP CODE

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WASHINGTON, DC 20019**

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R 202	Continued From page 1 safety/wellness checks. Specifically, the facility failed to: (1) ensure timely initiation of emergency response, including activation of Emergency Medical Services (EMS) and cardiopulmonary resuscitation (CPR); (II) monitor and respond to significant changes in residents' conditions for two of three residents in the investigation (Residents #1 and #5). Findings included: I. The ALR failed to timely initiate an emergency response, including activation of EMS and initiation of cardiopulmonary resuscitation (CPR). A review of the facility's Emergency Response policy dated April 2022 required that "In case of a medical emergency call 911 immediately." The policy defined a medical emergency as, "A Medical Emergency is any injury or other circumstance that results in an imminent threat to a resident's health including, but not limited to, an apparent life-threatening medical crisis." Review of Resident #1's nursing progress note dated 02/20/2026 indicated that at approximately 2:30 AM, the resident complained of difficulty breathing and sounded congested, a nebulizer treatment was administered and documented as effective. The resident's February Medication Administration Record (MAR) also revealed that on 02/20/2026 Resident #1 received Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puffs orally at 02:56 AM and Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG/0.5ML 1 unit orally via nebulizer every 8 hours at 06:32 AM.	R 202		

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R 202	Continued From page 2 Resident #1's medical history included but was not limited to chronic obstructive pulmonary disease (COPD), atrial fibrillation, and chronic kidney disease. Continued review of the resident's medical record failed to show any documented evidence that the facility staff notified the physician, performed a follow-up respiratory assessment, increased the resident's monitoring or reassessed the effectiveness of the treatments beyond the initial note. The review of a facility incident report dated 02/20/2026 at 8:21 PM revealed the following, "On Friday, 02/20/2026 at approximately 1605Hrs [4:05 PM] writer [the Director of Nursing] was called to the fourth floor by the assigned charge nurse stating that there is a medical emergency. Upon arrival to the fourth-floor writer observed [Resident #1] sitting on a chair holding her chest as in respiratory distress. While the charge nurse was administering care to the resident, writer asked the assigned Certified Nurse Assistant (CNA) to call 911. Writer proceeded to print out documents for 911 and returned to the scene at 1614Hrs [4:14 PM] and assisted charge nurse and other clinicians to provide CPR to [Resident #1]." The facility's incident report detailed the following timeline of events: - At 3:50 PM, Resident #1 activated her emergency pendant and charge nurse responded. - At 3:55 PM, the resident verbalized to the charge nurse that she felt as if she was unable to belch. - At 3:56 PM, the resident picked and put her	R 202		

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R 202	Continued From page 3 sneakers on and started to ambulate from her apartment to the 4th floor lounge with charge nurse by her side. - At 4:04 PM, the charge nurse assisted the resident in a sitting position by the 4th floor lounge. - At 4:05 PM, Resident #1 was observed in distress, 911 call activated, CPR was initiated by facility clinicians, following - American Heart Association Resuscitation protocols. - At 4:08 PM, first team of 911 arrived on scene, assisting the facility employees with CPR. - At 4:14 PM, automated external defibrillators attached to the resident and first shock rendered, resumed CPR. - At 4:19 PM, 911 Advanced Cardiovascular Life Support team and Metropolitan police arrived on scene, assumed control of the emergency interventions until 4:52 PM when Resident #1 was pronounced dead by team 911. On 03/09/2026 at 2:51 PM, the Department of Health (DOH) received a complaint (DC#00014181) regarding services rendered at the facility that referenced, "On 02/20/2026 there was a medical emergency at the facility where CPR was delayed for one resident until 911 Emergency Medical Services (EMS) arrived." On 03/11/2026 at 10:33 AM, a review of the facility's surveillance video revealed the following chain of events that occurred on 02/20/2026 when Resident #1 remained seated and not moving while seated in a chair in the lobby area on the fourth floor:	R 202		

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R 202	Continued From page 4 -3:50 PM - 3:53 PM: The video showed Resident #1 ambulating towards the fourth-floor lobby with LPN #2, and while ambulating towards the chair, the resident's legs appeared to "buckle". LPN #2 and RCA #6 could then be seen assisting the resident to the chair. Once in the chair, another resident (Resident #2) who was sitting in a chair directly beside the resident got up and walked towards the elevator with her four-wheel walker. - At 3:53 PM: After Resident #1 was seated, LPN #2 appeared to retrieve an item from the medication cart. LPN #2 walked to a table located in front of the elevator, retrieved an item and returned to the resident. LPN #2 can be seen tapping the resident on the leg and then instructing the RCA #6 to perform a task, after which the staff left the floor. LPN #2 retrieved a laptop and walked over to the resident while looking at the laptop. - From 3:54 PM - 3:55 PM: LPN #2 walked to the phone located on a table in front of the elevator and placed a call to someone. The LPN then returned to the resident and was seen tapping the resident on the leg in an apparent attempt to obtain a response and can be seen moving back and forth between the cart and the resident. The LPN retrieved a laptop, returned to the cart by the elevators, then returned again to the resident and continued taping the resident's leg. - At 3:55:44 PM: The RCD returned back to the fourth floor with RCA 6, walked over to the resident and appeared to ask LPN #2 something. The video showed the RCD leaning over towards the resident and appeared to solicit a response. - At 3:56 PM - LPN #2 brought what appeared to	R 202		

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R 202	Continued From page 5 be a blood pressure cuff over to the resident and attempted to obtain a blood pressure reading. The RCD appeared to gesture something to RCA #6 nearby who then left the fourth floor via the elevator. LPN #2 and the RCD could be seen in the video standing in front of the resident. - At 3:57 PM - 3:58 PM: LPN #2 retrieved an item from the medication cart and returned back to the resident. Simultaneously, the RCD retrieved an item from the medication cart and returned back to the resident. The RCD could be seen attempting again to obtain blood pressure reading. The RCD and LPN #2 were observed hovering in front of the resident. - At 3:59 PM, a third resident (Resident #3) walked towards the lobby with a rollator walker and sat down in a chair and appeared to watch the incident with Resident #1. The RCD again grabbed an item from the medication cart, and then LPN #2 placed the item back on the medication cart. - At 4:00 PM - 4:01 PM: The RCD appeared to be looking for something near the medication cart while the LPN #2 moved back and forth between the resident and the medication cart. The RCD walked over to the resident and appeared to solicit a response by tapping the resident. Walked over and threw something into the trashcan and returned back to the medication cart. A few seconds later, the RCD walked towards the elevator, pressed the elevator button and the proceeded around the corner to the stairwell leaving the fourth floor. - At 4:02 PM: LPN #2 was observed standing near the resident holding an item in his hands, while the resident remained seated and not	R 202		

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R 202	Continued From page 6 moving. - At 4:03 PM: LPN #2 returned to the medication cart, retrieved an item, and walked back near the resident while holding the item, stepped back and looked out of the window for a few seconds, meanwhile no lifesaving intervention was initiated during this time. - At 4:04 PM: LPN #3 was exited the stairwell on the fourth floor, and walked toward the medication cart, retrieved what appeared to be hand sanitizer and proceeded towards the resident where LPN #2 was standing. Spoke with LPN #2 before going over to the resident. - At 4:05 PM: LPN #4 also exited the stairwell on the fourth floor, and walked towards the medication cart, retrieved what appeared to be hand sanitizer, and then walked towards the resident, the LPN #2 and LPN #3. LPN #4 could be seen in the video having a conversation with LPN #2, LPN #3,, and a few seconds later, LPN #2, LPN #3 and LPN #4 were observed placing the resident on the floor. - At 4:06 PM: LPN #4 started chest compressions while the LPN #2 and LPN #3 were present, as woman wearing a black outfit carrying a black briefcase exited the elevator and walked towards the scene. - At 4:07 PM: Emergency Medical Services (EMS) arrived on the fourth floor and assumed care of the resident. A review of the EMS records revealed the following notes: - On 02/20/2026 at 4:00:26 PM - EMS received an alert from dispatch.	R 202			

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R 202	Continued From page 7 - On 02/20/2026 at 4:04:57 PM - EMS arrived on scene. - On 02/20/2026 at 4:06:00 PM - Patient contact. The EMS record documented that upon assessment, Resident #1 was unresponsive, had no pulse, not breathing and had a Glasgow Coma Scale score of 3 upon assessment. During an interview on 03/10/2026 at 2:02 PM, regarding the resident's death, the facility's Vice President of Resident Services (VRS) revealed that she had just met with the Resident #1's family and showed the family parts of the video of the incident. Per the VRS "I believed that seeing the entire video would be traumatic to the family." The VRS provided to the survey team a verbal timeline of the events of what happened to the resident based on a review of the video of the incident. LPN #2 on 03/12/2026 at 11:10 AM and 03/19/2026 12:26 PM respectively during a phone and face-to-face interview indicated he was the nurse that cared for Resident #1 on 02/20/2026. Per LPN #2, he was on the fifth floor when he received a call over the Walkie-Talkie that Resident #1 needed assistance and had pressed her pendant. LPN #2 stated that upon assessment, the resident told him that she could not "belch", that he asked the resident if she wanted some water, and the Resident #1 said "No, I have drunk enough water already, and that the water wasn't working." LPN #2 stated that he told the resident, "Maybe you need to go for a walk" and that the resident walked with him down the hallway towards the lobby and as she got closer to the lobby, the resident told him that she	R 202		

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R 202	Continued From page 8 could not move her legs. LPN #2 stated that he called the Resident Care Assistant (RCA #6) who was in the lobby to help assist Resident #1 to a chair. LPN #2 stated that, "She was gasping for air. I was a little bit panicked." "I grabbed the inhaler and tried to give her a puff, but she closed her eyes and dropped her head. I said to the resident, stay with me, stay with me! Everything happened so suddenly. I was just panicking." When asked if he remember when the resident stopped breathing, LPN #2 said, "I can't tell you when she stopped. I was panicking". When asked why he did not call 911 or have RCA #6 call 911 and start CPR, he said, "My boss (the RCD) had instructed us to call him first in an emergency before anyone else". LPN #2 stated that he told RCA #6 to go get the RCD, and that he then walked over to the telephone to call the RCD because the resident was unresponsive. "I panicked. I didn't know what to do honestly. I don't remember a lot that happened, I panicked!!!" Further interview with LPN #2 revealed that the RCD arrived on the fourth floor, and that he told the RCD that the resident was unresponsive. "I was panicking." LPN #2 stated that the RCD checked the residents pulse and pulse oximeter which he said was in the low 90s. "I was panicking." LPN #2 also stated that the RCD asked for the residents CODE Status, and he checked the laptop but could not find it under the residents profile section on the electronic medical record. LPN #2 stated that LPN #3 and LPN #4 arrived, checked the resident's vitals, placed her on the floor and initiated CPR. "I was just there. My mind was shaking." On 03/12/2026 at 11:55 AM, during a phone interview, LPN #4 confirmed initiating CPR on Resident #1 on 02/20/2026. Per LPN #4, he was working on the second floor when he was asked	R 202		

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R 202	Continued From page 9 by the RCD to go to the fourth floor to assist with an emergency, and he did not hear any CODE blue call throughout the facility. Upon arriving on the fourth floor, he noted the resident's head was in a downward position with no movement, and that the resident was not responding to any verbal or physical stimuli and did not have a pulse. LPN #4 stated that he, LPN #2 and LPN #3 placed the resident on the floor and began chest compressions until the EMS arrived on the scene. When asked when CPR should be initiated, LPN #4 stated that, "We should check the level of consciousness of the person, check to see what the person needs." For example, if the person needs CPR, we will initiate CPR, call 911 and ask for assistance." An interview with RCA #6 on 03/12/2026 at 12:10 PM and on 03/19/2026 at 2:18 PM respectively, revealed that she assisted LPN #2 with Resident #1 to a seat in the lobby on 02/20/2026. RCA #6 indicated that she responded to the call around 3:15 PM, and that when she arrived at the resident's room on the fourth floor, Resident #1 complained of stomach pain. RCA #6 stated that she shared this information with LPN #2 who arrived at the resident's unit shortly afterwards from the fifth floor, and that a few minutes later, she observed Resident #1 ambulating with her rollator near the fourth-floor lobby with LPN #2 directly beside her. RCA #6 stated that Resident #1 looked like she was about to fall, so she ran over to help LPN #2 assist the resident to the chair. RCA #6 stated that LPN #2 went to the medication cart, retrieved an inhaler and verbally instructed Resident #1 to open her mouth to take a puff, but that the resident was not responding and LPN # 2 began shaking the resident to solicit a response. When asked if the resident ever received a puff of the	R 202		

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R 202	Continued From page 10 inhaler, the RCA #6 said, "She never received the inhaler from what I can see." RCA #6 stated that LPN #2 told her to go downstairs to get the RCD. RCA #6 stated that Resident #1 was not responding to verbal or physical stimuli "at all" when she left the fourth floor and that when she returned back to the fourth floor, the resident's eyes were closed and she was still unresponsive. RCA #6 stated that the RCD instructed LPN #2 to check the resident's blood pressure and for her to go back downstairs to the lobby and have the front desk staff call 911. When asked why she did not use the telephone across from the elevators on the fourth floor, the RCA responded by saying, "I was told to go downstairs to the lobby to have front desk staff make the call." The RCD during a telephone interview on 03/12/2026 at 2:05 PM, regarding Resident #1's incident that occurred on 02/20/2026, stated that RCA #6 came to his office and informed him that there was an emergency with a resident on the fourth floor. Per the RCD, upon arriving on the fourth floor, LPN #2 informed him that he had giving the resident a breathing treatment (Inhaler) but that the resident was not responding. The RCD stated that he looked at the resident, asked her if she was ok and that the resident responded in a "lethargic way" saying, "hmm" and that "The resident is on and off". The RCD stated that he performed a sternal rub and asked LPN #2 to obtain blood pressure and blood glucose reading, but that they did not get any reading because it was difficult to obtain one with her clothes on. The RCD stated that he asked RCA #6 to go to the front desk to call 911 while LPN #1 was taking vital signs. The RCD confirmed leaving the fourth floor to go print papers on the second floor in preparation for EMS arrival, and when asked why he left LPN #2 on the fourth floor to go get	R 202		

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R 202	Continued From page 11 paperwork, the RCD stated that "911 was coming. I didn't want them to be delayed in the paperwork." When asked, "Do you think LPN #2 should have called 911 instead of sending staff to go get you?" the RCD said, "Not necessary." The RCD further stated that he had trained the nurses to call him when there is a change in a resident's condition, and that he did not think 911 should have been called in this situation. On 03/19/2026 at 2:49 PM, LPN # 3, during a phone interview regarding the incident stated that he was asked by the RCD to go on the fourth floor to assist LPN #2 with Resident #1, and upon arrival, observed the resident in the chair with her head down. LPN #3 indicated that he tried to solicit a response by verbally calling the resident's name and physically tapping the resident but did not get a response. LPN #3 stated that he assessed the resident, noted that there was no pulse, and as a CPR instructor, asked LPN #2, LPN #4 to assist him lower Resident #1 to the floor to initiate CPR. He stated that LPN #4 started chest compressions until EMS services arrived. When asked, LPN #3 stated that "911 and CPR should have been initiated as soon as the resident became unresponsive or when her condition changed." During a telephone interview on 03/20/2026, at 2:14 PM, regarding the incident, Resident #2 stated that Resident #1 always sat next to her in the lobby during medication administration, and that the resident always complained about having shortness of breath (SOB). Resident #2 stated that when Resident #1 sat down next to her, she appeared to have some breathing issues. Resident #2 became emotional and ended the interview.	R 202		

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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
R 202	Continued From page 12 Resident #3 during an interview on 03/20/2026, at 2:34 PM, stated that the incident was too traumatic for her, and wished not to discuss the incident. LPN #8 on 03/20/2026, at 2:52 PM, in a phone interview confirmed working the 11:00 PM to 7 AM on the fourth floor taking care of Resident #1. According to LPN #8, Resident #1 activated her call pendant a few times throughout the shift for various needs (i.e., wanted the RCAs to stay with her or to speak with the Registered Nurse Supervisor). LPN #8 confirmed that Resident #1 had experienced difficulty breathing that night and that she administered "breathing treatment" and also acknowledged that she did not contact the Resident's physician or escalated the incident to anyone else. II) The ALR failed to monitor Resident #5 when there was a change in her condition (i.e. not showing up for breakfast, lunch or dinner during the week of 03/09/2026 through 03/14/2026), evidenced below: On 03/16/2026 at 1:31 PM, the Department of Health (DOH) received a complaint (DC#00014181) According to the complaint "It has been reported that on March 14, a female resident on the second floor of the facility was discovered deceased only after staff noticed a strong odor coming from the unit. When the resident was located, she was reportedly cold to touch and determined to be deceased on arrival (DOA)." Due to the nature of this allegation, an on-site investigation was conducted beginning on 03/18/2026. A review of the facility's incident report dated 03/14/2026, revealed that at approximately 09:55	R 202		

