Health Reaulat1on & Ucensinc Administration

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 _____	12/09/2022

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

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R00C	Initial Comments An annual licensure survey was conducted on 12/07/2022, 12/08/2022, and 12/09/2022, 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 43 residents and employed 34 personnel, to include professional and administrative staff. A sample of 17 resident records, 15 employee record were selected for review. The findings of the survey were based on observations throughout the facility, including a medication administration pass, clinical and administrative record review, and resident, family, and staff interviews.	R000		
R475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all Individualized Service Plans (ISP's) were consistently signed by the resident or a surrogate and a representative of the ALR, as required, for 7 of the 17 residents in the sample (Residents #3, 4, 6, 7, 12. 13, and 14). Findings included: 1. On 12/08/2022 at 1:37 PM, a review of Resident #3's medical record showed that an ISP review was conducted on 05/10/2022. The ISP was signed by the Registered Nurse (RN) but failed to show evidence that the ISP was signed by the resident or a surrogate.	R475	The corrective action to accomplish and address the identified deficient practice will be to have the resident, surrogate, or family/ friends of resident's choice in attendance of ISP meetings. They will sign the actual ISP upon agreement of ISP review if meeting is done in person. When the ISP meeting/ review is done virtually or by telephone, all attendees will provide in writing proof of the occurrence and their attendance in the ISP meeting/review. The systemic changes to be made to ensure this deficient practice does not recur include updating the Policy and Procedures of Maple Heights Senior Living to include the acknowledgment of verification of attendance in ISP meetings/review done virtually or on the telephone in writing by all attendees. Attendees of virtual and telephonic meetings will notify community via email of their attendance in lieu of their signature on ISP document.	12/22/2022 1/1/2023

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R475	Continued From page 1 2. On 12/08/2022 at 3:02 PM, a review of Resident #4's medical record showed that a 30-day ISP review was conducted on 07/04/2022. The ISP was signed by the Registered Nurse (RN) but failed to show evidence that the ISP was signed by the resident or a surrogate. 3. On 12/08/2022 at 3:02 PM, a review of Resident #6's medical record showed that an ISP review was conducted on 07/21/2022. The ISP was signed by the Registered Nurse (RN) but failed to show evidence that the ISP was signed by the resident or a surrogate. 4. On 12/08/2022 at 11:04 AM, a review of Resident #7's medical record showed that an ISP was developed on 10/14/2022. The document failed to show evidence that the ISP was reviewed and signed by the resident or a surrogate and a representative of the ALR. 5. On 12/08/2022 at 11:00 AM, a review of Resident #12's medical record showed that ISP's were developed and reviewed by the RN on 03/30/2022 and 09/01/2022. However, there was no evidence that the resident or a surrogate participated in the ISP reviews. 6. On 12/09/2022 at 9:42 AM, a review of Resident #13's medical record showed that ISP's were reviewed by the RN on 10/01/2021, 11/06/2021 and 06/27/2021, however, there was no evidence that the resident or a surrogate participated in the ISP reviews 7. On 12/09/2022 at 11:17 AM, a review of Resident #14's medical record showed that an ISP was developed on 10/15/2021 and revised on 11/14/21. The document failed to show evidence	R475	The corrective action utilized to monitor and ensure this deficient practice does not recur includes the use of the spreadsheet listing all Assessments required for all residents, the frequency they are to be completed, the date they are completed and the next due date. The ISP is included with the Comprehensive Senior Living Assessment which is done in Pre-Admission, upon Admission, at 30 days post Admission, semi-annually and upon Reentry to the community after hospitalization/ Rehabilitation. The ISP will be kept in the resident record along with the required signatures if done in person or a copy of the written verification provided by the attendees if done virtually or by telephone. The DON will be responsible to ensure that this deficient practice does not recur.	1/16/2023

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R 475	Continued From page 2 that the ISP was reviewed and signed by the resident or a surrogate and a representative of the ALR. On 12/09/2022 at 3:00 PM, the Assisted Living Administrator said during the exit that the ISP's were not conducted in person and that the ALR had not developed a system to show documented evidence of the resident or surrogate and a representative of the ALR participated in the development and review of the ISP. At the time of the survey the ALR failed to ensure all ISP's were signed by a resident or surrogate and a representative of the ALR.	R475	The corrective action to accomplish and address the identified deficient practice includes completion of the pre-admission ISP of all new admissions, and a review/update at 30 days post admission for the recent admissions. Going forward, all significant changes in resident condition resulting in hospitalization and/or significant changes in care needs will be updated in the ISP if occurrence is prior to the 6 month review. Resident #14 ISP has been updated to show this resident's habit of leaving the facility without his phone and the strategy to be implemented to be aware of his whereabouts while in the facility and when he decides to leave the facility. The measures put in place to ensure the deficient practice does not recur includes a spreadsheet created listing all required documents for the residents listed in the ALR Regulations, including the frequency of ISP review and updates. Upon completion of the ISP updates and ISP reviews with the residents, surrogate and family friends of resident's choice invited to be in attendance, completion date will be added to the spreadsheet along with the next scheduled due date per regulations.	
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 record review and interview, the ALR failed to ensure all ISP's were updated with each significant change in the residents' condition, for 4 of 17 residents in the sample (Residents #3, 6, 14, and 16). Findings included: 1. On 12/08/2022 at 1:37 PM, review of Resident #3's record showed the resident was transported	R483		12/22/2022 1/15/2023

