Health R	egulation & Licensing	Administration						
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPL			
		ALR-0042	B. WING		05/26	/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DDRESS, CITY, STATE, ZIP CODE					
ABRAM I	HALL AL OPCO, DBA	ABRAM ASSILED	IN DRIVE, WASHINGTON, DC20012 GTON, DC 20012					
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R 000	05/23/2023, 05/24/2 05/26/2023, to deter Assisted Living Law et seq) and Assisted Title 22-B DCMR (P Chapter 101. The Asprovided care for 34 personnel, including staff. A sample of 20 records were selected The findings of the sobservations throug medication administ	survey was conducted on 023, 05/25/2023 and mine compliance with the (DC Official Code § 44-101.01 I Living Residence Regulations, ublic Health and Medicine) ssisted Living Residence (ALR) residents and employed 40 professional and administrative resident records, 15 employee	R 000	Please start typing your responses	s here:			
R 154	10113.5 A "post move 604 of the Act (D.C. be conducted by or eseventy-two (72) hor Based on interviews Assisted Living Resisthe Registered Nurs move-in" assessment resident's admission sample (Resident #1 12, 13, 14, 15 and 16 Findings included:	re-in" assessment required by § Official Code § 44-106.04) shall on behalf of the ALR within urs of a resident's admission.  and record reviews, the dence (ALR) failed to ensure e (RN) performed a "post nt within 72 hours of each for 16 of the 20 residents in the 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 6).		1. Corrective Action to be accomplished RN has reviewed each post move-in assess collaboration with the ADON and RN has si each post move-in assessment that was procompleted by an LPN. The name of our mossessment is being changed in PointClick clearly identify it as the post move-in assess.  2. Measures Implemented to ensure it does recur  Our new resident move-in workflow has be updated to include the RN signature on the move-in assessment within 72 hours.  3. QA Program Action to Monitor compliant corrective measures  Our monthly QA monitoring program will not a review of any admissions within the last and the required post move-in assessment an RN.	igned eviously ove-in Care to sment. s not een e post ce with ow include month,			
	#1's clinical records			4. Date to be completed: June 30, 2023				

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

TITLE

(X6) DATE

PRINTED: 06/13/2023 **FORM APPROVED** Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 154 Continued From page 1. R 154 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.

PRINTED: 06/13/2023 **FORM APPROVED** Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 154 Continued From page 2. R 154 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

the RN within

#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

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING. ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 154 Continued From page 3. R 154 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

PRINTED: 06/13/2023 **FORM APPROVED** Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: \_\_\_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 154 Continued From page 4. R 154 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 281 10116.15f Staffing Standards R 281 R281 1. Corrective Action to be accomplished 10116.15f A healthcare practitioner's written statement as to whether the employee bears any TB testing has been completed for the employees communicable diseases, including communicable who were missing the proof. All employees now have a written statement from a healthcare tuberculosis. practitioner. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to show 2. Measures Implemented to ensure it does not evidence that each employee had obtained a written statement from a healthcare practitioner within the Evidence of being free from communicable past 12 months declaring them free from diseases will be required for all new employees communicable diseases, for 11 of the 15 staff prior to the first day of work. A form will be used to have the ALA sign off on new hires before they whose health screening/ physician's certification start, showing that proof was provided. was requested (Employees #1, 2, 3, 5, 6, 7, 8, 9, 11, 12, and 13). 3. QA Program Action to Monitor compliance with corrective measures Findings included: The Business Office Director will provide a monthly report for QA that shows all new hires, and the date Observations on 05/23/2023 beginning at 10:21 am, of hire and date evidence was provided. The ALA showed the following employees (Employees #1, 2, will review this monthly to ensure compliance. 3, 5, 6, 7, 8, 9,11, 12, and 13) providing direct care services to the residents in the dining room area, on 4. Date to be completed: June 23, 2023 the 1st, 2nd, 3rd floors and in the commercial

kitchen located in the basement:

statement from a healthcare

At 10:59 am, the surveyor requested documentation showing that each employee had obtained a

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R 281	Continued From pag	ge 5.	R 281			
4		hat he or she was free of ase. A follow-up request was 3 at 2:37 pm.				
	the personnel record documented evidence	inning at 9:48 am, a review of ds showed that there was no ce that Employees #1, 2, 3, 5, 6 13 had been screened by a	,			
	healthcare practition	ner 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					
	regarding communic tuberculosis (TB) he #1, 2, 3, 5, 6, 7, 8, 9	ctitioner's Written Statement cable disease, including calth screenings for Employees 0, 11, 12, and 13. The hat she would follow up with the		×		
	Human Resources (					
	during an interview to newly hired employe	1:25 am, the HR Director said that she was responsible for the ees. When asked why there screenings to ensure staff were				
	free of communicabl Director said that sho no health care scree stated that she had of facility since March 2	le disease, including TB, the HR are was not sure why there were enings for staff. The HR Director only been employed by the 2023, and was not aware that creened for communicable				
		were made for employee health				
	certificates on 05/26/ only four of the 15 er	3/2022 at 11:44 am; however, mployee health certificates were prior to the exit on 05/26/2023				