Health Regulation & Licensing Administration

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R 202	Continued From page 13 AM, the nurse was notified by the assigned Certified Nursing Assistant (CNA) that Resident #5 was found unresponsive in her room. Per the report, the resident was found face down, cold to touch, and without vital signs. Cardiopulmonary Response (CPR) was initiated, and Emergency Medical Service was contacted, and the resident was pronounced deceased at 10:08 AM. A review of the facility's "I'm Okay" dining policy with a revised dated of March 2025 listed that the "The I'm Okay" program offers the opportunity for three safety checks during the course of the day at mealtimes. These three safety checks are in alignment with the three mealtime offerings. The Dining Room staff and the Resident Care Associates work together to determine the location of each resident at mealtime and are able to identify if there are any changes or disruptions to their regular patterns." The I'm Okay policy further listed the following: "The I'm Okay check will begin throughout the meal service as wait staff/RCAs check off residents as they come to meals. When there are about 20 minutes left for meal service, the lists will be reviewed and notations made to names that have had Tray Service to their rooms. The I'm Okay policy required that if a resident has not come to the meal, or had arrangements for tray service, the following actions will occur: - The front desk sign out log will be checked to determine if the resident is out of the building. If that does not appear to be the case then: - The resident cell phone will be called, and a visit will be made to the apartment for a wellness check.	R 202		

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NAME OF PROVIDER OR SUPPLIER

THE RESIDENCES AT KENILWORTH PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

**1650 KENILWORTH AVE, 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
R 202	Continued From page 14 - If this does not appear to be the case, the ED/RCD/manager on duty will call the family to determine if they "Forgot" to sign out. - If this is not the case, an elopement drill will proceed." A review of the facility's surveillance camera from 02/28/2026 through 03/14/2026 revealed that Resident #5 was not seen on camera throughout the facility (i.e. sitting in the lobby outside of the dining room across from the elevators, or leaving her unit) on any of the days, however, a progress note dated 03/12/2026 at 22:58 [5:58 PM] documented, "Resident responded when writer knock on the door this evening around 6pm and states that she is doing good, did not allow the writer in. She stated good night and she does not need anything at this moment." The cameras did not capture the resident and/or staff going in or out of the resident's room on the second floor. The facility's "Meal Check" forms from 03/09/2026 through 03/14/2026 revealed the following details: - On 03/09/2026, there was no documented evidence that Resident #5 had breakfast, lunch and dinner. Further review of Resident #5's records failed to show that RCA #3 contacted the front desk to check the signout logbook, called the resident or went to her unit for a wellness check or escalated the concerns to the manager on duty as required by the I'm Okay policy. - On 03/10/2026, RCA #1 and RCA #2 documented that Resident #5 refused breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that the RCAs escalated concerns to the Resident Care Director (RCD) or the manager on	R 202		

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NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, NE WASHINGTON, DC 20019		
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R 202	Continued From page 15 duty. - On 03/11/2026, there was no documented evidence that Resident #5 had breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that RCA #2 contacted the front desk to check the sign out logbook, called the resident or went to her unit for a wellness check or escalated the concerns to the manager on duty as required by the I'm Okay policy. - On 03/12/2026, there was a verbal report from a staff that she knocked on Resident #5's door and the resident stated, "I'm ok". - On 03/13/2026, there was no documented evidence that Resident #5 had breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that RCA #3 and RCA #4 contacted the front desk to check the sign out logbook, called the resident or visited her unit for a wellness check or escalated the concerns to the manager on duty as stated on facility's the I'm Okay policy. - On 03/14/2026, there was no documented evidence that Resident #5 had breakfast. Further review of Resident #5's records failed to show any evidence that RCA #2 contacted the front desk to check the sign out logbook, called the resident or visited her unit for a wellness check or escalated the concerns to the manager on duty as stated on the I'm Okay policy. During a walkthrough of the facility on 03/25/2026 at approximately 12:56 PM, the survey team observed a white board with a list of residents in the RCA's office titled "Do not Check". Resident #5's name was among the do not check list. The	R 202			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 202	Continued From page 16 staffing scheduler who was in the office at the time when asked stated, "they are residents who don't want to be disturbed." In another interview at 1:10 PM regarding the white board, RCA #10 stated that those " are resident who do not want people coming to their rooms." LPN #5 during an interview on 03/25/2026 at 1:53 PM, regarding Resident #5, stated that she worked on the second floor on 03/10/2026 and 03/12/2026 during the 3:00 PM - 11:00 PM shift but that the second floor was not her assigned floor. LPN #5 stated that she did not recall seeing Resident #5 on 03/10/2026 and 03/12/2026 during the shift. According to LPN #5, during the medication rounds on 03/12/2026 at about 6:00 PM, she knocked on Resident #5's door, and she heard the resident say, "Don't come in." LPN #5 stated that when she tried to use the fob to enter her room she was unable to go in so she talked to the resident through the door. At 2:00 PM on 03/25/2026, LPN #7 (Agency Nurse) during a phone interview regarding Resident #5 revealed working on 03/14/2024 during the 7:00 AM - 3:00 PM shift and was informed by the RCA that the resident was not responding inside her unit. LPN #7 stated that she pushed through the door which was barricaded by a small couch with the help of the Maintenance Technician and observed the resident lying on the floor. LPN #7 stated that she called the Resident Care Director (RCD) and he instructed her to call 911 and initiate CPR. "I could tell she had been dead a while. She was very stiff. There was a strong odor that was inside the unit. Her room was junkie." The Maintenance Technician (MT) in an interview on 03/25/2026 at 2:12 PM, regarding Resident	R 202		

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R 202	Continued From page 17 #5's death on 03/14/2026, stated that he was getting off the elevator and saw RCA #1 knocking on the resident's door, who asked him to help open door. The MT stated that once they got inside the unit, he moved the chair that was blocking the door and noticed that the resident was lying on face down unresponsive. Per the MT, "there was a bad odor that came from the room, and the facility had to take out all the carpet from the unit." In a phone interview on 03/26/2026 at 9:43 AM, RCA #6 stated that she was assigned to conduct meal checks on 03/09/2026 during dinner and did not see Resident #5. Per RCA #6, when residents do not show up for dinner, the RCAs would have to get permission to take food to the resident's unit from the kitchen staff. RCA #6 stated that in Resident #5's case, "I don't recall taking food to her unit" and that she last saw Resident #5 towards the end of February 2026 and beginning of March 2026. RCA #6 stated that she last heard her voice through the door last week before her death. "I can't recall the exact date." RCA #6 stated that the resident said to her through the door, "I'm ok but I am feeling sick" but confirmed not reporting the conversation to management. On 03/26/2026 at 11:00 AM, RCA #1 stated during interview that she was assigned to do meal checks during breakfast on 03/10/2026. When asked why she documented that Resident #4 had refused breakfast, RCA #1 indicated that Resident #5 never come down during breakfast and lunch. RCA #1 confirmed not going to Resident #5's unit after breakfast to perform a wellness check because it was the resident's routine not to eat breakfast. Per RCA #1, "We knew this, we just mark refuse on the meal check form."	R 202		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

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R 202	Continued From page 18 RCA #4 on 03/26/2026 at 11:14 AM, during interview regarding Resident #5's "Meal Checks" documentation during the week of 03/09/2026 through 03/14/2026, indicated that he saw the resident the week she died. RCA #4 stated that he spoke to the resident either on 03/09/2026 or 03/10/2026, while she was sitting across from the elevator on the first floor near the dining hall, and that the resident had told him she was not feeling well. RCA #4 stated that both him and RCA #1 knocked on Resident #5's door on 03/10/2026 to see if she wanted to come down for breakfast, and that the resident responded by saying, "No, I'm ok". RCA #4 stated that he did not see her for the rest of that week. When asked, RCA #4 revealed that he was assigned to conduct "Meal Checks" for breakfast on 03/09/2026, 03/12/2026 and 03/13/2026. When asked why he did not document whether the resident was present, had her food delivered and/or refused to come to the dining hall on the above days, RCA #4 stated that the resident never comes down for breakfast, and that was why he documented a refusal. When asked if he conducted a wellness check on the resident, RCA #4 stated, "No, I did not". At 11:17 AM, the surveyors shared with RCA #4 that Resident #5 was not seen on the facility's video surveillance cameras seated near the dining area across from the elevators from 03/09/2026 through 03/14/2026. RCA #4 then changed his statement and stated, "I thought I saw her on one of those days. Maybe it was a different week". On 03/26/2026 at 12:18 PM, RCA #9 during interview regarding Resident #5's "Meal Checks" from 03/09/2026 through 03/14/2026 stated he was responsible for doing the meal checks for lunch on 03/10/2026, breakfast and lunch on 03/11/2026, lunch on 03/12/2026 and breakfast	R 202		

Health Regulation & Licensing Administration

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R 202	Continued From page 19 on 03/14/2026. The RCA stated, "I haven't seen [resident name]. I can't recall when I saw her last time. She rarely came down for breakfast and lunch. If she did, she would sit across from the elevator." When asked why he did not document on the meal check form, RCA #9 stated that the staff on the second floor was supposed to let him know that the resident did not come down for meal. RCA #9 confirmed not going upstairs on 03/09/2026 to perform a wellness check on Resident #5. On 03/26/2026 at 12:59 PM, the Dietary Aide during interview regarding the last time she saw Resident #5 in the dining room, stated she last saw the resident approximately two weeks before her death but could not recall the specific date. The Dietary Aide stated that Resident #5 looked like she had been losing a lot of weight, and that she had previously asked the resident if she had food in her room and the resident responded, "I'm Okay." RCA #10 on 03/26/2026 at 1:02 PM, during a phone interview stated she was assigned to conduct meals for dinner on 03/10/2026, does not recall Resident #5 came down for dinner and did not document on the meal check form for the resident. Per RCA #10, she was supposed to check on the residents after dinner if the residents did not attend dinner, but she did not go to Resident #5's unit to conduct a wellness check after dinner. RCA #10 stated she last saw Resident #5 on 03/12/2026 seated in the lobby area that evening, but a review of the facility's video surveillance cameras for the entire week of 03/09/2026 through 03/14/2026 showed that Resident #5 was not seen sitting near the dining area across from the elevators.	R 202		

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R 202	Continued From page 20 During an interview on 03/26/2026 at 2:23 PM regarding the last time Resident #5 ate a meal in the dining room, the Dining Services Supervisor (DSS) stated that she had not seen the resident in over a week prior to her death. Per the DSS, "the resident often sat outside of the dining area across from the main elevators, and that Resident #5 did not usually eat breakfast or lunch, however, she would usually eat dinner." When asked what the RCAs should do if a resident did not show up for meals, the DSS indicated that the RCAs should document on the "I'm Okay" form and complete a wellness check on the resident. Resident #11 on 03/27/2026 at 10:05 AM, during an interview revealed that she went to check on Resident #5 because she had been in that room for almost a month, and that she had been communicating with Resident #5 through the door a few times a week during the month. Resident #11 stated that she knew "Resident #5 wasn't feeling well, she was up there a whole month but could not understand why the facility staff did not check on the resident." Resident #11 revealed that she went to Resident #5's unit on 03/13/2026 to check on her, and "I believe I heard her but, not sure. I called her name a few times and she didn't answer. She mumbled something and she went quietly. I didn't hear anything after that." During an interview on 03/25/2026 at 3:18 PM and 3/27/2026 at 12:00 PM regarding Resident #5's death, the facility's RCD stated that he received a call from the assigned LPN that the resident was found on the floor in her unit unresponsive and he had instructed the nurse to call 911, and to initiate CPR. Per the RCD, when he saw the resident's unit for the first time (03/14/2026), he described the unit as "having	R 202		

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R 202	Continued From page 21 fecal matter on the bathroom floor, toilet was backed up with urine, expired food in the refrigerator and the room temperature was humid with a strong smell of urine in the unit." The RCD indicated that Resident #5 appeared to be a hoarder based on the visual appearance of her unit. "I believe she had Psych issues and the unit needed to be professionally cleaned after her death." When asked why he was not made aware that Resident #5 had not been eating meals, the RCD stated that it was the dining team's responsibility to communicate to the nursing team that the resident had not been eating. According to the RCD "people that knew Resident #5 had an attitude and say, "I'm not going to check on [resident name] because I know she's going to refuse." The RCD added, "There are a lot of problems in this building, and the communication is not good here." The RCD denied knowledge of the "I'm Okay" policy and acknowledged that he was aware that there was a "Do not check" list but he does not know who created the list.	R 202		
R 272	Sec. 503.1 Dignity. (1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible; Based on the review of a phone video, interviews and record reviews, the Assisted Living Resident (ALR) failed to ensure a safe, clean comfortable and homelike environment for the two residents in the investigation (Residents #1 and #5). Findings included: 1) On 03/16/2026 at 1:31 PM, the Department of Health (DOH) received an email alleging that on	R 272		

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R 272	Continued From page 22 03/14/2026, a female resident on the second floor of the facility was discovered deceased only after staff noticed a strong odor coming from the unit. When the resident was located, she was reportedly cold to touch and determined to be deceased on arrival (DOA). Due to the nature of this allegation, an on-site investigation was conducted beginning on 03/18/2026. A review of the ALR's Residency and Services Agreement Portfolio on page 6 of 49 listed under Provision of Services, "Housekeeping - once per week. Your Unit will receive vacuuming, bathroom cleaning, light trash removal, light dusting. Bed Sheets and Towels Laundering - once per week". The ALR's Residents Handbook on page 16 entitled, "HOUSEKEEPING SERVICES" indicated that, "While we acknowledged independence, we also understand that you may need some assistance keeping your apartment neat and clean; therefore, we will coordinate with you for housekeeping services to be scheduled weekly for your apartment." This includes: - Dusting furniture after small or delicate items have been removed under your direction - Vacuuming carpets - Cleaning the bathroom floor, shower, toilet bowl, sink and vanity - Cleaning the counter tops and sink - Emptying waste baskets - Changing and laundering of bed linens and towels - Toilet paper A review of the facility's Daily Housekeeping Cleaning & Supply Log for March 10, 2026, revealed that the housekeeper did not complete	R 272		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2026
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NAME OF PROVIDER OR SUPPLIER

