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	02/23/2021, 02/24/2 03/01/2021, 03/02/2 determine complianc Law (DC Official Co Assisted Living Resic DCMR (Public Heal 101. The Assisted Li provided care for 18 personnel, to include administrative staff. resident records, 11 contractor's record v findings of the surve observations throug	A random sample of 10 employee records and one were selected for review. The ey were based on hout the facility, clinical and d review, and resident, family,	R403	R403 #3 Initiated on Mar 12, 2021 The intermedi	ate Care Facilities	
-	designee shall deter appropriate for admi resident's needs car needs of the other re Based on interview a Assisted Living Resite Intermediate Car Admission/Annual Me	and record review, the dence (ALR) failed to ensure re Facilities Division edical Certification form was f 10 residents in the sample		Division form will be completed by the DON/des ALA at least 48 business hours prior to the resider Admin/DON to conduct bi-monthly audit of rand that the intermediate Care Facilities Division form reviewed accordingly.	nt's admission. Iom files in order to ensure	
	Findings included:					
	#3's medical certifica	5:00 PM, review of Resident atton form, dated 04/30/2019, tion entitled, "Medication" by the physician.		#3 Initiated March 12 2021 all res have been reviewed to ensure co accuracy. Admin/DON to conduct bi-month	mpleteness and	
				order to ensure that the intermediate Care Facilitie completed and reviewed accordingly		

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Acting Administrator

US 05/85/2

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PRINTED, US/ 10/2021 FORM APPROVED Heath Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: B WING ALR-0040 03/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5100 GEORGIA AVENUE, NW PARADISE AT GEORGIA AVE, LLC DBA MAPLE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R 000 Initial Comments R 000 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

R403

determine compliance with the Assisted Living Law (DC Official Code 44-101.01 et seg) 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 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 i 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 #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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Health Regulation & Licensina Administration

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIPLE CONSTRUCTION A BU L DNG	(X3) DATE SURVEY
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STREET ADDRESS, CITY, STATE, ZIP CODE

#### PARADISE AT GEORGIA AVE, LLC DBA MAPLE

5100 GEORGIA AVENUE, NW WASHINGTON, DC 20011

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R 403

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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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 #Ts 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.

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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Health Reaulation & Licensma Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: B WING \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **ALR-0040** 03/03/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5100 GEORGIAAVENUE, NW PARADISE AT GEORGIA AVE, LLC DBA MAPLE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 403 Continued From page 2 R403 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. R 471 Sec. 604a1 Individualized Service Plans R 471 R471 Review of documentation for residents #3. #4,#5,#6,#7,#8, #9 and 10 were completed on (a)(1) An ISP shall be developed for each Mar 12,2021 and the Admin./DON to conduct bi-monthly audit resident prior to admission. of random files in order to ensure that the intermediate Care Facilities Division form is completed and reviewed accordingly. 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: #3 Beginning March 12,2021, the ALR will ensure 1. Review of Resident #3's medical record on that all new residents have a pre-admission ISP 02/26/2021 at 1:30 PM showed that the resident completed 48 business hours prior to admission. was admitted to the ALR on 09/09/2019. Further The DON/designee shall ensure that all ISP's are review of the record failed to show documented evidence that an ISP was developed prior to the reviewed and developed IAW the DOH guidelines resident's admission. and regulations moving forward. #4 Beginning March 12,2021, the ALR will ensure 2. Review of Resident #4's medical record on that all new residents have a pre-admission ISP 02/25/2021 at 4:00 PM, showed that the resident completed 48 business hours prior to admission. was admitted to the ALR on 03/16/2020. Further The DON/designee shall ensure that all ISP's are review of the record failed to show documented reviewed and developed IAW the DOH guidelines evidence that an ISP was developed prior to the and regulations moving forward. resident's admission. #5 Beginning March 12,2021, the ALR will ensure 3. Review of Resident #5's medical record on that all new residents have a pre-admission ISP 02/23/2021 at 3:50 PM, showed that the resident completed 48 business hours prior to admission. was admitted to the ALR on 10/29/2019. Further The DON/designee shall ensure that all ISP's are review of the record failed to show documented reviewed and developed IAW the DOH guidelines evidence that an ISP was developed prior to the and regulations moving forward.

resident's admission.

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R 471

### 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 the ALR 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 #10'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

#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 preadmission 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.

