STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0040	A. BUILDING: _____ B. WING _____	03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE AT GEORGIA AVE, LLC DBA MAPLE	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	R 000 Initial Comments An annual licensure survey was conducted on 02/23/2021, 02/24/2021, 02/25/2021, 02/26/2021, 03/01/2021, 03/02/2021, and 03/03/2021, to determine compliance with the Assisted Living Law (DC Official Code§ 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 18 residents and employed 26 personnel, to include professional and administrative staff. A random sample of 10 resident records, 11 employee records and one contractor's record were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, and resident, family, and staff interviews.	R 000		
R 403	R 403. Sec. 601b Admissions (b) Prior to admission of a resident, the ALA or designee shall determine that the resident is appropriate for admission to the ALR and that the resident's needs can be met in addition to the needs of the other residents. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed, for five of 10 residents in the sample (Residents #3, 4, 6, 7, and 10). Findings included: 1. On 02/25/2021 at 5:00 PM, review of Resident #3's medical certification form, dated 04/30/2019, showed that the section entitled, "Medication" was not addressed by the physician.	R403	R403 #3 Initiated on Mar 12, 2021 The intermediate Care Facilities Division form will be completed by the DON/designee and reviewed by the ALA at least 48 business hours prior to the resident's admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly. #3 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly	

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R OOO	Initial Comments An annual licensure survey was conducted on 02/23/2021, 02/24/2021, 02/25/2021, 02/26/2021, 03/01/2021, 03/02/2021, and 03/03/2021, to determine compliance with the Assisted Living Law (DC Official Code§ 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 18 residents and employed 26 personnel, to include professional and administrative staff. A random sample of 10 resident records, 11 employee records and one contractor's record were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, and resident, family, and staff interviews.	R 000		
R 403.	Sec. 601b Admissions (b) Prior to admission of a resident, the ALA or designee shall determine that the resident is appropriate for admission to the ALR and that the resident's needs can be met in addition to the needs of the other residents. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed, for five of 10 residents in the sample (Residents #3, 4, 6, 7, and 10). Findings included: 1. On 02/25/2021 at 5:00 PM, review of Resident #3's medical certification form, dated 04/30/2019, showed that the section entitled, "Medication" was not addressed by the physician.	R403	R403 #3 Initiated on Mar 12, 2021 The intermediate Care Facilities Division form will be completed by the DON/designee and reviewed by the ALA at least 48 business hours prior to the resident's admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly. #3 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Health Regulation & Licensing Administration

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R 403	Continued From page 1 2. On 03/02/2021 at 3:00 PM, review of Resident #4's medical certification form, dated 02/27/2020, showed that the following sections were not addressed by the physician: a. Behavior; b. Mental Health; c. Self-Medication Assessment; and d. Medications. Further review of the medical certification form did not indicate that Resident #4 was not in need of 24-hour skilled nursing care and was not in need of continual acute or long term medical or nursing care or supervision. In addition, the physician did not sign the form. 3. On 02/08/2021 at 2:28 PM, review of Resident #6's medical certification form dated 12/10/2020, showed that the section entitled, "Required Services" was not addressed by the physician. 4. On 02/26/2021 at 2:34 PM, review of Resident #7's medical certification form, dated 12/17/2020, showed that the physician did not indicate that Resident #7 was not in need of 24-hour skilled nursing care and was not in need of continual acute or long term medical or nursing care or supervision. 5. On 03/01/2021 at 2:30 PM, review of Resident #10's medical certification form, dated 06/07/2019, showed that the physician did not list the resident's medications on the form. During the exit interview on 03/03/2021 at 11:30 AM, the ALR's Director of Nursing stated that going forward, she would ensure that all sections on the Immediate Care Facilities Division Admission/Annual Medical Certification form was completed the physician.	R 403	#4 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy and reviewed by the DON/designee for accuracy and completeness with a minimum of 48 business hours prior to admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly #4 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy and reviewed by the DON/designee for accuracy and completeness with a minimum of 48 business hours prior to admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly #6 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy and reviewed by the DON/designee for accuracy and completeness with a minimum of 48 business hours prior to admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly #7 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy and reviewed by the DON/designee for accuracy and completeness with a minimum of 48 business hours prior to admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly #10 Initiated March 12 2021 all residents charts have been reviewed to ensure completeness and accuracy and reviewed by the DON/designee for accuracy and completeness with a minimum of 48 business hours prior to admission. Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly	