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R 272	Continued From page 23 the checklist for Resident #5's unit. No other daily housekeeping cleaning & supply log was made available for review for the month of March 2026. When asked during a telephone interview on 03/25/2026 at 2:12 PM, about cleaning, the Maintenance Technician (MT) indicated that the residents units should be cleaned at least once a week. When asked about Resident #5's apartment being cleaned on a weekly basis, the MT stated, "Resident #5 would not let anyone inside to clean her unit, and that the resident had a small chair blocking entry into the apartment". Per the MT, on 03/14/2026, when he opened Resident #5's unit, there was a really bad odor in the unit, and that an outside cleaning company had to be called, and the carpeting had to be removed on 03/15/2026. The facility's Housekeeper on 03/26/2026 at 11:46 AM, during an interview stated that she has never cleaned Resident #5's unit since she started working for the ALR in January 2025, because the resident usually positions a couch or small chair in front of the door to prevent entry. The Housekeeper acknowledged that she had not been consistent in completing the checklist forms for the resident, and that management was aware of the resident's refusal to allow housekeeping staff to enter the unit and that no further action was taken. On 03/26/2026 at 3:00 PM, the Executive Director (ED) said during an interview that she and the facility's management were aware that Resident #5 prevented entry into her room by having a small chair or couch blocking the front door. A telephone interview conducted with Resident #5's family member (Niece) on 03/27/2026 at 1:46 PM revealed that she was confused as to why her niece's apartment unit looked like she	R 272		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2026
NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, 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
R 272	Continued From page 24 had been living like a homeless person under a bridge for 30 years. She described the unit as having dirty laundry all over the unit, opened expired food on the kitchenette counter, a large stain in the carpet, feces/urine and max pads clogged the toilet, toiletries everywhere, etc. According to the niece "how could they not have known this if they were cleaning the rooms at least once weekly. This is a total failure on the facility." NOTE: It should be noted that on 03/27/2026 at 2:04 PM, a review of Resident #5's family members phone video sent to the surveyors confirmed the ALR's report that Resident #5's unit was in extremely poor living conditions. Per the video, dirty clothes were all over the unit, feces/urine and maxi pads clogged the toilet, open food was on the kitchenette counter, a large stained was observed on the carpet, etc. 2) A review of the facility's Emergency Response System policy dated May 2022 and revised in January 2023, and December 2025 stated "Sufficient staff will be provided to meet urgent and emergency needs of residents. It is the expectation that staff will be able to clear up an emergency call that has been alerted within 7 minutes. An alert that remains uncleared at 7 minutes will trigger an escalation. All emergency calls that take greater than 7 minutes to clear will be investigated and documentation of the investigation will be maintained for the quarter". Resident #1's progress notes dated 02/20/2026 at approximately 2:30 AM revealed that the resident complained of difficulty breathing and was noted sounded congested, and a nebulizer treatment was administered and documented as effective.	R 272		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 272	Continued From page 25 A review of Resident #1's February Medication Administration Record (MAR) revealed that on 02/20/2026, Resident #1 received Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puffs inhaled orally at 02:56 AM and Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG/0.5ML 1 unit inhaled orally via nebulizer every 8 hours at 06:32 AM. Resident #1's records revealed that the medical history included chronic obstructive pulmonary disease (COPD), atrial fibrillation, chronic kidney disease, and other comorbid conditions placing the resident at high risk for cardiopulmonary complications. Continued review of the resident's record failed to show any documented evidence that the staff notified the physician, performed a follow-up respiratory assessment, increased the resident's monitoring or reassessed the effectiveness of treatment beyond the initial note. A review of the facility's call system records on 02/20/2026 for Resident #1 revealed multiple delays in the staff response to the resident's calls throughout the day, including delays of approximately 8 minutes, 25 minutes, 36 minutes, and up to 50 minutes. A summary of the ALR's call bell system data is as follows: <table border="0"> <tr> <td>Call Time</td> <td></td> <td>Acknowledged</td> </tr> <tr> <td>Time</td> <td>Delay</td> <td></td> </tr> <tr> <td>2:08 PM</td> <td></td> <td>2:58 PM</td> </tr> <tr> <td>50 minutes</td> <td></td> <td></td> </tr> <tr> <td>10:24 AM</td> <td></td> <td>10:32 AM</td> </tr> <tr> <td>8 minutes</td> <td></td> <td></td> </tr> <tr> <td>8:48 AM</td> <td></td> <td>8:52 AM</td> </tr> <tr> <td>4 minutes</td> <td></td> <td></td> </tr> <tr> <td>8:03 AM</td> <td></td> <td>8:39 AM</td> </tr> </table>	Call Time		Acknowledged	Time	Delay		2:08 PM		2:58 PM	50 minutes			10:24 AM		10:32 AM	8 minutes			8:48 AM		8:52 AM	4 minutes			8:03 AM		8:39 AM	R 272		
Call Time		Acknowledged																													
Time	Delay																														
2:08 PM		2:58 PM																													
50 minutes																															
10:24 AM		10:32 AM																													
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8:03 AM		8:39 AM																													

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NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, NE WASHINGTON, DC 20019		
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R 272	Continued From page 26 36 minutes 7:19 AM 7:27 AM 8 minutes 1:53 AM 2:01 AM 8 minutes 1:19 AM 1:44 AM 25 minutes During an interview on 03/18/2026 at 11:00 AM, the Resident Care Director (RCD) stated that he was unaware that Resident #1 pressed her pendant 6 to 8 times during the morning of 02/20/2026 for difficulty breathing. On 03/20/2026, at 2:34 PM, a telephone interview conducted with LPN #4 revealed that she worked the night shift from 11:00 PM to 7 AM on 02/19/2026. The LPN said that Resident #1 activated her call pendant a few times throughout her shift for various needs (i.e. wanting the RCA to stay with her, speak to the Registered Nurse Supervisor). LPN #4 stated that the resident had experienced difficulty breathing that night and she was administered "breathing treatment." When asked, LPN #4 confirmed that she did not contact the resident's primary care physician or escalated the incident of difficulty breathing to anyone.	R 272		
R 282	Sec. 503.11 Dignity. (11) To be free from mental, verbal, emotional, sexual and physical abuse, neglect, involuntary seclusion, and exploitation; and Based on observation (including video surveillance), record reviews, and staff and resident interviews, the Assisted Living Residence (ALR) failed to 1. ensure residents were free from neglect, 2. to implement and follow their policies and procedures for emergency response,	R 282		

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R 282	Continued From page 27 monitoring of changes in condition and required safety/wellness checks. Specifically, the facility failed to: (1) ensure timely initiation of emergency response, including activation of Emergency Medical Services (EMS) and cardiopulmonary resuscitation (CPR); (II) monitor and respond to significant changes in residents' conditions for two of three residents in the investigation (Residents #1 and #5). Findings included: I. The ALR failed to timely initiate an emergency response, including activation of EMS and initiation of cardiopulmonary resuscitation (CPR). A review of the facility's Emergency Response policy dated April 2022 required that "In case of a medical emergency call 911 immediately." The policy defined a medical emergency as, "A Medical Emergency is any injury or other circumstance that results in an imminent threat to a resident's health including, but not limited to, an apparent life-threatening medical crisis." On 03/09/2026 at 2:51 PM, the Department of Health (DOH) received a complaint (DC#00014181) regarding services rendered at the facility. According to the complaint, "on 02/20/2026 there was a medical emergency at the facility where CPR was delayed for one resident until 911 Emergency Medical Services (EMS) arrived." Review of Resident #1's nursing progress note dated 02/20/2026 indicated that at approximately 2:30 AM, the resident complained of difficulty breathing and sounded congested, a nebulizer treatment was administered and documented as effective. The resident's February Medication	R 282		

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R 282	Continued From page 28 Administration Record (MAR) also revealed that on 02/20/2026 Resident #1 received Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puffs orally at 02:56 AM and Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG/0.5ML 1 unit orally via nebulizer every 8 hours at 06:32 AM. Resident #1's medical history included but was not limited to chronic obstructive pulmonary disease (COPD), atrial fibrillation, and chronic kidney disease Continued review of the resident's medical record failed to show any documented evidence that the facility staff notified the physician, performed a follow-up respiratory assessment, increased the resident's monitoring or reassessed the effectiveness of the treatments beyond the initial note. The review of a facility incident report dated 02/20/2026 at 4:05 PM indicated that the Resident Care Director (RCD) was called to the fourth floor by Licensed Practical Nurse (LPN) #2 for a medical emergency, and upon arrival saw Resident #1 sitting in a chair holding her chest as in respiratory distress. According to the incident report, the RCD asked Resident Care Aide (RCA) #1 to call 911 and then proceeded to print out documents to give to the 911 personnel. The RCD returned to the fourth floor at 4:14 PM to assist LPN #2 and the other clinicians in providing CPR to Resident #1. The facility's incident report detailed the following timeline of events: - At 3:50 PM, Resident #1 activated her	R 282			

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R 282	Continued From page 29 emergency pendant and charge nurse responded. - At 3:55 PM, the resident verbalized to the charge nurse that she felt as if she was unable to belch. - At 3:56 PM, the resident picked and put her sneakers on and started to ambulate from her apartment to the 4th floor lounge with charge nurse by her side. - At 4:04 PM, the charge nurse assisted the resident in a sitting position by the 4th floor lounge. - At 4:05 PM, Resident #1 was observed in distress, 911 call activated, CPR was initiated by facility clinicians, following - American Heart Association Resuscitation protocols. - At 4:08 PM, first team of 911 arrived on scene, assisting the facility employees with CPR. - At 4:14 PM, automated external defibrillators attached to the resident and first shock rendered, resumed CPR. - At 4:19 PM, 911 Advanced Cardiovascular Life Support team and Metropolitan police arrived on scene, assumed control of the emergency interventions until 4:52 PM when Resident #1 was pronounced dead by team 911. On 03/11/2026 at 10:33 AM, a review of the facility's surveillance video revealed the following chain of events that occurred on 02/20/2026 when Resident #1 remained seated and not moving while seated in a chair in the lobby area on the fourth floor:	R 282		

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R 282	Continued From page 30 -3:50 PM - 3:53 PM: The video showed Resident #1 ambulating towards the fourth-floor lobby with LPN #2, and while ambulating towards the chair, the resident's legs appeared to "buckle". LPN #2 and RCA #6 could then be seen assisting the resident to the chair. Once in the chair, another resident (Resident #2) who was sitting in a chair directly beside the resident got up and walked towards the elevator with her four-wheel walker. - At 3:53 PM: After Resident #1 was seated, LPN #2 appeared to retrieve an item from the medication cart. LPN #2 walked to a table located in front of the elevator, retrieved an item and returned to the resident. LPN #2 can be seen tapping the resident on the leg and then instructing the RCA #6 to perform a task, after which the staff left the floor. LPN #2 retrieved a laptop and walked over to the resident while looking at the laptop. - From 3:54 PM - 3:55 PM: LPN #2 walked to the phone located on a table in front of the elevator and placed a call to someone. The LPN then returned to the resident and was seen tapping the resident on the leg in an apparent attempt to obtain a response and can be seen moving back and forth between the cart and the resident. The LPN retrieved a laptop, returned to the cart by the elevators, then returned again to the resident and continued taping the resident's leg. - At 3:55:44 PM: The RCD returned back to the fourth floor with RCA 6, walked over to the resident and appeared to ask LPN #2 something. The video showed the RCD leaning over towards the resident and appeared to solicit a response. - At 3:56 PM - LPN #2 brought what appeared to	R 282		

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R 282	Continued From page 31 be a blood pressure cuff over to the resident and attempted to obtain a blood pressure reading. The RCD appeared to gesture something to RCA #6 nearby who then left the fourth floor via the elevator. LPN #2 and the RCD could be seen in the video standing in front of the resident. - At 3:57 PM - 3:58 PM: LPN #2 retrieved an item from the medication cart and returned back to the resident. Simultaneously, the RCD retrieved an item from the medication cart and returned back to the resident. The RCD could be seen attempting again to obtain blood pressure reading. The RCD and LPN #2 were observed hovering in front of the resident. - At 3:59 PM, a third resident (Resident #3) walked towards the lobby with a rollator walker and sat down in a chair and appeared to watch the incident with Resident #1. The RCD again grabbed an item from the medication cart, and then LPN #2 placed the item back on the medication cart. - At 4:00 PM - 4:01 PM: The RCD appeared to be looking for something near the medication cart while the LPN #2 moved back and forth between the resident and the medication cart. The RCD walked over to the resident and appeared to solicit a response by tapping the resident. Walked over and threw something into the trashcan and returned back to the medication cart. A few seconds later, the RCD walked towards the elevator, pressed the elevator button and the proceeded around the corner to the stairwell leaving the fourth floor. - At 4:02 PM: LPN #2 was observed standing near the resident holding an item in his hands, while the resident remained seated and not	R 282		

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R 282	Continued From page 32 moving. - At 4:03 PM: LPN #2 returned to the medication cart, retrieved an item, and walked back near the resident while holding the item, stepped back and looked out of the window for a few seconds, meanwhile no lifesaving intervention was initiated during this time. - At 4:04 PM: LPN #3 exited the stairwell on the fourth floor, walked toward the medication cart, retrieved what appeared to be hand sanitizer and proceeded towards the resident where LPN #2 was standing. Spoke with LPN #2 before going over to the resident. - At 4:05 PM: LPN #4 also exited the stairwell on the fourth floor, walked towards the medication cart, retrieved what appeared to be hand sanitizer, and then walked towards the resident. LPN #4 could be seen in the video having a conversation with LPN #2, LPN #3,, and a few seconds later, LPN #2, LPN #3 and LPN #4 were observed placing the resident on the floor. - At 4:06 PM: LPN #4 started chest compressions while the LPN #2 and LPN #3 were present, as woman wearing a black outfit carrying a black briefcase exited the elevator and walked towards the scene. - At 4:07 PM: Emergency Medical Services (EMS) arrived on the fourth floor and assumed care of the resident. A review of the EMS records revealed the following notes: - On 02/20/2026 at 4:00:26 PM - EMS received an alert from dispatch.	R 282		

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R 282	Continued From page 33 - On 02/20/2026 at 4:04:57 PM - EMS arrived on scene. - On 02/20/2026 at 4:06:00 PM - Patient contact. The EMS record documented that upon assessment, Resident #1 was unresponsive, had no pulse, not breathing and upon assessment had a Glasgow Coma Scale score of 3. During an interview on 03/10/2026 at 2:02 PM, regarding the resident's death, the facility's Vice President of Resident Services (VRS) revealed that she had just met with the Resident #1's family and showed the family parts of the video of the incident. Per the VRS "I believed that seeing the entire video would be traumatic to the family." The VRS provided to the survey team a verbal timeline of the events of what happened to the resident based on a review of the video of the incident. LPN #2 on 03/12/2026 at 11:10 AM and 03/19/2026 12:26 PM respectively during a phone and face-to-face interview indicated he was the nurse that cared for Resident #1 on 02/20/2026. Per LPN #2, he was on the fifth floor when he received a call over the Walkie-Talkie that Resident #1 needed assistance and had pressed her pendant. LPN #2 stated that upon assessment, the resident told him that she could not "belch", that he asked the resident if she wanted some water, and the Resident #1 said "No, I have drunk enough water already, and that the water wasn't working." LPN #2 stated that he told the resident, "Maybe you need to go for a walk" and that the resident walked with him down the hallway towards the lobby and as she got closer to the lobby, the resident told him that she	R 282		

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R 282	Continued From page 34 could not move her legs. LPN #2 stated that he called the Resident Care Assistant (RCA #6) who was in the lobby to help assist Resident #1 to a chair. LPN #2 stated that, "She was gasping for air. I was a little bit panicked." "I grabbed the inhaler and tried to give her a puff, but she closed her eyes and dropped her head. I said to the resident, stay with me, stay with me! Everything happened so suddenly. I was just panicking." When asked if he remember when the resident stopped breathing, LPN #2 said, "I can't tell you when she stopped. I was panicking". When asked why he did not call 911 or have RCA #6 call 911 and start CPR, he said, "My boss (the RCD) had instructed us to call him first in an emergency before anyone else". LPN #2 stated that he told RCA #6 to go get the RCD, and that he then walked over to the telephone to call the RCD because the resident was unresponsive. "I panicked. I didn't know what to do honestly. I don't remember a lot that happened, I panicked!!!" Further interview with LPN #2 revealed that the RCD arrived on the fourth floor, and that he told the RCD that the resident was unresponsive. "I was panicking." LPN #2 stated that the RCD checked the residents pulse and pulse oximeter which he said was in the low 90s. "I was panicking." LPN #2 also stated that the RCD asked for the residents CODE Status, and he checked the laptop but could not find it under the residents profile section on the electronic medical record. LPN #2 stated that LPN #3 and LPN #4 arrived, checked the resident's vitals, placed her on the floor and initiated CPR. "I was just there. My mind was shaking." On 03/12/2026 at 11:55 AM, during a phone interview, LPN #4 confirmed initiating CPR on Resident #1 on 02/20/2026. Per LPN #4, he was working on the second floor when he was asked	R 282		

