STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0042	A. BUILDING: ______ B. WING ______	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRAM HALL AL OPCO, DBA ABRAM ASSITED	1320 MAIN DRIVE, WASHINGTON, DC20012 WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments 0000 Initial Comments An annual licensure survey was conducted on 05/23/2023, 05/24/2023, 05/25/2023 and 05/26/2023, 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 34 residents and employed 40 personnel, including professional and administrative staff. A sample of 20 resident records, 15 employee records 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	Please start typing your responses here:	
R 154	10113.5 Individualized Service Plans (ISPs) 10113.5 A "post move-in" assessment required by § 604 of the Act (D.C. Official Code § 44-106.04) shall be conducted by or on behalf of the ALR within seventy-two (72) hours of a resident's admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Registered Nurse (RN) performed a "post move-in" assessment within 72 hours of each resident's admission for 16 of the 20 residents in the sample (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16). Findings included: 1. On 05/25/2023 at 1:52 pm, a review of Resident #1's clinical records showed that the	R 154	R154 1. Corrective Action to be accomplished RN has reviewed each post move-in assessment in collaboration with the ADON and RN has signed each post move-in assessment that was previously completed by an LPN. The name of our move-in assessment is being changed in PointClickCare to clearly identify it as the post move-in assessment. 2. Measures Implemented to ensure it does not recur Our new resident move-in workflow has been updated to include the RN signature on the post move-in assessment within 72 hours. 3. QA Program Action to Monitor compliance with corrective measures Our monthly QA monitoring program will now include a review of any admissions within the last month, and the required post move-in assessment signed by an RN. 4. Date to be completed: June 30, 2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director/Assisted Living Administrator 06/23/2023

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R 154	Continued From page 1. resident was admitted on 11/29/2022. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 2. On 05/25/2023 at 1:52 pm, a review of Resident #2's clinical records showed that the resident was admitted on 11/29/2022. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 3. On 05/24/2023 at 12:03 am, a review of Resident #3's clinical records showed that the resident was admitted on 02/27/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 4. On 05/24/2023 at 1:45 pm, a review of Resident #4's clinical records showed that the resident was admitted on 05/05/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 5. On 05/25/2023 at 2:25 pm, a review of Resident #5's clinical records showed that the resident was admitted on 04/27/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 6. On 05/25/2023 at 11:16 am, a review of Resident #6's clinical records showed that the resident was admitted on 02/16/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission.	R 154		

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R 154	Continued From page 2. 7. On 05/25/2023 at 9:19 am, a review of Resident #7's clinical records showed that the resident was admitted on 12/28/2022. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 8. On 05/24/2023 at 12:57 pm, a review of Resident #8's clinical records showed that the resident was admitted on 10/02/2022. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 9. On 05/24/2023 at 12:57 pm, a review of Resident #9's clinical records showed that the resident was admitted on 10/02/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 10. On 05/25/2023 at 11:17 am, a review of Resident #10's clinical records showed that the resident was admitted on 01/19/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 11. On 05/24/2023 at 12:57 pm, a review of Resident #11's clinical records showed that the resident was admitted on 10/02/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission. 12. On 05/25/2023 at 2:03 pm, a review of Resident #12's clinical records showed that the resident was admitted on 01/10/2023. There was no documented evidence to show that the resident was assessed by the RN within	R 154		

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R 154	Continued From page 3.	R 154		

Continued From page 3.

seventy-two (72) hours of admission.

13. On 05/25/2023 at 12:36 pm, a review of Resident #13's clinical records showed that the resident was admitted on 05/17/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission.

14. On 05/25/2023 at 10:32 am, a review of Resident #14's clinical records showed that the resident was admitted on 04/27/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission.

15. On 05/25/2023 at 12:18 pm, a review of Resident #15's clinical records showed that the resident was admitted on 09/06/2022. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission.

16. On 05/25/2023 at 12:18 pm, a review of Resident #16's clinical records showed that the resident was admitted on 09/06/2023. There was no documented evidence to show that the resident was assessed by the RN within seventy-two (72) hours of admission.

On 05/26/2023, a record review of the facility's Individualized Service Plan Policy and Procedure showed that "Within seventy-two (72) hours of move-in, a post move-in assessment will be completed by the registered nurse..."

In an interview on 05/26/2023 at approximately 12:40 pm, the Assistant Director of Nursing and the Assistant Living Administrator acknowledged that there was no documented evidence in the

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R 154	Continued From page 4. records showing that the residents were assessed by the RN within seventy-two (72) hours of admission. At the time of the survey, the ALR failed to ensure that it's RN performed a "post move-in" assessment within seventy-two (72) hours of each resident's admission as required by § 604 of the Act (D.C. Official Code § 44-106.04) and as stated by its policy.	R 154		
R 281	10116.15f Staffing Standards 10116.15f A healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to show evidence that each employee had obtained a written statement from a healthcare practitioner within the past 12 months declaring them free from communicable diseases, for 11 of the 15 staff whose health screening/ physician's certification was requested (Employees #1, 2, 3, 5, 6, 7, 8, 9, 11, 12, and 13). Findings included: Observations on 05/23/2023 beginning at 10:21 am, showed the following employees (Employees #1, 2, 3, 5, 6, 7, 8, 9,11, 12, and 13) providing direct care services to the residents in the dining room area, on the 1st, 2nd, 3rd floors and in the commercial kitchen located in the basement: At 10:59 am, the surveyor requested documentation showing that each employee had obtained a statement from a healthcare	R 281	R281 1. Corrective Action to be accomplished TB testing has been completed for the employees who were missing the proof. All employees now have a written statement from a healthcare practitioner. 2. Measures Implemented to ensure it does not recur Evidence of being free from communicable diseases will be required for all new employees prior to the first day of work. A form will be used to have the ALA sign off on new hires before they start, showing that proof was provided. 3. QA Program Action to Monitor compliance with corrective measures The Business Office Director will provide a monthly report for QA that shows all new hires, and the date of hire and date evidence was provided. The ALA will review this monthly to ensure compliance. 4. Date to be completed: June 23, 2023	

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R 281	Continued From page 5.	R 281		

practitioner saying that he or she was free of communicable disease. A follow-up request was made on 05/24/2023 at 2:37 pm.

On 05/25/2022 beginning at 9:48 am, a review of the personnel records showed that there was no documented evidence that Employees #1, 2, 3, 5, 6, 7, 8, 9, 11, 12, and 13 had been screened by a healthcare practitioner for communicable diseases.

At 10:09 am, the Administrator confirmed during an interview that facility's Employees File Checklist were not checked off as having been completed by the Healthcare Practitioner's Written Statement regarding communicable disease, including tuberculosis (TB) health screenings for Employees #1, 2, 3, 5, 6, 7, 8, 9, 11, 12, and 13. The Administrator said that she would follow up with the Human Resources (HR) personnel.

On 05/26/2023 at 11:25 am, the HR Director said during an interview that she was responsible for the newly hired employees. When asked why there were no health care screenings to ensure staff were free of communicable disease, including TB, the HR Director said that she was not sure why there were no health care screenings for staff. The HR Director stated that she had only been employed by the facility since March 2023, and was not aware that the staff were not screened for communicable disease.

Additional requests were made for employee health certificates on 05/26/2022 at 11:44 am; however, only four of the 15 employee health certificates were given to the surveyor prior to the exit on 05/26/2023.

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R 281	Continued From page 6. At the time of the survey, there was no evidence that the Assisted Living Residence (ALR) required and ensured that each employee obtained a healthcare practitioner's statement at the time of hire and thereafter, certifying that he or she is free from communicable disease. In addition, there was no evidence that the ALR developed and implemented written policies and procedures regarding employees being screened for communicable diseases.	R 281		
R 326	10120.1 & 2 *Unlicensed Personnel Criminal Background Che 10120.1 No ALR shall employ or contract an unlicensed person to work on the ALR's premises until a criminal background check has been conducted for that person. 10120.2 An ALR shall implement and comply with the criminal background check standards and requirements for unlicensed personnel prescribed by D.C. Official Code §§ 44-551 et seq. and 22-B DCMR §§ 4700 et seq. Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed to show evidence that criminal background checks for non-licensed job applicants were performed in accordance with the requirements for unlicensed personnel prescribed by 22-B DCMR §4701.1 and §4701.2, for one of 15 Employees (Employee #13). Findings included: Observations on 05/23/2023 at 1:17 pm, showed the dining room hand sink located in the kitchen (first floor) showed a water temperature that measured 116.8 °F. The Administrator called the	R 326	1. Corrective Action to be accomplished The contracted Maintenance Director has now signed a release form and Abrams has completed our own criminal background check on him, in addition to the letter previously provided by his employer. 2. Measures Implemented to ensure it does not recur Any future contracted personnel will be required to have a criminal background check prior to working in the Assisted Living. 3. QA Program Action to Monitor compliance with corrective measures The Business Office Director will supply a report on all staff and contracted personnel monthly for the QA Committee, which will include the status of all required pre and post-employment documentation. 4. Date to be completed: June 23, 2023	

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R 326	Continued From page 7. maintenance staff (Employee #13), who joined the survey team during the walk-thru of the dining room located on the first floor at 1:23 pm. Employee #13 confirmed that he had water temperatures readings between 120.0 °F and 117.0 °F in the units. Employee #13 stated that the hot water temperature was controlled by the boiler room in the old Walter Reed facility. He said that the ALR shared the hot water with two other buildings on the facility grounds, and that he would have to speak to his people to see if they can adjust the hot water temperature. On 05/25/2023 beginning at 9:48 am, a review of the personnel records maintained for unlicensed employees showed no documented evidence that Employee #13 had obtained a criminal background check. During an interview on 05/26/2023 at 1:24 pm, the administrator said that Employee #13 was responsible for providing maintenance duties for two other buildings. When asked to provide the employees with a criminal background check, the administrator was told that the information could not be shared with the surveyor by the Management Group because Employee #13 was not employed by the ALR. The administrator said that the management group would send an email indicating that Employee #13 had a criminal back check. The surveyor informed the Administrator that the facility needed to provide evidence that a background check had been conducted on Employee #13. The information requested was not provided as at the time of the survey exit. At the time of the survey, there was no evidence that the ALR complied with the standards and requirements prescribed in 22-B DCMR §4700 et seq.	R 326		

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R 330	10122.1 On Site Medication Review 10122.1 The on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued. Based on interview and record reviews, the Assisted Living Residence (ALR) failed to ensure the Registered Nurse (RN) conducted a review of each resident's medication regimen every 45-days to include documentation of any changes to the resident's medication profile, changes in dosing, and any added or discontinued medications for 15 of the 20 residents in the sample (Residents' #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15). Findings included: From 05/24/2023 through 05/26/2023, a record review of the sampled residents' starting at 9:00 am showed no evidence that the ALR's RN conducted reviews of each resident's medication regimen every 45-days as required. 1. On 05/25/2023 at 1:52 pm, a review of Resident #1's clinical record revealed that the resident was admitted on 11/29/2022. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 2. On 05/25/2023 at 1:52 pm, a review of Resident #2's clinical record revealed that the resident was admitted on 11/29/2022. There was no documented evidence to show that the	R 330	R330 1. Corrective Action to be accomplished The RN has completed a medication review for all residents who have been in residence at least 45 days. 2. Measures Implemented to ensure it does not recur We are creating a custom assessment in PCC that will prompt the RN to complete the 45-day review on each resident. 3. QA Program Action to Monitor compliance with corrective measures The 45-day review will be customized in PCC so that it auto-generates to be completed every 45 days for each resident. The RN and ALA will monitor the PCC clinical dashboard to show assessment due for reassessment, in progress and past due. 4. Date to be completed: June 30, 2023	