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R483	Continued From page 3 to the emergency room (ER) on 05/04/2022. an incident report dated 09/06/19, showed that Resident #2 sustained a fall without injury. However, there was no documented evidence that the ISP dated 11/13/2021, had been updated to reflect the resident's vaginitis rash and the interventions needed to treat it. 2. On 12/08/2022 at 3:02 PM, review of Resident #6's medical record showed the resident complained of chest pain and was transported to the ER on 09/18/22. Review of the resident's ISP 07/01/2022 failed to have documented evidence that the resident's ER visit for chest pain was addressed with interventions for staff to implemenUreport. 3. On 12/07/2022 starting at 1:52 PM, during the review of the ALR's incident reports showed an incident involving Resident #14. According to an incident dated 08/05/2022, Resident #14 left the facility on 08/04/2022 and did not return for meals and medication. The staff notified the police. The police located the resident in Annapolis MD after police responded to a disorderly patient at the hospital. The Resident was taken into police custody due to an outstanding warrant from 2019. 4. On 12/09/2022 at 11:17 AM, a review of Resident #14's medical record showed that the resident left the facility on 12/01/2022 at 7:30 PM and did not return to receive his evening medications. Review of the corresponding incident report showed that several attempts were made to contact the resident but were unsuccessful because the resident did not have his phone. The facility contacted the police at 3:00 AM. On 12/05/2022, the facility received a call from INOVA hospital informing them that the	R483	The Director of Nursing will review the Spreadsheet monthly (every first Wednesday) to determine upcoming due dates or more frequently if there is a resident change in condition necessitating more frequent review. Monthly meetings with DON and ED along with any other member of the health care team will be conducted to discuss resident behaviors of concern, changes, ISP meetings and what is being done to ensure compliance. The spreadsheet will be kept online and will be available to the Executive Director and the Director of Nursing. DON will be responsible for ensuring the strategy for implementation is done and this deficient practice does not recur.	

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R483	Continued From page 4 resident was ready to be discharged. It was discovered that the resident went to the MGM Casino and became intoxicated. The resident was transported the hospital and treated for seizures and alcohol intoxication. On 12/09/2022 at 11: 17 AM, review of Resident #14's revised on 11/14/2021 failed to show documented evidence that the resident's ISP was updated to reflect the resident's habit of leaving the facility without his phone strategies for ensuring the resident can be contacted while in the community. 5. On 12/09/2022 at 12:50 PM, review of Resident #16's medical record showed that the resident was hospitalized from 05/05/2022 to 10/21/2022. according to the Care Manager Coordinator, the resident was now on dialysis three days a week. Review of an ISP dated 12/08/2022, failed to show evidence that the resident's need for dialysis was addressed. During an interview on 11/08/19 at 3: 15 PM, the ALA and RN acknowledged that the information had not been documented on the residents' ISPs and that going forward resident's ISPs will reflect significant changes along with interventions. At the time of survey, the ALR failed to ensure all ISPs were updated when there were significant changes in the residents' condition.	R483		
R596	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 observations, interview and record reviews, the Executive Director (ED) failed to	R596		