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R 403	Continued From page 2 At the time of the survey, the ALR failed to ensure all sections of the Immediate Care Facilities Division Admission/Annual Medical Certification forms was completed by the physician.	R403		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure each resident had a pre-admission Individual Service Plan (ISP) prior to admission, for nine of 10 residents in the sample (Residents #3, 4, 5, 6, 7, 8, 9, and 10). Findings included: 1. Review of Resident #3's medical record on 02/26/2021 at 1:30 PM showed that the resident was admitted to the ALR on 09/09/2019. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 2. Review of Resident #4's medical record on 02/25/2021 at 4:00 PM, showed that the resident was admitted to the ALR on 03/16/2020. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 3. Review of Resident #5's medical record on 02/23/2021 at 3:50 PM, showed that the resident was admitted to the ALR on 10/29/2019. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission.	R 471	R471 Review of documentation for residents #3, #4,#5,#6,#7,#8, #9 and 10 were completed on Mar 12,2021 and the Admin./DON to conduct bi-monthly audit of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly. #3 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward. #4 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward. #5 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward.	

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R 471	Continued From page 3 4. Review of Resident #6's medical record on 02/27/2021 at 2:28 PM, showed that the resident was admitted to the ALR on 02/09/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 5. Review of Resident #7's medical record on 02/26/2021 at 2:34 PM, showed that the resident was admitted to theALR on 01/05/2021. Further review of the record showed that an ISP was completed on 01/05/2021, however; failed to show documented evidence that an ISP was developed prior to the resident's admission. 6. Review of Resident #8's medical record on 03/01/2021 at 3:30 PM, showed that the resident was admitted to theALR on 01/26/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 7. Review of Resident #9's medical record on 03/01/2021 at 2:55 PM showed that the resident was admitted to the ALR on 12/15/2019. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 8. Review of Resident #1O's medical record on 03/01/2021 at 2:30 PM, showed that the resident was admitted to the ALR on 12/15/2019. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. On 03/01/2021, at 11:49 AM, the ALR's Director of Nursing (DON) said during a telephone interview that she confirmed that she completed	R 471	#6 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward. #7 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward. #8 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward. #9 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward. #10 Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward.	

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R 471	Continued From page 4 Resident #7's ISP on the day of admission. On 03/02/2021 at 10:30 AM, a video conference call was held with the ALR's administrative staff. During the call, the DON and administrators stated that they would attempt to locate the missing pre-admission ISP documents for the residents. However, the ALR failed to present the pre-admission ISP documents prior to the survey exit on 03/03/2021. At the time of the survey the ALR failed to ensure all residents received an ISP prior to admission.	R 471	Beginning March 12,2021, the ALR will ensure that all new residents have a pre-admission ISP completed 48 business hours prior to admission. The DON/designee shall ensure that all ISP's are reviewed and developed IAW the DOH guidelines and regulations moving forward.	
R 475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that all Individual Service Plans (ISPs)s were consistently signed by the resident or a surrogate and a representative of the ALR, as required, for eight of 1O residents in the sample (Residents #1, 2, 3, 4, 5, 7, 9, and 10). Findings included: 1. Review of Resident #1's medical record on 02/26/2021 at 2:20 PM, showed that an ISP was conducted on 02/09/2021. The ISP was signed by the Director of Nursing, however, the document failed to show documented evidence that the ISP was signed by the resident or a surrogate. 2. Review of Resident #2's medical record on 02/25/2021 at 5:30 PM, showed that ISPs was conducted on 11/17/2020. The ISP record failed to show documented evidence that the ISPs were signed by the resident or a surrogate and a representative of the ALR.	R 475	R 475 Review of the resident #1 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures was put into place on the assigned date of the ISP review. R 475 Review of the resident # 2 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures was put into place on the assigned date of the ISP review.	