PRINTED: 03/16/2021 FORM APPROVED Health Reaulation & Licens1na Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: B. WING ALR,0040 0310312021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5100 GEORGIA AVENUE, NW PARADISE AT GEORGIA AVE, LLC DBA MAPLE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (XS) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Beginning March 12,2021, the ALR will ensure R 471 Continued From page 4 R 471 that all new residents have a pre-admission ISP Resident #7's ISP on the day of admission. On completed 48 business hours prior to admission. 03/02/2021 at 10:30 AM, a video conference call The DON/designee shall ensure that all ISP's are was held with the ALR's administrative staff. reviewed and developed IAW the DOH guidelines During the call, the DON and administrators and regulations moving forward. 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 475 Sec. 604a5 Individualized Service Plans R 475 (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 10 residents in the sample (Residents #1, 2, 3, 4, 5, 7, 9, and 10). Findings included: R 475 Review of the resident #1 chart completed 1. Review of Resident #1's medical record on and on Mar 12, 2021 a plan was put in place to 02/26/2021 at 2:20 PM, showed that an ISP was ensure the DON/designee review all care plans conducted on 02/09/2021. The ISP was signed by for completeness and all required signatures was the Director of Nursing, however, the document put into place on the assigned date of the ISP failed to show documented evidence that the ISP was signed by the resident or a surrogate. review. 2. Review of Resident #2's medical record on

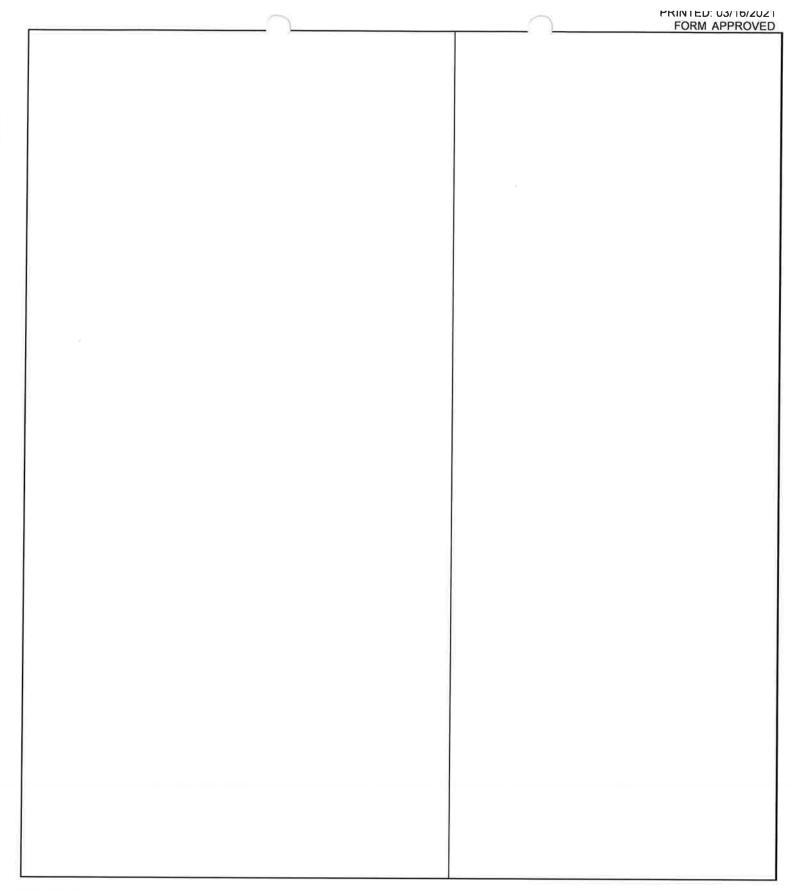
R 475 Review of the resident # 2 chart completed and on Mar 12, 2021 a plan was put in place to ensure the DON/designee review all care plans for completeness and all required signatures was put into place on the assigned date of the ISP review.