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R 596	Continued From page 5 show evidence that each employee had a written statement from a healthcare practitioner stating that they were free from tuberculosis in a communicable form, for eight of 15 employees providing services to the residents (Employees #3, 4, 5, 6, 9, 13, 14 and 15). Findings included: Observations conducted from 12/07/2022 through 12/09/2022 showed Employees #3, 4, 5, 6, and 9 providing direct care services to the residents' (i.e., assisting with lunch, Activities of Daily Living, group bingo, etc.). Employee #13 was observed prepping for the resident's lunch in the commercial kitchen on 12/08/2022 at 12:14 PM. On 12/09/2022 beginning at 11:50 AM, a review of the personnel records for Employees #3, 4, 5, 6, 9, 13, 14 and 15 showed that the records did not contain written statements from a healthcare practitioner indicating that they were free from communicable disease. At 2:23 PM, interview with the Executive Director said that the employees had a communicable disease/tuberculosis screening questionnaire that all employees completed during the hiring process. When asked if that screening questionnaire was completed by a healthcare practitioner, the ED said no. The ED stated that she would double check the employee's personnel's records to see if a health certificate or tuberculosis screwing had been completed by a licensed physician or healthcare practitioner. At 3:20 PM, additional requests were made for employee health certificates; however, no new information was made available for review.	R 596	The corrective action implemented to accomplish and address the identified deficient practice involves a call made to the facility Health Care Provider to discuss the availability to administer TB screening and administration of PPD and written statement to document that all staff are free from tuberculosis in addition to the staff identified in the licensure survey. The facility's Health Care Provider agreed to complete TB screening of all staff and provide written signed statements that the staff are free from communicable diseases. It was also agreed that annual TB screenings will also be conducted with written, signed statements documenting all staff are free from communicable diseases including tuberculosis. To ensure the deficient practice does not recur, the spreadsheet will be monitored by the ED monthly and updated with receipt of written verification of employee's freedom from communicable diseases including TB initially and annually. The written verification shall be placed in the employee records. The Executive Director will ensure that this deficient practice does not recur.	2/15/2023

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R 596	Continued From page 6 At the time of survey, the facility failed to ensure evidence a signed statement from a healthcare practitioner that each personnel staff was free from communicable diseases. At the time of the survey, the ALR failed to document that each employee was free from communicable diseases including tuberculosis.	R 596		
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 interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Registered Nurses (RN) assessed each resident's medication regimen every 45 days, for 13 of the 17 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 14, 15, and 17). Findings included: 1. On 12/09/2022 at 9:00 AM, a review of Resident #1's medical record showed that the resident was admitted on 01/10/2021. There was one 45-day review in the record dated 10/12/2022. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 2. On 12/9/2022 at 10:35 PM, a review of Resident #2's medical record showed that the resident was admitted on 08/01/2021. There were two 45-day reviews in the record dated	R 800	The corrective action to accomplish and address the identified deficient practice involves the DON starting with the current medication changes, then the recent changes of the resident's medication regimen and response to the medication. These 45 day assessments have been done. The DON has begun to get the 45 day assessments done of all other residents starting with the residents identified by the surveyors, and will continue with medication reviews for all every 45 days. The measures put in place to ensure the deficient practice does not recur includes a spreadsheet created listing all required documents for the residents listed in the ALR Regulations, including the Medication Management Review to include the frequency of the review. Upon completion of the 45 day reviews, the completion date will be added to the spreadsheet along with the next scheduled due date per regulations.	2/3/2023

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R 800	Continued From page 7 10/01/2021 and 05/10/2022. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 3. On 12/08/2022 at 1:37 PM, a review of Resident #3's medical record showed that the resident was admitted on 10/13/2021. There were five medication review in the record, however the record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days. 4. On 12/08/2022 at 1:40 PM, a review of Resident #4's medical record showed that the resident was admitted on 10/15/2021. There were two 45-day reviews in the record dated 11/04/2021 and 06/29/2022. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 5. On 12/08/2022 at 12:32 PM, a review of Resident #5's medical record showed that the resident was admitted on 10/14/2021. There were two medication reviews in the record dated 07/21/2022 and 10/21/2022. the record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days, prior to the days noted above. 6. On 12/08/2022 at 3:02 PM, a review of Resident #6's medical record showed that the resident was admitted on 12/10/2021. The record failed to show any documented evidence	R 800	The corrective action utilized to monitor and ensure this deficient practice does not recur includes the use of the spreadsheet listing all Assessments required for all residents, including the 45 day medication review of the resident's medication regimen and response to the medication, the frequency they are to be completed, the date they are completed and the next due date. Documentation will be done on the spreadsheet with each completion. Monthly review of the spreadsheet will be completed by the DON. The 45 day medication management review will be kept in the resident record. The spreadsheet will be kept online. The DON will be responsible to ensure that this deficient practice does not recur.	