PRINTED: 06/13/2023 **FORM APPROVED** Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: B. WING \_ ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012

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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							

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)ID. COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 326 Continued From page 7. R 326 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

Health Regulation & Licensing Administration

seq.

time of the survey exit.

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

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

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R 330	registered nurse that forty-five (45) days, (D.C. Official Code & documentation of an medication profile, ir any medications that discontinued.  Based on interview a Assisted Living Resiste Living Resiste Registered Nurseach resident's medication and any added or disof the 20 residents ir 3, 4, 5, 6, 7, 8, 9, 10.  Findings included:  From 05/24/2023 thr review of the sample showed no evidence reviews of each residence reviews of each residented on 11/29/20 evidence to show that regimen was reviewed 2. On 05/25/2023 at #2's clinical record residence record residence record residence to show that regimen was reviewed 2. On 05/25/2023 at #2's clinical record residence record resid	esite medication review to is arranged to occur expursuant to § 903 of the state of 44-109.03), shall includy changes to the residence of the residence of the test of the tes	exery e Act ade ent's sing and ensure view of 15-days o the sing, s for 15 s' #1, 2, cord 9:00 am aducted nen esident nt was umented on esident nt was	R 330	R330  1. Corrective Action to be accomplished. The RN has completed a medication reall residents who have been in resident 45 days.  2. Measures Implemented to ensure it recur.  We are creating a custom assessment that will prompt the RN to complete the review on each resident.  3. QA Program Action to Monitor complete with corrective measures.  The 45-day review will be customized it that it auto-generates to be completed days for each resident. The RN and All monitor the PCC clinical dashboard to assessment due for reassessment, in pand past due.  4. Date to be completed: June 30, 202	does not in PCC 45-day bliance n PCC so I every 45 A will show progress		

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R 330	Continued From pag	 је 9.		R 330	¥					
	resident medication 45-days.	regimen was review	wed every							
	3. On 05/24/2023 at #3's clinical record re									
	admitted on 02/27/20									
	evidence to show the regimen was reviewed		ication							
	4. On 05/25/2023 at #6's clinical record re									
	admitted on 02/16/20	023. There was no	documented							
	evidence to show the regimen was reviewed		ication							
	_									
	5. On 05/25/2023 at #7's clinical record re									
	admitted on 12/28/20	022. There was no	documented							
	evidence to show the regimen was reviewed		ication							
	6. On 05/24/2023 at									
	#8's clinical record re admitted on 10/02/20									
	evidence to show that	at the resident med								
	regimen was reviewe	ed every 45-days.								
	7. On 05/24/2023 at #9's clinical record re									
	admitted on 10/02/20									
	evidence to show that		ication							
	regimen was reviewe	ed every 45-days.								
	8. On 05/25/2023 at #10's clinical record		of Resident							

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R 330	Continued From pag	je 10.		R 330				
	resident was admitte						1	
	documented evidend						1	
	medication regimen	was reviewed every	/ 45-days.				1	
	9. On 05/24/2023 at	· 12·57 nm a review	of Resident				1	
	#11's clinical record						!	
	admitted on 10/02/2	022. There was no	documented				1	
	evidence to show the		cation		1		1	
	regimen was review	ed every 45-days.					1	
	10. On 05/25/2023 a	et 2:03 pm, a review	of Resident					
	#12's clinical record						1	
	admitted on 01/10/20	023. There was no	documented				1	
	evidence to show that		cation				1	
	regimen was reviewe	ed every 45-days.	1				1	
	   11. On 05/25/2023 a	at 12:36 pm, a revier	w of				1	
	Resident #13's clinic						1	
	resident was admitte	ed on 05/17/2023. T	here was no				1	
	documented evidend			1			1	
	medication regimen							
	12. On 05/25/2023 a						1	
	Resident #15's clinic							
	resident was admitte						1	
	medication regimen	00 10 011011 11101 1110 1						
		·						
	13. On 05/25/2023 a			1			ļ	
	Resident #15's clinic			1 !			ļ	
	resident was admitte			1 '				
	documented evidence medication regimen			1 /				
	modical roginis.	Was 101101104 010.,	40 days.	1 /				
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PRINTED: 06/13/2023 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 330 Continued From page 11. R 330 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 383 R 383 10125.4a Reporting Complaints to The Director R 383 1. Corrective Action to be accomplished An ALR shall notify the Director of any 10125.4a A written notification will be submitted for all prior incidents to the Department of Health. unusual incident that substantially affects a resident. Notifications of unusual incidents shall be 2. Measures Implemented to ensure it does not made by contacting the Department of Health by phone promptly, and shall be followed up by written We have created a checklist for facility staff based notification to the same within twenty-four (24) on the Incident Reporting policy and are providing hours or the next business day; and additional training on how, what and when to make Based on interview and record reviews, the reports. Assisted Living Residence (ALR) failed to promptly 3. QA Program Action to Monitor compliance with notify the Department of Health (DOH) by telephone corrective measures of all incidents that substantially affected a resident, followed by written notification within 24 hours, for A review of all incident reports and the status of their required reporting will be included in the 13 of the 20 residents in the sample (Residents #1, monthly QA review. 3, 6, 7, 8, 9, 11, 13, 15, 16, 17, 18, and 20). 4. Date to be completed: June 30, 2023 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