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R 475	Continued From page 5 3. Review of Resident #3's medical record on 02/26/2021 at 1:30 PM, showed that an ISP was conducted on 02/17/2021. The record failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR. 4. Review of Resident #4's medical record on 02/25/2021 at 4:00 PM showed that an ISP was conducted on 11/18/2020. The record failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR. 5. Review of Resident #S's medical record on 02/23/2021 at 3:50 PM showed that an ISP was conducted on 02/23/2021. The record failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR. 6. Review of Resident #7's medical record on 02/26/2021 at 2:20 PM, showed that an ISP was conducted on 01/05/2021. The ISP was signed by the Director of Nursing, however, the document failed to show documented evidence that the ISP was signed by the resident or a surrogate. 7. Review of Resident #9's medical record on 03/01/2021 at 2:55 PM showed that an ISP was conducted on 12/12/2020. The record failed to show documented evidence that the ISP was signed by the resident or a surrogate and a representative of the ALR. 8. Review of Resident #1O's medical record on 03/01/2021 at 2:30 PM showed that an ISP was conducted on 12/08/2020. The record failed to show documented evidence that the ISP was	R 475	R 475 Review of the resident #3 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures was put into place on the assigned date of the ISP review R 475 Review of the resident #4 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures was put into place on the assigned date of the ISP review R 475 Review of the resident #5 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures were put into place on the assigned date of the ISP review R 475 Review of the resident #7 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures were put into place on the assigned date of the ISP review R 475 Review of the resident #9 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures were put into place on the assigned date of the ISP review	

	R 475 Review of the resident #10 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures were put into place on the assigned date of the ISP review

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R 475	Continued From page 6 signed by the resident or a surrogate and a representative of the ALR. During the video conference call on 03/03/2021 beginning at 11:00 AM, the Director of Nursing (DON) confirmed that all ISPs had not been signed by the resident or the surrogate. The DON stated that going forward, she would ensure all ISPs are signed not only by the nurse, but also by the resident and or their surrogate. At the time of the survey, the ALR failed to ensure all ISPs were signed by a resident or surrogate and a representative of the ALR.	R 475	R 475 Review of all residents' charts completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures were put into place on the assigned date of the ISP review	
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure Individual Support Plans (ISP)s included when, how often, and by whom services will be provided, for two of 10 residents in the sample (Resident #1 and 10). Findings included: 1. On 02/26/2021 at 2:20 PM, review of Resident #1's clinical record showed that Resident #1 fell on 12/08/2020 and sustained a right humerus fracture. Review of the resident's ISP dated 02/09/2021, revealed that the resident "will receive Occupational Therapy/Physical Therapy (OT/PT)." The ISP lacked documented evidence of when, how often and by whom OT/PT services were to be provided to the resident.	R 481	R 481 After a complete review of all resident's charts on March 12, 2021 a plan was devised for the DON/designee to review an ensure that all ancillary services are notated on the ISP with the following identifying information: service provided, , when and how often the services will be provided, and how and by whom all services will be provided and accessed. The plan consists of random audits to determine compliance conducted by the DON or their designee. R 481 #1 on March 12, 2021 a plan was devised for the DON/designee to review an ensure that all ancillary services are notated on the ISP with the following identifying information: service provided, , when and how often the services will be provided, and how and by whom all services will be provided and accessed.	