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R 800	Continued From page 8 that the assisted living residence's RN assessed the resident's response to her medications every 45 days since the date of admission. 7. On 12/09/2022 at 11:35 PM, a review of Resident #9's medical record showed that the resident was admitted on 02/16/2022. There was one 45-day reviews in the record dated 09/18/2022. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 8. On 12/08/2022 at 3:28 PM, a review of Resident #10's medical record failed to show that the resident was admitted on 10/03/2022. There were no medication regimen reviews noted in the records, and no documented evidence that the assisted living residence's RN assessed the resident's response to his medications every 45 days. 9. On 12/08/2022 at 3:53 PM, a review of Resident #11's medical record showed that the resident was admitted on 02/24/2022. There were two 45-day reviews in the record dated 07/05/2022 and 10/10/2022. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 12. On 12/08/2022 at 11:00 AM, a review of Resident #12's medical record showed that the resident was admitted on 03/30/2022. There was one 45-day reviews in the record dated 06/03/2022. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the	R 800		

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R 800	Continued From page 9 resident's medication regimen and response to the medications every 45 days. 13. On 12/9/2022 at 11: 17 AM, a review of Resident #14's medical record showed that the resident was admitted on 10/15/2021. There were no day reviews in the record. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 14. On 12/08/2022 at 11:00 AM, a review of Resident #15's medical record showed that the resident was transferred to the memory unit on 02/19/2021. There were two 45-day reviews in the record dated 07/06/2021 and 08/17/2021. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. 15. On 12/9/2022 at 11:00AM, a review of Resident #1 Ts medical record showed that the resident was admitted on 07/21/2021. There were two 45-day reviews in the record dated 08/18/2021 and10/01/2021. The record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to the medications every 45 days. On 12/09/2022 at 3:18 PM, the Assisted Living's Residences Director of Nursing (DON) acknowledged that the resident's medications were not reviewed every 45 days as required prior to her arrival in May 2022. The DON said she is working on ensuring the resident's medication regimens will be reviewed every 45 days consistently.	R 800		

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R 800	Continued From page 10 At the time of the survey, the assisted living residence's registered nurse failed to consistently review the residents' medication regimen and their responses to their medications every 45 days.	R 800		
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 using 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 observations, interview and record reviews, the Assisted Living Residence (ALR) failed to ensure that water temperatures did not exceed 110 degrees Fahrenheit, for two of the two kitchenettes and hand sinks located on the first and third floors and two of the two kitchenettes and bathroom sinks in Apartments #211 and 212. Findings included: On 12/08/2022 beginning at 11:52 AM, a walk-thru of the facility with the Executive Director (ED) showed the following: - At 11:55 AM, the kitchenette sinks, and hand sink located on the first floor across from the dining area showed water temperatures that measured 121.3- and 121.0-degrees Fahrenheit (° F). - At 12:27 PM, the kitchenette sinks, and bathroom sink located in Apartment #211 showed water temperatures that measured 124.7 and 121.3	R1003	The corrective action accomplished to address the identified deficient practice was done by the ED the same day we were informed of the deficient practice. The ED contacted our maintenance contractor who arrived right away and tested each location identified where the water temperatures were high. Adjustment to the hot water temperatures were made on the hot water heater located in the basement. By the next morning all temperatures were within the normal range in accordance with the stated local requirements. The measures put in place to ensure the deficient practice does not recur include the maintenance contractor completing weekly testing of the water in all residential rooms common areas, bathrooms, kitchen areas and the back of the community. New thermometers were purchased and put in place to ensure that when the water temperatures are tested weekly, the water temperature does not exceed 110 degrees F. If the water does exceed 110 degrees F, the maintenance contractor will adjust mixing valve, retake water temperature and repeat the steps necessary to ensure water temperatures do not exceed the normal range in accordance with the local requirements.	12/8/2022

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	ALR-0040	A. BUILDING: _____ B. WING _____	12/09/2022

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

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R1003	Continued From page 11 degrees °F. -At 12:32 PM, the kitchenette sinks, and bathroom sink located in Apartment #212 showed water temperatures that measured 123.4 and 123.7 degrees °F. -At 12:45 AM, the kitchenette sinks, and hand sink located on the third floor across from dining area showed water temperatures that measured 120.9 and 120.4 degrees °F. At 1: 18 PM, when asked about the parameters for the hot water temperatures; the ED stated that the hot water temperatures should not exceed 110 degrees Fahrenheit. The ED said that she would call the maintenance contractor to come and adjust the hot water temperatures. Additionally, the ED was asked if there were incidents or complaints related to the hot water temperatures, and she replied by saying, "some of the residents thought the water was cold." At 2:50 PM, the maintenance contractors arrived at the facility to adjust the hot water temperatures. At 2:59 PM, the maintenance contractor was observed testing each location where the water temperatures were high and confirmed the surveyor's findings. The maintenance contractor stated that he would adjust the hot water temperatures on the hot water heater located in the basement of the facility, but that it may take some time for the water to adjust given the size and layout of the facility. On 12/09/2022 beginning at 9:50 AM, follow-up observations showed that the maintenance staff adjusted the hot water temperatures in the locations noted above, and that the readjusted	R1003	The water temperatures will be documented in a weekly log by the maintenance contractor. The weekly log will be kept in ED's office. The ED will review the log book weekly and will be responsible for ensuring this deficient practice does not recur.	