The facility case worker sent

following:

1. A report dated 05/03/2023 showed that Resident #1 was outside and refused to come back inside.

Health R	egulation & Licensing	g Administration				7.111.07.23	
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:	9	COMP	PLETED	
		ALR-0042	B, WING		05/2	6/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE			
ADDAMI	AALL AL OBCO DRA	ARRAM ASSITED 1320 MAII	N DRIVE, WA	SHINGTON, DC20012			
ADRAWI	HALL AL OPCO, DBA	WASHING	TON, DC 2	0012			
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				DEFICIENCY)			
R 383	Continued From page	ge 12.	R 383				
	·						
		he resident, but the resident still nto the facility. The staff then					
		gency services, but the resident					
		hospital. The police were called,					
		took the resident for a					
		on. There was no evidence that					
	the DOH was notified of the incident.						
		lent #3's discharge summary					
		showed that Resident #3 was					
		gton Hospital Center from 6/2023 with diagnoses that					
		ency anemia (IDA); Chronic					
	obstructive pulmona	ary disease (COPD); Acute					
		ith hypoxia; BPH (benign					
		a); Right renal mass, Acute on ystolic and diastolic CHF					
		ilure); History of ischemic					
		(I (acute kidney injury);					
		troponin; Moderate aortic					
		ΓN (hypertension). There was no OH was notified of the incident.					
	evidence that the Di	on was notified of the incident.			360		
	3. On 05/24/2023 at	1:00 pm, a review of Resident					
		showed a discharge summary					
		he discharge summary					
		sident was admitted for Heart and renal mass. There was no					
		ce that the DOH was notified of					
	the hospitalization.						
	4 A report dated 00	124/2022 showed that Basidant			[		
		/24/2023 showed that Resident g room area for dinner and was					
		nd swelling on or around her					
		the resident stated that she did					
		she fell. The staff applied ice					
	documented evidence	20 minutes. There was no					
	accumented evident						

Health Regulation & Licensing Administration				and the same of th				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPL		(X2) MULTIPLI	E CONSTRUCTION		(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATIO	N NOINBEK:	A, BUILDING:		i i	COM	IPLETED
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NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, ST.				
ABRAMI	HALL AL OPCO, DBA	ABRAM ASSITED			SHINGTON, DC20012			
			WASHING	TON, DC 2	0012			
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R 383	Continued From pag	10 13		R 383				
1 303				1 1 303				
	that the DOH was no		nich led to the					
	resident's injuries to	her face.						
	E A report detect OF	/15/2022 abouted t	hat Daaidant					
	5. A report dated 05/ #6 was found seated							
	bathroom. The repor							
	not responsive but b							
	present. The nurse a							
	911 emergency med	lical services, and	the resident					
	was transported to the							
	documented evidend							
	the incident which le	d to 911 being cal	led for the					
	resident.							
	6. The review showe	ad that on 02/07/20	123 Resident					
	#7 stated that he fell							
	tried to walk using hi							
	facility called 911 em							
	no evidence that the		of the falls					
	which led to 911 beir	ng called.						
	·	1.11 1 04/00/00	00 5					
	7. The report showed							
	#7 exhibited general unsteady gait. The re							
	went to my room to s							
	The nurse assessed							
	elevated blood sugar	r reading of 240 m	g/dl. The					
	resident was transpo							
	evaluation. There wa							
	was notified of the incident which led to 911 being							
	called.							
	9 Continued review	of the report show	ad that an					
	<ol> <li>Continued review</li> <li>03/04/2023 Resident</li> </ol>							
	got dizzy and fell in t							
	himself off the floor b							
	cane. The report sho							
	the resident and note							
	his leg, and medicate		-					
I				l l				I

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 383 R 383 Continued From page 14. 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.