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R 282	Continued From page 35 by the RCD to go to the fourth floor to assist with an emergency, and he did not hear any CODE blue call throughout the facility. Upon arriving on the fourth floor, he noted the resident's head was in a downward position with no movement, and that the resident was not responding to any verbal or physical stimuli and did not have a pulse. LPN #4 stated that he, LPN #2 and LPN #3 placed the resident on the floor and began chest compressions until the EMS arrived on the scene. When asked when CPR should be initiated, LPN #4 stated that, "We should check the level of consciousness of the person, check to see what the person needs." For example, if the person needs CPR, we will initiate CPR, call 911 and ask for assistance." An interview with RCA #6 on 03/12/2026 at 12:10 PM and on 03/19/2026 at 2:18 PM respectively, revealed that she assisted LPN #2 with Resident #1 to a seat in the lobby on 02/20/2026. RCA #6 indicated that she responded to the call around 3:15 PM, and that when she arrived at the resident's room on the fourth floor, Resident #1 complained of stomach pain. RCA #6 stated that she shared this information with LPN #2 who arrived at the resident's unit shortly afterwards from the fifth floor, and that a few minutes later, she observed Resident #1 ambulating with her rollator near the fourth-floor lobby with LPN #2 directly beside her. RCA #6 stated that Resident #1 looked like she was about to fall, so she ran over to help LPN #2 assist the resident to the chair. RCA #6 stated that LPN #2 went to the medication cart, retrieved an inhaler and verbally instructed Resident #1 to open her mouth to take a puff, but that the resident was not responding and LPN # 2 began shaking the resident to solicit a response. When asked if the resident ever received a puff of the inhaler, the RCA #6 said,	R 282		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, 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
R 282	Continued From page 36 "She never received the inhaler from what I can see." RCA #6 stated that LPN #2 told her to go downstairs to get the RCD. RCA #6 stated that Resident #1 was not responding to verbal or physical stimuli "at all" when she left the fourth floor and that when she returned back to the fourth floor, the resident's eyes were closed and she was still unresponsive. RCA #6 stated that the RCD instructed LPN #2 to check the resident's blood pressure and for her to go back downstairs to the lobby and have the front desk staff call 911. When asked why she did not use the telephone across from the elevators on the fourth floor, the RCA responded by saying, "I was told to go downstairs to the lobby to have front desk staff make the call." The RCD during a telephone interview on 03/12/2026 at 2:05 PM, regarding Resident #1's incident that occurred on 02/20/2026, stated that RCA #6 came to his office and informed him that there was an emergency with a resident on the fourth floor. Per the RCD, upon arriving on the fourth floor, LPN #2 informed him that he had giving The resident a breathing treatment (Inhaler) but that the resident was not responding. The RCD stated that he looked at the resident, asked her if she was ok and that the resident responded in a "lethargic way" saying, "hmm" and that "The resident is on and off". The RCD stated that he performed a sternal rub and asked LPN #2 to obtain blood pressure and blood glucose reading, but that they did not get any reading because it was difficult to obtain one with her clothes on. The RCD stated that he asked RCA #6 to go to the front desk to call 911 while LPN #1 was taking vital signs. The RCD confirmed leaving the fourth floor to go print papers on the second floor in preparation for EMS arrival, and when asked why he left LPN #2 on the fourth	R 282		

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R 282	Continued From page 37 floor to go get paperwork, the RCD stated that "911 was coming. I didn't want them to be delayed in the paperwork." When asked, "Do you think LPN #2 should have called 911 instead of sending staff to go get you?" the RCD said, "Not necessary." The RCD further stated that he had trained the nurses to call him when there is a change in a resident's condition, and that he did not think 911 should have been called in this situation. On 03/19/2026 at 2:49 PM, LPN # 3, during a phone interview regarding the incident stated that he was asked by the RCD to go on the fourth floor to assist LPN #2 with Resident #1, and upon arrival, observed the resident in the chair with her head down. LPN #3 indicated that he tried to solicit a response by verbally calling the resident's name and physically tapping the resident but did not get a response. LPN #3 stated that he assessed the resident, noted that there was no pulse, and as a CPR instructor, asked LPN #2, LPN #4 to assist him lower Resident #1 to the floor to initiate CPR. He stated that LPN #4 started chest compressions until EMS services arrived. When asked, LPN #3 stated that "911 and CPR should have been initiated as soon as the resident became unresponsive or when her condition changed." During a telephone interview on 03/20/2026, at 2:14 PM, regarding the incident, Resident #2 stated that Resident #1 always sat next to her in the lobby during medication administration, and that the resident always complained about having shortness of breath (SOB). Resident #2 stated that when Resident #1 sat down next to her, she appeared to have some breathing issues. Resident #2 became emotional and ended the	R 282		

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R 282	Continued From page 38 interview. Resident #3 during an interview on 03/20/2026, at 2:34 PM, stated that the incident was too traumatic for her, and wished not to discuss the incident. LPN #8 on 03/20/2026, at 2:52 PM, in a phone interview confirmed working the 11:00 PM to 7 AM on the fourth floor taking care of Resident #1. According to LPN #8, Resident #1 activated her call pendant a few times throughout the shift for various needs (i.e., wanted the RCAs to stay with her or to speak with the Registered Nurse Supervisor). LPN #8 confirmed that Resident #1 had experienced difficulty breathing that night and that she administered "breathing treatment" and also acknowledged that she did not contact the Resident's physician or escalated the incident to anyone else. II) The ALR failed to monitor Resident #5 when there was a change in her condition (i.e. not showing up for breakfast, lunch or dinner during the week of 03/09/2026 through 03/14/2026), evidenced below: On 03/16/2026 at 1:31 PM, the Department of Health (DOH) received a complaint (DC#00014181) According to the complaint "It has been reported that on March 14, a female resident on the second floor of the facility was discovered deceased only after staff noticed a strong odor coming from the unit. When the resident was located, she was reportedly cold to touch and determined to be deceased on arrival (DOA)." Due to the nature of this allegation, an on-site investigation was conducted beginning on 03/18/2026. A review of the facility's incident report dated	R 282		

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THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 282	Continued From page 39 03/14/2026, revealed that at approximately 09:55 AM, the nurse was notified by the assigned Certified Nursing Assistant (CNA) that Resident #5 was found unresponsive in her room. Per the report, the resident was found face down, cold to touch, and without vital signs. Cardiopulmonary Response (CPR) was initiated, and Emergency Medical Service was contacted, and the resident was pronounced deceased at 10:08 AM. A review of the facility's "I'm Okay" dining policy with a revised dated of March 2025 listed that the "The I'm Okay" program offers the opportunity for three safety checks during the course of the day at mealtimes. These three safety checks are in alignment with the three mealtime offerings. The Dining Room staff and the Resident Care Associates work together to determine the location of each resident at mealtime and are able to identify if there are any changes or disruptions to their regular patterns." The I'm Okay policy further listed the following: "The I'm Okay check will begin throughout the meal service as wait staff/RCA's check off residents as they come to meals. When there are about 20 minutes left for meal service, the lists will be reviewed and notations made to names that have had Tray Service to their rooms. The I'm Okay policy required that if a resident has not come to the meal, or had arrangements for tray service, the following actions will occur: - The front desk sign out log will be checked to determine if the resident is out of the building. If that does not appear to be the case then: - The resident cell phone will be called, and a visit will be made to the apartment for a wellness	R 282		

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R 282	Continued From page 40 check. - If this does not appear to be the case, the ED/RCD/manager on duty will call the family to determine if they "Forgot" to sign out. - If this is not the case, an elopement drill will proceed." A review of the facility's surveillance camera from 02/28/2026 through 03/14/2026 revealed that Resident #5 was not seen on camera throughout the facility (i.e. sitting in the lobby outside of the dining room across from the elevators, leaving her unit) on any of the days except for a verbal report from a staff that on 03/12/2026 she knocked on the residents door, and the resident stated, "don't come in, I'm ok". The cameras did not capture the resident and/or staff going in or out of the resident's room on the second floor. The facility's "Meal Check" forms from 03/09/2026 through 03/14/2026 revealed the following details: - On 03/09/2026, there was no documented evidence that Resident #5 had breakfast, lunch and dinner. Further review of Resident #5's records failed to show that RCA #3 contacted the front desk to check the signout logbook, called the resident or went to her unit for a wellness check or escalated the concerns to the manager on duty as required by the I'm Okay policy. - On 03/10/2026, RCA #1 and RCA #2 documented that Resident #5 refused breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that the RCAs escalated concerns to the Resident Care Director (RCD) or the manager on duty.	R 282		

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R 282	Continued From page 41 - On 03/11/2026, there was no documented evidence that Resident #5 had breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that RCA #2 contacted the front desk to check the sign out logbook, called the resident or went to her unit for a wellness check or escalated the concerns to the manager on duty as required by the I'm Okay policy. - On 03/12/2026, there was a verbal report from a staff that she knocked on Resident #5's door and the resident stated, "I'm ok". - On 03/13/2026, there was no documented evidence that Resident #5 had breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that RCA #3 and RCA #4 contacted the front desk to check the sign out logbook, called the resident or visited her unit for a wellness check or escalated the concerns to the manager on duty as stated on facility's the I'm Okay policy. - On 03/14/2026, there was no documented evidence that Resident #5 had breakfast. Further review of Resident #5's records failed to show any evidence that RCA #2 contacted the front desk to check the sign out logbook, called the resident or visited her unit for a wellness check or escalated the concerns to the manager on duty as stated on the I'm Okay policy. During a walkthrough of the facility on 03/25/2026 at approximately 12:56 PM, the survey team observed a white board with a list of residents in the RCA's office title "Do not Check". Resident #5's name was among the do not check list. The staffing scheduler who was in the office at the time when asked about the names on the board	R 282		

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R 282	Continued From page 42 stated, "they are residents who don't want to be disturbed." In another interview at 1:10 PM regarding the whiteboard, RCA #10 stated that those "are resident who do not want people coming to their rooms." LPN #5 during an interview on 03/25/2026 at 1:53 PM, regarding Resident #5, stated that she worked on the second floor on 03/10/2026 and 03/12/2026 during the 3:00 PM - 11:00 PM shift but that the second floor was not her assigned floor. LPN #5 stated that she did not recall seeing Resident #5 on 03/10/2026 and 03/12/2026 during the shift. According to LPN #5, during the medication rounds on 03/12/2026 at about 6:00 PM, she knocked on Resident #5's door, and she heard the resident say, "Don't come in." LPN #5 stated that when she tried to use the fob to enter her room she was unable to go in so she talked to the resident through the door. At 2:00 PM on 03/25/2026, LPN #7 (Agency Nurse) during a phone interview regarding Resident #5 revealed working on 03/14/2024 during the 7:00 AM - 3:00 PM shift and was informed by the RCA that the resident was not responding inside her unit. LPN #7 stated that she pushed through the door which was barricaded by a small couch with the help of the Maintenance Technician and observed the resident lying on the floor. LPN #7 stated that she called the Resident Care Director (RCD) and he instructed her to call 911 and initiate CPR. "I could tell she had been dead a while. She was very stiff. There was a strong odor that was inside the unit. Her room was junkie." The Maintenance Technician (MT) in an interview on 03/25/2026 at 2:12 PM, regarding Resident #5's death on 03/14/2026, stated that he was	R 282			

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R 282	Continued From page 43 getting off the elevator and saw RCA #1 knocking on the resident's door, who then asked him to help open the door. The MT stated that once they got inside the unit, he moved the chair that was blocking the door and noticed that the resident was lying on face down unresponsive. Per the MT, "there was a bad odor that came from the room, and the facility had to take out all the carpet from the unit." In a phone interview on 03/26/2026 at 9:43 AM, RCA #6 stated that she was assigned to conduct meal checks on 03/09/2026 during dinner and did not see Resident #5. Per RCA #6, when residents do not show up for dinner, the RCAs would have to get permission to take food to the resident's unit from the kitchen staff. RCA #6 stated that in Resident #5's case, "I don't recall taking food to her unit" and that she last saw Resident #5 towards the end of February 2026 and beginning of March 2026. RCA #6 stated that she last heard her voice through the door last week before her death. "I can't recall the exact date." RCA #6 stated that the resident said to her through the door, "I'm ok but I am feeling sick" but confirmed not reporting the conversation to management. On 03/26/2026 at 11:00 AM, RCA #1 stated during interview that she was assigned to do meal checks during breakfast on 03/10/2026. When asked why she documented that Resident #4 had refused breakfast, RCA #1 indicated that Resident #5 never come down during breakfast and lunch. RCA #1 confirmed not going to Resident #5's unit after breakfast to perform a wellness check because it was the resident's routine not to eat breakfast. Per RCA #1, "We knew this, we just mark refuse on the meal check form."	R 282			

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NAME OF PROVIDER OR SUPPLIER

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R 282	Continued From page 44 RCA #4 on 03/26/2026 at 11:14 AM, during interview regarding Resident #5's "Meal Checks" documentation during the week of 03/09/2026 through 03/14/2026, indicated that he saw the resident the week she died. RCA #4 stated that he spoke to the resident either on 03/09/2026 or 03/10/2026, while she was sitting across from the elevator on the first floor near the dining hall, and that the resident had told him she was not feeling well. RCA #4 stated that both him and RCA #1 knocked on Resident #5's door on 03/10/2026 to see if she wanted to come down for breakfast, and that the resident responded by saying, "No, I'm ok". RCA #4 stated that he did not see her for the rest of that week. When asked, RCA #4 revealed that he was assigned to conduct "Meal Checks" for breakfast on 03/09/2026, 03/12/2026 and 03/13/2026. When asked why he did not document whether the resident was present, had her food delivered and/or refused to come to the dining hall on the above days, RCA #4 stated that the resident never comes down for breakfast, and that was why he documented a refusal. When asked if he conducted a wellness check on the resident, RCA #4 stated, "No, I did not". At 11:17 AM, the surveyors shared with RCA #4 that Resident #5 was not seen on the facility's video surveillance cameras seated near the dining area across from the elevators from 03/09/2026 through 03/14/2026. RCA #4 then changed his statement and stated, "I thought I saw her on one of those days. Maybe it was a different week". On 03/26/2026 at 12:18 PM, RCA #9 during interview regarding Resident #5's "Meal Checks" from 03/09/2026 through 03/14/2026 stated he was responsible for doing the meal checks for lunch on 03/10/2026, breakfast and lunch on 03/11/2026, lunch on 03/12/2026 and breakfast on 03/14/2026. The RCA stated, "I haven't seen	R 282		

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R 282	Continued From page 45 [resident name]. I can't recall when I saw her last time. She rarely came down for breakfast and lunch. If she did, she would sit across from the elevator." When asked why he did not document on the meal check form, RCA #9 stated that the staff on the second floor was supposed to let him know that the resident did not come down for meal. RCA #9 confirmed not going upstairs on 03/09/2026 to perform a wellness check on Resident #5. On 03/26/2026 at 12:59 PM, the Dietary Aide during interview regarding the last time she saw Resident #5 in the dining room, stated she last saw the resident approximately two weeks before her death but could not recall the specific date. The Dietary Aide stated that Resident #5 looked like she had been losing a lot of weight, and that she had previously asked the resident if she had food in her room and the resident responded, "I'm Okay." RCA #10 on 03/26/2026 at 1:02 PM, during a phone interview stated she was assigned to conduct meals for dinner on 03/10/2026, does not recall Resident #5 came down for dinner and did not document on the meal check form for the resident. Per RCA #10, she was supposed to check on the residents after dinner if the residents did not attend dinner, but she did not go to Resident #5's unit to conduct a wellness check after dinner. RCA #10 stated she last saw Resident #5 on 03/12/2026 seated in the lobby area that evening, but a review of the facility's video surveillance cameras for the entire week of 03/09/2026 through 03/14/2026 showed that Resident #5 was not seen sitting near the dining area across from the elevators. During an interview on 03/26/2026 at 2:23 PM	R 282		