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R1003	Continued From page 12 water temperatures measured the following: - The kitchenette sinks, and hand sink located on the first floor across from dining area showed water temperatures that measured 109.2 and 107.8.0 degrees °F. - The kitchenette sinks, and bathroom sink located in Apartment #211 showed water temperatures that measured 107.7 and 106.5 degrees °F. - The kitchenette sinks, and bathroom sink located in Apartment #212 showed water temperatures that measured 104.9 and 108.2 degrees °F. - The kitchenette sinks, and hand sink located on the third floor across from dining area showed water temperatures that measured 106.1 and 108.4 degrees °F. Beginning at 10: 11 AM, review of the water temperature logs from November 2021 through June 2022 showed the temperatures remained within the normal range in accordance with local requirements. At 10: 12 AM, review of the Water Policy (undated) showed that water temperatures in the resident's apartments and public areas in the facility will be checked and recorded at a minimum of once weekly, to ensure that hot water temperatures will not exceed 110 degrees Fahrenheit. 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		

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R 000	Initial Comments 0000 Initial Comments An annual licensure survey was conducted on 12/07/2022, 12/08/2022, and 12/09/2022, 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 43 residents and employed 34 personnel, to include professional and administrative staff. A sample of 17 resident records, 15 employee record were selected for review. The findings of the survey were based on observations throughout the facility, including a medication administration pass, clinical and administrative record review, and resident, family, and staff interviews.	R 000	The corrective action to be accomplished to address the identified deficient practice will be the following: Residents 2, 4, 6, 11, 12, 13, 14, and 17 - the current Primary Care Physician (PCP) on record will be notified	
R 074	10108.2 Admissions 10108.2 Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division Admission/Annual Medical Certification form (Medical Certification Form) was completed with all areas addressed, for 11 of 17 residents in the sample (Residents #2, 4, 6, 7, 10, 11, 12, 13, 14, 15, and 17). Findings included: The ALR failed to ensure that medical certification forms were completed with all areas addressed, as evidenced below: a. On 12/08/2022 at 3:02 PM, a review of	R 074	and request made to complete in its entirety within the next 30 days the Intermediate Care Facilities Division Admission/**Annual** Medical Certification Form. Residents 7, 10, and 15 which are the most recent admissions will also have the Intermediate Care Facilities Division **Admission**/Annual Medical Certification Form completed within 30 days by the current Primary Care Physician. The systemic changes put in place to ensure the deficient practice does not recur will include that inital assessment will always be completed by Primary Care Physician or the Physician responsible for initiating the transfer of incoming	2/6/2023

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R 074	Continued From page 1 Resident #6's medical certification form, dated 12/07/2022, showed that the physician failed to indicate if the resident had or needed a Prostate-Specific Antigen (PSA) or Colonoscopy. In addition, the resident's medications were not listed on the form. b. On 12/08/2022 at 11:04 AM, review of Resident #7's medical certification form, dated 11/14/2022, showed that the physician failed to document the resident's vital signs, did not indicate if the resident was exhibiting signs of communicable disease and if the resident required assistance with transferring. c. On 12/08/2022 at 3:28 PM, review of Resident #10s medical certification form, dated 08/18/2022, showed that the physician failed to indicate if the resident had or needed a PSA, Colonoscopy, PAP test, or mammogram. Failed to indicate if the resident was exhibiting signs suggestive of a communicable disease, if the resident was capable of self-medicating, needed assistance with all areas of activities of daily living (ADLs), if the resident had impaired vision, hearing, speech, dental, podiatrist and skin. The physician did not address the resident's dietary, continence status, if the resident was dependent on medical equipment and any other required services needed. d. On 12/08/2022 at 3:53 PM, review of Resident #11 's medical certification form, dated 02/18/2022, showed that the physician failed to document the resident's Tuberculosis status (TB), the reason for the examination, and the resident's mental health status. e. On 12/09/2022 at 11: 17 AM, review of Resident #14's medical certification form, dated	R074	prospective residents. The standardized form required will be provided to the physician within 30 days of admission to include a medical, rehabilitation, and psychosocial assessment of each resident. The form will be completed in its entirety and include the following: 1) The individual's medical history with a recent evaluation , including vital signs 2) Any significant medical conditions affecting function, including the individual's ability for self care, cognition, behavior and psychosocial activities 3) Presence of allergies 4) Confirmation that the applicant is free from communicable TB and from other active infectious, and reportable communicable diseases 5) Current medication profile and projected and other needed medications, treatments and service; review of non-prescription drugs and review of possible adverse interactions 6) Current dietary needs and restrictions 7) Medically necessary limitations or precautions 8) Monitoring or tests that may be need to be performed or followed up after admission 9) Level of functioning in activities of daily living including bathing, dressing, grooming, eating, toileting and mobility 10) Level of support and intervention, including any special equipment and supplies required to compensate for the individual's deficitis in Activity of Daily Living	

