PRINTED: 01/07/2020
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0040	A. BUILDING: ______ B. WING ______	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE AT GEORGIA AVE, LLC DBA MAPLE HEIGI	5100 GEORGIA AVENUE, NW WASHINGTON, DC 20011

(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	R 000		

An annual survey was conducted on 11/20/19, 11/21/19 and 11/26/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. Additionally, a follow up visit was conducted on 12/18/19. The ALR provided care for 16 residents and employed 33 personnel to include professional and administrative staff. A random sample of 10 resident records and 12 employee records were selected for review. The findings of the survey were based on observation, clinical and administrative record review, and resident and staff interviews.

On 12/18/19 a complaint was received that alleged that Resident #8's apartment thermostat was inoperable, and space heaters were being used. As a result, Resident #8 had to be moved to another apartment. The complainant alleged that the new unit was smaller than Resident #1's previous unit, however, the monthly fees increased.

The complaint was not substantiated. Incidental findings, however, were discovered through the course of the investigation. Deficiencies were identified and cited in this report.

Listed below are abbreviations that appear in the body of this report:

ALA - Assisted Living Administrator
ALR - Assisted Living Residence
ER - emergency room
ISP - Individualized Service Plan
RN - Registered Nurse

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: N. Oh — TITLE: Executive Director — (X6) DATE: 1/17/20

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R 483	Continued From page 1	R 483		
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on interview and record review, the ALR failed to ensure each resident's ISP was reviewed 30 days after admission or updated with significant changes for eight of ten residents in the sample (Residents #1, 3, 4, 5, 6, 7, 8 and10). Findings included: I. The facility failed to document that each resident's ISP was reviewed 30 days after admission, as evidenced by: a. On 11/20/19 at 3:06 PM, review of Resident #1's medical record showed that the resident was admitted on 06/24/19. Review of Resident #1's ISP showed that it was signed and dated by the Care Coordinator and the resident's surrogate at admission and on 08/23/19 (60 days after admission). b. On 11/21/19 at 9:56 AM, review of Resident #3's medical record showed that the resident was admitted on 10/4/19. Review of Resident #3's ISP showed that it was signed and dated by the Care Coordinator at admission. There was no other evidence that the ISP was reviewed 30 days after the resident was admitted.	R 483	All resident ISPs have been reviewed to determine if required to update based on: a) significant change, and/or b) semi-annual frequency All residents who's ISPs met one of the above conditions have completed or been scheduled for a care plan meeting to ensure compliance with DC ST Section 44-106.04. On the date of admissions, a preliminary ISP will be reviewed with and signed by the resident, the resident's surrogate, and the RN. 30 days post-admission, the RN will develop a comprehensive ISP based on resident's needs/preferences, clinical assessments, and staff observations. The Registered Nurse will be responsible for reviewing and updating the ISP thereafter. The ALA will be responsible for monitoring ISP review and updates.	1/13/20 & Ongoing

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R 483	Continued From page 2	R 483		
	c. On 11/21/19 at 10:37 AM, review of Resident #4's medical record showed that the resident was admitted on 07/15/19. Review of Resident #4's ISP showed that it was signed and dated by the Care Coordinator and the resident's surrogate at admission and on 09/25/19 (72 days after admission).			
	d. On 11/21/19 at 11:25 AM, review of Resident #6's medical record showed that the resident was admitted on 06/20/19. Review of Resident #6's ISP showed that it was signed and dated by the Care Coordinator and the resident's surrogate at admission and on 09/25/19 (97 days after admission).			
	e. On 11/21/19 at 12:14 PM, review of Resident #7's medical record showed that the resident was admitted on 08/22/19. Review of Resident #7's ISP showed that it was signed and dated by the Care Coordinator and the resident's surrogate at admission. There was no other evidence that the ISP was reviewed 30 days after the resident was admitted.		All resident ISPs have been reviewed to determine if required to update based on: a) significant change, and/or b) semi-annual frequency	1/13/20 & Ongoing
	II. The facility failed to update the resident's ISP with significant changes, as evidenced by:		All residents who's ISPs met one of the above conditions have completed or been scheduled for a care plan meeting to ensure compliance with DC ST Section 44-106.04.	
	a. On 11/20/19 at 3:06 PM, review of Resident #1's medical record showed an ISP, dated 06/24/19. Further review of the record showed that the resident was moved from the standard ALR to the memory care unit of the ALR on 08/23/19, following a hospitalization. The ISP, however, did not document that the resident was transferred to the memory care unit.		Significant changes will be reported to the RN and ALA as soon as reasonably possible. The Registered Nurse will be responsible for reviewing and updating the ISP to incorporate a significant change. The ALA will be responsible for monitoring ISP review and updates.	
	On 11/21/19 at 10:15 AM, the Care Coordinator stated that Resident #1 displayed some episodes			