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R 481	Continued From page 7 2. On 03/01/2021 at 2:30 PM, review of Resident #1O's medical evaluation revealed that the resident was receiving services at the Veterans Administration for post-traumatic stress disorder (PTSD). On 03/02/2021 at 4:44 PM, review of the residents ISP dated 03/29/2020, failed to show documented evidence of when and how often the resident received the services for PTSD. During the video conference call on 03/03/2021 beginning at 11:00 AM, the Director of Nursing said going forward she would ensure that the ISPs would contain information on when, how often, and by whom services would be provided on all residents' ISPs, when applicable. At the time of the survey, the ALR failed to provide documented evidence that all ISPs included when, how often, and by whom services would be provided.	R 481	R 481 #10 on March 12, 2021 a plan was devised for the DON/designee to review an ensure that all ancillary services are notated on the ISP with the following identifying information: service provided, , when and how often the services will be provided, and how and by whom all services will be provided and accessed. The plan consists of random audits to determine compliance conducted by the DON or their designee.	
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 Assisted Living Residence (ALR) failed to address significant changes in the resident's	R 483	The DON reviewed resident #10's documentation and updated the required information ie. Who, what, when, where, why and how often? Also, 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.	

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R 483	Continued From page B condition on the Individual Service Plan (ISP), for one of 10 residents in the sample (Resident #4). Findings included: Review of a document entitled "Falls and Hospitalizations" on 02/24/2021, at 10:47 showed that Resident #4 was hospitalized from 06/13/2020 through 06/17/2020 for a urinary tract infection (UTI). Review of the resident's ISP dated 11/18/2020, on 03/02/2021 at 4:51 PM, failed to show documented evidence that the ALR addressed the Resident #4's hospitalization for a UTI. During the video conference call on 03/03/2021 starting at 11:30 AM, the DON said that she usually captures all significant events on the residents ISPs and going forward she would ensure all significant events were documented on the ISPs. At the time of the survey, the ALR failed to address all significant changes in the resident's condition on the ISP.	R483	R483 #4 on March 12, 2021 a plan was devised for the DON/designee to review an ensure that all ancillary services are notated on the ISP with the following identifying information: service provided, , when and how often the services will be provided, and how and by whom all services will be provided and accessed. The plan consists of random audits to determine compliance conducted by the DON or their designee.	
R 595	Sec. 701d8 Staffing Standards. (8) Assure that each employee has a background check pursuant to federal and District of Columbia law executed at the time of initial employment; Based on observation, interview and record review, the Assisted Living Administrator (ALA) failed to show evidence that each management personnel had obtained a comprehensive background check for the District of Columbia (DC) prior to working in the Assisted Living	R 595	R595 March 12, 2021 a plan was devised to ensure that all team members working within the District of Columbia complete a background check. That adheres to the Regulations and Rules both Federal and local government. The Business Office Manager will ensure that all team members have a completed background check 24 business hours prior to the start of their first day of work.	

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R 595	Continued From page 9 Residence (ALR), for two of two ALAs and one Vice President of Sales and Marketing employee, who assisted in the completion of the annual survey process (ALAs #1, 2 and Vice President of Sales and Marketing). Findings included: During the entrance conference on 02/23/2021 beginning at 9:57 AM, ALA#2 stated that he was currently the Acting ALA for ALA #1, who was quarantine at home due to possible exposure to the Coronavirus. The Vice President of Sales and Marketing, who was also present for the entrance conference, stated that she would be assisting in the completion of the survey process. When asked, both the Vice President of Sales and Marketing and ALA #2 indicated that they were part of the management company that was hired to oversee the services of the ALR. The surveyors requested to see their personnel files as part of the administrative review. Beginning at 10:35 AM, the Vice President of Sales and Marketing and ALA #2 assisted the surveyors with a tour of the ALR. At 12:45 PM, The Vice President of Sales and Marketing was observed giving a resident a hug after lunch. On 02/25/2021 beginning at 2:11 PM, review of the personnel records showed that there were no DC comprehensive backgrounds checks completed for ALA #1, ALA #2 and the Vice President of Sales and Marketing. During the video conference call on 03/03/2021 beginning at 11:00 AM, ALA #1 said that he had been employed as the ALA since November 2020. ALA #2 stated during the video telephone conference he had been serving as the Acting	R 595	R 595 ALA#1, ALA#2, Vice President of Marketing Were instructed to and completed background investigations and going forward The BOM will ensure compliance prior to allowing team members to work within the community.	