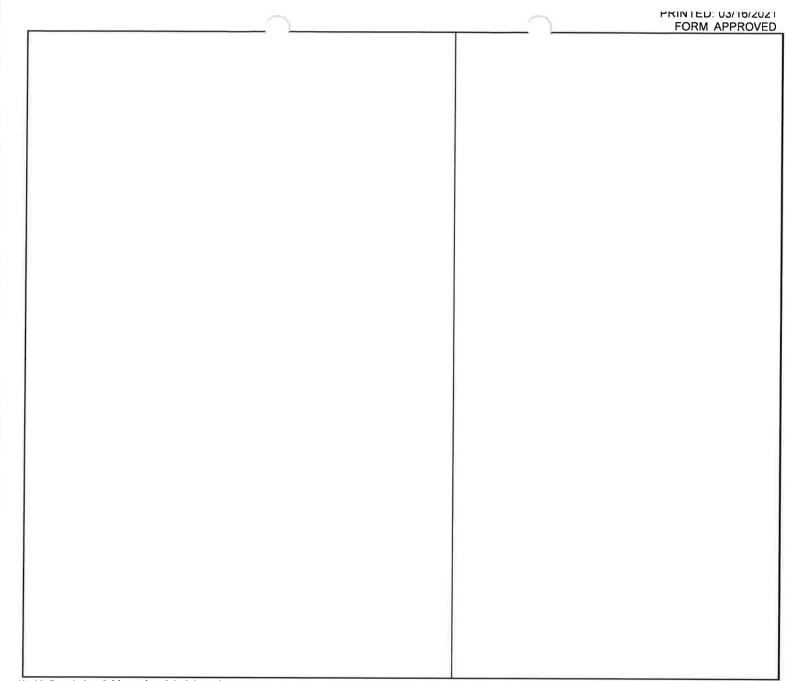
02/25/2021 at 5:30 PM, showed that ISPs was

signed by the resident or a surrogate and a representative of the ALR.

conducted on 11/17/2020. The ISP record failed

to show documented evidence that the ISPs were





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R 475	Continued From page	ne 5	R 475		

# 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.
- 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
- 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.

was signed by the resident or a surrogate.

8. Review of Resident #10'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 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

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	and on Mar 12, 2021 a ensure the DON/design	sident #10 chart completed plan was put in place to nee review all care plans fo equired signatures were
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WASHINGTON, DC 20011

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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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 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 475

R 481

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 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.

FORM APPROVED Health Reaulation & Licensma Admm1stration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B WING ALR-0040 03/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5100 GEORGIA AVENUE, NW PARADISE AT GEORGIA AVE, LLC DBA MAPLE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) R 481 #10 on March 12, 2021 a plan was devised R 481: Continued From page 7 R 481 for the DON/designee to review an ensure that all ancillary services are notated on the ISP with the 2. On 03/01/2021 at 2:30 PM, review of Resident following identifying information: service provided. :#10's medical evaluation revealed that the when and how often the services will be provided, and resident was receiving services at the Veterans how and by whom all services will be provided and Administration for post-traumatic stress disorder accessed. The plan consists of random audits to (PTSD). determine compliance conducted by the DON or their designee. 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 483 Sec. 604d Individualized Service Plans R 483 The DON reviewed resident #10's documentation (d) The ISP shall be reviewed 30 days after and updated the required information ie. Who, admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there what, when, where, why and how often? Also. is a significant change in the resident's condition. The ISP shall be reviewed 30 days after admission and The resident and, if necessary, the surrogate at least every 6 months thereafter. The ISP shall be shall be invited to participate in each updated more frequently if there is a significant change reassessment. The review shall be conducted by in the resident's condition. an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the

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Based on interview and record review, the Assisted Living Residence (ALR) failed to address significant changes in the resident's

If continuation sheet 8 of 18

Health Regulation & Licensing Administrat, on

R 595 i Sec. 701d8 Staffing Standards.

R 595

(8) Assure that each employee has a background check pursuant to federal and Di strict 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

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.