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R 282	Continued From page 46 regarding the last time Resident #5 ate a meal in the dining room, the Dining Services Supervisor (DSS) stated that she had not seen the resident in over a week prior to her death. Per the DSS, "the resident often sat outside of the dining area across from the main elevators, and that Resident #5 did not usually eat breakfast or lunch, however, she would usually eat dinner." When asked what the RCAs should do if a resident did not show up for meals, the DSS indicated that the RCAs should document on the "I'm Okay" form and complete a wellness check on the resident. Resident #11 on 03/27/2026 at 10:05 AM, during an interview revealed that she went to check on Resident #5 because she had been in that room for almost a month, and that she had been communicating with Resident #5 through the door a few times a week during the month. Resident #11 stated that she knew Resident #5 wasn't "feeling well, she was up there a whole month but could not understand why the facility staff did not check on the resident." Resident #11 revealed that she went to Resident #5's unit on 03/13/2026 to check on her, and "I believe I heard her but, not sure. I called her name a few times and she didn't answer. She mumbled something and she went quietly. I didn't hear anything after that." During an interview on 03/25/2026 at 3:18 PM and 3/27/2026 at 12:00 PM regarding Resident #5's death, the facility's RCD stated that he received a call from the assigned LPN that the resident was found on the floor in her unit unresponsive and he had instructed the nurse to call 911, and to initiate CPR. Per the RCD, when he saw the resident's unit for the first time (03/14/2026), he described the unit as having fecal matter on the bathroom floor, toilet was	R 282		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/27/2026
NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, 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
R 282	Continued From page 47 backed up with urine, expired food in the refrigerator and the room temperature was humid with a strong smell of urine in the unit. The RCD indicated that Resident #5 appeared to be a hoarder based on the visual appearance of her unit. "I believe she had Psych issues and the unit needed to be professionally cleaned after her death." When asked why he was not made aware that Resident #5 had not been eating meals, the RCD stated that it was the dining team's responsibility to communicate to the nursing team that the resident had not been eating. According to the RCD "people that knew Resident #5 had an attitude and say, "I'm not going to check on [resident name] because I know she's going to refuse." The RCD added, "There are a lot of problems in this building, and the communication is not good here." The RCD denied knowledge of the "I'm Okay" policy and acknowledged that he was aware that there was a "Do not check" list but he does not know who created the list.	R 282			
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; Based on interviews, record reviews and video surveillance reviews, the Assisted Living Residence (ALR) failed to ensure that each resident received adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with the resident's health and physical and mental capabilities for one of	R 292			

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NAME OF PROVIDER OR SUPPLIER

THE RESIDENCES AT KENILWORTH PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

**1650 KENILWORTH AVE, 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
R 292	Continued From page 48 the residents in the investigation (Resident #5). Findings included: The review of Resident #5's records revealed an Individualized Service Plan (ISP) dated 08/20/2025 that required staff to conduct routine monitoring checks on the resident three (3) times daily (morning, afternoon and night), provide toileting support, including setting up bedside commode nightly, emptying/cleaning it daily and reporting any changes in the residents ability to eat. A review of the facility's video surveillance for the week of 03/09/2026 through 03/14/2026 revealed that Resident #5 was not observed in the dining area, common areas or coming out of her room during that time. Also, the meal check forms for the week of 03/09/2026 through 03/14/2026, revealed that the Resident Care Assistant's (RCA) documented that Resident #5 did not attend meals throughout these periods and documented "refusal" without any visual confirmation. The record review showed no documented evidence that the RCA's performed a wellness check when the residents did not attend meals or escalated the concerns to nursing or management. During an interview on 03/26/2026 at 09:43 AM, Resident Care Assistant (RCA) #6 stated that she was assigned to meal checks for dinner on 03/09/2026 and did not document on the meal check form because she did not see the resident come for dinner. RCA #6 stated that she did not recall taking food to the resident's room. RCA #6 stated she last saw the resident at the end of February or early March 2026 and last heard her voice through the door approximately one week	R 292		

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R 292	Continued From page 49 prior to her death. RCA #6 stated the resident said, "I'm ok but I am not feeling sick." RCA #6 denied reporting the findings to management. RCA #1 during an interview on 03/26/2026 at 11:00 AM, stated that she was assigned to meal checks for breakfast on 03/10/2026, and that the resident did not typically come to breakfast and that staff would usually mark "refused" without confirmation with the resident. RCA #1 acknowledged not going to the resident's unit to conduct a wellness check and that, "We knew this, we just mark refuse on the meal check form." RCA on 03/26/2026 at 11:14 AM, stated during interview that he knocked on Resident #5's door on 03/10/2026 and that the resident responded, "No, I'm ok." RCA #4 stated that he did not see the resident for the remainder of the week and confirmed that he did not conduct a wellness check when the resident did not attend meals. The facility's Housekeeper (HK) stated during an interview on 03/26/2026 at 11:46 AM that she has never cleaned Resident #5's unit since she started working for the ALR in January 2025. According to the HK, the resident would position a couch or small chair in front of the door to prevent entry and acknowledged that she had not been consistent in completing the checklist forms for the resident. The HK confirmed that management was aware of Resident #5's refusal to allow housekeeping staff to enter the unit and that no action was taken. On 03/26/2026 at 12:18 PM, RCA #2 stated in an interview that he could not recall the last time he saw Resident #5 and that he did not go to the resident's unit during the week of 03/09/2026 for	R 292			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 292	Continued From page 50 a wellness check. RCA #2 stated he relied on other staff to notify him if the resident did not attend meals. RCA #7 on 03/26/2026 at 1:02 PM stated that she did not recall Resident #5 attending dinner and confirmed not completing the meal check documentation or conduct a follow-up check on the resident. In an interview on 03/26/2026 at 1:47 PM, RCA #9 stated she did not complete the meal check form for Resident #5 and did not notify the person in charge when the resident did not attend dinner. On 03/26/2026 at 12:59 PM, the Dietary Aide stated she "last saw Resident #5 approximately two weeks prior to her death and reported the resident had been losing weight." No Dietary Aide documentation or follow-up was identified. On 03/27/2026 at 10:05 AM, Resident #11 stated that Resident #5 had been in her room for approximately one month and was not feeling well. Resident #11 stated that she attempted to check on the resident on 03/13/2026, heard mumbling, and then no response. The Resident Care Director (RCD) in an interview on 03/27/2026 at beginning at 12:00 PM stated that upon entering Resident #5's unit on 03/14/2026, the unit contained fecal matter, urine backed up in the toilet, expired food in the refrigerator, and a strong odor of urine, indicating the resident had not been receiving care for an extended period. The RCD acknowledged communication issues within the facility and stated that staff may avoid checking on residents who are known to refuse care. The RCD also acknowledged awareness of a "Do Not Check"	R 292		

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R 292	Continued From page 51 list but stated that he did not know who created the list. On 03/27/2026 at 3:18 PM, the Executive Director (ED) confirmed during an interview that she was aware of a "Do Not Check" list but stated that she did not know who created the list. Per the ED, "For all I know, it could have been created by RCAs". On 03/27/2026 at 3:27 PM, the Assistant Executive Director (AED) also acknowledged awareness of a "Do Not Check" list but stated that she did not know who developed the list.	R 292		
R 293	Sec. 504.2 Accommodation Of Needs. (2) To have access to appropriate health and social services, including social work, home health, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being; Based on record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure that residents had access to appropriate health care services, specifically missing Cardiology appointment for one resident in the investigation (Resident #4). Findings included: Review of Resident #4's Cardiology consultation form dated 10/13/2025 revealed that the Cardiologist ordered a dobutamine stress test to be completed and that the resident should return to the Cardiology clinic on 01/13/2026. Continued review of the resident's record showed that	R 293		

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R 293	Continued From page 52 Resident #4 completed an ECHO on 11/06/2025. On 02/23/2026 at 2:00 PM Resident #4 reported to the survey team during interview that he "had missed some very important Cardiology appointments due to the facility rescheduling his appointments for 3 months later and not having enough escort staff to assist him in getting to his appointment." In an interview on 02/23/2026 at 2:46 PM, the facility's scheduling coordinator (SC), reported there was only one assigned escort for appointments with residents on Tuesdays and Thursdays. The SC shared that on 02/24/2026 there were six appointments scheduled and with only one escort for the appointments, she would have to find coverage by asking additional staff who are not on the schedule for help. Per the SC, "if a resident's appointment is scheduled for Monday, Wednesday, or Friday, she would have to contact the resident's family member to accompany the resident to the appointment or else it will have to be rescheduled for a later date, and this happens often." During an interview on 02/23/2026 at 3:29 PM, the Executive Director (ED) confirmed that the facility typically schedules appointments for Tuesdays and Thursdays and has an escort to assist residents to appointments. Per the ED, "if an appointment is scheduled on Monday, Wednesday or Friday, a family member will have to escort the resident to the appointment, or the appointment will have to be rescheduled, but that the facility could make accommodations for important appointments." The Resident Care Director when asked on 02/23/2026 at 3:42 PM, during interview about the	R 293		

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R 293	Continued From page 53 missed appointment, revealed that he was unaware that Resident #4 had missed appointments. During a phone interview on 03/05/2026 at 2:16 PM, the cardiology clinic staff confirmed that Resident #4 had multiple scheduled cardiology appointments that were not completed, including an appointment on 11/03/2025, 01/21/2026, 01/30/2026 which was cancelled and an appointment on 01/27/2026 where the resident was a "no show." The clinic staff further confirmed that the resident had a history of missed cardiology appointments. It should be noted that review of the facility's "Resident Handbook" (undated) failed to reveal specific guidance on prohibition of transportation for appointments on certain days of the week.	R 293		
R 353	Sec. 505a2 Representation And Resolution Of Grievances (2) To uncoerced consent; Based on interviews and record reviews, the facility failed to support one resident in exercising his rights without interference, coercion, or threats of retaliation (Resident #4). Findings included: A complaint received by DC Health, (#DC00014139) alleged that Resident #4 had received past due recertification notice right after he refused to show his direct express ATM receipt. Resident #4 during an interview on 02/23/2026 at 2:03 PM revealed that he received a "Past-Due	R 353		

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R 353	Continued From page 54 Recertification Notice" after refusing to provide an ATM receipt showing his account balance to the facility and contacting the Adult Protective Services (APS). Per the resident, "the notice was placed under my door without any explanation." The resident further shared that he is blind and depends on staff assistance to read documents. A review of the notice, which was neither signed nor dated, indicated that the residents failure to submit the requested documentation by 02/20/2026 could result in the issuance of a 45-day notice initiating eviction proceedings. During an interview on 02/23/2026 at 3:11 PM, the Executive Director confirmed that Resident #4 had received the notice because he had not submitted a Direct Express ATM receipt reflecting his balance. The ED revealed that there was a total of 33 residents that received Past-Due Recertification Notices from Administrator Compliance Support Specialist for the management company during the first week of February 2026 (02/02- 02/06/2026). When asked, the ED stated that Resident #4 received his notice either on 02/03/2026 or 02/04/2026. Also, the ED stated that some of the residents were past the due date of 02/20/2026 and would receive letter during the first week of March 2026 indicating that the eviction process has begun. An APS personnel member confirmed during a phone interview that the resident's case was assigned to a staff member on 02/03/2026. The ALR's Billing Specialist on 02/24/2026 at 11:34 AM during an interview stated that residents were required to provide documentation	R 353		

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R 353	Continued From page 55 of income and assets, including bank statements and receipts, as part of the recertification process for the LIHTC program. Per the Billing Specialist reported that there were no issues with Resident #4 last year, but "I speculate that he may have gotten more money from Social Security." The Billing Specialist further stated that this requirement was explained to residents during the admission process. In an interview on 03/24/2026 at 2:34 PM, the Resident Care Director (RCD) revealed that he transported Resident #4 to Wholefoods grocery store and 7-Eleven on 02/27/2026 to obtain the ATM balance, and that the resident "fought tooth and nail for a long time" not to provide the ATM balance. The resident had a "change of heart." The RCD said, "I don't know who got to him, but he was willing to provide the ATM balance on that day."	R 353		
R 389	Sec. 509a Abuse, Neglect, and Exploitation. (a) An ALR shall develop and implement policies and procedures prohibiting abuse, neglect, and exploitation of residents. Based on observation (including video surveillance), record reviews, and staff and resident interviews, the Assisted Living Residence (ALR) failed to 1. ensure residents were free from neglect, 2. implement and follow the facility's policies and procedures for emergency response, monitoring changes in condition, and required safety/wellness checks. Specifically, the facility failed to: (1) ensure timely initiation of emergency response, including activation of Emergency Medical Services (EMS) and cardiopulmonary resuscitation (CPR); (II) monitor and respond to significant changes in residents' conditions for	R 389		

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R 389	Continued From page 56 two of the three residents in the investigation (Residents #1 and #5). Findings included: 1. The ALR failed to timely initiate an emergency response, including activation of EMS and initiation of cardiopulmonary resuscitation (CPR). A review of the facility's Emergency Response policy dated April 2022 required that "In case of a medical emergency call 911 immediately." The policy defined a medical emergency as, "A Medical Emergency is any injury or other circumstance that results in an imminent threat to a resident's health including, but not limited to, an apparent life-threatening medical crisis." On 03/09/2026 at 2:51 PM, the Department of Health (DOH) received a complaint (DC#00014181) regarding services rendered at the facility. According to the complaint, on 02/20/2026 there was a medical emergency at the facility where CPR was delayed for one resident until 911 Emergency Medical Services (EMS) arrived. Review of Resident #1's nursing progress note dated 02/20/2026 indicated that at approximately 2:30 AM, the resident complained of difficulty breathing and sounded congested, a nebulizer treatment was administered and documented as effective. Resident #1's February Medication Administration Record (MAR) also revealed that on 02/20/2026 Resident #1 received Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puffs orally at 02:56 AM and Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG/0.5ML 1 unit orally via nebulizer every 8 hours at 06:32 AM.	R 389		

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R 389	Continued From page 57 Resident #1's medical history included but was not limited to chronic obstructive pulmonary disease (COPD), atrial fibrillation, and chronic kidney disease Continued review of the resident's medical record failed to show any documented evidence that the facility staff notified the physician, performed a follow-up respiratory assessment, increased the resident's monitoring or reassessed the effectiveness of the treatments beyond the initial note. A review of the facility's submitted incident report dated 02/20/2026 at 4:05 PM indicated that the Resident Care Director (RCD) was called to the fourth floor by Licensed Practical Nurse (LPN) #2 for a medical emergency, and upon arrival saw Resident #1 sitting in a chair holding her chest as in respiratory distress. According to the incident report, the RCD asked Resident Care Aide (RCA) #6 to call 911 and then proceeded to print out documents to give to the 911 personnel. The RCD returned to the fourth floor at 4:14 PM to assist LPN #2 and the other clinicians in providing CPR to Resident #1. The facility's incident report detailed the following timeline of events: - At 3:50 PM, Resident #1 activated her emergency pendant and charge nurse responded. - At 3:55 PM, the resident verbalized to the charge nurse that she felt as if she was unable to belch. - At 3:56 PM, the resident picked and put her sneakers on and started to ambulate from her apartment to the 4th floor lounge with charge	R 389		

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R 389	Continued From page 58 nurse by her side. - At 4:04 PM, the nurse charge assisted the resident in a sitting position by the 4th floor lounge. - At 4:05 PM, Resident #1 was observed in distress, 911 call activated, CPR was initiated by facility clinicians, following - American Heart Association Resuscitation protocols. - At 4:08 PM, first team of 911 arrived on scene, assisting the facility employees with CPR. - At 4:14 PM, automated external defibrillators attached to the resident and first shock rendered, resumed CPR. - At 4:19 PM, 911 Advanced Cardiovascular Life Support team and Metropolitan police arrived on scene, assumed control of the emergency interventions until 4:52 PM when Resident #1 was pronounced dead by team 911. On 03/11/2026 at 10:33 AM, a review of the facility's surveillance video revealed the following chain of events that occurred on 02/20/2026 when Resident #1 remained seated and not moving while seated in a chair in the lobby area on the fourth floor: -3:50 PM - 3:53 PM: The video showed Resident #1 ambulating towards the fourth-floor lobby with LPN #2, and while ambulating towards the chair, the resident's legs appeared to "buckle". LPN #2 and RCA #6 could then be seen assisting the resident to the chair. Once in the chair, another resident (Resident #2) who was sitting in a chair directly beside the resident got up and walked towards the elevator with her four-wheel walker.	R 389		