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R 595	Continued From page 10 ALA since 02/16/2021. In an earlier telephone interview conducted with the management company's Human Resource (HR) personnel on 02/26/2021 at 10:57 AM, it was revealed that DC background checks had not been completed for ALA #1, ALA #2 and the Vice President of Sales and Marketing. At the time of the survey, the ALR failed to ensure that the management personnel, assisting with the survey process, obtained a DC comprehensive background check.	R 595	R 595 ALA#1, ALA#2, Vice President of Marketing Were instructed to and completed background investigations and going forward The BOM will ensure compliance prior to allowing team members to work within the community.	
R 596	Sec. 701d9 Staffing Standards. (9) Assure that members of the staff appear to be free from apparent signs and symptoms of communicable disease, as documented by a written statement from a healthcare practitioner; Based on observation, interview and record review, the Assisted Living Administrator (ALA) failed to show evidence that each management personnel had a written statement from a healthcare practitioner stating that they were free from communicable diseases working in the Assisted Living Residence (ALR), one of one ALA and one of one Vice President of Sales and Marketing employee, who assisted in the completion of the annual survey process (ALA# 2 and Vice President of Sales and Marketing). Findings included: During the entrance conference on 02/23/2021 beginning at 9:57 AM, ALA#2 stated that he was currently the interim ALA for ALA #1, who was quarantine at home due to possible exposure to the Coronavirus. The Vice President of Sales and	R 596	R 596 ALA#2 On 3/6/21 Received a copy of their PPD ensuring that he was free of any communicable diseases. Going forward the BOM will ensure this process and the receiving of documentation verifying the status of being free of communicable disease 24 business hours prior to a team member's first day of work. R596 Vice President of Marketing was instructed to complete to process to ensure that she was free from any communicable disease. VP complied and documentation was received. Going forward the BOM will ensure this process and the receiving of documentation verifying the status of being free of communicable disease 24 business hours prior to a team member's first day of work.	

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R 596	Continued From page 11	R 596		

Marketing, who was also present for the entrance conference, stated that she would be assisting in the completion of the survey process. When asked, both the Vice President of Sales and Marketing and ALA #2 indicated that they were part of the management company that was hired to oversee the services of the ALR. The surveyors request to see their personnel files as part of the administrative review.

Beginning at 10:35 AM, the Vice President of Sales and Marketing and ALA #2 assisted the surveyors with a tour of the ALR. At 12:45 PM, The Vice President of Sales and Marketing was observed giving a resident a hug after lunch.

On 02/25/2021 beginning at 2:11 PM, review of the personnel records for ALA #2 and Vice President of Sales and Marketing showed that the records did not contain written statements from a healthcare practitioner indicating that the management personnel were free from communicable disease.

During the exit conference on 03/03/2021 beginning at 11:00 AM, ALA #2 stated during the video telephone conference he had been serving as the interim ALA towards the end of February 2021.

In an earlier telephone interview conducted with the management company's Human Resource **(HR)** personnel on 02/26/2021 beginning at 10:57 AM, it was revealed that ALA #2 and the Vice President of Sales and Marketing had no written statements from a healthcare practitioner indicating that they both were free from communicable disease. The HR staff did indicated that ALA #2 and the Vice President would be screen for tuberculosis on 03/04/2021.