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R 330	Continued From page 9. resident medication regimen was reviewed every 45-days. 3. On 05/24/2023 at 12:03 pm, a review of Resident #3's clinical record revealed that the resident was admitted on 02/27/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 4. On 05/25/2023 at 11:16 am, a review of Resident #6's clinical record revealed that the resident was admitted on 02/16/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 5. On 05/25/2023 at 9:19 am, a review of Resident #7's clinical record revealed that the resident was admitted on 12/28/2022. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 6. On 05/24/2023 at 12:57 pm, a review of Resident #8's clinical record revealed that the resident was admitted on 10/02/2022. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 7. On 05/24/2023 at 12:57 pm, a review of Resident #9's clinical record revealed that the resident was admitted on 10/02/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 8. On 05/25/2023 at 11:17 am, a review of Resident #10's clinical record revealed that the	R 330		

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R 330	Continued From page 10. resident was admitted on 01/19/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 9. On 05/24/2023 at 12:57 pm, a review of Resident #11's clinical record revealed that the resident was admitted on 10/02/2022. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 10. On 05/25/2023 at 2:03 pm, a review of Resident #12's clinical record revealed that the resident was admitted on 01/10/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 11. On 05/25/2023 at 12:36 pm, a review of Resident #13's clinical record revealed that the resident was admitted on 05/17/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 12. On 05/25/2023 at 12:18 pm, a review of Resident #15's clinical record revealed that the resident was admitted on 09/06/2022. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days. 13. On 05/25/2023 at 12:18 pm, a review of Resident #15's clinical record revealed that the resident was admitted on 09/06/2023. There was no documented evidence to show that the resident medication regimen was reviewed every 45-days.	R 330		

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R 330	Continued From page 11. During an interview on 05/26/2023 at 12:32 pm, the Assistant Director of Nursing said that the pharmacist reviews the drug regimen, however acknowledged that the RN had not conducted the 45 days medication reviews. At the time of the survey, the ALR failed to ensure residents' medication regimen were reviewed every 45-days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03).	R 330		
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 promptly notify the Department of Health (DOH) by telephone of all incidents that substantially affected a resident, followed by written notification within 24 hours, for 13 of the 20 residents in the sample (Residents #1, 3, 6, 7, 8, 9, 11, 13, 15, 16, 17, 18, and 20). Findings included: On 05/23/2023 beginning at 2:06 pm, a review of the facility's incidents reports which included falls reports, complaints and medical records showed the following: 1. A report dated 05/03/2023 showed that Resident #1 was outside and refused to come back inside. The facility case worker sent	R 383	R 383 1. Corrective Action to be accomplished A written notification will be submitted for all prior incidents to the Department of Health. 2. Measures Implemented to ensure it does not recur We have created a checklist for facility staff based on the Incident Reporting policy and are providing additional training on how, what and when to make reports. 3. QA Program Action to Monitor compliance with corrective measures A review of all incident reports and the status of their required reporting will be included in the monthly QA review. 4. Date to be completed: June 30, 2023	

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ABRAM HALL AL OPCO, DBA ABRAM ASSITED	1320 MAIN DRIVE, WASHINGTON, DC20012 WASHINGTON, DC 20012

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someone to talk to the resident, but the resident still refused to go back into the facility. The staff then called 911 for emergency services, but the resident refused to go to the hospital. The police were called, and they came and took the resident for a psychiatric evaluation. There was no evidence that the DOH was notified of the incident.

2. A review of Resident #3's discharge summary dated 04/25/2023, showed that Resident #3 was admitted to Washington Hospital Center from 04/19/2023 to 04/25/2023 with diagnoses that included iron deficiency anemia (IDA); Chronic obstructive pulmonary disease (COPD); Acute respiratory failure with hypoxia; BPH (benign prostatic hyperplasia); Right renal mass, Acute on chronic combined systolic and diastolic CHF (congestive heart failure); History of ischemic cardiomyopathy; AKI (acute kidney injury); Dementia; Elevated troponin; Moderate aortic regurgitation and HTN (hypertension). There was no evidence that the DOH was notified of the incident.

3. On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed a discharge summary dated 04/25/2023. The discharge summary indicated that the resident was admitted for Heart failure exacerbation and renal mass. There was no documented evidence that the DOH was notified of the hospitalization.

4. A report dated 02/24/2023 showed that Resident #6 went to the dining room area for dinner and was noted with bruises and swelling on or around her face. Per the report, the resident stated that she did not remember when she fell. The staff applied ice pack to her face for 20 minutes. There was no documented evidence

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R 383	Continued From page 13. that the DOH was notified of the fall which led to the resident's injuries to her face. 5. A report dated 05/15/2023 showed that Resident #6 was found seated upright on the floor near the bathroom. The report stated that the resident was not responsive but breathing and pulses were present. The nurse assessed the resident, called 911 emergency medical services, and the resident was transported to the hospital. There was no documented evidence that the DOH was notified of the incident which led to 911 being called for the resident. 6. The review showed that on 02/07/2023, Resident #7 stated that he fell two times yesterday when he tried to walk using his walker in his bedroom. The facility called 911 emergency services. There was no evidence that the DOH was notified of the falls which led to 911 being called. 7. The report showed that on 01/03/2023, Resident #7 exhibited generalized weakness and an unsteady gait. The resident said, "I feel weak, and I went to my room to sleep from outside balcony." The nurse assessed the resident and noted an elevated blood sugar reading of 240 mg/dl. The resident was transported to the hospital for further evaluation. There was no evidence that the DOH was notified of the incident which led to 911 being called. 8. Continued review of the report showed that on 03/04/2023 Resident #7 informed the nurse that he got dizzy and fell in the bathroom, and that he got himself off the floor by holding and leaning on his cane. The report showed that the nurse assessed the resident and noted soreness to the right side of his leg, and medicated the resident	R 383		

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with Tylenol for pain. There was no evidence that the DOH was notified about the fall incident.

9. The reports showed that on 03/28/2023, Resident #8 was found on the floor. When asked, the resident said she fell after rolling over in the bed, and after being assessed, the nurse called 911 for emergency services. There was no evidence that the DOH was notified of the incident which led to 911 being called.

10. Reports showed that on 05/02/2023 Resident #8 was found sitting upright near the bathroom in his unit. The resident said that he lost his balance and fell to the floor and was assessed by the nurse. The resident was assisted to his feet and ambulated to a chair, with no complaints of pain. There was no evidence that the DOH was notified about the fall.

11. Reports showed that on 02/03/2023, Resident #9 went outside to smoke a cigarette, and fell to the ground on his left side. The nurse called for emergency services, but the resident refused to go to the hospital. There was no evidence that the DOH was notified about the fall.

12. Reports showed that on 11/26/2022, Resident #11 was found in a seated position next to a chair in her unit. The resident did not have shoes on, and said she was going to turn off the television and fell. There was no evidence that the DOH was informed about the fall.

13. Reports showed that on 05/18/2023, Resident #13 said he stood up and lost his balance and fell. The nurse assessed the resident with no injuries noted. There was no evidence that the DOH was notified about the fall.

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R 383	Continued From page 15. 14. Reports showed that on 03/03/2023, Resident #15 complained of pain in the right knee, and left rib area. The resident said she was cleaning her unit when her leg gave out and she fell on her knees. The resident denied hitting her head and was assessed by the nurse and refused to go to the hospital for further evaluation. There was no evidence that the DOH was informed of the resident's fall. 15. The reports showed that on 12/20/2022, observations showed that Resident #16 was not in his room. A search was initiated, and the resident was found unharmed on the street near the facility. When asked the resident said, "I am going home." The resident was assessed by the nurse, and no issues were noted, with his vital signs within normal limits. 16. A report dated 03/05/2023, showed that Resident #17 fell in the bathroom and hit his head on the wall. The resident was transported to the hospital via 911 emergency services to have a complete scan of the head. A further review of the incident report showed that the Department of Health (DOH) was not notified of the resident's fall which led to 911 being called. 17. The reports showed that on 04/07/2023, Resident #17 was discharged from the hospital, and that while on the toilet, the resident had a seizure activity that lasted 45 seconds. The nurse assessed the resident and noted a low blood pressure of 84/46, pulse 77, respirations 20, blood sugar 166 mg/dl and oxygen saturation of 97%. The nurse called 911 for emergency services and the resident was transported to the hospital. There was no evidence that the DOH was notified of the incident.	R 383		

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R 383	Continued From page 16. 18. On 01/19/2023, the report showed that Resident #18 eloped from the facility and was brought back to the facility with no injuries observed. There was no evidence that the DOH was notified of the resident's elopement. 19. An incident report showed that 01/29/2023, Resident #18 said he lost his balance, fell, and sustained an injury to his upper left arm. The resident was transported to the hospital via ambulance. There was no evidence that the DOH was notified of the resident's hospitalization. 20. The reports showed that on 03/30/2023, Resident #20 reported that she fell while trying to retrieve her phone from the floor. The nurse assessed the resident and noted her vital signs were within normal parameters. There was no evidence that the DOH was notified of the fall. 21. It should be noted that during the entrance conference on 05/23/2023 at 10:59 am, the ALA informed the surveyors that there were two residents (Resident #16 and 18) that died. A review of the ALR's incidents reports failed to show evidence that an incident report was completed for the deaths. In addition, there was no evidence that the deaths were reported to DOH, as required. On 05/24/2023 at 11:35 am, the Administrator was interviewed regarding their process, and procedure for reporting incidents to the DOH. The administrator said incidents that interfere with the client's health and safety should be reported to DOH. On 05/24/2023 at 11:38 am, a review of the ALR's "Incident Reporting" policy, dated 03/18/2022 showed the following instruction:	R 383		

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R 383	Continued From page 17. - The ALR will notify the DOH of any unusual incidents that substantially affect a resident. -The Administrator or their designee will contact the DOH by phone promptly and shall follow-up with a written notification via email within 24 hours or the next business day. Further review of the incident report policy defined unusual incidents as an accident resulting in significant injury to a resident and unexpected death. At the time of the survey, the ALR failed to promptly notify the DOH by telephone of all incidents that substantially affected a resident, followed by written notification within 24 hours.	R 383		