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R 074	Continued From page 2 10/11/2021, showed that the physician failed to indicate the reason for the evaluation and did not list the resident's medication on the form. f. On 12/09/2022 at 10:35 AM, review of Resident #2's medical certification form, dated 07/09/2021, showed that the physician failed to indicate the reason for the evaluation, tuberculosis status, and did not list the resident's medication on the form. g. On 12/08/2022 at 1:40 PM, review of Resident #4's medical certification form, dated 10/12/2021, showed that the physician failed to list the resident's medication on the form. h. On 12/08/2022 at 11:00 AM, review of Resident #12's medical certification form, dated 03/23/2022, showed that the last page of the form was not in the record to indicate the resident's medication regimen, or if the resident required medical or laboratory services. The missing page also would have the physician's signed attestation that the resident was not in need of continual acute or long-term medical care or supervision which would require placement in a hospital or nursing home or 24-hour skilled nursing care. i. On 12/09/2022 at 9:42 AM, review of Resident #13's medical certification form, dated 09/24/2021, showed that the physician failed to list the resident's medication on the form. j. On 12/09/2022, at 3:00 PM a review of Resident #1 S's record showed that the resident was initially admitted to the facility on 06/24/2019, but due to a change in the resident's status, the resident was transferred to the memory unit on 02/19/2021. The record failed to show documented evidence that a medical assessment, due to a change in the resident's	R 074	11) Current physical or psychological symptoms of the individual requiring monitoring, support or other intervention by the ALR 12) Capacity of the individual for making personal and healthcare related decisions 13) Presence of disruptive behaviors or behaviors which present a risk to the physical or emotional health and safety of self or others 14) Social factors including: 15) Significant problems with family circumstances and personal relational relationships 16) Spiritual status and needs 17) Ability to participate in structured and group activities and the resident's current involvement in such activities Any resident that requires a change from Assisted Living to Memory Care or readmission after a prolonged hospital/rehabilitation stay will require the Intermediate Care Facilities Division Admission/Annual Medical Certification form completed in its entirety as stated above prior to the transfer due to a change in resident's condition/ health care status as well as within 30 days of any readmission after a prolonged hospital/rehabilitation stay prior to returning to the facility. No resident will be admitted to Maple Heights Senior Living without receipt of the Intermediate Care Facilities Division Admission/Annual Medical Certification Form. Upon receipt, the Director of Nursing will review for completion. A spreadsheet will be created listing all required admission documents. When completion of the Medical Certification Form s verified, the receipt date will be placed on the spreadsheet which will be used as the tickler system to keep track of dates the documents were received and the dates when updates are due.	1/15/2023

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R 074	Continued From page 3 condition had been conducted and documented on a medical certification form as required. k. On 12/09/2022 at 11:00 PM, a review of Resident #17's medical certification form, dated 07/06/2021, showed that the physician failed to document the resident's tuberculosis status, indicate if the resident was or was not exhibiting signs and symptoms suggestive of a communicable disease, and if the resident had or needed a PSA test or colonoscopy. The form also showed that the physician circled that the resident needed continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home. In addition, the physician did not indicate that the resident was not in need of 24-hour skilled nursing care. During an interview with the ALR's administrator on 12/09/2022 starting at approximately 11:00 AM the findings of the medical certification form was reviewed. The administrator acknowledged the findings and stated that the ALR would explore strategies to get the physicians to complete all sections on the Immediate Care Facilities Division Admission/Annual Medical Certification form. At the time of the survey, the ALR failed to ensure that all sections of the Immediate Care Facilities Division Admission/Annual Medical Certification forms were completed by the physician.	R 074	The Director of Nursing will review the Spreadsheet monthly (every first Wednesday) to determine upcoming due dates or more frequently if there is a resident change in condition necessitating more frequent review. Monthly meetings with DON and ED along with any other member of the health care team will be conducted to discuss resident behaviors of concern, changes, ISP meetings and what is being done to ensure compliance. DON will be responsible for ensuring the strategy for implementation is done and this deficient practice does not recur.	
R 150	10113.4 Individualized Service Plans (ISPs) 10113.4 In accordance with§ 604 of the Act (D.C. Official Code§ 44-106.04), the ISP developed following the completion of the "post move-in" assessment shall be based on the following	R 150		