Health Regulation & L1censmgAdmiriistration

STATE FORM 6899 3T5011 If continuation sheet 9 of 18

Health Reaulation & Licensi	naAdminisແລມວ່າ			FORWI APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG:	(X3) DATE SURVEY COMPLETED
	ALR-0040	B. WING		03/03/2021
NAME OF PROVIDER OR SUPPLIER			, STATE, ZIP CODE	
PARADISE AT GEORGIA AVE	, LLC DBA MAPLE	RGIA AVE	·	
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES	STON, DC	PROVIDER'S PLAN OF CORRECTION	NA
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Vice President of S who assisted in the survey process (Al Sales and Marketin Findings included:  During the entranc beginning at 9:57 A currently the Acting quarantine at home the Coronavirus. Th Marketing, who wa conference, stated the completion of th asked, both the Vice Marketing and ALA part of the manage to oversee the serv surveyors requeste as part of the admir  Beginning at 10:35 Sales and Marketin surveyors with a tou The Vice President observed giving a re  On 02/25/2021 begithe personnel record	for two of two ALAs and one Sales and Marketing employee, a completion of the annual LAs #1, 2 and Vice President of Ing).  The conference on 02/23/2021 and, ALA#2 stated that he was ALA for ALA #1, who was a due to possible exposure to the Vice President of Sales and a salso present for the entrance that she would be assisting in the survey process. When the President of Sales and #2 indicated that they were ment company that was hired it inces of the ALR. The dot osee their personnel files histrative review.  AM, the Vice President of g and ALA #2 assisted the pur of the ALR. At 12:45 PM, of Sales and Marketing was esident a hug after lunch.  Inning at 2:11 PM, review of the showed that there were no backgrounds checks 1, ALA #2 and the Vice	R 595	R 595 ALA#1, ALA#2, Vice Pres Were instructed to and complete investigations and going forward ensure compliance prior to allow members to work within the com	ed background d The BOM will ving team
During the video con beginning at 11:00 A been employed as t 2020. ALA #2 stated	ference call on 03/03/2021  M, ALA #1 said that he had  he ALA since November  during the video telephone been serving as the Acting	×		

FORM APPROVED Health Reaulation & Licensina Administration (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: \_ \_ \_ ALR-0040 03/03/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5100 GEORGIA AVENUE, NW PARADISE AT GEORGIA AVE, LLC OBA MAPLE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 595 ALA#1, ALA#2, Vice President of Marketing R 595 Continued From page 10 R 595 Were instructed to and completed background ALA since 02/16/2021 investigations and going forward The BOM will ensure compliance prior to allowing team In an earlier telephone interview conducted with members to work within the community. 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 596 ALA#2 On 3/6/21 Received a copy of their R 596 Sec. 701d9 Staffing Standards. R 596 PPD ensuring that he was free of any communicable diseases. Going forward the BOM (9) Assure that members of the staff appear to will ensure this process and the receiving of be free from apparent signs and symptoms of documentation verifying the status of being free of communicable disease, as documented by a written statement from a healthcare practitioner; communicable disease 24 business hours prior to a team member's first day of work. Based on observation, interview and record review, the Assisted Living Administrator (ALA) failed to show evidence that each management R596 Vice President of Marketing was instructed personnel had a written statement from a to complete to process to ensure that she was healthcare practitioner stating that they were free free from any communicable disease. VP from communicable diseases working in the complied and documentation was received. Going Assisted Living Residence (ALR), one of one ALA forward the BOM will ensure this process and the and one of one Vice President of Sales and receiving of documentation verifying the status of Marketing employee, who assisted in the being free of communicable disease 24 business completion of the annual survey process (ALA# 2 and Vice President of Sales and Marketing). hours prior to a team member's first day of work.

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

Health Regulation & Licensing Administration

Health Reaulation & Licensin	na Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0040	B. WING		03/03/2021
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R 596 Continued From page	ge 11	R 596		
Marketing, who was conference, stated the completion of the asked, both the Vice Marketing and ALA apart of the manager to oversee the service surveyors request to part of the administration of the Vice President observed giving a record of Sales are cords did not continuous did not co	s also present for the entrance that she would be assisting in the survey process. When the President of Sales and the Indicated that they were ment company that was hired ces of the ALR. The consect set in personnel files as the profession of the ALR. At 12:45 PM, and Sales and Marketing was resident a hug after lunch.  The profession of the ALR and Vice and Marketing showed that the air of the ALR and Vice and Marketing showed that the air written statements from a mer indicating that the aner indicating that the aner indicating that the aner were free from the second of February of the interview conducted with many's Human Resource 2/26/2021 beginning at 10:57 that ALA #2 and the Vice and Marketing had no written ealthcare practitioner			
	se. The HR staff did			

i would be screen for tuberculosis on 03/04/2021.