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R 483	Continued From page 3	R 483		

of confusion and was transferred to the memory care to ensure the resident's safety.

b. On 11/21/19 at 12:00 PM, review of Resident #5's medical record showed an ISP, dated 09/09/19. Further review of the record showed that the resident sustained four falls since the ISP was written. However, the ISP was not updated with the falls.

At 12:24 PM the Care Coordinator confirmed that the resident sustained four falls and stated that the ALR would have a meeting with the resident and the resident's family to discuss the resident's safety. The Care Coordinator said that the ISP would be updated with the changes.

c. On 11/21/19 at 1:35 PM, review of Resident #8's medical record showed an ISP, dated 04/30/19. Further review of the record showed that the resident sustained a fall on 11/14/19 and was sent to the ER. The resident's ISP, however, was not updated with the fall.

d. On 11/21/19 at 2:40 PM, review of Resident #10's medical record showed an ISP, dated 07/08/19. Further review of the record showed that the resident was found unresponsive after a fall on 10/02/19, and was sent to the ER. The ISP was not updated with this significant change.

On 11/21/19 at 3:00 PM, the Care Coordinator stated that the residents' ISPs would be updated with each significant change.

At the time of the survey, the facility failed to provide documented evidence that all ISPs were updated 30 days after admission, every six months thereafter, and updated when there were significant changes in the resident's health care

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R 483	Continued From page 4 status. III. On 12/18/19 at 10:24 AM, interview with the complainant showed that Resident #8 was transferred to the memory care unit, due to a diagnosis of Dementia. At 12:34 PM, review of Resident #8's medical record showed that the resident was admitted on 04/30/19. The record documented that on 05/03/19, the resident's sister was informed that there was a room available on the memory care unit. However, the record failed to indicate on what date the resident was moved. Review of Resident #6's ISP showed that the ALR failed to document the resident's move to the memory care unit. At 2:08 PM, interview with the Care Coordinator showed that Resident #8 was moved to the memory care unit "a few days" after the resident's sister was informed. The Care Coordinator said that the ISP would be updated with the changes. At the time of survey, the ALR failed to ensure that Resident #6's ISP was updated with the resident's significant change.	R 483	Resident records have been updated to reflect accurate and current resident information. Training on functions of Electronic Medical Record System has been initiated to ensure timely updates to resident's records. The Charge Nurse will be responsible updating the resident's records to reflect resident relocation. The Care Coordinator will be responsible for ensuring that resident records are updated as needed to reflect the most current resident information.	1/13/20 & Ongoing
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on Interview and record review, the facility failed to ensure that the RN assessed each resident's response to their medication every 45 days, for eight of ten residents that received medications. (Residents #1,4,5,6,7,8,9,10). Findings included:	R 802	Contracted Registered Nurse will review resident records and complete 45 day assessement for each resident. The Registered Nurse will be responsible for completing assessments of resident's response to medication every 45 days thereafter. The ALA will be responsible for ensuring assessments are completed for residents every 45-days as required.	1/27/20 & Ongoing

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R 802	Continued From page 5 On 11/20/19 and 11/21/19, starting at 9:45 AM, review of the medical records for Residents #1, 4, 5, 6, 7, 8, 9, and 10 failed toevidence that the facility's RN had assessed the residents' response to their prescribed medications every 45 days. On 11/21/19 at 10:56 AM, the Care Coordinator stated that the overnight nurse assessed the medications monthly, but did not document the assessment. She further stated that the nurse would document the residents' responses to their medications monthly going forward. At the time of the follow-up visit, the ALR failed to ensure that each resident was assessed for a response to their medications every 45 days.	R 802		

CRFMR
Rev. 9/02

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
899 North Capitol St., NE
Washington DC 20002
2nd Floor (2224)
202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Paradise at Georgia Ave d/b/a Maple Heights ALR -0040	5100 Georgia Ave, NW Washington, D.C. 20011	11/20/19, 11/21/19, 11/26/19 Follow-up Dates(s): 12/18/19