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R 150	Continued From page 4 factors: Based on interview and record reviews, the Assisted Living Residence (ALR) failed to ensure that each resident had a pre-admission Individualized Service Plan (ISP) completed 30 days prior to admission to the assisted living residence, for 5 of the 17 residents in the sample (Residents #8, 10, 11, 12, and 15). Findings included: A review of the ALR's medical records revealed the following information regarding the completion of the pre-admission ISP: 1. On 12/08/2022 at 3:28 PM, a review of Residents #1 Os medical record showed that the resident was admitted to the ALR on 10/03/2022. Further review of the record failed to show evidence that a pre-admission ISP was completed. 2 On 12/08/2022 at 3:53 PM, a review of Residents #11 's medical record showed that the resident was admitted to the ALR on 02/24/2022. Further review of the record failed to show evidence that a pre-admission ISP was completed. 3. On 12/09/2022 at 12:20 PM, a review of Residents #B's medical record showed that the resident was admitted to the ALR on 05/11/2022. Further review of the record failed to show evidence that a pre-admission ISP was completed. 4. On 12/08/2022 at 11:00 AM, a review of Residents #12's medical record showed that the resident was admitted to the ALR on 03/30/2022. An ISP dated 03/30/2022 (date of admission) was	R 150	Going forward a pre-admission Individualized Service Plan (ISP) will be developed within 30 days of admission for all residents after the completed assessment by the Director of Nursing or an authorized licensed health care professional. Family, friends or others selected by the the resident may participate in the development and review of the ISP. The measures put in place to ensure the deficient practice does not recur includes a spreadsheet created listing all required admission documents including the pre-admission ISP, date of completion, move in date, post move in assessment to be done within 72 hours of move-in, post admission ISP with any revisions and the completion date. Any changes in the resident's health status or relocation within the community will necessitate an updated ISP along with a planned ISP meeting with all parties involved in resident's care. A minimum of 7 days shall be given in writing to all participants of the ISP review. One written reminder will be given prior to the ISP review. The resident or surrogate will be encouraged to participate along with family or friends of the resident's choice. The parties will be permitted to reschedule to a date and time that is mutually agreeable. The date the ISP meeting is actually completed will be recorded on the spreadsheet along with the due date next ISP meeting as a reminder.	1/15/2023

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R 150	Continued From page 5 noted in the resident's records. Further review of the record failed to show evidence that an ISP was completed prior to the resident's admission to the ALR. 5. On 12/09/2022, at 3:00 PM a review of Resident #15's record showed that the resident was initially admitted to the facility on 06/24/2019. Due to a change in the resident's status, the resident was transferred to the memory unit on 02/19/2021. The record failed to show documented evidence that an ISP was developed or revised as required prior to the resident's relocation. On 12/09/2022, at 3:30 PM, during the exit conference, the ALR's Administrator acknowledged the ISPs were not documented prior to the resident's day of admission and that going forward, she would ensure that the ISP's would be completed, as required. At the time of the survey, the ALR failed to ensure an ISP was developed prior to admission.	R 150	The Director of Nursing will review the Spreadsheet monthly (every first Wednesday) to determine upcoming due dates or more frequently if there is a resident change in condition necessitating more frequent review. Monthly meetings with DON and ED along with any other member of the health care team will be conducted to discuss resident behaviors of concern, changes, ISP meetings and what is being done to ensure compliance. The spreadsheet will be kept online and will be available to the Executive Director and the Director of Nursing. DON will be responsible for ensuring the strategy for implementation is done and this deficient practice does not recur. The corrective action implemented to accomplish and address the identified deficient practice involves a call made to the facility Health Care Provider to discuss the availability to administer TB screening and administration of PPD and written statement to document that all staff are free from tuberculosis in addition to the staff identified in the licensure survey. The facility's Health Care Provider agreed to complete TB screening of all staff and provide written signed statements that the staff are free from communicable diseases. It was also agreed that annual TB screenings will also be conducted with written, signed statements documenting all staff are free from communicable diseases including tuberculosis.	
R 283	10116.17 Staffing Standards 10116.17 All employees, including the ALA, shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Documentation shall be provided by the employee's licensed healthcare practitioner. Based on observations, interview and record reviews, the Executive Director (ED) failed to show evidence that each employee had a written statement from a healthcare practitioner stating that they were free from tuberculosis in a communicable form, for eight of 15 employees providing services to the residents (Employees	R 283		2/15/2023