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R 000	Initial Comments An annual licensure survey was conducted on 05/23/2023, 05/24/2023, 05/25/2023 and 05/26/2023, 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 34 residents and employed 40 personnel, including professional and administrative staff. A sample of 20 resident records, 15 employee records 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	Please start typing your responses here: R293 1. Corrective Action to be accomplished DON and ADON have reviewed all discharge summaries and ICFD Admission/Annual Medical Certification forms for each resident and have followed up on orders and recommendations for appropriate medical and health services. 2. Measures Implemented to ensure it does not recur Create a checklist to review prior to admission to include the discharge summary, medical certification form and physician orders with specific items for use the DON/ADON and ALA to ensure that the AL records incorporate the information from all sources. Any discrepancies between sources will be clarified with the primary care provider. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 30, 2023	
R 293	Sec. 504.2 Accommodation of Needs. (2) To have access to appropriate health and social services, including social work, home health, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, it was determined that the Assisted Living Residence (ALR) failed to ensure that six of 20 residents in the sample had access to appropriate medical and health services, dietary, psychiatric services, physical therapy services. (Residents' #3, 4, 5, 8, 10, and 15) Findings included: a). On 05/24/2023 at 1:00 pm, a review of	R 293		

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Resident #3's medical record showed a discharge summary dated 04/25/2023, which showed that the resident was admitted for Heart failure exacerbation and renal mass. The discharge summary also recommended that resident #3 should receive no added salt, mechanical soft diet. A review of Resident #3's current ISP dated 02/28/2023, did not reflect the diagnosis of Heart failure exacerbation and renal mass or any goals and interventions to manage these concerns. The ISP failed to reflect that the resident should receive no added salt, mechanical soft diet. There was no evidence that the resident was receiving a no added salt, mechanical salt diet.

b). On 05/24/2023 at 12:03 pm, a review of Resident #3's Intermediate Care Facilities Admission/Annual Medical Certification form dated 02/14/2023 showed that the resident had Dementia, and the physician noted that he needed a mental assessment by the Psychiatrist. Resident #3's current ISP dated 02/28/2023 did not reflect the diagnosis of Dementia, Psychiatric concerns or any goals and interventions to manage these concerns. There was no evidence in the record of strategies to manage Resident #3's Dementia and Psychiatric concerns.

c). A review on 05/24/2023 at 2:00 pm, of Resident #4's medical record showed an order for physical therapy (PT). There was no documented evidence that the resident had been assessed by PT or had an appointment scheduled for PT.

d). On 05/25/2023 at 2:40 pm, a review of Resident #5's Intermediate Care Facilities Admission/Annual Medical Certification form dated 04/21/2023 showed that the resident had a diagnosis of Diabetes Mellitus and an order for no concentrated sweets diet. Resident #5's current

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ISP dated 05/02/2023 did not reflect the diagnosis of Diabetes Mellitus, a diet order for no concentrated sweets diet or any goals and interventions to manage these concerns. There was no documented evidence that the resident was receiving a no concentrated sweets diet.

e). On 05/24/2023 at 1:03 pm, a review of Resident #8's Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/12/2022 showed that the resident had a diagnosis of Schizophrenia and a recommendation for a Psychiatric follow up. The residents ISP dated 10/03/2022 revealed a focus area of falls and Elopement risk. Continued review of the residents nursing progress notes showed that the resident had repeated falls on 10/14/2022, 12/10/2022 and 05/02/2023. Resident #8's current ISP dated 10/03/2022 did not reflect any interventions to manage her Psychiatric needs, elopement risk and falls. There was no evidence in the records that the resident had followed up with the Psychiatrist as ordered or had strategies in place to prevent falls and elopement.

f). On 05/24/2023 at 1:03 pm, a review of Resident #8's medical record showed an order dated 09/06/2023 for a bilateral diagnostic mammogram with Computer-aided detection (CAD) for a clinical history of a breast mass seen on ultrasound on 9/2022. There was no documented evidence that Resident #8 completed the test as ordered.

g). On 05/24/2023 at 1:03 pm, a review of Resident #8's Intermediate Care Facilities Admission/Annual Medical Certification form dated 09/28/2022 showed an order for an Oncology evaluation for Multiple Myeloma.

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Further review of the medical record revealed an Oncology appointment completed on 10/06/2022 noting follows up in 1 month. There was no documented evidence showing that Resident #8 followed up with Oncology 1 month later as recommended.

h). On 05/24/2023 at 1:20 pm, a review of Resident #15's Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/06/2022 showed that the resident had an allergy to latex, codeine, pork, and nuts. Resident #15's current ISP dated 06/06/2022 did not reflect a focus area or interventions to address her allergy to pork and nuts. There was no documented evidence that the resident's allergy to latex, codeine, pork, and nuts have been addressed.

i). On 05/24/2023 at 1:03 pm, a review of Resident #15's medical record showed an order for physical therapy (PT). There was no documented evidence that the resident had been assessed by PT or had an appointment scheduled for PT.

j). On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that the resident had a diagnosis of Diabetes Mellitus with hyperglycemia and nutritional anemia. The residents Intermediate Care Facilities Admission/Annual medical certification form dated 01/13/23 showed the resident required a no concentrated sweets diet. Continued review of the resident's current Individualized Service Plan (ISP) initiated on 01/19/2023, did not reflect the diagnosis of Diabetes Mellitus, the current diet order for no concentrated sweets or any goals, and interventions to manage these concerns.

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R 293	Continued From page 4. During an interview on 05/24/2023 at 2:00 pm, the Assistant Director of Nursing (ADON) said that she was not aware that a mental assessment by the Psychiatrist was ordered, and she will make an appointment as soon as possible. The ADON also acknowledged that these concerns should have been updated on the resident's current ISP. The ADON also acknowledged that there was no physical therapy documentation in the record. When asked about Resident #8's Oncology and mammogram appointment, the ADON stated that she does not have the documents in the record. At the time of the survey, the Assisted Living Residence (ALR) failed to ensure that residents had access to appropriate medical and health services, psychiatric services, physical therapy services in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being.	R 293		
R 375	Sec. 506a4 Privacy and Confidentiality. (4) To have their records maintained for up to 3 years after discharge or death; and Based on interview and attempted record review, the Assisted Living Residence (ALR) failed to ensure records of deceased residents were maintained for up to three years for one of the two deceased residents of the facility (Resident #16) Findings included: On 05/23/2023 at 10:59 am, during the entrance conference, the Assisted Living Administrator (ALA) informed the surveyors that there had been two resident deaths in the facility, Residents #16 and 17. On 05/26/2023, the surveyor requested to	R 375	R375 1. Corrective Action to be accomplished There is only one resident who expired onsite (#16) whose chart has been maintained in the Director of Nursing office, and in PointClickCare as a moved-out resident. The DON will request a copy of the death certificate and place that information inside the existing chart. Resident #17 is alive and residing at the ALR. Resident #18 passed away at a hospital, and his closed chart is maintained in the DON office and in PointClickCare. 2. Measures Implemented to ensure it does not recur Request death certificate of any resident who is pronounced dead at the ALR at the time of death from the health entity who certified the death and include in the closed medical records kept by the ALR. 3. QA Program Action to Monitor compliance with corrective measures When residents move out or pass away, the final closed chart will be reviewed by the ALA to ensure that all necessary documentation is complete. A closed record cover sheet will be signed by both the DON and the ALA. 4. Date to be completed: June 30, 2023	

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R 375	Continued From page 5. see Resident #16's record for review. After attempting to locate the resident's record, the Assistant Director of nursing (ADON) informed the surveyor that the record could not be located. At 12:44 pm, the ALA said that the original record was given to the Office of the Chief Medical Examiner and that the ALR had not made a copy of the record to be maintained in the facility. At the time of the survey, the ALR failed to maintain the records of deceased residents for up to three years.	R 375		
R 421	Sec. 602a Resident Agreements (a) A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following: Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to obtain a written agreement for all residents prior to admission, for 12 of the 20 residents in the sample (Resident #1, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, and 15). Findings included: 1. On 05/25/2023 at 1:52 pm, review of Resident #1's clinical record revealed that the resident was admitted on 11/29/2022. The record showed that the Resident's Agreement was signed by the resident on 11/29/2022, the same day the resident moved in. 2. On 05/24/2023 at 12:03 am, review of Resident #3's clinical record revealed that the resident was	R 421	R421 1. Corrective Action to be accomplished The Resident Agreement is a legal document, signed by both the Resident and/or their surrogate and the ALR. We cannot change the date of the already signed agreements. 2. Measures Implemented to ensure it does not recur The regulation states that the "written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR." Because the agreement stipulates the care and services the ALR will provide and is responsible for, it cannot be signed in advance of the date the services will be provided. The ALR will provide the Resident Agreement in advance of admission to the residents or surrogate, and will get signed receipt that they received it, however, the date of the Residency Agreement will need to be the date services begin, which is the day of admission. 3. QA Program Action to Monitor compliance with corrective measures The Admissions Director will provide a report for the monthly QA meeting to include any new admissions. The report will include the date of admission, date that documents were provided with receipt. 4. Date to be completed: June 23, 2023	

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R 421	Continued From page 6. admitted on 02/27/2023. The record showed that the Resident's Agreement was signed by the resident on 02/27/2023, the same day the resident moved in. 3. On 05/24/2023 at 1:45 pm, review of Resident #4's clinical record revealed that the resident was admitted on 05/05/2023. The record showed that the Resident's Agreement was signed by the resident on 05/05/2023, the same day the resident moved in. 4. On 05/25/2023 at 2:25 pm, review of Resident #5's clinical record revealed that the resident was admitted on 04/27/2023. The record showed that the Resident's Agreement was signed by the resident on 04/27/2023, the same day the resident moved in. 5. On 05/25/2023 at 11:16 am, review of Resident #6's clinical record revealed that the resident was admitted on 02/16/2023. The record showed that the Resident's Agreement was signed by the resident on 02/16/2023, the same day the resident moved in. 6. On 05/25/2023 at 9:19 am, review of Resident #7's clinical record revealed that the resident was admitted on 12/28/2022. The record showed that the Resident's Agreement was signed by the resident on 12/28/2022, the same day the resident moved in. 7. On 05/24/2023 at 12:57 pm, review of Resident #8's clinical record revealed that the resident was admitted on 10/02/2023. The record showed that the Resident's Agreement was signed by the resident on 10/02/2023, the same day the resident moved in.	R 421		

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R 421	Continued From page 7.	R 421		

8. On 05/25/2023 at 11:17 am, review of Resident #10's clinical record revealed that the resident was admitted on 01/19/2023. The record showed that the Resident's Agreement was signed by the resident on 01/19/2023, the same day the resident moved in.

9. On 05/25/2023 at 2:03 pm, review of Resident #12's clinical record revealed that the resident was admitted on 01/10/2023. The record showed that the Resident's Agreement was signed by the resident on 01/10/2023, the same day the resident moved in.

10. On 05/25/2023 at 12:36 pm, review of Resident #13's clinical record revealed that the resident was admitted on 05/17/2023. The record showed that the Resident's Agreement was signed by the resident on 05/17/2023, the same day the resident moved in.