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NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, NE WASHINGTON, DC 20019		
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R 389	Continued From page 59 -3:53 PM: After Resident #1 was seated, LPN #2 appeared to retrieve an item from the medication cart. Licensed Practical Nurse (LPN) #2 walked to a table located in front of the elevator, retrieved what appeared to be tissue, and returned to the resident. LPN #2 can be seen tapping the resident on the leg and then instructing the RCA #6 to perform a task, after which RCA #6 left the floor. LPN #2 retrieved a laptop and walked over to the resident while looking at the laptop. -3:54 PM - 3:55 PM: LPN #2 walked to the phone located on a table in front of the elevator and placed a call. LPN #2 then returned to the resident and was seen tapping the resident on the leg. LPN #2 and can be seen moving back and forth between the cart and the resident. The LPN retrieved a laptop, returned to the cart by the elevators, then returned again to the resident and continued taping the resident's leg. -3:55:44 PM: The RCD returned back to the fourth floor with RCA 6, walked over to the resident and appeared to ask LPN #2 something. The video showed the RCD leaning over towards the resident. -3:56 PM - LPN #2 brought what appeared to be a blood pressure cuff over to the resident and attempted to obtain a blood pressure reading. The RCD appeared to gesture something to RCA #6 nearby who then left the fourth floor via the elevator. LPN #2 and the RCD could be seen in the video standing in front of the resident. -3:57 PM - 3:58 PM: LPN #2 retrieved an item from the medication cart and returned back to the resident. Simultaneously, the RCD retrieved an item from the medication cart and returned back	R 389		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/27/2026
NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, NE WASHINGTON, DC 20019		
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R 389	Continued From page 60 to the resident. The RCD could be seen attempting again to obtain blood pressure reading. The RCD and LPN #2 were observed hovering in front of the resident. - 3:59 PM, a third resident (Resident #3) walked towards the lobby with a rollator walker and sat down in a chair and appeared to watch the incident with Resident #1. The RCD again grabbed an item from the medication cart, and then LPN #2 placed the item back on the medication cart. - 4:00 PM - 4:01 PM: The RCD appeared to be looking for something near the medication cart while LPN #2 moved back and forth between the resident and the medication cart. The RCD walked over to the resident and could be seen tapping the resident. The RCD walked over and threw something into the trashcan and returned back to the medication cart. A few seconds later, the RCD walked towards the elevator, pressed the elevator button and proceeded around the corner to the stairwell leaving the fourth floor. -4:02 PM: LPN #2 was observed standing near the resident holding an item in his hands, while the resident remained seated and not moving. -4:03 PM: LPN #2 returned to the medication cart, retrieved an item and walked back near the resident while holding the item, stepped back and looked out of the window for a few seconds. -4:04 PM: LPN #3 arrived on the fourth floor via the stairwell, walked toward the medication cart, retrieved what appeared to be hand sanitizer and proceeded towards the resident where LPN #2 was standing. LPN #3 could be speaking to LPN #2 before going over to Resident #1	R 389			

Health Regulation & Licensing Administration

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R 389	Continued From page 61 -4:05 PM: LPN #4 arrived at the fourth floor via the stairwell, walked towards the medication cart, retrieved what appeared to be hand sanitizer, and then walked towards the resident, the LPN #2 and LPN #3. LPN #4 could be seen in the video having a conversation with LPN #2 and LPN #3, and a few seconds later, LPN #2, LPN #3 and LPN #4 were observed placing the resident on the floor. -4:06 PM: LPN #4 started chest compressions while the LPN #2 and LPN #3 were present. A woman wearing a black outfit carrying a black briefcase exited the elevator and walked towards the scene. -4:07 PM: Emergency Medical Services (EMS) arrived on the fourth floor and assumed care of the resident. A review of the EMS records revealed the following notes: - On 02/20/2026 at 4:00:26 PM - EMS received an alert from dispatch. - On 02/20/2026 at 4:04:57 PM - EMS arrived on scene. - On 02/20/2026 at 4:06:00 PM - Patient contact. The EMS record documented that upon assessment, Resident #1 was unresponsive, had no pulse, not breathing and had a Glasgow Coma Scale score of 3 upon assessment. During an interview on 03/10/2026 at 2:02 PM, the facility's Vice President of Resident Services (VRS) provided to the survey team a verbal	R 389		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, 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
R 389	Continued From page 62 timeline e related to Resident #1's death, based on a review of the video of the incident. LPN #2 on 03/12/2026 at 11:10 AM during a phone and face-to-face interview indicated he was the nurse that cared for Resident #1 on 02/20/2026. During an interview with LPN #2 on 3/12/26 at 11:10 AM, he indicated he was on the fifth floor when he received a call over the Walkie-Talkie that Resident #1 needed assistance and had pressed her pendant. LPN #2 stated that upon assessment, the resident told him that she could not "belch", that he asked the resident if she wanted some water, and the Resident #1 said "No, I have drunk enough water already, and that the water wasn't working." LPN #2 stated that he told the resident, "Maybe you need to go for a walk" and that the resident walked with him down the hallway towards the lobby and as she got closer to the lobby, the resident told him that she could not move her legs. LPN #2 stated that he called the Resident Care Assistant (RCA #6) who was in the lobby to help assist Resident #1 to a chair. LPN #2 stated that, "She was gasping for air. I was a little bit panicked ...I grabbed the inhaler and tried to give her a puff, but she closed her eyes and dropped her head. I said to the resident, stay with me, stay with me! Everything happened so suddenly. I was just panicking." When asked if he remembered when the resident stopped breathing, LPN #2 said, "I can't tell you when she stopped. I was panicking". When asked why he did not call 911 or have the RCA #6 to call 911 and start CPR, he said, "My boss (the RCD) had instructed us to call him first in an emergency before anyone else". LPN #2 stated that he told RCA #6 to go get the RCD, and that he then	R 389		

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R 389	Continued From page 63 walked over to the telephone to call the RCD because the resident was unresponsive. "I panicked. I didn't know what to do honestly. I don't remember a lot that happened, I panicked!" Further interview with LPN #2 revealed that the RCD arrived on the fourth floor, and that he told the RCD that the resident was unresponsive. "I was panicking." LPN #2 stated that the RCD checked the resident's pulse and pulse oximeter which he said was in the low 90s. "I was panicking." LPN #2 also stated that the RCD asked for the residents CODE Status, and he checked the laptop but could not find it under the resident's profile section on the electronic medical record. LPN #2 stated that LPN #3 and LPN #4 arrived, checked the resident's vitals, placed her on the floor and initiated CPR. "I was just there. My mind was shaking." On 03/12/2026 at 11:55 AM, during a telephone interview, LPN #4 confirmed initiating CPR on Resident #1 on 02/20/2026. Per LPN #4, he was working on the second floor when he was asked by the RCD to go to the fourth floor to assist with an emergency, and he did not hear any CODE blue called throughout the facility. Upon arriving on the fourth floor, he noted the resident's head was in a downward position with no movement, and that the resident was not responding to any verbal or physical stimuli and did not have a pulse. LPN #4 stated that he, LPN #2 and LPN #3 placed the resident on the floor and began chest compressions until the EMS arrived on the scene. When asked when CPR should be initiated, LPN #4 stated, "We should check the level of consciousness of the person, check to see what the person needs. For example, if the person needs CPR, we will initiate CPR, call 911 and ask for assistance."	R 389		

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R 389	Continued From page 64 An interview with RCA #6 on 03/12/2026 at 12:10 PM revealed that she assisted LPN #2 with Resident #1 to a seat in the lobby on 02/20/2026. RCA #6 indicated that she responded to the call around 3:15 PM, and that when she arrived at the resident's room on the fourth floor, Resident #1 complained of stomach pain. RCA #6 stated that she shared this information with LPN #2 who arrived at the resident's unit shortly afterwards from the fifth floor, and that a few minutes later, she observed Resident #1 ambulating with her rollator near the fourth-floor lobby with LPN #2 directly beside her. RCA #6 stated that Resident #1 looked like she was about to fall, so she ran over to help LPN #2 assist the resident to the chair. RCA #6 stated that LPN #2 went to the medication cart, retrieved an inhaler and verbally instructed Resident #1 to open her mouth to take a puff, but that the resident was not responding and LPN # 2 began shaking the resident to solicit a response. When asked if the resident ever received a puff of the inhaler, the RCA #6 said, "She never received the inhaler from what I could see." RCA #6 stated that LPN #2 told her to go downstairs to get the RCD. RCA #6 stated that Resident #1 was not responding to verbal or physical stimuli "at all" when she left the fourth floor and that when she returned back to the fourth floor, the resident's eyes were closed and she was still unresponsive. RCA #6 stated that the RCD instructed LPN #2 to check the resident's blood pressure and for her to go back downstairs to the lobby and have the front desk staff call 911. When asked why she did not use the telephone across from the elevators on the fourth floor, the RCA responded by saying, "I was told to go downstairs to the lobby to have front desk staff make the call." During a telephone interview with the RCD on	R 389		

Health Regulation & Licensing Administration

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R 389	Continued From page 65 03/12/2026 at 2:05 PM, regarding the 2/20/26 incident with Resident #1, he stated that RCA #6 came to his office and informed him that there was an emergency with a resident on the fourth floor. Per the RCD, upon arriving on the fourth floor, LPN #2 informed him that he had given the resident breathing treatment (Inhaler) but that the resident was not responding. The RCD stated that he looked at the resident, asked her if she was ok and that the resident responded in a "lethargic way" saying, "hmm" and that "The resident was on and off". The RCD stated that he performed a sternal rub and asked LPN #2 to obtain blood pressure and blood glucose reading, but that they did not get any reading because it was difficult to obtain one with her clothes on. The RCD stated that he asked RCA #6 to go to the front desk to call 911 while LPN #1 was taking vital signs. The RCD confirmed leaving the fourth floor to go print papers on the second floor in preparation for EMS arrival, and when asked why he left LPN #2 on the fourth floor to go get paperwork, the RCD stated that, "911 was coming. I didn't want them to be delayed in the paperwork." When asked, "Do you think LPN #2 should have called 911 instead of sending staff to go get you?" the RCD said, "Not necessary." The RCD further stated that he had trained the nurses to call him when there is a change in a resident's condition, and that he did not think 911 should have been called at that time. During a telephone interview on 03/19/2026 at 2:49 PM, LPN # 3 was interviewed regarding the incident involving Resident #1 and stated that he was asked by the RCD to go on the fourth floor to assist LPN #2 with Resident #1, and upon arrival, observed the resident in the chair with her head down. LPN #3 indicated that he tried to solicit a response by verbally calling the resident's name	R 389		

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R 389	Continued From page 66 and physically tapping the resident but did not get a response. LPN #3 stated that he assessed the resident, noted that there was no pulse, and as a CPR instructor, asked LPN #2, LPN #4 to assist him lowering Resident #1 to the floor to initiate CPR. He stated that LPN #4 started chest compressions until EMS services arrived. When asked, LPN #3 stated that 911 and CPR should have been initiated as soon as the resident became unresponsive or when her condition changed. LPN #8 on 03/20/2026, at 2:52 PM, in a telephone interview confirmed working the 11:00 PM to 7:00 AM shift on the fourth floor taking care of Resident #1. According to LPN #8, Resident #1 activated her call pendant a few times throughout the shift for various needs (i.e., wanted the RCAs to stay with her or to speak with the Registered Nurse Supervisor). LPN #8 confirmed that Resident #1 had had trouble breathing that night and that she administered a "breathing treatment" and also acknowledged that she did not contact the Resident's physician or escalate the incident to anyone else. There was no evidence that LPN #8 documented Resident #1's response to the treatment. 2. The ALR failed to monitor Resident #5 when there was a change in her behavior (i.e. not showing up for breakfast, lunch or dinner during the week of 03/09/2026 through 03/14/2026), evidenced below: A review of Resident #5's medical record revealed diagnosis including Seizure, Essential Hypertension, Osteoarthritis, Seizures, Glaucoma, Gastro-esophageal reflux disease, Major Depressive disorder and Hyperlipidemia.	R 389		

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R 389	Continued From page 67 A review of the facility's "I'm Okay" dining policy with a revised dated of March 2025 listed that the "The I'm Okay program offers the opportunity for three safety checks during the course of the day at mealtimes. These three safety checks are in alignment with the three mealtime offerings. The Dining Room staff and the Resident Care Associates (RCA) work together to determine the location of each resident at mealtime and are able to identify if there are any changes or disruptions to their regular patterns." The I'm Okay policy further listed the following: "The I'm Okay check will begin throughout the meal service as wait staff/RCAs check off residents as they come to meals. When there are about 20 minutes left for meal service, the lists will be reviewed and notations made to names that have had Tray Service to their rooms. The I'm Okay policy required that if a resident has not come to the meal, or had arrangements for tray service, the following actions will occur: - The front desk sign out log will be checked to determine if the resident is out of the building. If that does not appear to be the case then: - The resident cell phone will be called, and a visit will be made to the apartment for a wellness check. - If this does not appear to be the case, the ED/RCD/manager on duty will call the family to determine if they "Forgot" to sign out. - If this is not the case, an elopement drill will proceed."	R 389		

Health Regulation & Licensing Administration

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R 389	Continued From page 68 A review of the facility submitted incident report dated 03/14/2026, revealed that at approximately 09:55 AM, the nurse was notified by the assigned Certified Nursing Assistant (CNA) that Resident #5 was found unresponsive in her room. Per the report, the resident was found face down, cold to touch, and without vital signs. Cardiopulmonary Response (CPR) was initiated, and Emergency Medical Service was contacted, and the resident was pronounced deceased at 10:08 AM. On 03/16/2026 at 1:31 PM, the Department of Health (DOH) received a complaint DC#00014181 alleging that on 03/14/2026, a female resident on the facility's second floor was discovered deceased only after staff noticed a strong odor coming from the unit. Per the complainant, when the resident was found, she was reportedly cold to the touch and determined to be deceased on arrival (DOA). A review of the facility's surveillance camera from 02/28/2026 through 03/14/2026 revealed that Resident #5 was not seen on camera throughout the on any of the days. The cameras did not capture the resident and/or staff going in or out of the resident's room on the second floor. The facility's "Meal Check" forms from 03/09/2026 through 03/14/2026 revealed the following details: - On 03/09/2026, there was no documented evidence that Resident #5 had breakfast, lunch or dinner. Further review of Resident #5's records failed to show that RCA #3 contacted the front desk to check the sign-out logbook, called the resident or went to her unit for a wellness check or escalated the concerns to the manager on duty	R 389		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 389	Continued From page 69 as required by the "I'm Okay" policy. - On 03/10/2026, RCA #1 and RCA #2 documented that Resident #5 refused breakfast, lunch and dinner. Further review of Resident #5's records failed to show any documented evidence that the RCAs escalated concerns to the Resident Care Director (RCD) or the manager on duty. - On 03/11/2026, there was no documented evidence that Resident #5 had breakfast, lunch or dinner. Further review of Resident #5's records failed to show any documented evidence that RCA #2 contacted the front desk to check the sign out logbook, called the resident, went to her unit for a wellness check, or escalated the concerns to the manager on duty as required by the "I'm Okay" policy. - On 03/12/2026, there was no documented evidence that Resident #5 had breakfast, lunch or dinner, however, a progress note dated 03/12/2026 at 22:58 [5:58 PM] documented, "Resident responded when writer knock on the door this evening around 6pm and states that she is doing good, did not allow the writer in. She stated good night and she does not need anything at this moment." - On 03/13/2026, there was no documented evidence that Resident #5 had breakfast, lunch or dinner. Further review of Resident #5's records failed to show any documented evidence that RCA #3 and RCA #4 contacted the front desk to check the sign out logbook, called the resident, visited her unit for a wellness check, or escalated the concerns to the manager on duty as stated on facility's the "I'm Okay" policy.	R 389		

Health Regulation & Licensing Administration

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R 389	Continued From page 70 - On 03/14/2026, there was no documented evidence that Resident #5 had breakfast. Further review of Resident #5's records failed to show any evidence that RCA #2 contacted the front desk to check the sign out logbook, called the resident, visited her unit, for a wellness check, or escalated the concerns to the manager on duty as stated on the "I'm Okay" policy. During a walkthrough of the facility on 03/25/2026 at approximately 12:56 PM, the survey team observed a white board with a list of resident names in the RCA's office titled "Do not Check". Resident #5's name was found on this list. During an interview on 3/25/26 at 1:53 PM regarding Resident #5, LPN #5, stated that she worked on the second floor on 03/10/2026 and 03/12/2026 during the 3:00 PM - 11:00 PM shift but that the second floor was not her assigned floor. LPN #5 stated that she did not recall seeing Resident #5 on 03/10/2026 and 03/12/2026 during the shift. According to LPN #5, during the medication rounds on 03/12/2026 at about 6:00 PM, she knocked on Resident #5's door, and she heard the resident say, "Don't come in." LPN #5 stated that when she tried to use the fob to enter the room she was unable to go in so she talked to the resident through the door. During a telephone interview at 2:00 PM on 03/25/2026 regarding Resident #5, LPN #7 (Agency Nurse) stated she was working on 03/14/2024 during the 7:00 AM - 3:00 PM shift and was informed by the RCA that the resident was not responding inside her unit. LPN #7 stated that she pushed through the door which was barricaded by a small couch with the help of the Maintenance Technician and observed the resident lying on the floor. LPN #7 stated that she	R 389		