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R283	Continued From page 6 #3, 4, 5, 6, 9, 13, 14 and 15). Findings included: Observations conducted from 12/07/2022 through 12/09/2022 showed Employees #3, 4, 5, 6, and 9 providing direct care services to the residents' (i.e., assisting with lunch, Activities of Daily Living, group bingo, etc.). Employee #13 was observed prepping for the resident's lunch in the commercial kitchen on 12/08/2022 at 12:14 PM. On 12/09/2022 beginning at 11:50 AM, a review of the personnel records for Employees #3, 4, 5, 6, 9, 13, 14 and 15 showed that the records did not contain written statements from a healthcare practitioner indicating that they were free from communicable disease. At 2:23 PM, interview with the Executive Director said that the employees had a communicable disease/tuberculosis screening questionnaire that all employees completed during the hiring process. When asked if that screening questionnaire was completed by a healthcare practitioner, the ED said no. The ED stated that she would double check the employee's personnel's records to see if a health certificate or tuberculosis screwing had been completed by a licensed physician or healthcare practitioner. At 3:20 PM, additional requests were made for employee health certificates; however, no new information was made available for review. At the time of survey, the facility failed to ensure evidence a signed statement from a healthcare practitioner that each personnel staff was free from communicable diseases.	R283	The measures put in place to ensure the deficient practice does not recur includes a spreadsheet created by the Executive Director (ED) listing all required staff documentation completed initially and annually including a written statement by a health care practitioner as to whether the employees has any communicable diseases, including tuberculosis. To ensure the deficient practice does not recur, the spreadsheet will be monitored by the ED monthly and updated with receipt of written verification of employee's freedom from communicable diseases including TB initially and annually. The written verification shall be placed in the employee records. The Executive Director will ensure that this deficient practice does not recur.	

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(X4) D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 283	Continued From page 7 At the time of the survey, the ALR failed to document that each employee was free from communicable diseases including tuberculosis.	R283		
R 383	10125.4a Reporting Complaints to The Director 10125.4a An ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day; and Based on interview and record reviews, the Assisted Living Residence (ALR) failed to report timely, an unusual incident of a missing person to the Department of Health (DOH), for one of the 17 residents in the sample (Resident #14). Findings included: On 12/08/2022, the Department of Health (DOH) received an unusual incident report via an email notification of a missing resident from the Assisted Living Residence (ALR) facility. According to the incident report, on 12/01/2022 at approximately 7:30 PM, Resident #14 left the facility and had not returned to the facility to receive evening medications. The facility contacted the police at 3:00 AM. On 12/05/2022, the facility received a call informing them that the resident was ready to be discharged. It was discovered that the resident went to the MGM Casino and became intoxicated and was transported to a hospital located in Virginia for treatment. The incident was reviewed during the annual survey as part of the incidenUfall/complaint record review on	R 383	The corrective action to accomplish and address the identified deficient practice will involve the notification of unusual incidents to be made to the Department of Health promptly by phone, and followed up in writing within 24 hours or the next business day. The Metropolitan Police Department will be notified of any unusual incident before notifying the Director pursuant to paragraph 10125.4 The measure put in place to ensure that the deficient practice does not recur involves all administrators receiving the Assisted Living Residence Regulations to be our resource and to be used to maintain compliance. The resource pool also includes names and numbers of the Department of Health to reach out to with any questions or concerns. The administrators are now aware of what are considered unusual occurences which include, but is not limited to accidents resulting in significant injury to a resident, unexpected death, a sustained utility outage, environmental hazards, misappropriation of a resident's property or funds, or an occurrence requiring or resulting in intervention from law enforcement or emergency response personnel. Written documentation of all calls and follow up correspondence made to the Director at the Department of Health will be placed in resident record along with the outcomes. A record of all instances of unusual occurrences shall be kept for a minimum of three (3) years after the date of occurrence.	12/12/2022

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 _____	12/09/2022

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 383	Continued From page 8 12/07/2022 beginning at 1:52 PM. During an interview on 12/08/2022 at approximately 3:00 PM, the Executive Director (ED) said Resident #14 was independent, comes and goes as he pleases. One problem with the resident leaving is that he frequently forgets to take his cell phone and cannot be reached while out of the community. When asked who was notified about the incident, the ED said the incident was reported to the Elderly and Persons with Physical Disabilities (EPD) program and the Ombudsman. The ED acknowledged that DOH was not notified timely and that going forward she would ensure timely incident reporting to DOH. On 12/09/2022 At 11 :59 PM, a review of the ALR's Missing Resident's policy (undated) showed that the facility was to notify DOH; however, did not specify when DOH was to be notified. At the time of the survey, the ALR failed to notify DOH by phone promptly, and follow-up with written notification within 24 hours or the next business day of an unusual incident (missing resident) that substantially affected residents	R 383		