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R 596	6 Continued From pag	ge 12	R 596		
R 705	records failed to evifrom a healthcare ppersonnel staff was diseases.  Sec. 802b Medical, Assess.  (b) The ALR shall mobtained from a statement approved information shall incapplicant's current pstatus relevant to deapplicant's psycholoso indicated during the Based on interview Assisted Living Resthat all medical assess on the Immediate Candmission/Annual Massigners approved by the residents in the same	clude a description of the obysical condition and medical efining care needs, and the ogical and cognitive status, if the medical assessment. and record review, the sidence (ALR) failed to ensure essments were documented are Facilities Division Medical Certification form that e Mayor, for one of 10	R 705	R 705 On March 12, 2021 a plar ensure that all residents shall be using the standardized physiciar approved by the Mayor. The information of the applicant's current and medical status relevant to defin the applicant's psychological and coindicated during the medical assessm DON/designee will ensure this is done hours prior to admission with the exceadmissions whereas the time frame medical assessments.	e evaluated by n's statement ation shall include a t physical condition ing care needs, and ognitive status, if so ment. The e up to 48 business eption for emergency
	02/25/2021 at 5:30 F rehabilitation and psy 01/18/2020. The ass	standardized form approved		#2 On March 12, 2021 a plan wa ensure that all residents shall be using the standardized physician approved by the Mayor. The informates description of the applicant's current and medical status relevant to defining the applicant's psychological and co	evaluated by i's statement ation shall include a physical condition ag care needs, and
	Director of Nursing ( telephone interview t	ining at 11:49 AM, the (DON) said during a that she would send the		indicated during the medical assessm DON/designee will ensure this is done hours prior to admission with the exce admissions whereas the time frame m	nent. The e up to 48 business eption for emergency

telephone interview that she would send the resident's assessment that was incorporated on

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Health Regulation & licensing Administration

PRINTED: 03/16/2021 FORM APPROVED Health Reaulation & Licensina Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: ALR-0040 03/03/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5100 GEORGIA AVENUE, NW PARADISE AT GEORGIA AVE, LLC DBA MAPLE WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R 705 On March 12, 2021 a plan was instituted to R 705 Continued From page 13 R 705 ensure that all residents shall be evaluated by the approved form by the Mayor. However, the using the standardized physician's statement DON failed to present the a medical assessment approved by the Mayor. The information shall include a documented on the Immediate Care facilities description of the applicant's current physical condition Division Admission/Annual Medical Certification and medicalstatus relevant to defining care needs, and form as approved by the Mayor as required, prior the applicant's psychological and cognitive status, if so to the survey exit on 03/03/2021. indicated during the medical assessment. The DON/designee will ensure this is done up to 48 business At the time of the survey, the ALR failed to ensure hours prior to admission with the exception for emergency each residents assessments were documented admissions whereas the time frame may be reduced. on the Immediate Care Facilities Division Admission/Annual Medical Certification form. R 800 Beginning 3/12/21 the ALR will ensure that an R 800 Subheading On-Site Review R 800 onsite review by an RN will be conducted every 45 days. The DON/designee will be responsible for conducting Sec. 903. On-site review. reviews and will be subject to audits by the ED. A tracking tool has been implemented to ensure all reviews are The ALR shall arrange for an on-site review by a completed NLT 45 days for all residents. 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