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R 389	Continued From page 71 called the Resident Care Director (RCD) and he instructed her to call 911 and initiate CPR. "I could tell she had been dead a while. She was very stiff. There was a strong odor that was inside the unit. Her room was junkie." Interview on 03/25/2026 at 2:12 PM, regarding Resident #5's death on 03/14/2026, the Maintenance Technician (MT) in an, stated that he was getting off the elevator and saw RCA #1 knocking on the resident's door, then she asked him to help open the door. The MT stated that once they got inside the unit, he moved the chair that was blocking the door and noticed that the resident was lying face down and unresponsive. Per the MT, "there was a bad odor that came from the room, and the facility had to take out all the carpet from the unit." In a phone interview on 03/26/2026 at 9:43 AM, RCA #6 stated that she was assigned to conduct meal checks on 03/09/2026 during dinner and did not see Resident #5. Per RCA #6, when residents do not show up for dinner, the RCAs would have to get permission to take food to the resident's unit from the kitchen staff. RCA #6 stated that in Resident #5's case, "I don't recall taking food to her unit," and that she last saw Resident #5 towards the end of February 2026 and beginning of March 2026. RCA #6 stated that she last heard her voice through the door last week before her death. "I can't recall the exact date." RCA #6 stated that the resident said to her through the door, "I'm ok but I am feeling sick" but confirmed not reporting the conversation to management. On 03/26/2026 at 11:00 AM, RCA #1 stated during interview that she was assigned to do meal checks during breakfast on 03/10/2026. When asked why she documented that Resident	R 389		

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 389	Continued From page 72 #4 had refused breakfast, RCA #1 indicated that Resident #5 never come down during breakfast and lunch. RCA #1 confirmed not going to Resident #5's unit after breakfast to perform a wellness check because it was the resident's routine not to eat breakfast. Per RCA #1, "We knew this, we just mark refuse on the meal check form." RCA #4 on 03/26/2026 at 11:14 AM, during interview regarding Resident #5's "Meal Checks" documentation during the week of 03/09/2026 through 03/14/2026, indicated that he saw the resident the week she died. RCA #4 stated that he spoke to the resident either on 03/09/2026 or 03/10/2026, while she was sitting across from the elevator on the first floor near the dining hall, and that the resident had told him she was not feeling well. RCA #4 stated that both him and RCA #1 knocked on Resident #5's door on 03/10/2026 to see if she wanted to come down for breakfast, and that the resident responded by saying, "No, I'm ok". RCA #4 stated that he did not see her for the rest of that week. When asked, RCA #4 revealed that he was assigned to conduct "Meal Checks" for breakfast on 03/09/2026, 03/12/2026 and 03/13/2026. When asked why he did not document whether the resident was present, had her food delivered and/or refused to come to the dining hall on the above days, RCA #4 stated that the resident never comes down for breakfast, and that was why he documented a refusal. When asked if he conducted a wellness check on the resident, RCA #4 stated, "No, I did not". At 11:17 AM, the surveyors shared with RCA #4 that Resident #5 was not seen on the facility's video surveillance cameras seated near the dining area across from the elevators from 03/09/2026 through 03/14/2026. RCA #4 then changed his statement and stated, "I thought I saw her on one	R 389		

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R 389	Continued From page 73 of those days. Maybe it was a different week". On 03/26/2026 at 12:18 PM, RCA #9 during interview regarding Resident #5's "Meal Checks" from 03/09/2026 through 03/14/2026 stated he was responsible for doing the meal checks for lunch on 03/10/2026, breakfast and lunch on 03/11/2026, lunch on 03/12/2026 and breakfast on 03/14/2026. The RCA stated, "I haven't seen [Resident #5]. I can't recall when I saw her last time. She rarely came down for breakfast and lunch. If she did, she would sit across from the elevator." When asked why he did not document on the meal check form, RCA #9 stated that the staff on the second floor was supposed to let him know that the resident did not come down for meal. RCA #9 confirmed not going upstairs on 03/09/2026 to perform a wellness check on Resident #5. On 03/26/2026 at 12:59 PM, the Dietary Aide during interview regarding the last time she saw Resident #5 in the dining room, stated she last saw the resident approximately two weeks before her death but could not recall the specific date. The Dietary Aide stated that Resident #5 looked like she had been losing a lot of weight, and that she had previously asked the resident if she had food in her room and the resident responded, "I'm Okay." RCA #10 on 03/26/2026 at 1:02 PM, during a phone interview stated she was assigned to conduct meals for dinner on 03/10/2026, does not recall Resident #5 coming down for dinner, and did not document on the meal check form for the resident. Per RCA #10, she was supposed to check on the residents after dinner if the residents did not attend dinner, but she did not go to Resident #5's unit to conduct a wellness check	R 389			

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R 389	Continued From page 74 after dinner. RCA #10 stated she last saw Resident #5 on 03/12/2026 seated in the lobby area that evening, but a review of the facility's video surveillance cameras for the entire week of 03/09/2026 through 03/14/2026 showed that Resident #5 was not anywhere in the facility or seen sitting near the dining area across from the elevators. During an interview on 03/26/2026 at 2:23 PM regarding the last time Resident #5 ate a meal in the dining room, the Dining Services Supervisor (DSS) stated that she had not seen the resident in over a week prior to her death. Per the DSS, "the resident often sat outside of the dining area across from the main elevators, and that Resident #5 did not usually eat breakfast or lunch, however, she would usually eat dinner." When asked what the RCAs should do if a resident did not show up for meals, the DSS indicated that "the RCAs should document on the "I'm Okay" form and complete a wellness check on the resident." Resident #11 on 03/27/2026 at 10:05 AM, during an interview revealed that she went to check on Resident #5 because she had been in that room for almost a month, and that she had been communicating with Resident #5 through the door a few times a week during the month. Resident #11 stated that she knew Resident #5 wasn't "feeling well, she was up there a whole month." but could not understand why the facility staff did not check on the resident. Resident #11 revealed that she went to Resident #5's unit on 03/13/2026 to check on her, and "I believe I heard her but, not sure. I called her name a few times and she didn't answer. She mumbled something and she went quietly. I didn't hear anything after that".	R 389		

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R 389	Continued From page 75 During an interview on 03/25/2026 at 3:18 PM and 3/27/2026 at 12:00 PM regarding Resident #5's death, the facility's RCD stated that he received a call from the assigned LPN that the resident was found on the floor in her unit unresponsive and he had instructed the nurse to call 911, and to initiate CPR. Per the RCD, when he saw the resident's unit for the first time (03/14/2026), he described the unit as "having fecal matter on the bathroom floor, toilet was backed up with urine, expired food in the refrigerator and the room temperature was humid with a strong smell of urine in the unit." The RCD indicated that Resident #5 appeared to be a hoarder based on the visual appearance of her unit. "I believe she had Psych issues and the unit needed to be professionally cleaned after her death." When asked why he was not made aware that Resident #5 had not been eating meals, the RCD stated that it was the dining team's responsibility to communicate to the nursing team that the resident had not been eating. According to the RCD "people that knew Resident #5 had an attitude and say, "I'm not going to check on [Resident #5] because I know she's going to refuse." The RCD added, "There are a lot of problems in this building, and the communication is not good here." The RCD denied knowledge of the "I'm Okay" policy and acknowledged that he was aware that there was a "Do not check" list but he does not know who created the list.	R 389		
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	R 483		

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R 483	Continued From page 76 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. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to review the resident's Individual Service Plan (ISP): I) 30 days after admission, II) at least every 6 months thereafter and III) update the ISP when there was a significant change in the resident's condition, for two residents in the investigation (Resident #5 and #7). Findings included: I) The review of Resident #5's records revealed that the resident was admitted to the ALR on 08/21/2025. Further review revealed that the resident's ISP was initiated on 08/20/2025. The resident's records failed to show any documented evidence that the resident's ISP was reviewed within 30 days of admission to the ALR. II) A review of Resident #5's records revealed that the resident's ISP was initiated on 08/20/2025, however there was no documented evidence of a six-month review completed as required by 02/20/2026. Also, a review of Resident #7's records revealed that the resident's ISP was last completed on 06/03/2024. There was no documented evidence to show any subsequent six-month review since the last update on 06/24/2024. III) Review of the facility's video surveillance for the week of 03/09/2026 through 03/14/2026 revealed that Resident #5 was not observed in	R 483		

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R 483	Continued From page 77 the facility's dining and common areas or coming out of her room during those days. A review of the facility's meal check forms for the week of 03/09/2026 through 03/14/2026 revealed that the Resident Care Assistant's (RCA) documented "refusal" on the forms without any visual confirmation of the resident. There was no documented evidence that the resident's ISP was updated to reflect meal refusals and a plan to mitigate the issue. Resident #5's ISP dated 08/20/2025 indicated that the resident will maintain independence with housekeeping, however, there was no documented evidence that the resident was reassessed to determine the resident's ability to maintain independence with housekeeping. There were no other reviews or updates to the ISP noted on the record since 08/20/2025. During an interview beginning at 12:00 PM on 03/27/2026, the Resident Service Director (RCD) acknowledged that not all the residents' ISPs had been updated or reviewed. The RCD stated that they have hired a quality assurance nurse to help with the ISP reviews and the ISPs are not currently up to date.	R 483			
R 501	Sec. 605a Shared Responsibility Agreements (a) Whenever disagreements arise as to lifestyle, personal behavior, safety, and service plans the ALR staff, resident or surrogate, and other relevant service providers shall attempt to develop a shared responsibility agreement. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to develop a shared agreement to address	R 501			

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R 501	Continued From page 78 resident's safety specifically, daily shift checks for one of the three residents in the investigation who were found deceased in their units (Resident #5). Finding included: A review of the ALR's "I'm Okay" dining policy with a revised date of March 2025 showed that the "The I'm Okay program offers the opportunity for three safety checks during the course of the day at mealtimes. These three safety checks are in alignment with the three mealtime offerings. The Dining Room staff and the Resident Care Associates (RCAs) work together to determine the location of each resident at mealtime and are able to identify if there are any changes or disruptions to their regular patterns". The I'm Okay check will begin throughout the meal service as wait staff/RCAs check off residents as they come to meals. When there are about 20 minutes left for meal service, the lists will be reviewed and notations made to names that have had Tray Service to their rooms. The I'm Okay check policy required that if a resident has not come to the meal, or had arrangements for tray service, the following actions will occur: 1. The front desk sign out log will be checked to determine if the resident is out of the building. If that does not appear to be the case then: 2. The resident cell phone will be called, and a visit will be made to the apartment for a wellness check. 3. If this does not appear to be the case, the Executive Director (ED)/Resident Care Director (RCD) manager on duty will call the family to determine if they "Forgot" to sign out.	R 501			

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R 501	Continued From page 79 4. If this is not the case, an elopement drill will proceed. On 03/25/2026 at 12:56 PM, observations of the "Do Not Check" board in the RCA office showed that there were 23 residents listed on a white board, including Residents #5. The review of Residents #5 records failed to show any developed shared agreement between the resident and ALR as required in provision of services including supervision and oversight to ensure the well-being and safety of the resident. Review of the facility's meal check forms for the week of 03/09/2026 through 03/14/2026 revealed that the Resident Care Assistant's (RCAs) documented that Resident #5 failed to attend meals. Staff documented "refusal" without visual confirmation. On 03/26/2026 at 11:46 AM, the Housekeeper said during an interview that she has never cleaned Resident #5's unit since she started working for the ALR in January 2025. She stated that "the resident would position a couch or small chair in front of the door to prevent entry." The Housekeeper acknowledged that she had not been consistent in completing the checklist forms for the resident. She indicated that management was aware of Resident #5's refusal to allow housekeeping staff to enter the unit and that no further action was taken. On 03/26/2026 at 12:18 PM, RCA #2 stated in an interview that he could not recall the last time he saw Resident #5. RCA #2 confirmed that he did not go to the resident's unit during the week of 03/09/2026, and that he relied on other staff to notify him if the resident did not attend meals.	R 501		

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R 501	Continued From page 80 On 03/26/2026 at 1:47 PM, RCA #9 stated she did not complete the meal check form for Resident #5 and did not notify the person in charge when the resident did not attend dinner. On 03/27/2026 at beginning at 12:18 PM, the RCD stated in an interview that "upon entering Resident #5's unit on 03/14/2026, the unit contained fecal matter, urine backed up in the toilet, expired food in the refrigerator, and a strong odor of urine." The RCD acknowledged communication issues within the facility and stated that staff may avoid checking on residents who are known to refuse care. The RCD also acknowledged awareness of a "Do Not Check" list but stated that he did not know who created the list. The RCD acknowledged that none of the residents have a shared agreement in place and these issues had not been escalated to the residents' primary care physicians. On 03/27/2026 at 3:18 PM, the ED stated during an interview that she was aware of a "Do Not Check" list but does not know who created the list. The ED stated, "For all I know, it could have been created by RCAs". When asked if the residents listed on the "Do not Check" board had shared agreements, the ED replied by saying, "No".	R 501			
R 513	Sec. 606 3 Resident Records (3) A physician's statement, including medical orders and rehabilitation plans; Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that each resident's record was completed and accurately maintained, including a current	R 513			

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R 513	Continued From page 81 physician's statement and medical orders reflecting the resident's code status, for two residents in the investigation (Residents #1 and #5). Finding included: 1) The review of a facility incident report dated 02/20/2026 at 4:05 PM indicated that the Resident Care Director (RCD) was called to the fourth floor by LPN #2 for a medical emergency, and upon arrival saw Resident #1 sitting in a chair holding her chest as in respiratory distress. According to the incident report, the RCD asked RCA #1 to call 911 and then proceeded to print out documents to give to the 911 personnel. The RCD returned to the fourth floor at 4:14 PM to assist LPN #2 and the other clinicians in providing CPR to Resident #1. The incident report detailed a timeline of events as below: - At 3:50 PM, Resident #1 activated her emergency pendant and charge nurse responded. - At 3:55 PM, the resident verbalized to the charge nurse that she felt as if she was unable to belch. - At 3:56 PM, the resident picked and put her sneakers on and started to ambulate from her apartment to the 4th floor lounge with charge nurse by her side. - At 4:04 PM, the charge nurse assisted the resident in a sitting position by the 4th floor lounge.	R 513		

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R 513	Continued From page 82 - At 4:05 PM, Resident #1 was observed in distress, 911 call activated, CPR was initiated by facility clinicians, following - American Heart Association Resuscitation protocols. - At 4:08 PM, first team of 911 arrived on scene, assisting the facility employees with CPR. - At 4:14 PM, automated external defibrillators attached to the resident and first shock rendered, resumed CPR. - At 4:19 PM, 911 Advanced Cardiovascular Life Support team and Metropolitan police arrived on scene, assumed control of the emergency interventions until 4:52 PM when Resident #1 was pronounced dead by team 911. On 03/11/2026 at 10:33 AM, a review of the facility's surveillance video revealed the following chain of events that occurred on 02/20/2026 when Resident #1 remained seated and not moving while seated in a chair in the lobby area on the fourth floor - From 3:50 PM - 3:53 PM: The video showed Resident #1 ambulating towards the fourth-floor lobby with LPN #2, and while ambulating towards the chair, the resident's legs appeared to "buckle" which prompted LPN #2 and the Resident Care Assistant (RCA #6) to assist the resident to the chair. Once in the chair, another resident (Resident #2) who was sitting in a chair directly beside the resident got up and walked towards the elevator with her four-wheel walker. - At 3:53 PM: After Resident #1 was seated, the nurse appeared to retrieve an item from the medication cart. Licensed Practical Nurse (LPN) #2 walked to a table located in front of the	R 513		