11. On 05/25/2023 at 10:32 am, review of Resident #14's clinical record revealed that the resident was admitted on 04/27/2023. The record showed that the Resident's Agreement was signed by the resident on 04/27/2023, the same day the resident moved in.

12. On 05/25/2023 at 12:18 am, review of Resident #15's clinical record revealed that the resident was admitted on 09/06/2023. The record showed that the Resident's Agreement was signed by the resident on 09/06/2023, the same day the resident moved in.

On 05/25/2023 at 2:30 pm, the above findings were discussed with the Admissions Director (AD), who stated that he recently started working as the AD. He further stated that moving forward, he will make sure the documents are signed prior

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R 421	Continued From page 8. to admissions. In that interview, he acknowledged that the resident agreements were not signed prior to the resident admission as required. At the time of the survey, the ALR failed to ensure that each resident agreement was signed prior to the resident's admission.	R 421		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure its Registered Nurse (RN) developed an Individualized Service Plan (ISP) prior to admission for 15 of 20 residents in the sample (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15). Findings included: Review of the sampled residents' records starting at 9:00 am from 05/24/2023 through 05/26/2023 showed no evidence that the ALR's RN developed an ISP prior to resident's admission at follows: 1. On 05/24/2023 at 1:52 pm, a review of Resident #1's medical record showed that the resident was admitted on 11/29/2022 and an ISP was initiated on 11/29/2022, the day of admission. 2. On 05/24/2023 at 1:01 pm, a review of Resident #2's medical record showed that the resident was admitted on 05/04/2023 and an ISP was initiated on 05/26/2023, 22 days after admission.	R 471	R471 1. Corrective Action to be accomplished These residents have already been admitted, so the ISP cannot be completed prior to admission. The 30 day, 6 month and upon significant change reviews have been completed. Effective immediately, the RN will complete an ISP prior to admission. 2. Measures Implemented to ensure it does not recur The RN will complete a preliminary ISP during the pre-admission assessment for those applicants who have been approved. Once approved the RN will complete the ISP with the information gathered from the discharge summary, pre-admission assessment, and the ICFD Admission/Annual Medical Certification forms 3. QA Program Action to Monitor compliance with corrective measures The DON will provide a monthly report for QA which includes all residents, dates of admission, dates of initial and 30-day post move in ISP reviews. 4. Date to be completed: June 30, 2023	

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R 471	Continued From page 9.	R 471		

3. On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed that the resident was admitted on 02/27/2023 and an ISP was initiated on 02/28/2023, one day after the admission.

4. On 05/24/2023 at 1:55 pm, a review of Resident #4's medical record showed that the resident was admitted on 05/05/2023 and an ISP was initiated on 05/05/2023, the same day of the admission.

5. On 05/25/2023 at 2:40 pm, a review of Resident #5's medical record showed that the resident was admitted on 04/27/2023 and an ISP was initiated on 05/02/2023, five days after the admission.

6. On 05/24/2023 at 116 am, a review of Resident #6's medical record showed that the resident was admitted on 02/16/2023 and an ISP was initiated on 02/17/2022, the day after admission.

7. On 05/25/2023 at 9:19 am, a review of Resident #7's medical record showed that the resident was admitted on 12/28/2022 and an ISP was initiated on 11/28/2022, the same day of admission.

8. On 05/24/2023 at 1:05 pm, a review of Resident #8's medical record showed that the resident was admitted on 10/02/2022 and an ISP was initiated on 10/03/2022, one day after the admission.

9. On 05/24/2023 at 12:08 pm, a review of Resident #9's medical record showed that the resident was admitted on 02/01/2023 and an ISP was initiated on 02/03/2023, the day after admission.

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R 471	Continued From page 10. 10. On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that the resident was admitted on 01/19/2023 and an ISP was initiated on 01/19/2023, the same day of admission. 11. On 05/25/2023 at 12:08 pm, a review of Resident #11's medical record showed that the resident was admitted on 11/23/2022 and an ISP was initiated on 11/23/2022, the same day of admission. 12. On 05/25/2023 at 2:15 pm, a review of Resident #12's medical record showed that the resident was admitted on 01/10/2023 and an ISP was initiated on 01/10/2023, the same day of the admission. 13. On 05/25/2023 at 12:36 pm, a review of Resident #13's medical record showed that the resident was admitted on 05/17/2023 and an ISP was initiated on 05/18/2023, the day after admission. 14. On 05/25/2023 at 10:40 pm, a review of Resident #14's medical record showed that the resident was admitted on 04/27/2023 and an ISP was initiated on 04/28/2023, one day after the admission. 15. On 05/25/2023 at 12:18 pm, a review of Resident #15's medical record showed that the resident was admitted on 09/06/2022 and an ISP was initiated on 09/09/2022, three days after the admission. During an interview on 05/26/2023 at 12:38 pm, the Assistant Living Administrator (ALA) and the Assistant Director of Nursing (ADON)	R 471		

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R 471	Continued From page 11. acknowledged that the RN had not developed an ISP prior to admission as required. At the time of the survey, the ALR failed to ensure residents' ISPs were developed prior to admission.	R 471		
R 475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that all resident's Individualized Service Plans (ISPs) were signed by the resident, or surrogate, and a representative of the ALR for 15 of 20 residents in the sample (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15). Findings included: 1. On 05/24/2023 at 1:52 pm, a review of Resident #1's medical record showed that an ISP was initiated on 11/29/2022. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 2. On 05/24/2023 at 1:01 pm, a review of Resident #2's medical record showed that an ISP was initiated on 05/26/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 3. On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed that an ISP was initiated on 02/28/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate.	R 475	R475 1. Corrective Action to be accomplished The DON and ADON have reviewed all resident ISPs with the residents and obtained signatures from the resident or surrogate to confirm their participation and review in addition to the signature of a representative of the ALR. 2. Measures Implemented to ensure it does not recur The admissions checklist will be updated and include an ISP meeting with the resident and/or surrogate. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 30, 2023	

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R 475	Continued From page 12. 4. On 05/24/2023 at 1:55 pm, a review of Resident #4's medical record showed that an ISP was initiated on 05/05/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 5. On 05/25/2023 at 2:40 pm, a review of Resident #5's medical record showed that an ISP was initiated on 05/02/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 6. On 05/24/2023 at 11:16 am, a review of Resident #6's medical record showed that an ISP was initiated on 02/17/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 7. On 05/25/2023 at 9:19 am, a review of Resident #7's medical record showed that an ISP was initiated on 11/28/2022. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 8. On 05/24/2023 at 1:05 pm, a review of Resident #8's medical record showed that an ISP was initiated on 10/03/2022. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 9. On 05/24/2023 at 12:08 pm, a review of Resident #9's medical record showed that an ISP was initiated on 02/03/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 10. On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that an ISP was initiated on 01/19/2023. The ISP was not signed by the Registered Nurse (RN), the	R 475		

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R 475	Continued From page 13. resident or a surrogate. 11. On 05/25/2023 at 12:08 pm, a review of Resident #11's medical record showed that an ISP was initiated on 11/23/2022. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 12. On 05/25/2023 at 2:15 pm, a review of Resident #12's medical record showed that an ISP was initiated on 01/10/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 13. On 05/25/2023 at 12:36 pm, a review of Resident #13's medical record showed that an ISP was initiated on 05/18/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 14. On 05/25/2023 at 10:40 pm, a review of Resident #14's medical record showed that an ISP was initiated on 04/28/2023. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. 15. On 05/25/2023 at 12:18 pm, a review of Resident #15's medical record showed that an ISP was initiated on 09/09/2022. The ISP was not signed by the Registered Nurse (RN), the resident or a surrogate. During an interview on 05/26/2023 at 12:38 pm, the Assistant Director of Nursing and the Assistant Living Administrator acknowledged that there was no signature on the ISP document as required. At the time of the survey, the ALR failed to ensure all ISPs were signed by a resident or surrogate	R 475		

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R 475	Continued From page 14. and a representative of the ALR.	R 475		
R 478	Sec. 604a7a Individualized Service Plans (A) The medical, rehabilitation, and psychosocial assessment of the resident. Based on record reviews and interview, it was determined that the facility's resident's Individual Service Plans (ISP) were not developed based on their medical, rehabilitation, and psychosocial assessment for five of the 20 residents in the sample (Residents #3, 5, 8, 10 and 15). Findings included: a). On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record had a discharge summary dated 04/25/2023, which showed that the resident was admitted for Heart failure exacerbation and renal mass. The discharge summary recommended that the resident should receive no added salt, and a mechanical soft diet. The resident's ISP dated 02/28/2023 failed to reflect the diagnosis of Heart failure exacerbation and renal mass or any goals and interventions to manage these concerns. Furthermore, the current ISP did not reflect that the resident should receive no added salt, and mechanical soft diet. b). On 05/24/2023 at 12:03 pm, a review of Resident #3's Intermediate Care Facilities Admission/Annual Medical Certification form dated 02/14/2023 showed that the resident had Dementia and that the physician documented that the resident needed a mental health assessment by the Psychiatrist. The resident current ISP dated 02/28/2023 failed to reflect the diagnosis of Dementia, Psychiatric concerns or any goals and interventions to manage these concerns.	R 478	R478 1. Corrective Action to be accomplished The DON/ADON reviewed each resident's current ISP, discharge summary and medical certification forms to update the current ISP based on their medical, rehabilitation and psychosocial assessments. They are in the process of updating each ISP with the most current information. 2. Measures Implemented to ensure it does not recur Create a checklist to review the discharge summary, medical certification form and physician orders with specific items for use the DON/ADON and AL to ensure that the AL records incorporate the information from all sources. Any discrepancies between sources will be clarified with the primary care provider. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 30, 2023	

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R 478	Continued From page 15. c). On 05/25/2023 at 2:40 pm, a review of Resident #5's Intermediate Care Facilities Admission/Annual Medical Certification form dated 04/21/2023 showed that the resident had a diagnosis of Diabetes Mellitus and an order for no concentrated sweets diet. A review of resident #5's current ISP dated 05/02/2023 failed to reflect the diagnosis of Diabetes Mellitus, the current diet order for no concentrated sweets diet or any goals and interventions to manage these concerns. d). On 05/24/2023 at 1:03 pm, a review of Resident #8's Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/12/2022 showed that the resident had showed a diagnosis of Schizophrenia and a recommendation for Psychiatric follow up. A review of the residents ISP dated 10/03/2022 revealed a focus area of falls and Elopement risk. Continued review of Resident #8's nursing progress notes showed that the resident had repeatedly fallen on 10/14/2022, 12/10/2022 and 05/02/2023. The resident current ISP dated 10/03/2022 failed to reflect any interventions to manage her Psychiatric needs, falls, and elopement risk. e). On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that the resident had a diagnosis of Diabetes Mellitus with hyperglycemia and nutritional anemia. Further review of the Intermediate Care Facilities Admission/Annual medical certification form dated 01/13/23 showed the resident required a no concentrated sweets diet. Continued review of the resident's current Individualized Service Plan (ISP) initiated on 01/19/2023 failed to reflect the diagnosis of Diabetes Mellitus, the current diet	R 478		