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R 800 Continued Fro	n page 14	R 800		
was admitted the record rev 12/29/2020 (1 show documer	on 01/17/2020. Further review of called a medication review dated months later). The record failed to the devidence that the ALR's RN resident's response to medications			
02/24/2021 at was admitted the records sh 02/17/2020 (5 show documen	desident #3's medical record on 1:30 PM, showed that the resident on 09/09/2019. Further review of lowed a medication review dated months later). The record failed to ted evidence that the ALR's RN esident's response to medications		#3 Beginning 3/12/21 the ALR will ereview by an RN will be conducted eDON/designee will be responsible for and will be subject to audits by the Ebeen implemented to ensure all review NLT 45 days for all residents	every 45 days. The or conducting reviews ED. A tracking tool has
02/25/2021 at admitted on 03 record showed 02/14/2021 (11 to show docum	esident #4's medical record on 4:00 PM, showed the resident was /16/2020. Further review of the a medication review dated months later). The record failed ented evidence that the ALR's RN esident's response to medications		#4 Beginning 3/12/21 the ALR will er review by an RN will be conducted e DON/designee will be responsible fo and will be subject to audits by the E been implemented to ensure all revien NLT 45 days for all residents	very 45 days. The or conducting reviews D. A tracking tool has
5. Review of R 02/23/2021 at 3 admitted on 10 record showed record failed to	esident #S's medical record on 3:50 PM, showed the resident was /29/2020. Further review of the 02/14/2021 (4 months later). The show documented evidence that ssessed the resident's response every 45 days.		#5 Beginning 3/12/21 the ALR will er review by an RN will be conducted e DON/designee will be responsible fo and will be subject to audits by the E been implemented to ensure all revie NLT 45 days for all residents.	very 45 days. The r conducting reviews D. A tracking tool has
03/01/2021 at 2 was admitted o the record show 02/04/2021 (14	esident #9's medical record on ::55 PM, showed that the resident in 12/15/2019. Further review of wed a medication review dated months later). The record failed to		#9 Beginning 3/12/21 the ALR will er review by an RN will be conducted er DON/designee will be responsible for and will be subject to audits by the E been implemented to ensure all review NLT 45 days for all residents	very 45 days. The r conducting reviews D. A tracking tool has

show documented evidence that the ALR's RN assessed the resident's response to medications

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
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	WASHINGTON, DC 20011									
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R	800 Continued From pa	age 15	R 800							
	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			#10 Beginning 3/12/21 the ALI review by an RN will be conduct DON/designee will be responsionand will be subject to audits by been implemented to ensure at NLT 45 days for all residents.	cted every 45 days. The ible for conducting reviews the ED. A tracking tool has					
R10	the survey exit on 0  At the time of the succonsistently assess	urvey the ALR's RNs failed to the resident's response to discommon areas their 45 days.	R1003	R 1003 On March 12, 2021 a pensure that all resident rooms a temperature remain IAW Feder	and common areas water					
	the hot water at all t access is controlled controlled mixing va including control at t temperature does no	sure that the temperature of caps to which residents have by the use of thermostatically alves or by other means, the source, so that the water ot exceed 110 degrees		and guidelines. The Maintenar housekeeper will test one room each floor to ensure that the ter specified range.	nce director or and common area on					
	review, the ALR faile temperatures did no Fahrenheit, for one	on, interview and record d to ensure water at exceed 110 degrees of four hand sinks, two of four sinks and one of three								

Health Regulation & Licensing Administration

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTII A. BUIL DIN	PLE CONSTRUCTION  G:	(X3) DATE SURVEY COMPLETED			
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R1003	Continued From page	ge 16	R1003					
	resident's bathroom on the second floor.	s (apartment #205) located						
	Findings included:							
	walk-thru of the facili	nning at 10:35 AM, a ty with CNA #1 and the g Administrator (ALA) g:						
	- 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.			R 1003 Kitchenette R 1003 On M policy was implemented to ensure the and common areas water temperature. Federal and local regulations and gu Maintenance director or housekeepe and common area on each floor daily temperatures are within the specified R 1003 R 1003 On March 12, 2021 a implemented to ensure that all reside common areas water temperature reand local regulations and guidelines. director or housekeeper will test one area daily on each floor to ensure the are within the specified range.	at all resident rooms re remain IAW idelines. The re will test one room re to ensure that the drange. a policy was ent rooms and main IAW Federal The Maintenance room and common			
	Assisted Living Residentemperature. At 1:40 to the surveyors that temperature at the betore the hot water below 110 degrees F							
	Follow-up observation	ns on 02/23/2021, showed						

that the plumber adjusted the hot water

Health Reaulation & Licens⊪ a Administration							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
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	temperatures in the and that the readjus measured 106 degries water temperature in for the month of Jar survey ended on 03.  At 2:40 PM, review Testing policy (unda a safe and secure eithe hot water temperegularly to ensure the safe range establish Health.  At the time of the suthat the hot water temperegularly.	aforementioned locations, sted water temperatures ees Fahrenheit. There was no ogs provided to the surveyor nuary 2021, by the time the	R1003	R 1003 R 1003 On March 12, 2021 implemented to ensure that all reside common areas water temperature rerand local regulations and guidelines. director or housekeeper will test one area on each floor daily to ensure that are within the specified range.	nt rooms and nain IAW Federal The Maintenance room and common		