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	A licensure survey was conducted on 11/20/19, 11/21/19 and 11/26/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the ALR emergency and proposed regulations. Additionally, a follow-up visit was conducted on 12/18/19. The ALR provided care for 17 residents and employed 33 personnel to include professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALA – Assisted Living Administrator CNA – Certified Nurse Aide			

M. Walker / C. Stringfield / T. [illegible] — Name of Inspector — Date Issued

[signature] — Facility Director/Designee — 1/17/20 — Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	EOP – Emergency Operations Plan EP – Emergency Preparedness EPP – Emergency Preparedness Program LPN – Licensed Practical Nurse NSA – Nurse Staffing Agency			
10110 Required Policies and Procedures	**10110.01 (k) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR & 483.73;** This regulation is not met as evidenced by:			
E-0015	**(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:** **(ii) Alternative sources of energy to maintain the following:** **(A) Temperatures to protect patient health and safety and sanitary of provisions.** **(B) Emergency Lighting.** **(C) Alarm systems.** Based on observations, interview and record review, the ALR failed to develop EP policies and procedures to address alternative sources of energy (portable generator) that would be used to maintain temperatures, emergency lighting and fire alarm systems, for 17 of 17 residents in the facility (Residents #1-17).		To be determined by January 27, 2020.	1/27/20

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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Findings included:

On 12/18/19 beginning at 9:36 AM, review of the ALR's POC dated 08/04/19 showed that in the event of a power failure, the facility is equipped to receive a portable generator that has the capacity to power the entire building (i.e. maintain temperatures, fire alarm systems, main kitchen walk-in refrigerator, HVAC system, etc.). Further review of the POC showed that the ALR had developed written policies and procedures to address the use of alternate energy sources (portable generator) during emergency situations. Additionally, the POC showed that if the building reach extreme temperatures prior to the delivery of the emergency generator, the residents will be moved to the designated evacuation points.

Beginning at 12:15 PM, the ALA was asked during an interview if the ALR had developed policies and procedures to address the use of alternate energy sources (portable generator) that would be used to supply to the entire building during a power outage. The ALA said she had not developed any policies and procedures regarding the use of the portable generator. When asked about policies and procedures regarding relocating the residents due to extreme temperatures prior to the delivery of the emergency generator in the event of a power outage, the ALA said no.

Beginning at 12:20 PM, review of the EOP confirmed that ALA's interview that policies and procedures had not been developed to address the use of alternate energy source (portable generator) to use during an emergency power

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Tag	Statement of Deficiencies		Plan of Correction	Date
	failure. The EOP also failed to document any policies and procedures regarding the relocation of residents during emergency situations while awaiting for an emergency generator. At the time of the follow-up visit, the ALR failed to ensure policies and procedures had been developed to address alternative energy sources (portable generator) used to power the entire facility during an emergency and failed to develop policies and procedures regarding the relocation of residents due to extreme temperatures prior to the delivery of the emergency generator.			
E-0007	**EP Program Patient Population** **The plan must do the following:** **(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency.** Based on interview and record review, the ALR failed to develop a plan that addressed the residents at risk and most vulnerable during an emergency, for 14 of 14 residents located on the Memory Unit (Residents #1-14). Findings included: On 12/18/19 beginning at 9:36 AM, review of the ALR's POC dated 08/04/19 showed the ALR incorporated an individualized risk assessment to identify the most vulnerable		An emergency list of persons at-risk has been developed and will be maintained in easily accessible locations in the event of an emergency. Resident ISPs have been updated to include the resident's ability to exit the building in the event of an emergency. Evacuation policy/ procedure has been developed to incorporate the assistance needed by the resident demographic. Employee training on the revised policy/procedure has been satisfied. The ALA will be responsible for implementing this policy and procedure. Semi-annual interdisciplinary quality assurance (QA) meetings will incorporate review of the effectiveness of EP policies.	1/9/20 & Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	residents in the facility. At 1:22 PM, observations conducted throughout the second floor memory unit showed there were residents using walkers, wheelchairs and other assistive devices for mobility. Further observations showed LPNs and CNAs assisting the residents with ambulating to their bedroom rooms and group activities. At 1:42 PM, the ALA said during an interview that the ALR had not developed individualized strategies to assist vulnerable residents during an emergency evacuation. Beginning at 12:20 PM, review of the ALR's EOP confirmed that ALA's interview that individualized strategies had not been developed to address residents at risk and most vulnerable during an emergency evacuation. At the time of the follow-up visit, the ALR failed to develop individualized strategies to assist residents at risk and most vulnerable during an emergency.			
E-0026	**Role under a Waiver Declared by Secretary** **[(b) Policies and Procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section. At a minimum, the policies and procedures must do the following:]**		An Emergency Preparedness policies/ procedures have been developed to include alternate alternate sheltering in the event evacuation is necessary. Employee training on the revised policy/procedure has been satisfied. The ALA will be responsible for implementing emergency preparedness policy/procedures. Semi-annual quality assurance meetings will include review of the effectiveness of EP policies.	1/9/20 & Ongoing