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R 478	Continued From page 16. order for no concentrated sweets or any goals and interventions to manage these concerns. f). On 05/24/2023 at 1:03 pm, a review of Resident #15's Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/06/2022 showed that the resident had an allergy to latex, codeine, pork, and nuts. Further review of Resident #15's current ISP dated 06/06/2022 failed to reflect any focus areas or interventions to address her allergy to latex, codeine, pork, and nuts. During interview on 05/24/2023 at 2:00 pm, the Assistant Director of Nursing (ADON) said that she was not aware that a mental assessment by the Psychiatrist was ordered, and that she will made an appointment as soon as possible. The ADON also acknowledged that these concerns should have been updated on the resident's current ISP. At the time of the survey the ALR failed to ensure all resident's ISPs were developed ISP based on their medical, rehabilitation, and psychosocial assessment.	R 478		
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	R 483		

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	ALR-0042	A. BUILDING: ______ B. WING ______	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRAM HALL AL OPCO, DBA ABRAM ASSITED	1320 MAIN DRIVE, WASHINGTON, DC20012 WASHINGTON, DC 20012

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R 483	Continued From page 17. ALR. Based on interview, and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Individualized Support Plan (ISP) was reviewed I) 30 days after admission, II) at least every six months, III) updated with significant changes, and IV) that the ISPs had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate, for 15 of the 20 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15). Findings included: I). The ALR failed to review each resident's ISP 30 days after admission, as follows: a. On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed that the resident was admitted on 02/27/2023. The ISP was initiated on 02/28/2023, however, there was no evidence that the ISP was reviewed thereafter. b. On 05/24/2023 at 11:16 am, a review of Resident #6's medical record showed that the resident was admitted on 02/16/2023. The ISP was initiated on 02/17/2023. There was no evidence that the ISP was reviewed thereafter. c. On 05/25/2023 at 9:19 am, a review of Resident #7's medical record showed that the resident was admitted on 12/28/2023. The ISP was initiated on 12/28/2023. There was no evidence that the ISP was reviewed thereafter. d. On 05/24/2023 at 1:05 pm, a review of Resident #8's medical record showed that the resident was admitted on 10/02/2022. The ISP was initiated on 10/03/2022, however, there was	R 483	R483 1. Corrective Action to be accomplished The DON/ADON have reviewed the ISP for each resident who has resided with us for at least 30 days. They are completing the 6-month reviews, as well as those of any resident who has had a significant change. They are also scheduling ISP review meetings with the residents and/or their surrogates. Updated ISPs are being shared with providers for their review as well. 2. Measures Implemented to ensure it does not recur The DON will ensure that a 30-day post admission IDT ISP meeting is conducted and the resident and/or their surrogate and their healthcare provider will be invited to participate. The same will be done every 6 months or more frequently if there is a change in condition. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review a report of all residents that includes their date of admission to ensure that ISP's are being reviewed at 30-days post admission, at least every 6 months thereafter, and upon any significant change in condition. The ALA will review to ensure that all parties have been invited to participate and sign. 4. Date to be completed: July 7, 2023	

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no evidence that the ISP was reviewed thereafter.

e. On 05/24/2023 at 12:08 pm, a review of Resident #9's medical record showed that the resident was admitted on 02/01/2023. The ISP was initiated on 02/03/2023. There was no evidence that the ISP was reviewed thereafter.

f. On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that the resident was admitted on 01/19/2023. The ISP was initiated on 01/19/2023. There was no evidence that the ISP was reviewed thereafter.

g. On 05/25/2023 at 12:08 pm, a review of Resident #11's medical record showed that the resident was admitted on 11/23/2022. The ISP was initiated on 11/23/2022. There was no evidence that the ISP was reviewed thereafter.

h. On 05/25/2023 at 2:15 pm, a review of Resident #12's medical record showed that the resident was admitted on 01/10/2023. The ISP was initiated on 01/10/2023, however, there was no evidence that the ISP was reviewed thereafter.

i. On 05/25/2023 at 12:18 pm, a review of Resident #15's medical record showed that the resident was admitted on 09/06/2022. The ISP was initiated on 09/09/2022, however, there was no evidence that the ISP was reviewed thereafter.

II). The ALR failed to update each resident's ISP every six months, as follows:

a. On 05/24/2023 at 1:05 pm, a review of Resident #8's medical record showed that the resident was admitted on 10/02/2022. The ISP was initiated on 10/03/2022, however, there was no evidence that the ISP was reviewed thereafter.

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Continued From page 19.

b. On 05/25/2023 at 12:18 pm, a review of Resident #15's medical record showed that the resident was admitted on 09/06/2022. The ISP was initiated on 09/09/2022, however, there was no evidence that the ISP was reviewed thereafter.

III). The ALR failed to review and update each resident's ISP after a significant change, as follows:

On 05/23/2023 at 2:14 pm, a review of the ALR's incident reports showed that on 05/03/2023, Resident #1 was observed outside and refused to come back into the facility. After several attempts to convince the resident to come back into the facility the police were called, and the resident was transported to an area hospital for a psychiatric evaluation. The resident was hospitalized for six days. It was noted that the resident had a diagnosis of bipolar disorder.

A review of the resident's ISP initiated on 11/29/2022 failed to show documented evidence that the resident's psychiatric concerns were addressed with strategies to manage them.

a. On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed a discharge summary dated 04/25/2023, showing that the resident was admitted for Heart failure exacerbation and renal mass. The discharge summary recommended that the resident should receive no added salt, mechanical soft diet. Resident #3's ISP dated 02/28/2023 failed to reflect the diagnosis of Heart failure exacerbation and renal mass or any goals and interventions to manage these concerns. Furthermore, the current ISP failed to reflect that the resident should receive no added salt, mechanical soft diet.

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b. On 05/24/2023 at 12:03 pm, a review of Resident #3's Intermediate Care Facilities Admission/Annual Medical Certification form dated 02/14/2023 showed that the resident had Dementia and the physician documented that he needed a mental assessment by the Psychiatrist. A review of Resident #3's ISP dated 02/28/2023 failed to reflect the diagnosis of Dementia, Psychiatric concerns or any goals and interventions to manage these concerns. There was no documented evidence in the record of strategies to manage the residents Dementia and Psychiatric concerns.

During an interview on 05/24/2023 at 2:00 pm, the Assistant Director of Nursing (ADON) said that she was not aware that a mental health assessment by the Psychiatrist was ordered, and that she will make an appointment as soon as possible. The ADON also acknowledged that these concerns should have been updated on the resident's current ISP.

c. On 05/25/2023 at 2:40 pm, a review of Resident #5's Intermediate Care Facilities Admission/Annual Medical Certification form dated 04/21/2023 showed that the resident had a diagnosis of Diabetes Mellitus and an order for no concentrated sweets diet. A review of Resident #5's current ISP dated 05/02/2023 failed to reflect the diagnosis of Diabetes Mellitus, the residents current diet order for no concentrated sweets diet or any goals and interventions to manage these concerns.

d. On 05/23/2023 at 2:06 pm, a review of the ALR's incident reports showed that on 05/15/2023 Resident #6 was found on the floor in her unit

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R 483	Continued From page 21. near the bathroom. The resident was unresponsive but was breathing and had a pulse. The resident was assessed by the nurse and transported to the hospital. Further review of the resident's current ISP initiated on 03/17/2023 failed to show evidence that the resident's unresponsiveness resulting in a hospitalization was addressed with strategies to manage it. e. On 05/23/2023 at 3:15 pm, a review of the ALR's incident reports showed the following incidents regarding Resident #7: 1. On 01/03/2023 Resident #7 was observed with generalized weakness and unsteady gait. The resident said, "I feel weak, and I went to my room to sleep from the outside balcony." The resident was assessed by the nurse and an elevated blood sugar reading (240 mg/Dl) was obtained. The resident was subsequently transported to the hospital via ambulance, and was diagnosed with hypoglycemia, and had a contusion to the hip. 2. The report noted that on 02/07/2023, Resident #7 reported that he fell twice the previous day. The resident said he fell when he tried to walk using his walker in his room. 3. According to the report, on 03/04/2023, Resident #7 fell in the bathroom. The resident said he felt dizzy, complained of soreness to his right leg and was medicated for the pain. 4. On 03/30/2023, Resident #7 the resident said he felt dizzy. The resident was assessed by the nurse, and a blood sugar of 315 mg/Dl was noted. The resident was transported to the hospital and subsequently admitted for an acute head injury.	R 483		

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R 483	Continued From page 22. 5. On 04/02/2023, Resident #7 complained of dizziness. The nurse assessed the resident and noted that his blood sugar was 468 mg/Dl. The resident was transported to the hospital via ambulance. Further review of Resident #7's current ISP initiated on 12/28/2022 failed to show evidence that the resident's hyperglycemia, and weakness resulting in a hospitalization were addressed with strategies to manage it. In addition, the ISP has a focus area for falls, however the falls on 01/03/2023, 2/07/2023, were not documented with strategies to manage the falls. d. On 05/24/2023 at 1:03 pm, a review of Resident #8's Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/12/2022 showed that the resident had a diagnosis of Schizophrenia and there was a recommendation for a Psychiatric follow up. Further review of the residents ISP dated 10/03/2022 showed a focus area of falls and Elopement risk. Continued review of Resident #8's nursing progress notes showed that the resident had repeatedly fallen on 10/14/2022, 12/10/2022 and 05/02/2023. A review of Resident #8's current ISP dated 10/03/2022 did not reflect any interventions to manage the residents' Psychiatric needs, falls, and elopement risk. On 05/23/2023 at 3:10 pm, a review of the ALR's incident reports showed that on 02/03/2023, Resident #9 went outside to smoke a cigarette. The resident said that he felt dizzy and fell to the ground. The nurse called for emergency services/911, but the resident refused to go to the hospital. Further review of the resident's current ISP initiated on 02/03/2023 showed that falls were a focus area, however there were no	R 483		

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strategies/interventions documented to manage the residents falls.

On 05/23/2023 at 3:14 pm, a review of the ALR's incident reports showed that on 11/26/2022, Resident #11 was found seated on the floor next to a chair in her unit, with no shoes on. The resident said she was attempting to turn off the television. The nurse assessed the resident and found no injuries and was encouraged to wear shoes at all times. Further review of the resident's current ISP initiated on 11/23/2022 showed that falls were a focus area, however; the 11/26/2022 fall was not documented and there were no strategies/interventions documented to manage the resident's falls.

e. On 05/24/2023 at 1:03 pm, a review of Resident #15's Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/06/2022 showed that the resident had an allergy to latex, codeine, pork, and nuts. The resident current ISP dated 06/06/2022 failed to reflect any focus areas or interventions to address her allergy to latex, codeine, pork, and nuts.

IV) The ALR failed to provide evidence that the resident's ISPs had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate and a representative of the ALR as follows:

1. On 05/24/2023 at 1:52 pm, a review of Resident #1's medical record showed that an ISP was initiated on 11/29/2022. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.

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2. On 05/24/2023 at 1:01 pm, a review of Resident #2's medical record showed that an ISP was initiated on 05/26/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.