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WASHINGTON, DC 20019**

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R 513	Continued From page 83 elevator, retrieved an item, and returned to the resident. LPN #2 can be seen tapping the resident on the leg and then instructing the RCA #6 to perform a task, after which the staff left the floor. LPN #2 retrieved a laptop and walked over to the resident while looking at the laptop. - From 3:54 PM - 3:55 PM: LPN #2 walked to the phone located on a table in front of the elevator and placed a call to someone. The LPN then returned to the resident and was seen tapping the resident on the leg in an apparent attempt to obtain a response and can be seen moving back and forth between the cart and the resident. The LPN retrieved a laptop, returned to the cart by the elevators, then returned again to the resident and continued taping the resident's leg. - At 3:55:44 PM: The RCD returned back to the fourth floor with RCA 6, walked over to the resident and appeared to ask LPN #2 something. The video showed the RCD leaning over towards the resident and appeared to solicit a response. - At 3:56 PM - LPN #2 brought what appeared to be a blood pressure cuff over to the resident and attempted to obtain a blood pressure reading. The RCD appeared to gesture something to RCA #6 nearby who then left the fourth floor via the elevator. LPN #2 and the RCD could be seen in the video just standing in front of the resident. - At 3:57 PM - 3:58 PM: LPN #2 retrieved an item from the medication cart and returned back to the resident. Simultaneously, the RCD retrieved an item from the medication cart and returned back to the resident. The RCD could be seen attempting again to obtain blood pressure reading. The RCD and LPN #2 were observed hovering in front of the resident.	R 513		

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER THE RESIDENCES AT KENILWORTH PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 KENILWORTH AVE, NE WASHINGTON, DC 20019		
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R 513	Continued From page 84 - At 3:59 PM, a third resident (Resident #3) walked towards the lobby with a rollator walker and sat down in a chair and appeared to watch the incident with Resident #1. The RCD again grabbed an item from the medication cart, and then LPN #2 placed the item back on the medication cart. - At 4:00 PM - 4:01 PM: The RCD appeared to be looking for something near the medication cart while the LPN #2 moved back and forth between the resident and the medication cart. The RCD walked over to the resident and appeared to solicit a response by tapping the resident. Walked over and threw something into the trashcan and returned back to the medication cart. A few seconds later, the RCD walked towards the elevator, pressed the elevator button and the proceeded around the corner to the stairwell leaving the fourth floor. - At 4:02 PM: LPN #2 was observed standing near the resident holding an item in his hands, while the resident remained seated and not moving. - At 4:03 PM: LPN #2 returned to the medication cart, retrieved an item, and walked back near the resident while holding the item, stepped back and looked out of the window for a few seconds, meanwhile no lifesaving intervention was initiated during this time. - At 4:04 PM: LPN #3 exited the stairwell on the fourth floor, and walked toward the medication cart, retrieved what appeared to be hand sanitizer and proceeded towards the resident where LPN #2 was standing. Spoke with LPN #2 before going over to the resident.	R 513		

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R 513	Continued From page 85 - At 4:05 PM: LPN #4 also exited the stairwell on the fourth floor, and walked towards the medication cart, retrieved what appeared to be hand sanitizer, and then walked towards the resident, the LPN #2 and LPN #3. LPN #4 could be seen in the video having a conversation with LPN #2, LPN #3,, and a few seconds later, LPN #2, LPN #3 and LPN #4 were observed placing the resident on the floor. - At 4:06 PM: LPN #4 started chest compressions while the LPN #2 and LPN #3 were present, as woman wearing a black outfit carrying a black briefcase exited the elevator and walked towards the scene. - At 4:07 PM: Emergency Medical Services (EMS) arrived on the fourth floor and assumed care of the resident. A review of the EMS records revealed the following notes: - On 02/20/2026 at 4:00:26 PM - EMS received an alert from dispatch - On 02/20/2026 at 4:04:57 PM - EMS arrived on scene - On 02/20/2026 at 4:06:00 PM - Patient contact Continued review of the EMS records revealed that upon EMS assessment, the EMS found Resident #1 with no pulse, not breathing, unresponsive and upon assessment had a Glasgow Coma Scale score of 3. During an interview on 03/10/2026 at 2:02 PM, regarding Resident #1's death, the facility's Vice	R 513		

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NAME OF PROVIDER OR SUPPLIER

THE RESIDENCES AT KENILWORTH PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 513	Continued From page 86 President of Resident Services (VRS) revealed that she had just met with the resident's family and showed the family parts of the video of the incident. Per the VRS she "believed that seeing the entire video would be traumatic to the family." The VRS provided a verbal timeline of events of what happened to Resident #1 based on a review of the video of the incident to the surveyors. On 03/12/2026 at 11:10 AM and 03/19/2026 12:26 PM respectively, LPN #2 during a telephone and face-to-face interview revealed that he was the nurse that cared for Resident #1 on 02/20/2026. LPN #2 stated that he was on the fifth floor when he received a call over the Walkie-Talkie that Resident #1 pressed her pendant and needed assistance. LPN #2 stated that upon assessment, the resident told him that she could not "belch", that he asked the resident if she wanted some water, and the Resident #1 said "No, I have drunk enough water already, and that the water wasn't working." LPN #2 stated that he told the resident, "Maybe you need to go for a walk" and that the resident walked with him down the hallway towards the lobby and as she got closer to the lobby, the resident told him that she could not move her legs. LPN #2 stated that he called the Resident Care Assistant (RCA #6) who was in the lobby to help assist Resident #1 to a chair. LPN #2 stated that, "She was gasping for air. I was a little bit panicked." "I grabbed the inhaler and tried to give her a puff, but she closed her eyes and dropped her head. I said to the resident, stay with me, stay with me! Everything happened so suddenly. I was just panicking." When asked if he remember when the resident stopped breathing, LPN #2 said, "I can't tell you when she stopped. I was panicking". When asked why he did not call 911 or have the RCA #6 to call 911 and start CPR, he said, "My boss (the RCD)	R 513		

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R 513	Continued From page 87 had instructed us to call him first in an emergency before anyone else". LPN #2 stated that he told RCA #6 to go get the RCD, and that he then walked over to the telephone to call the RCD because the resident was unresponsive. "I panicked. I didn't know what to do honestly. I don't remember a lot that happened, I panicked!!!" Further interview with LPN #2 revealed that the RCD arrived on the fourth floor, and that he told the RCD that the resident was unresponsive. "I was panicking." LPN #2 stated that the RCD checked the residents pulse and pulse oximeter which he said was in the low 90s. "I was panicking." LPN #2 also stated that the RCD asked for the residents CODE Status, and he checked the laptop but could not find it under the residents profile section on the electronic medical record. LPN #2 stated that LPN #3 and LPN #4 arrived, checked the resident's vitals, placed her on the floor and initiated CPR. "I was just there. My mind was shaking." 2) A review of the facility's incident report dated 03/14/2026, revealed that at approximately 09:55 AM, the charge nurse was notified by the assigned Certified Nursing Assistant (CNA) that Resident #5 was found unresponsive in her room. The report indicated that the resident was found face down, cold to touch, and without vital signs. Cardiopulmonary Response (CPR) was initiated, and Emergency Medical Service was contacted, and the resident was pronounced deceased at 10:08 AM. A review of Resident #5's medical record failed to show any documented evidence of the resident's code status. During an interview on 03/12/2026 at 2:05 PM, the Resident Care Director (RCD) acknowledged	R 513		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
WASHINGTON, DC 20019**

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R 513	Continued From page 88 that a code status had not been documented on the resident's records, and that it is usually documented on the resident's profile page.	R 513		
R 522	Sec. 607a1 Services To Be Provided 1) Twenty-four-hour supervision and oversight to ensure the well-being and safety of its residents; Based on interviews, review of surveillance camera video footage, and record reviews, the Assisted Living Residence (ALR) failed to consistently provide supervision and oversight to ensure the safety and well-being for one of the three residents in the investigation who were found deceased in their units (Residents #5). Finding included: 1) A review of the ALR's "I'm Okay" dining policy with a revised date of March 2025 indicated that the program offers the opportunity for three safety checks during the course of the day at mealtimes. Per the policy, these safety checks are in alignment with the three mealtime offerings, and that the Dining Room staff and the Resident Care Associates work together to determine the location of each resident at mealtime and are able to identify if there are any changes or disruptions to their regular patterns". The policy required that the I'm Okay check will begin throughout the meal service as wait staff/RCA's check off residents as they come to meals. Also, when there are about 20 minutes left for meal service, the lists will be reviewed and notations made to names that have had Tray Service delivered to their rooms. Per the policy, if a resident fails to come to any meal, or had arrangements for tray service, the	R 522		

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R 522	Continued From page 89 following actions will occur: a. The front desk sign out log will be checked to determine if the resident is out of the building. If that does not appear to be the case then: b. The resident cell phone will be called, and a visit will be made to the apartment for a wellness check. c. If this does not appear to be the case, the ED/RCD/manager on duty will call the family to determine if they "Forgot" to sign out. d. If this is not the case, an elopement drill will proceed. A review of the facility's meal check forms for the week of 03/09/2026 through 03/14/2026, revealed that the Resident Care Assistant's (RCA) documented that Resident #5 was not observed during meals, and checked "refusal" without visual confirmation. 2) Observations in the RCA's office on 02/23/2026 at 2:50 PM, revealed a "Do Not Check" list of resident names on a white board, including Residents #5. When asked about the list, the Schedule Coordinator who was in the office at the time shared that the listed residents did not want staff to check on them. During an interview on 03/25/2026 at 12:44 PM, RCA #12 confirmed working from 7:00 AM to 3:00 PM on 03/14/2026 the morning Resident #5 was found unresponsive on the second floor. RCA #12 when asked if she conducted room checks at the beginning of her shift, RCA #12 said, "No, she is on the Do not Check" board. When asked further about the "Do not Check Board", the RCA confirmed that there were several other residents listed on the board, and that, "it's there right not to be checked on every shift".	R 522		

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R 522	Continued From page 90 RCA #1 during an interview on 03/26/2026 at 11:45 AM, reported that Resident #5 had expressed on numerous occasions that she did not want staff to enter her room or check on her every shift. When asked how the facility would know if something was wrong or if she was not attending meals, RCA #1 stated that "we just try and communicate with her by speaking to her through her door to make sure she's ok without physically seeing her." On 03/26/2026 at 12:18 PM, RCA #2 during interview stated that he could not recall when last he saw Resident #5 and confirmed that he did not go to the resident's unit during the week of 03/09/2026. According to RCA #2, he relied on other staff to notify him if the resident did not attend meals. RCA #9 during interview on 03/26/2026 at 1:47 PM, confirmed not completing the meal check form for Resident #5 and did not notify the person in charge when the resident did not attend dinner. During an interview on 03/27/2026 at beginning at 12:18 PM, the Resident Care Director (RCD) described Resident #5's apartment after death as "containing fecal matter, urine backed up in the toilet, expired food, humid conditions, and a strong odor." The RCD acknowledged communication issues within the facility and shared that staff may avoid checking on residents who are known to refuse care. The RCD acknowledged being aware of a "Do Not Check" list but that he did not know who created the list.	R 522		
R 528	Sec. 607c Services To Be Provided	R 528		

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R 528	Continued From page 91 (c) An ALR shall provide or coordinate scheduled transportation to community-based services. Based on interviews and record review, the Assisted Living Residence (ALR) failed to ensure residents received access to necessary medical services through coordination of transportation and appointment assistance, specifically a cardiology appointment for one resident in the investigation (Resident #4). Findings included: On 02/08/2026 at 12:47 PM, the Department of Health (DOH) received an anonymous email alleging concerns about the care of a resident at the ALR. Review of complaint #DC00014139 revealed allegations that "Resident #4 is blind, requires assistance with activities of daily living (ADLs), and had missed a critical cardiology appointment due to the facility's failure to provide necessary assistance and transportation." The review of Resident #4's medical records revealed that the resident was visually impaired (blind) and required assistance with ADLs, including attending medical appointments. Further review of the records showed that the resident attended a cardiology appointment on 10/13/2025, during which a dobutamine stress test was scheduled for 11/06/2025. The consultation sheet also indicated a return appointment scheduled for 01/13/2026. There was no documented evidence to show that the resident returned to the cardiology clinic after the 11/06/2025 dobutamine stress test. Resident #4 during an interview on 02/23/2026 starting at 2:00 PM, reported that he required assistance with scheduling medical appointments and transportation. The resident reported missing	R 528		

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R 528	Continued From page 92 important cardiology appointment because he did not have an escort or transportation. During an interview on 02/23/2026 at 2:46 PM, the facility's Staff Scheduler (SS) indicated that her responsibilities included "scheduling medical appointments and arranging transportation, and that the facility administrators instructed her that appointments could only be scheduled on Tuesdays and Thursdays due to limited escort staff." When asked how appointments scheduled on Mondays, Wednesdays, and Fridays were handled, the SS stated that "those appointments would have to be handled by the resident's family, or the facility would have to reschedule the appointment." The SS denied missing any appointments for Resident #4 during the year. The Executive Director (ED) during an interview on 02/23/2026 at 3:09 PM, confirmed that the facility provided escort services for visually impaired residents only on Tuesdays and Thursdays, and that appointments scheduled for Mondays, Wednesdays, or Fridays would need to be rescheduled or attended by the resident's family. The cardiology clinic staff confirmed during a telephone interview on 03/05/2026 at 2:16 PM that Resident #4 had multiple scheduled appointments and a history of missed appointments, including: · 11/03/2025 - Appointment Cancelled · 01/21/2026 - Appointment Cancelled · 01/27/2026 - No-Show · 01/30/2026 - Appointment Cancelled When asked during an interview about Resident #4's missed appointments on 03/05/2026 at 2:51	R 528		

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R 528	Continued From page 93 PM, the Director of Resident Care (RCD) stated, "I know nothing about it; ask the Staff Scheduler, she will know."	R 528		
R 803	Sec. 903.3 On-Site Review. (3) Assess the resident's ability to continue to self-administer his or her medications. Based on interviews and record reviews, the facility failed to ensure a Registered Nurse (RN) completed a required 45-day medication regimen review to assess the resident's ability to safely continue to self-administer medications for one resident in the investigation (Resident #5). Findings included: A review of the facility's Medication Policy/ Medication Management dated July 2022, revised December 2022 and March 2025 listed that, "Each resident will be assessed by the RN regarding their ability to safely participate with independent medication management, self-management of medications prior to move-in, and every 45 days including the need for "as needed" (PRN) medications." Review of Resident #5's record revealed that the resident was admitted to the ALR in August 2025 with diagnoses that included Hypertension, Major depressive disorder, Seizure disorder, Osteoarthritis and Glaucoma. The resident's Medication Administration Record (MAR) for March 2026 showed that Resident #5 was prescribed multiple medications Amlodipine, Hydralazine, Hydrochlorothiazide, Atorvastatin, Duloxetine, Quetiapine, Mirtazapine, Levetiracetam, Gabapentin, Zolpidem, Nicotine patch and Ondansetron (PRN). All medications	R 803		

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R 803	Continued From page 94 were documented as unsupervised self-administration on MAR. Further review of the records revealed an initial 45-day medication review conducted on 10/09/2025 by the facility's previous Director of Resident Care (RCD). There was no documented evidence that a Registered Nurse completed a 45-day medication regimen review following the initial assessment of 10/09/2025. During an interview on 03/18/2026 at 12:00 PM, regarding the 45-day medication reviews for Resident #5, the Quality Assurance (QA) nurse indicated that a 45-day medication review was completed for the resident by the Registered Nurse (RN) 03/06/2026. The QA nurse later acknowledged that she did not complete the 45-day medication review as documented and did not physically assess the president's ability to continue to self-administer her medications. On 03/18/2026 at 12:22 PM, during an interview, the Director of Resident Care (RCD) acknowledged that only one 45-day medication review dated 10/19/2025 was present in Resident #5's medical records. The RCD further indicated that the RN was terminated after it was determined that the 45-day medication review dated 03/06/2026 had not been completed	R 803			
R 981	Sec. 1004a General Building Interior (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. Based on observations, interviews, and record reviews, the facility failed to ensure the interior of	R 981			

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R 981	Continued From page 95 the Assisted Living Residence (ALR) was maintained in good sanitary condition for the 144 residents residing in the facility. Findings Include: 1) The review of a pest control invoice dated 02/16/2026 documented "serious cleanliness issues in the facility's kitchen, including food debris on walls, floors, and equipment, and warned of increased pest risk issues in the ALR." Observations of the kitchen on 02/25/2026 beginning at 11:56 AM revealed that there was multiple pest traps set on the floor in the food preparation areas. During an interview at 12:44 PM, the Food Services Director confirmed that a mouse had been observed in the kitchen/dining area and that the facility contracted pest control company had advised that the kitchen was not being properly cleaned.	R 981			