

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 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 012	10102.4 Authority To Operate An Assisted Living Resid 10102.4 A Licensee shall be responsible for the health, safety, and welfare of the ALR's residents. Based on observations, interviews, and record reviews, the facility failed to ensure the interior of the Assisted Living Residence (ALR) was maintained in good sanitary condition for the 144 residents residing in the facility. Findings Include:	R 012		

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

TITLE

(X6) DATE

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R 012	Continued From page 1 1. The review of a pest control invoice dated 02/16/2026 revealed a documentation the stated "serious cleanliness issue in the kitchen, including food debris all around the walls, floors, and equipment. This is going to cause major issues with pests in the kitchen." Observations of the ALR's kitchen on 02/25/2026 beginning at 11:56 AM revealed that there were 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 012		
R 079	10109.2 Resident's Rights And Quality Of Life 10109.2 The ALR shall support the resident (or surrogate) in exercising the resident's rights under this chapter without interference, coercion, discrimination, or threat of retaliation. 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: Review of complaint #DC00014139 revealed allegations that Resident #4 had received a 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	R 079		

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R 079	Continued From page 2 2:03 PM revealed that he received a "Past Due Recertification Notice" after refusing to provide an ATM receipt showing his account balance to the facility. Per the resident, the notice was placed under his door without any explanation. The resident further shared that he is blind and depends on staff assistance to read documents. The review of a recertification notice, issued by the facility, which was neither signed nor dated, indicated that the resident's failure to submit the requested documentation by 02/20/2026 could result in the issuance of a 45-day notice initiating eviction proceedings. The ALR's Billing Specialist on 02/24/2026 at 11:34 AM during an interview stated that residents were required to provide documentation of income and assets, including bank statements and receipts, as part of the recertification process for the Low-Income Housing Tax Credit program. 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 the residents during the initial facility admission process. 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 receipt reflecting his balance.	R 079		
R 115	10110.2h Required Policies And Procedures 10110.2(h) Preventing, investigating, reporting, and remediating abuse, neglect, and exploitation of residents; Based on observations (including video	R 115		

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R 115	Continued From page 3 surveillance), record reviews, 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 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	R 115		

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R 115	Continued From page 4 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 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.	R 115		

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R 115	Continued From page 5 - 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: -3:50 PM - 3:53 PM: The video showed Resident	R 115		

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R 115	Continued From page 6 #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 be a blood pressure cuff over to the resident and attempted to obtain a blood pressure reading.	R 115		

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R 115	Continued From page 7 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 moving. - At 4:03 PM: LPN #2 returned to the medication cart, retrieved an item, and walked back near the	R 115		

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R 115	Continued From page 8 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. - On 02/20/2026 at 4:04:57 PM - EMS arrived on scene.	R 115		

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R 115	Continued From page 9 - 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. On 03/09/2026 at 2:51 PM, the Department of Health (DOH) received a complaint (DC#00014138) regarding services rendered at the facility that referenced, "A February 20, 2026, medical emergency where a CPR was delayed until EMS arrival." 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	R 115		

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R 115	Continued From page 10 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 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	R 115		

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R 115	Continued From page 11 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 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	R 115		

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WASHINGTON, DC 20019**

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R 115	Continued From page 12 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 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	R 115		

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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 115	Continued From page 13 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 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	R 115		

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R 115	Continued From page 14 that when Resident #1 sat down next to her, she appeared to have some breathing issues. Resident #2 became emotional and ended the 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 the touch and determined to be deceased on arrival (DOA)." Due to the nature of this	R 115		

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R 115	Continued From page 15 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 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. 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	R 115		

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R 115	Continued From page 16 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." 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. A progress note dated 03/12/2026 at 22:58 [5:58 PM] documented that, "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 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.	R 115		

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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 115	Continued From page 17 - 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 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, 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. - 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	R 115		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RESIDENCES AT KENILWORTH PARK

**1650 KENILWORTH AVE, NE
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R 115	Continued From page 18 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 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 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	R 115		

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R 115	Continued From page 19 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 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.	R 115		

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R 115	Continued From page 20 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." 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	R 115		

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R 115	Continued From page 21 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 [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	R 115		

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R 115	Continued From page 22 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 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,	R 115		

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R 115	Continued From page 23 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 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 115		
R 330	10122.1 On Site Medication Review 10122.1 The on-site medication review by a	R 330		

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 330	Continued From page 24 registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued. 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 residents 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 were documented as unsupervised self-administration on MAR.	R 330		

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R 330	Continued From page 25 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 resident'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 330		
R 342	10124.1 Medication Administration 10124.1 A resident shall be permitted to self-administer his or her medications, provided that the resident has been determined capable of self-administering his or her own medication as defined in paragraphs (a) or (b) of § 10124.2 by the most recent on-site medication review required under the Act or, if he or she is a new resident, by the initial assessment conducted	R 342		