1. On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed that an ISP was initiated on 02/28/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.

2. On 05/24/2023 at 1:55 pm, a review of Resident #4's medical record showed that an ISP was initiated on 05/05/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.

3. On 05/25/2023 at 2:40 pm, a review of Resident #5's medical record showed that an ISP was initiated on 05/02/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.

4. On 05/24/2023 at 11:16 pm, a review of Resident #6's medical record showed that an ISP was initiated on 02/17/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate.

5. On 05/25/2023 at 9:19 am, a review of Resident #7's medical record showed that an ISP was initiated on 12/28/2022. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident

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R 483	Continued From page 25. and/or the resident's surrogate. 6. On 05/24/2023 at 1:05 pm, a review of Resident #8's medical record showed that an ISP was initiated on 10/03/2022. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 7. On 05/24/2023 at 12:08 pm, a review of Resident #9's medical record showed that an ISP was initiated on 02/03/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 8. 4. On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that an ISP was initiated on 01/19/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 9. On 05/25/2023 at 12:08 pm, a review of Resident #11's medical record showed that an ISP was initiated on 11/23/2022. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 10. On 05/25/2023 at 2:15 pm, a review of Resident #12's medical record showed that an ISP was initiated on 01/10/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 11. On 05/25/2023 at 12:36 pm, a review of Resident #13's medical record showed that an ISP was initiated on 05/18/2023. There was no	R 483		

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R 483	Continued From page 26. evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 6. On 05/25/2023 at 10:40 pm, a review of Resident #14's medical record showed that an ISP was initiated on 04/28/2023. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. 7. On 05/25/2023 at 12:18 pm, a review of Resident #15's medical record showed that an ISP was initiated on 09/09/2022. There was no evidence that the ISP was reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. On 05/26/2023 at 12:40 pm, the above findings were discussed with the Assisted Living Administrator (ALA) and Assistant Director of Nursing (ADON), and both acknowledged the ISPs were not reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. At the time of the survey the ALR failed to ensure all ISPs were reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate, as required.	R 483		
R 511	Sec. 606 1 Resident Records (1) The resident agreement required by this title, including the "Resident's Rights" statement and any additional agreements. Based on interview, record review and attempted record review, the Assisted Living Resident (ALR)	R 511		

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R 511	Continued From page 27. failed to maintain the record of the resident's Resident Agreement for one of the 20 residents in the sample (Resident #4) and a signed resident's right for one of the 20 residents in the sample (Resident #14). The finding includes: a). During the entrance interview with the Assisted Living Administrator (ALA) on 05/23/2023 at approximately 11:15 am, the ALA was asked for a copy of the Resident Agreement, for the residents in the samples. The ALA returned with some resident's Resident Agreement but indicated that she was unable to locate Resident #4's agreement. In a further interview on 5/24/2023 at 2:00 pm. the ALA stated she will continue to look for the record but still could not find it at this time. On 05/26/2023, the surveyor requested again to see Resident #4's resident agreement for review. After attempting to locate the resident's record, the ALA said the record could not be located. b). On 5/25/2023 at approximately 10:32 am, a review of Resident's # 14 resident agreement dated 04/27/2023 revealed a "Resident's Rights" statement that was not signed by the resident. During an interview on 05/26/2023 at 12:00 pm, the ALA acknowledged that the resident right form was not signed by the resident. At the time of the survey, the ALR failed to ensure that Resident #4's resident agreement, including the "Resident's Rights" statement and any additional agreements was maintained and signed in the record as required.	R 511	R 511 1. Corrective Action to be accomplished Resident #4 was asked to sign the Residency Agreement on 5/25/23 while the survey was being conducted and she refused at the time. Staff were attempting to contact her surrogate to have them assist her with signing, when she went out of the building on personal leave and had an injury that resulted in hospitalization. The resident or her surrogate will be required to sign the Residency Agreement upon her return from short-term rehab. Resident #14 has signed the receipt of Resident's Rights. 2. Measures Implemented to ensure it does not recur The Admissions Director and ALA will review the Financial File of each resident to ensure that all documents have been accurately completed and signed before the resident file is considered complete. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 23, 2023	

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ABRAM HALL AL OPCO, DBA ABRAM ASSITED	1320 MAIN DRIVE, WASHINGTON, DC20012 WASHINGTON, DC 20012

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R 523	Continued From page 28.	R 523		
R 523	Sec. 607a2 Services to Be Provided (2) Three nutritious and attractive meals and additional snacks, modified to individual dietary needs as necessary, on a daily basis. Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed to provide meals on a daily basis that were modified to the resident's dietary requirements for three of the 20 residents in the sample. (Resident # 3, 5, and 10) Findings included: On 05/23/2023 at 12:07 pm, the residents were observed eating lunch in the dining area. The menu consisted of Pork chops, stuffed peppers, cauliflower, carrots, rice, and sauce. There was no alternative menu for modified diet observed during lunch time. A review of the resident records from 05/24/2023 - 05/25/2023 showed the following residents with dietary concerns that were not addressed: a). On 05/24/2023 at 1:00 pm, a review of Resident #3's medical record showed a discharge summary dated 04/25/2023, showing that the resident was admitted for Heart failure exacerbation and renal mass. The discharge summary also recommended that Resident #3 receive a no added salt, mechanical soft diet. b). On 05/25/2023 at 2:40 pm, a review of Resident #5's Medical Certification form dated 04/21/2023 showed that the resident had a diagnosis of Diabetes Mellitus and an order for a no concentrated sweets diet.	R 523	1. Corrective Action to be accomplished The RN has completed a review of each resident's medical record to ensure that a diet order is identified and provided the Dining Services department with an updated list of all residents and their diet orders. 2. Measures Implemented to ensure it does not recur The admissions checklist has been updated to include the diet order communication from Nursing to Dining. The RN will ensure that an updated diet order report will be provided to dining services each time there is a new diet order or a diet order change. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will ensure the diet orders match the diet order report for each resident chart they review. A record will be maintained of the review. 4. Date to be completed: June 30, 2023	

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R 523	Continued From page 29.	R 523		

c). On 05/25/2023 at 11:17 am, a review of Resident #10's medical record showed that the resident had a diagnosis of Diabetes Mellitus with hyperglycemia and nutritional anemia. A further review of the Intermediate Care Facilities Admission/Annual medical certification form dated 01/13/23 showed the resident required a regular no concentrated sweets diet.

e). On 05/24/2023 at 1:03 pm, a review of Resident #15's Medical Certification form dated 06/06/2022 showed that the resident had an allergy to pork and nuts.

During an interview on 05/24/2023 at 10:22 am, Resident #10 stated that she has Diabetes Mellitus, and she should be on a no concentrated sweets diet. She said that the ALR mostly cooks beans, noodles, and rice which she should not be eating due to her condition.

On 05/23/2023 at 12:16 pm, an interview with the Director of Food Services (DFS) showed that the only resident he is aware of is a resident with a chopped diet. He further stated that there were no residents on a calorie restricted diet.

On 05/23/2023 at 12:16 pm, during an interview with the Assisted Living Administrator (ALA), the surveyors notified her of Resident #10's concern. The ALA said that she would speak with the DFS.

At the time of the survey the ALR failed to provide meals that were modified to the resident's dietary needs as necessary.

R 669 — Sec. 702b Staff Training. — R 669

(b) Within 7 days of employment, an ALR shall

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R 669	Continued From page 30. train a new member of its staff as to the following: Based on record review and interview, the Assisted Living Resident (ALR) failed to ensure that eight of 15 newly hired staff received the required orientation within seven days of employment (Employees #1, 2, 3, 6, 7, 8, 10 and the Assistant Director of Nursing). Findings included: On 05/25/2023 beginning at 9:48 am, review of the personnel files showed the following: 1. Review of the ALR's "Employee File Checklist" form showed that Assistant Director of Nursing (ADON) was hired on 01/19/2023. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 2. Review of the ALR's "Employee File Checklist" form showed that Employee #1 was hired on 03/06/2023. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 3. Review of the ALR's "Employee File Checklist" form showed that Employee #2 was hired on 11/02/2022. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 4. Review of the ALR's "Employee File Checklist" form showed that Employee #3 was hired on 04/05/2023. Further review of the checklist form	R 669	R669 1. Corrective Action to be accomplished Each of the employees identified as missing the required orientation are completing the mandatory new employee orientation. 2. Measures Implemented to ensure it does not recur A Mandatory New Employee Orientation will be conducted every other week on Friday. All new employees will be started on a date such that they will be scheduled to participate in the orientation within their first 7 days of employment. 3. QA Program Action to Monitor compliance with corrective measures The Business Office Director will supply a report on all staff and contracted personnel monthly for the QA Committee, which will include the status of all required orientation and training. A record will be maintained of the review. 4. Date to be completed: June 30, 2023	

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R 669	Continued From page 31. showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 5. Review of the ALR's "Employee File Checklist" form showed that Employee #6 was hired on 04/17/2023. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 6. Review of the ALR's "Employee File Checklist" form showed that Employee #7 was hired on 12/09/2022. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 7. Review of the ALR's "Employee File Checklist" form showed that Employee #8 was hired on 02/21/2023. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. 8. Review of the ALR's "Employee File Checklist" form showed that Employee #10 was hired on 12/18/2022. Further review of the checklist form showed a blank space with New Hire Orientation Form (Completed by end of 1st week) that was not marked as having been completed in section 5. On 05/26/2023 at 11:25 am, the Business Officer/Human Resources Director confirmed during an interview that according to the ALR's	R 669		

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R 669	Continued From page 32.	R 669		

Employee File Checklist form, the employees were not oriented within seven days of employment. The Human Resources Director stated that going forward she would ensure all newly hired staff will be oriented within the first week.

At 11:31 am, review of the policies and procedures for "New Employee Orientation" dated 03/18/2022, showed that within 7 days of employment, all employees will receive training for the following with proof of understanding of the content matter: 1) Their specific duties and assignments... Further review of the policy showed that new employees may not work unsupervised without satisfactory completion of the required new employee orientation training.

At the time of the survey, the ALR lacked documented evidence that employees received the required orientation training within seven days of employment.

R 704 — Sec. 802a Medical, Rehabilitation, Psychosocial Assess. — R 704

(a) A medical, rehabilitation, and psychosocial assessment of the resident shall be completed within 30 days prior to admission.

Based on interviews and record Reviews, it was determined the Assistant Living Resident (ALR) failed to ensure the resident's medical, rehabilitation and psychosocial assessment was completed within 30 days prior to admission for one of the 20 residents in the sample (Resident #15.)