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R 596	Continued From page 12 At the time of survey, the management personnel records failed to evidence a signed statement from a healthcare practitioner that each personnel staff was free from communicable diseases.	R 596		
R 705	Sec. 802b Medical , Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so indicated during the medical assessment. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that all medical assessments were documented on the Immediate Care Facilities Division Admission/Annual Medical Certification form that was approved by the Mayor, for one of 10 residents in the sample (Resident #2). Findings included : Review of Resident #2's clinical record on 02/25/2021 at 5:30 PM, showed a medical rehabilitation and psychosocial assessment dated 01/18/2020. The assessment was not documented on the standardized form approved by the Mayor, as required. On 03/01/2021 beginning at 11:49 AM, the Director of Nursing (DON) said during a telephone interview that she would send the resident's assessment that was incorporated on	R 705	R 705 On March 12, 2021 a plan was instituted to ensure that all residents shall be evaluated by using the standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so indicated during the medical assessment. The DON/designee will ensure this is done up to 48 business hours prior to admission with the exception for emergency admissions whereas the time frame may be reduced. #2 On March 12, 2021 a plan was instituted to ensure that all residents shall be evaluated by using the standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medicalstatus relevant to defining care needs, and the applicant's psychological and cognitive status, if so indicated during the medical assessment. The DON/designee will ensure this is done up to 48 business hours prior to admission with the exception for emergency admissions whereas the time frame may be reduced.	

Health Regulation & licensing Administration

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R 705	Continued From page 13 the approved form by the Mayor. However, the DON failed to present the a medical assessment documented on the Immediate Care facilities Division Admission/Annual Medical Certification form as approved by the Mayor as required, prior to the survey exit on 03/03/2021. At the time of the survey, the ALR failed to ensure each residents assessments were documented on the Immediate Care Facilities Division Admission/Annual Medical Certification form.	R 705	R 705 On March 12, 2021 a plan was instituted to ensure that all residents shall be evaluated by using the standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medicalstatus relevant to defining care needs, and the applicant's psychological and cognitive status, if so indicated during the medical assessment. The DON/designee will ensure this is done up to 48 business hours prior to admission with the exception for emergency admissions whereas the time frame may be reduced.	
R 800	Subheading On-Site Review Sec. 903. On-site review. The ALR shall arrange for an on-site review by a registered nurse every 45 days to: : Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that the Registered Nurse (RN) consistently completed an onsite assessed each resident's response to their medication at least every 45 days for seven of 10 residents in the sample (Residents #1, 2, 3, 4, 5, 9, and 10). Findings included: 1. Review of Resident #1's medical record on 02/26/2021 at 2:20 PM, showed that the resident was admitted on 05/01/2019. Further review of the record revealed a medication review dated 10/03/2020 (17 months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications every 45 days 2. Review of Resident #1's medical record on 02/25/2021 at 5:30 PM, showed that the resident	R 800	R 800 Beginning 3/12/21 the ALR will ensure that an onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are completed NLT 45 days for all residents.	

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R 800	Continued From page 14 was admitted on 01/17/2020. Further review of the record revealed a medication review dated 12/29/2020 (11 months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications every 45 days. 3. Review of Resident #3's medical record on 02/24/2021 at 1:30 PM, showed that the resident was admitted on 09/09/2019. Further review of the records showed a medication review dated 02/17/2020 (5 months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications every 45 days. 4. Review of Resident #4's medical record on 02/25/2021 at 4:00 PM, showed the resident was admitted on 03/16/2020. Further review of the record showed a medication review dated 02/14/2021 (11 months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications every 45 days. 5. Review of Resident #S's medical record on 02/23/2021 at 3:50 PM, showed the resident was admitted on 10/29/2020. Further review of the record showed 02/14/2021 (4 months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications every 45 days. 6. Review of Resident #9's medical record on 03/01/2021 at 2:55 PM, showed that the resident was admitted on 12/15/2019. Further review of the record showed a medication review dated 02/04/2021 (14 months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications	R 800	#3 Beginning 3/12/21 the ALR will ensure that an onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are completed NLT 45 days for all residents #4 Beginning 3/12/21 the ALR will ensure that an onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are completed NLT 45 days for all residents #5 Beginning 3/12/21 the ALR will ensure that an onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are completed NLT 45 days for all residents. #9 Beginning 3/12/21 the ALR will ensure that an onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are completed NLT 45 days for all residents	