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R 342	Continued From page 26 during the ALR's admission process. Based on interviews and record reviews, the facility failed to ensure a Registered Nurse (RN) completed required 45-day medication reassessments for the one resident in the complaint (Resident #5). Findings included: A review of the facility's Medication Policy/ Medication Management dated July 2022, and revised December 2022/ 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 residents 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 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	R 342			

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R 342	Continued From page 27 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 resident's ability to continue to self-administer her medications.	R 342			
R 372	10124.6 Medication Administration 10124.6 An ALR shall require that administration or assistance in the administration of medication to a resident by a healthcare professional pursuant to §§ 10124.3 and 10124.5 be in accordance with the prevailing standard of acceptable medication administration rights in the healthcare professional's field. Based on record review and interviews, the facility failed to ensure that medications were administered in accordance with the standard of acceptable medication administration practices, specifically, medications were administered at the wrong time for one of the 32 residents in the sample (Resident #8). Findings included: A review of the Assisted Living Residences (ALR) Medication Policy/ Medication Management dated July 2022, and revised December 2022/ March 2025 listed, "The "6 R" of Medication Management are to be followed. a) Right Person, b) Right Medication, c) Right Date, d) Right Time, e) Right Route (topical, nasal, pill, etc.), f) Right to	R 372			

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R 372	Continued From page 28 Refuse." 1) During an interview on 02/24/2026 at 4:09 PM, Resident #8 reported to the surveyors that on 02/22/2026, he did not receive his scheduled 8:00 AM medications until approximately 12:00 PM. A review of the resident's Medication Administration Record (MAR) for 02/22/2026 revealed that the resident's scheduled 8:00 AM medications-including Clopidogrel Bisulfate 75 mg, Jardiance 10 mg, Losartan Potassium 25 mg, Metoprolol Succinate ER 50 mg, Cyclobenzaprine HCl 10 mg, Amlodipine Besylate 10 mg, Aspirin 81 mg (delayed release), Bupropion HCl ER, Chlorthalidone 25 mg, and Cholecalciferol 125 mcg-were not administered until approximately 1:08 PM (5-hours later) and documented at 1:14 PM. A review of the facility's incident report folder and progress notes failed to show any documented evidence that the medication error was reported to the Resident Care Director (RCD), resident's healthcare practitioner, prescriber, pharmacist, and the resident's responsible party (or surrogate). The RCD during an interview on 03/04/2026 at 12:20 PM, regarding overdue medications identified in the Medication Administration Record (MAR) in Point Click Care (PCC), acknowledged that medications were being administered and documented late. The RCD failed to provide any evidence that the delayed medication administration was reported as a medication error.	R 372		
R 374	10124.8 Medication Administration	R 374		

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R 374	Continued From page 29 10124.8 An ALR shall ensure that all employees and all licensed practical nurses, registered nurses, advanced practice registered nurses, physicians, physician assistants, or certified medication aides responsible for administering or assisting in the administration of medication to a resident while on the ALR's premises, immediately report any medication error or adverse drug reactions to the ALR's available registered nurse and ALA upon discovery. The ALR shall require the ALA or Acting Administrator to report the medication error or adverse drug reaction, to the resident's healthcare practitioner, prescriber, pharmacist, and the resident (or surrogate), as appropriate. Based on record reviews and interviews, the facility failed to ensure that a medication error was immediately reported to the resident's healthcare practitioner, prescriber, pharmacist, and the resident's responsible party (or surrogate) as required for one resident in the investigation (Resident #8). Findings included: During an interview on 02/24/2026 at 4:09 PM, Resident #8 reported to the surveyors that on 02/22/2026, he did not receive his scheduled 8:00 AM medications until approximately 12:00 PM. A review of the resident's Medication Administration Record (MAR) for 02/22/2026 revealed that the resident's scheduled 8:00 AM medications-including Clopidogrel Bisulfate 75 mg, Jardiance 10 mg, Losartan Potassium 25 mg, Metoprolol Succinate ER 50 mg, Cyclobenzaprine HCl 10 mg, Amlodipine Besylate 10 mg, Aspirin 81 mg (delayed release), Bupropion HCl ER, Chlorthalidone 25 mg, and Cholecalciferol 125 mcg-were not administered until approximately 1:08 PM (5-hours later) and	R 374		

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R 374	Continued From page 30 documented at 1:14 PM. A review of the facility's incident report folder and progress notes failed to show any documented evidence that the medication error was reported to the Resident Care Director (RCD), resident's healthcare practitioner, prescriber, pharmacist, and the resident's responsible party (or surrogate). The RCD during an interview on 03/04/2026 at 12:20 PM, regarding overdue medications identified in the Medication Administration Record (MAR) in Point Click Care (PCC), acknowledged that medications were being administered and documented late. The RCD failed to provide any evidence that the delayed medication administration was reported as a medication error.	R 374		
R 383	10125.4a Reporting Complaints To The Director 10125.4a. An ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day; and Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to promptly notify the Department of Health (DOH) as required by telephone of incidents, including falls with injuries and other incidents that substantially affected the residents (followed by written notification within 24 hours or the next business day), for the six (6) residents in the investigation (Residents #32, #33, #34, #35, #36 and #37).	R 383		