The finding includes:

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R 704	Continued From page 33. 1. On 05/25/2023 at 12:18 pm, a review of Resident #15's clinical record showed that the resident was admitted on 09/06/2022. Further review of the Medical Certification Form showed it was completed on 06/06/2022, 3 months prior to admission. During an interview on 05/26/2023 at 12:40 pm, the Assistant Director of Nursing (AD) and the Assistant Living Administrator acknowledged that the assessment was not completed within 30 days of admission. The AD said during the interview that he receives the Medical Certification Form and ensures its completeness within the 30 days window. He further said that he is new to the position and will make sure the documents are accurate moving forward. At the time of the survey, the ALR failed to ensure each resident's medical, rehabilitation, and psychosocial assessment of each resident was completed within 30 days prior to admission.	R 704	R704 1. Corrective Action to be accomplished This resident was the very first to be admitted to Abrams AL. Since then, the team has been verifying that the ICFD Admission/Annual Medical Certification form is dated no more than 30-days prior to admission. 2. Measures Implemented to ensure it does not recur The DON and ALA will both review the ICFD Admission/Annual Medical Certification form to ensure the primary care provider has fully completed it no more than 30 days prior to scheduled admission. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 23, 2023	
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so, indicated during the medical assessment. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Intermediate Care Facilities Division Admission (ICFD) /Annual Medical Certification form was completed with all	R 705		

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R 705	Continued From page 34. information required for 15 of the 20 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15). Findings included: The ALR failed to ensure each resident's (ICFD) Admission/Annual Medical Certification Form was completed with all assessment areas addressed as follows: 1. On 05/24/2023 at 1:52 pm, a review of Resident #1's (ICFD) Admission/Annual Medical Certification form dated 11/02/2023 showed no documented evidence that the physician assessed if the resident had or needed a mammogram, pap smear test, and prostate-specific antigen (PSA) test, any skin integrity issues, dental health concerns to include dentures, tuberculosis status, and if the resident was exhibiting signs or symptoms suggestive of a communicable disease. The physician also failed to document a list of the resident's current medications, including any supplements and vitamins. 2. On 05/24/2023 at 1:01 pm, a review of Resident #2's (ICFD) Admission/Annual Medical Certification form dated 04/24/2023 showed no documented evidence that the physician assessed if the resident had or needed a mammogram and a pap smear test, and the resident's dietary needs. The physician also failed to indicate if the resident needed 24-hour nursing care or not. 3. On 05/24/2023 at 12:03 pm, a review of Resident #3's (ICFD) Admission/Annual Medical Certification form dated 02/14/2023 showed no documented evidence that the physician	R 705	R705 1. Corrective Action to be accomplished We have requested updates to the ICFD Admission/Annual Medical Certification form for each of the residents identified from their primary care provider. 2. Measures Implemented to ensure it does not recur The DON and ALA will both review the ICFD Admission/Annual Medical Certification form to ensure the primary care provider has fully completed it prior to scheduling a move-in, and on annual renewal. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: Requests made to providers by 6/23/23, expected deadline for provider compliance is 07/07/23.	

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R 705	Continued From page 35.	R 705		

assessed the resident's vital signs, if the resident had any allergies, uses tobacco or alcohol, had a tetanus, influenza, or pneumonia vaccine, uses non-prescription medication, and failed to include the reason for admission. The physician failed to circle if the resident needed continued acute or long term medical or nursing care or supervision which would require placement in a hospital/nursing home or needed 24-hour nursing care. The physician documented under the medication list to see attached medication list, however, there was no attachment to the document.

4. On 05/24/2023 at 1:45 pm, a review of Resident #4's (ICFD) Admission/Annual Medical Certification form dated 04/27/2023 showed no documented evidence that the physician assessed if the resident had a tetanus or pneumonia vaccine, blood pressure, if the resident had allergies, if they previously had or needed a Papanicolaou (pap) test or a colonoscopy. The physician failed to document the facility's name and present address. The physician documented under the medication list to see attachment, however, there was no attachment to the document.

5. On 05/25/2023 at 2:25 pm, a review of Resident #5's (ICFD) Admission/Annual Medical Certification form dated 04/21/2023 showed no documented evidence that the physician assessed if the resident had any allergies, uses tobacco or alcohol, had a tetanus test, or had an influenza vaccine, and if the resident uses non-prescription medication. The physician failed to document if the resident had dental health concerns or used dentures.

6. On 05/24/2023 at 11:16 am, a review of

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Resident #6's (ICFD) Admission/Annual Medical Certification form dated 11/30/2022 showed no documented evidence that the physician assessed if the resident had or needed a colonoscopy or Papanicolaou (pap) test. The physician also failed to indicate if the resident needed 24-hour nursing care, and or needs continued acute or long-term care or supervision which would require placement in a hospital or nursing home.

7. On 05/25/2023 at 9:19 am, a review of Resident #7's (ICFD) Admission/Annual Medical Certification form dated 11/27/2022 failed to indicate the reason for the evaluation and showed no documented evidence that the physician assessed if the resident had or needed a colonoscopy, prostate specific antigen test (PSA) or Papanicolaou (pap) test. The resident's vital signs and weights were not measured, and failed to indicate if the resident was showing any signs or symptoms of a communicable disease. The physician also failed to indicate if the resident needed 24-hour nursing care, and or needs continued acute or long-term care or supervision which would require placement in a hospital or nursing home.

8. On 05/24/2023 at 12:57 pm, a review of Resident #8's (ICFD) Admission/Annual Medical Certification form dated 06/12/2022 showed no documented evidence that the physician assessed if the resident had a pneumonia or influenza vaccine and did not include the reason for admission. There was a single page document signed by Physician and dated 09/28/2022 (part of the Medical Certification form) which had no assessment attached to it.

9. On 05/24/2023 at 12:08 pm, a review of

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R 705	Continued From page 37. Resident #9's (ICFD) Admission/Annual Medical Certification form dated 02/01/2023 showed no documented evidence that the physician assessed if the resident required medical or laboratory services, had dental health concerns to include dentures, pain and the intensity, and if the resident was dependent on medical equipment. Also, the physician did not indicate if the resident was or was not in need of 24-hour nursing care and not in need of continued acute or long-term care or supervision which would require placement in a hospital or nursing home. 10. On 05/25/2023 at 11:17 am, a review of Resident #10's (ICFD) Admission/Annual Medical Certification form dated 01/13/2023 showed no documented evidence that the physician assessed if the resident had or needed a mammogram, pap test, and prostate-specific antigen (PSA) test. If the resident uses alcohol, or non-prescription drugs. Also, the physician did not document if the resident was exhibiting signs or symptoms suggestive of a communicable disease if the resident had dental health concerns to include dentures or if the physician recommended a mental health evaluation. The form showed that the resident had additional required medical and laboratory services, but did not indicate the reason, frequency, or duration for the services. 11. On 05/25/2023 at 12:08 pm, a review of Resident #11's (ICFD) Admission/Annual Medical Certification form dated 11/02/2022 showed no documented evidence that the physician assessed if the resident had any podiatric or dental concerns to include if the resident had dentures. The physician circled that the resident needed continued acute or long term medical or nursing care or supervision which would require	R 705		

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placement in a hospital or nursing home.

12. On 05/25/2023 at 2:02 pm, a review of Resident #12's (ICFD) Admission/Annual Medical Certification form dated 12/28/2022 showed no documented evidence that the physician assessed if the resident had a tetanus, influenza, or pneumonia vaccine. The physician documented under the medication list to see attached medication list, however, there was no attachment to the document. The physician circled that the resident needs continued acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.

13. On 05/25/2023 at 12:36 pm, a review of Resident #13's (ICFD) Admission/Annual Medical Certification form dated 04/25/2023 showed no documented evidence that the physician assessed if the resident had any visual impairment and did not list the resident's current medication.

14. On 05/25/2023 at 10:32 am, a review of Resident #14's (ICFD) Admission/Annual Medical Certification form dated 04/27/2023 showed no documented evidence that the physician completed the medication list. The physician documented under the medication list to see medication list, however, there was no attachment to the document.

15. On 05/25/2023 at 12:18 pm, a review of Resident #15's (ICFD) Admission/Annual Medical Certification form dated 06/06/2023 showed no documented evidence that the physician assessed if the resident had a tetanus or pneumonia vaccine. The physician documented under the medication list to see attachment,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRAM HALL AL OPCO, DBA ABRAM ASSITED	1320 MAIN DRIVE, WASHINGTON, DC20012 WASHINGTON, DC 20012

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R 705	Continued From page 39.	R 705		

However, there was no attachment to the document.

On 05/26/2023 at approximately 12:40 pm, the Assistant Director of Nursing and the Assistant Living Administrator during an interview acknowledged the omission of the information's and gave no additional information. In another interview with the Admissions Director (AD) on 5/25/2023 at approximately 2:30 pm, the AD explained that he receives the (ICFD) Admission/Annual Medical Certification Form and ensures its completeness and ensures that it within the 30 days window. He further stated that he is new to the position and will make sure the documents are accurate moving forward.

At the time of the survey, the Assisted Living Residence (ALR) failed to ensure each resident's Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all information required.

R 709 — Sec. 802 3 Medical, Rehabilitation, Psychosocial Assess. — R 709

(3) Presence of allergies.

Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Intermediate Care Facilities Division (ICFD) Admission/Annual Medical Certification form was completed with all required information including the presence of allergies for 2 of the 20 residents in the sample (Residents # 3 and 5).

Findings included:

The ALR failed to ensure each resident's (ICFD)

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R 709	Continued From page 40. Admission/Annual Medical Certification Form was completed with all assessment areas addressed as follows: 1. On 05/24/2023 at 12:03 pm a review of Resident #3's (ICFD) Admission/Annual Medical Certification form dated 02/14/2023 showed no documented evidence that the physician assessed the residents for the presence of allergies. 2. On 05/25/2023 at 2:25 pm A review of Resident #5's (ICFD) Admission/Annual Medical Certification form dated 04/21/2023 showed no documented evidence that the physician assessed the residents for the presence of allergies. In an interview on 05/26/2023 at approximately 12:40 pm, the Assistant Director of Nursing and the Assistant Living Administrator acknowledged the omission of the information and gave no additional information. In another interview with the Admissions Director (AD) on 5/25/2023 at approximately 2:30 pm, the AD explained that he receives the Medical Certification Form and ensures its completeness and is within the 30 days window. He further stated that he is new to the position and will make sure the documents are accurate moving forward. At the time of the survey, the ALR failed to ensure each resident's Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all information required to include the presence of allergies.	R 709	R709 1. Corrective Action to be accomplished The DON has requested provider updates to the ICFD) Admission/Annual Medical Certification Form for the 2 residents, so that it matches all other medical records. The resident records have been updated with their known allergies. 2. Measures Implemented to ensure it does not recur The DON and ALA will both review the ICFD Admission/Annual Medical Certification form to ensure the primary care provider has fully completed it prior to scheduling a move-in, and on annual renewal. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 23, 2023	
R 710	Sec. 802 4 Medical, Rehabilitation, Psychosocial Assess.	R 710		