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R 800	Continued From page 15 every 45 days. 7. Review of Resident #10's medical record on 03/01/2021 at 2:30 PM, showed that the resident was admitted on 06/12/2019. Further review of the record showed a medication review dated 03/29/2020 (nine months later). The record failed to show documented evidence that the ALR's RN assessed the resident's response to medications every 45 days. During a video conference call with the ALR's administrative staff on 03/02/2021 at 10:30 AM, the Director of Nursing (DON) said she and RN #1 had completed 45-day medication reviews for the residents. The DON stated that she would try and find the missing documents. However, the DON failed to present any additional 45 day medication assessments to the surveyors prior to the survey exit on 03/03/2021. At the time of the survey the ALR's RNs failed to consistently assess the resident's response to residents rooms and common areas their medications every 45 days.	R 800	#10 Beginning 3/12/21 the ALR will ensure that an onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are completed NLT 45 days for all residents.	
R1003!	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation, interview and record review, the ALR failed to ensure water temperatures did not exceed 110 degrees Fahrenheit, for one of four hand sinks, two of four kitchenette kitchen sinks and one of three	R1003	R 1003 On March 12, 2021 a policy was implemented to ensure that all resident rooms and common areas water temperature remain IAW Federal and local regulations and guidelines. The Maintenance director or housekeeper will test one room and common area on each floor to ensure that the temperatures are within the specified range.	

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R1003	Continued From page 16 , resident's bathrooms (apartment #205) located on the second floor. Findings included: On 02/23/2021 beginning at 10:35 AM, a walk-thru of the facility with CNA #1 and the Acting Assisted Living Administrator (ALA) showed the following: - At 11:09 AM, the kitchenette located on the second floor memory unit near the dining area showed that the water temperatures measured 115.9 degrees Fahrenheit at the hand sink and 116.4 degrees Fahrenheit at the kitchen sink. -At 11:15 AM, the bathroom sink located in apartment #205 showed that the water temperature measured 119.7 degrees Fahrenheit and the kitchenette sink water temperature measured 119.5 degrees Fahrenheit. When asked, Certified Nurse Aide (CNA) #1 stated that the resident was able to control the water in the apartment. The Acting ALA, who also accompanied the surveyor during the environmental walk-thru, stated that he would contact someone to come and adjust the hot water temperatures . The surveyor requested to see the water temperature log for the month of January 2021. At 1:29 PM, the contracted plumber arrived to the Assisted Living Residence to adjust the hot water temperature. At 1:40 PM, the plumber explained to the surveyors that after adjusting the water temperature at the boiler, it would take time before the hot water temperature to fall at or below 110 degrees Fahrenheit. Follow-up observations on 02/23/2021, showed that the plumber adjusted the hot water	R1003	R 1003 Kitchenette R 1003 On March 12, 2021 a policy was implemented to ensure that all resident rooms and common areas water temperature remain IAW Federal and local regulations and guidelines. The Maintenance director or housekeeper will test one room and common area on each floor daily to ensure that the temperatures are within the specified range. R 1003 R 1003 On March 12, 2021 a policy was implemented to ensure that all resident rooms and common areas water temperature remain IAW Federal and local regulations and guidelines. The Maintenance director or housekeeper will test one room and common area daily on each floor to ensure that the temperatures are within the specified range	

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R1003	Continued From page 17 temperatures in the aforementioned locations, and that the readjusted water temperatures measured 106 degrees Fahrenheit. There was no water temperature logs provided to the surveyor for the month of January 2021, by the time the survey ended on 03/03/2021. At 2:40 PM, review of the Water Temperature Testing policy (undated) showed that to maintain a safe and secure environment for the residents, the hot water temperatures will be monitored regularly to ensure temperatures stay within the safe range established by the DC Department of Health. At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110 degrees Fahrenheit throughout the facility.	R1003	R 1003 R 1003 On March 12, 2021 a policy was implemented to ensure that all resident rooms and common areas water temperature remain IAW Federal and local regulations and guidelines. The Maintenance director or housekeeper will test one room and common area on each floor daily to ensure that the temperatures are within the specified range.	