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R 383	Continued From page 31 Findings included: A review of the ALR's incident report policy with revised dates of January 2023/February 2023 indicated that all unusual incidents that substantially affect a resident shall be reported to DOH by telephone promptly and shall be followed up with written notification within twenty-four (24) hours or the next business day. On 02/24/2026 beginning at 10:42 AM, a telephone interview was conducted with a complainant (DC#00014187) regarding issues and concerns at the ALR. The complainant alleged that the facility was not reporting incidents timely to DC Health. On 02/26/2026 at 3:38 PM, a review of the facility's complaints and incident report binder from January 2026 through 03/27/2026, revealed the following: 1) The review of an incident report submitted to DOH on 01/23/2025 at 6:02 PM, at approximately 11:30 AM, revealed that Resident #11 was noted to be confused. The resident reported dizziness, generalized body weakness, diarrhea, frequent urination and poor appetite upon assessment, and was transferred to the emergency room (ER) via 911 for further evaluation. Although DOH received the incident on 01/23/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time that the incident occurred. 2) An incident report submitted to DOH on 01/23/2026 at 7:16 PM, at approximately 12:15 PM, indicated that staff went to Resident #12's room to remind her to go to the dining room for	R 383			

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R 383	Continued From page 32 lunch and found the resident lying on the floor on her right side. The resident reported that she got dizzy while standing and fell. The primary care physician (PCP) was contacted and advised that the resident should be sent to the ER via 911. Although DOH received the incident on 01/23/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time the incident occurred. 3) An incident report submitted to DOH on 01/23/2026 at 10:20 PM, at 3:04 PM, revealed that at 6:00 PM, Resident #13's social worker visited the facility to see the resident concerning his bilateral legs that were swollen and felt warm. After the completion of an assessment, it was decided that the resident should go to the ER via 911 for further evaluation. Although DOH received the incident on 01/23/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time that the incident occurred. 4) An incident report submitted to DOH on 02/07/2026 at 5:20 PM, revealed at about 1:30 PM, Resident #14 was observed with a runny nose, fast breathing, sweating and unable to speak. The resident was given an as needed epinephrine auto-injector 0.3 mg and resident immediately felt relief and resumed speaking. The resident stated that she had an allergic reaction to onions, although she had no history of allergy to onions. The resident's blood pressure (B/P) was elevated and 911 was called and the resident was transferred to the ER for further evaluation. Although DOH received the incident on 02/07/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time that the	R 383		

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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 383	Continued From page 33 incident occurred. 5) An incident report submitted to DOH on 02/09/2026 at 10:06 PM, revealed that at approximately 1:00 PM, Resident #15 complained of dizziness and discomfort due to continuous hematuria in her foley catheter bag. The PCP was notified and an order was given to transfer the resident to the ER for further evaluation. Although DOH received the incident on 02/09/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time that the incident occurred. 6) An incident report submitted to DOH on 02/11/2026 at 5:48 PM, revealed that at approximately 3:20 PM, Resident #16 was disoriented and unable to respond with full alertness to inquiries. The resident's pupil was dilated and unreactive to light, and the resident's vital signs showed a B/P of 70/40 and heart rate of 120. The DON was notified and 911 was called, and the resident was transferred to the ER for an altered mental status. Although DOH received the incident on 02/11/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time that the incident occurred. 7) An incident report submitted to DOH on 02/24/2026 at 5:42 PM, revealed that Resident #16 was sitting by the elevator and not responding to verbal cues or tactile stimuli. The resident was given a sternal rub and came through but was verbally incoherent. A dose of Narcan was administered by the DON and resident became responsive and stated that he may have taken something stronger than beer. The emergency services (EMT) evaluated the	R 383		

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R 383	Continued From page 34 resident and administered a second dose of Narcan and transported the resident to the hospital for further evaluation. Although DOH received the incident on 02/24/2026, there was no documented evidence that DOH received the incident promptly due to the absence of a date and time that the incident occurred. The Executive Director (ED) during an interview on 02/26/2026 at 3:40 PM indicated that the facility's process for reporting unusual incidents including falls with injuries and other incidents that interfered with the residents' health and safety stated that incidents that interfered with the president's health and safety should be reported to the DOH promptly by telephone, followed by written notification within 24 hours of the incident had not changed. The ED after reviewing the incident reports with the surveyor confirmed that there continues to be issues regarding staff not completing the incident reports properly to include the date and time the incident occurred in the description of the reports.	R 383			