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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(8)[(6), (6) C (iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care at an alternative care site identified by the emergency management officials.

Based on interview and record, the ALR failed to develop policies and procedures that described its role in providing care during an emergency waiver declaration by the Secretary, for 17 of 17 residents in the facility (Residents #1-17).

Findings included:

On 12/18/19 beginning at 9:36 AM, review of the ALR's POC dated 08/04/19 showed the facility's ALA is developing policies and procedures that will describe its role in providing care during an emergency waiver declaration.

Beginning at 12:15 PM, the ALA said during an interview that she had not developed policies and procedures regarding its role in providing care and treatment at alternative care sites under an 1135 waiver.

Beginning at 12:20 PM, review of the ALR's EOP confirmed the ALA's interview that the facility had not developed policies and procedures regarding the 1135 Waiver Act.

At the time of the follow-up visit, the ALR failed to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

E-0035	policies and procedures were developed describing its role during an emergency waiver declaration by the Secretary (1153 Waiver Act). **(8) The facility must develop a method for sharing information from the emergency plan, that the facility had determined is appropriate, with residents [or clients] and their families or representatives.** Based on interview and record review, the ALR failed to develop a method for sharing information with the residents, families and/or representatives regarding the facility's EPP, for 17 of 17 residents in the ALR (Residents #1-17). Findings included: On 12/18/19 beginning at 9:36 AM, review of the ALR's POC dated 08/04/19 showed that the facility's ALA had developed a process for sharing information from the EP with residents, families and/or representatives. The information will be disseminated through the residents handbook, resident meetings and newsletter. Beginning at 12:15 PM, the ALA said during an interview that she had not developed a process for sharing information with the residents, residents family members and/or their representatives. Beginning at 12:20 PM, review of the ALR's EOP confirmed		Monthly resident newsletter will be include an "Are You Ready" section will communicate information from the emergency plan each month. Activities Director will be responsible for incorporating emergency plan information into monthly newletter. ALA will be responsible for monitoring the delivery of emergency plan information to residents and families/legal representatives via the monthly newsletter	2/1/20 & Ongoing

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10125 Reporting Abuse, Neglect, Exploitation, and Unusual Incidents	the ALA's interview that a system had not been developed for sharing information with the residents, resident families and/or representatives. At the time of the follow-up visit, the ALR failed to develop a method for sharing information with residents, residents family member and/or representatives. **10125.02 In addition to the requirements to abuse, neglect, and exploitation of a resident provided in Section 509 of the Act (D.C. Official Code 44-105.09), each 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 immediately, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day.** This regulation was not as evidenced by: Based on interview and record review, the facility failed to report all unusual incidents to the Department of Health within 24 hours, for two of seven incidents. Findings included: 1. On 11/21/19 at 1:35 PM, review of Resident #8's record showed that the resident sustained a fall on 11/14/19, and was sent to the ER following the fall.		Registered Nurse was trained by DOH surveyor on the appropriate way to alert the DOH of unusual incidents. 1/1 unsual incidents have been reported to DOH post-renewal survey. The Registered Nurse will be responsible for communicating instances of unusual incidents to the ALA and the DOH. The ALA will monitor instances of unusal occurance and ensure proper steps are initiated to investigate and intervene as necessary.

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2. On 11/21/19 at 2:40 PM, review of Resident #10's record showed that the resident sustained a fall on 10/02/19 and was found unresponsive. The resident was sent to the ER.

On 11/21/19 at 3:02 PM, the ALA stated that the ALR had not reported any incidents to the Department of Health. He further stated that the facility would report unusual incidents going forward.

At the time of survey, the ALR failed to report all unusual incidents to the Department of Health within 24 hours.