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R 710	Continued From page 41. (4) Confirmation that the applicant is free from communicable TB and from other active, infectious, and reportable communicable diseases. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident was free from communicable TB and other active, infectious, and reportable communicable diseases for 4 of the 20 residents in the sample (Residents #1, 3, 10 and 15). Findings included: The ALR failed to ensure each resident's Intermediate Care Facilities Division (ICFD) Admission/Annual Medical Certification Form was properly completed with the following areas not addressed in the assessment form as noted below: 1. On 05/24/2023 at 1:52 pm, a review of Resident #1's (ICFD) Admission/Annual Medical Certification form dated 11/02/2023 showed no evidence that the physician confirmed that the applicant was free from communicable TB, and other active, infectious, and reportable communicable diseases. 2. On 05/24/2023 at 12:15 pm, a review of Resident #3's (ICFD) Admission/Annual Medical Certification form dated 02/14/2023 showed no evidence that the physician confirmed that the applicant was free from communicable TB, and other active, infectious, and reportable communicable diseases. 3. On 05/25/2023 at 11:17 am, a review of Resident #10's (ICFD) Admission/Annual Medical Certification form dated 01/13/2023 showed no	R 710	R710 1. Corrective Action to be accomplished The DON and ADON have reviewed every resident chart to ensure that the provider provided a response on the ICFD Admission/Annual Medical Certification Form regarding being free from communicable TB and other active, infectious and reportable communicable diseases. For those where the provider did not provide a response, a new test has been completed and documented. 2. Measures Implemented to ensure it does not recur The DON and ALA will both review the ICFD Admission/Annual Medical Certification form to ensure the primary care provider has fully completed it prior to scheduling a move-in, and on annual renewal. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: June 23, 2023	

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R 710	Continued From page 42. evidence that the physician confirmed that the applicant was free from communicable TB, and other active, infectious, and reportable communicable diseases. 4. On 05/25/2023 at 12:18 pm, a review of Resident #15's (ICFD) Admission/Annual Medical Certification form dated 06/06/2022 showed no evidence that the physician confirmed that the applicant was free from communicable TB, and other active, infectious, and reportable communicable diseases. During an interview on 05/26/2023 at approximately 12:40 pm, the Assistant Director of Nursing and the Assistant Living Administrator acknowledged the omission of the information and provided no additional information. In another interview with the Admissions Director (AD) on 5/25/2023 at approximately 2:30 pm, the AD explained that he receives the Medical Certification Form and ensures its completeness. He further stated that he is new to the position and will make sure the documents are accurate moving forward. At the time of the survey, there was no evidence that the ALR ensured residents were free from communicable TB and from other active, infectious, and reportable communicable diseases prior to admission.	R 710		
R 711	Sec. 802 5 Medical, Rehabilitation, Psychosocial Assess. (5) Current medication profile and projected and other needed medications, treatments, and service; review of nonprescription drugs and review of possible adverse interactions.	R 711		

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R 711	Continued From page 43. Based on record reviews and interviews, the Assisted Living Residences (ALR) failed to ensure the current medications for nine of the 20 residents in the facility was documented in the Intermediate Care Facilities Division (ICFD) Admission/Annual Medical Certification Form (Resident #1, 3, 4, 5, 10, 12, 13, 14, and 15) Findings included: 1. On 05/24/2023 at 1:52 pm, a review of Resident #1's ICFD Admission/Annual Medical Certification form dated 11/02/2023 showed no documented evidence that the physician documented a list of the resident's current medications including any supplements and vitamins. 2. On 05/24/2023 at 12:03 pm, a review of Resident #3's ICFD Admission/Annual Medical Certification form dated 02/14/2023 showed no documented evidence that the physician assessed if the resident uses any non-prescription medication. 3. On 05/24/2023 at 1:45 pm, a review of Resident #4's ICFD Admission/Annual Medical Certification form dated 04/27/2023 showed no documented evidence that the physician documented the resident's medication. Further review of the resident's record showed a documentation under the medication list to see attached medication list, however, there was no attachment provided. 4. On 05/25/2023 at 2:25 pm, a review of Resident #5's ICFD Admission/Annual Medical Certification form dated 04/21/2023 showed no documented evidence that the physician assessed if the resident uses any	R 711	R711 1. Corrective Action to be accomplished We have requested updates to the ICFD Admission/Annual Medical Certification form for each of the residents identified from their primary care provider to include a list of the resident's current medications including any supplements and vitamins. 2. Measures Implemented to ensure it does not recur The DON and ALA will both review the ICFD Admission/Annual Medical Certification form to ensure the primary care provider has fully completed it prior to scheduling a move-in, and on annual renewal. 3. QA Program Action to Monitor compliance with corrective measures The QA committee will review at least 10% of resident charts monthly to ensure the required documents are 100% complete. A record will be maintained of the review. 4. Date to be completed: Requests made to providers by 6/23/23, expected deadline for provider compliance is 07/07/23.	

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R 711	Continued From page 44. non-prescription medication. 5. On 05/25/2023 at 11:17 am, a review of Resident #10's ICFD Admission/Annual Medical Certification form dated 01/13/2023 showed no documented evidence that the physician assessed if the resident uses any non-prescription medication. 6. On 05/25/2023 at 2:02 pm, a review of Resident #12's ICFD Admission/Annual Medical Certification form dated 12/28/2022 showed no documented evidence that the physician documented the resident's medication. Further review of the resident's record showed a documentation under the medication list to see attached medication list, however, there was no attachment provided. 7. On 05/25/2023 at 12:36 pm, a review of Resident #13's ICFD Admission/Annual Medical Certification form dated 04/25/2023 showed no documented evidence of a list of the resident's current medication. 8. On 05/25/2023 at 10:32 am, a review of Resident #14's ICFD Admission/Annual Medical Certification form dated 04/27/2023 showed no documented evidence that the physician documented the resident's medication. Further review of the resident's record showed a documentation under the medication list to see attached medication list, however, there was no attachment provided. 9. On 05/25/2023 at 12:18 pm, a review of Resident #15's ICFD Admission/Annual Medical Certification form dated 06/06/2023 showed no documented evidence that the physician documented the resident's medication. Further	R 711		

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R 711	Continued From page 45. review of the residents record showed a documentation under the medication list to see attached medication list, however, there was no attachment provided. During an interview on 05/26/2023 at approximately 12:40 pm, the Assistant Director of Nursing and the Assistant Living Administrator acknowledged the omission of the information and provided no additional information. In another interview with the Admissions Director (AD) on 5/25/2023 at approximately 2:30 pm, the AD explained that he receives the ICFD Admission/Annual Medical Certification Form and ensures it's completeness. He further stated that he is new to the position and will make sure the documents are accurate moving forward. At the time of the survey, the ALR failed to ensure that all resident's ICFD Admission/Annual Medical Certification Form included the resident's current medications profile and review of nonprescription drugs.	R 711		
R 961	Sec. 1002 1 Fire Safety. (1) An ALR shall be in compliance with Chapter 22, New Residential Board and Care Occupancies, Life Safety Code of the National Fire Protection Association; and Based on record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure fire drills were conducted quarterly on each shift for three of the three shifts (the first, second, and third shifts). Findings included: On 05/25/2023 at 10:28 am, the administrator	R 961		

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R 961	Continued From page 46. said during an interview that the ALR staff shift hours were (7:00 am to 3:00 pm, 3:00 pm to 11:00 pm, and 11:00 pm to 7:00 am) Monday through Friday. The administrator stated that the weekend staff shift hours were the same as the weekday shift hours. At 2:13 pm, a review of the facility's Fire Drill report book showed there were only three fire drills conducted between September 2022 to 05/23/2023 (on 07/25/2022 at 11:30 am, 10/18/2022 at 11:30 am, and 10/13/2022 at 6:00 pm). There were no other fire drills made available for review. This was confirmed through an interview with the Assisted Living Administrator at 2:33 pm. The surveyor shared with the Assisted Living Administrator that fire drills should be conducted quarterly on each shift. The Assisted Living Administrator stated to the surveyor that going forward; she would ensure fire drills are conducted in accordance with the law and regulations. On 05/25/2023 at 2:15 pm, a review of the ALR's fire drill policy dated 03/18/2022, showed that at least every other month, shifts should be rotated so that each shift received two drills per year. At the time of survey, the facility failed to provide verifiable documentation showing that fire drills were conducted on each shift four times per year.	R 961	R961 1. Corrective Action to be accomplished The ALA will ensure that fire drills are completed on each shift, each quarter. Additional drills have been completed. 2. Measures Implemented to ensure it does not recur An annual checklist of required drills (1 per shift, per quarter) has been created and responsibility assigned. 3. QA Program Action to Monitor compliance with corrective measures The binder of fire drills including the annual schedule, completed forms and training documents will be reviewed by the QA committee at least quarterly. 4. Date to be completed: June 30, 2023	
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water	R1003		

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R1003	Continued From page 47. temperature does not exceed 110 degrees Fahrenheit. Based on observations, interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure water temperatures did not exceed 110 degrees Fahrenheit (°F), for two of the two kitchenette and bathroom sinks in (Apartments #202 and 309) and one dining room hand sink located on the First Floor. Findings included: On 05/23/2023 beginning at 12:57 am, a walk-through of the facility with the Administrator showed the following: - At 1:03 pm, the kitchenette and bathroom sinks located in Apartment #202 showed a water temperature reading that measured 120.0 and 120.2 °F. - At 1:09 pm, the kitchenette and bathroom sinks located in Apartment #309 showed a water temperature reading that measured 119.3 and 118.8 °F. The surveyor shared with the administrator that hot water temperatures should not exceed 110 °F. - At 1:17 pm, the dining room hand sink located in the kitchen on the first floor showed a water temperature reading that measured 116.8 °F. The Administrator called the maintenance staff (Employee #13), who joined the survey team during the walk-thru in the dining room located on the first floor at 1:23 pm. Employee #13 confirmed that he had water temperatures readings between 120.0 °F and 117.0 °F in the units. Employee #13 stated that the hot water temperature was controlled by the boiler room in the old Walter Reed facility, and that the ALR	R1003	R1003 1. Corrective Action to be accomplished The water temperature being delivered to the Assisted Living has been changed so that it does not exceed 110 degrees Fahrenheit. 2. Measures Implemented to ensure it does not recur The staff will monitor water temperatures in resident apartments and keep a written record. If any water temperatures exceed 110 degrees Fahrenheit the property management company and the engineer who controls the water delivery will be notified and corrective action taken. 3. QA Program Action to Monitor compliance with corrective measures The log of water temperatures will be reviewed during the monthly QA meeting. A record will be maintained of the review. 4. Date to be completed: June 30, 2023	

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R1003	Continued From page 48. shared hot water with two other buildings on the facility grounds. Employee #13 stated that he would have to speak to his people to see if they can adjust the hot water temperature. At 1:25 pm, the surveyor requested to see the water temperature logbook and the policies and procedures for monitoring hot water temperatures in the ALR. At 2:30 pm, follow-up observations showed that the hot water temperatures in the observed locations had been readjusted and measured at or below 110 °F. On the last day of survey (05/26/2023), the ALR failed to provide to the surveyor the facility's water temperature logbook and policies and procedures for monitoring hot water temperatures in the ALR requested on 05/23/2023 at 1:25 pm. At the time of the survey, the ALR failed to ensure hot water temperature did not exceed 110 °F throughout the facility.	R1003		