Health Regulation & Licensing Administration

Health R	Regulation & Licensing	Administration				.,
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0042	B. WING		05/:	26/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
ABRAM I	HALL AL OPCO, DBA	ARRANIASSIIFII		ASHINGTON, DC20012		
		WASHING	TON, DC 2	20012		
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R 383	Continued From pag	ge 15.	R 383			
	#15 complained of parea. The resident swhen her leg gave of The resident denied assessed by the nur hospital for further evidence that the Doresident's fall.  15. The reports show observations showed his room. A search wwas found unharmed When asked the resident was assissues were noted, wilmits.	that on 03/03/2023, Resident vain in the right knee, and left rib aid she was cleaning her unit out and she fell on her knees. hitting her head and was se and refused to go to the valuation. There was no DH was informed of the out of the valuation and the resident don the street near the facility ident said, "I am going home." sessed by the nurse, and no with his vital signs within normal of 5/05/2023, showed that he bathroom and hit his head				
	on the wall. The residence hospital via 911 emeromplete scan of the incident report shows Health (DOH) was not which led to 911 being 17. The reports shown Resident #17 was distinct while on the toile activity that lasted 45 the resident and note 84/46, pulse 77, resp	dent was transported to the orgency services to have a head. A further review of the ed that the Department of ot notified of the resident's fall				
	called 911 for emerge was transported to the	ency services and the resident the hospital. There was no DH was notified of the incident.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COI	SURVEY MPLETED
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R 383	Continued From pag	 је 16.	R 383			
	#18 eloped from the the facility with no inj	the report showed that Resider facility and was brought back t njuries observed. There was no OH was notified of the resident'	to			
	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.					
	Resident #20 reporter retrieve her phone from assessed the resider were within normal p	wed that on 03/30/2023, ed that she fell while trying to rom the floor. The nurse nt and noted her vital signs parameters. There was no DH 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.					
	interviewed regarding for reporting incidents administrator said inc	:35 am, the Administrator was g their process, and procedure is to the DOH. The cidents that interfere with the afety should be reported to				
		:38 am, a review of the ALR's policy, dated 03/18/2022 ginstruction:				

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R 383	Continued From pag	je 17 <u>.</u>	R 383			
	incidents that substa -The Administrator of DOH by phone proministration vinext business day.  Further review of the unusual incidents as significant injury to a death.  At the time of the sun notify the DOH by te	the DOH of any unusual antially affect a resident. Or their designee will contact the apply and shall follow-up with a ia email within 24 hours or the e incident report policy defined an accident resulting in a resident and unexpected arvey, the ALR failed to promptly elephone of all incidents that d a resident, followed by written hours.				

Health R	egulation & Licensing	Administration			1 Oldivi	ALLINOVED
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COM	SURVEY PLETED
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	ROVIDER OR SUPPLIER	ARRAM ASSITED 1320 MAIN		SHINGTON, DC20012		
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R 000	05/23/2023, 05/24/2 05/26/2023, to deter Assisted Living Law et seq) and Assisted Title 22-B DCMR (P Chapter 101. The Asprovided care for 34 personnel, including staff. A sample of 20 records were selected The findings of the sobservations throug medication administ	survey was conducted on 023, 05/25/2023 and mine compliance with the (DC Official Code § 44-101.01 I Living Residence Regulations, ublic Health and Medicine) esisted Living Residence (ALR) residents and employed 40 professional and administrative professional and administrative of resident records, 15 employee ed for review.	R 000	Please start typing your responses  R293  1. Corrective Action to be accomplished  DON and ADON have reviewed all dischar summaries and ICFD Admission/Annual M Certification forms for each resident and ha followed up on orders and recommendation	ge edical ave	
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	appropriate medical and health services.  2. Measures Implemented to ensure it doe recur  Create a checklist to review prior to admiss include the discharge summary, medical conform and physician orders with specific iter the DON/ADON and ALA to ensure that the records incorporate the information from all Any discrepancies between sources will be with the primary care provider.  3. QA Program Action to Monitor compliant corrective measures  The QA committee will review at least 10% resident charts monthly to ensure the required documents are 100% complete. A record maintained of the review.  4. Date to be completed: June 30, 2023	es not sion to certification ns for use e AL I sources. e clarified nce with	

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

TITLE

(X6) DATE

_ Health R	Regulation & Licensing	Administration					
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R 293	Continued From pag	ge 1.		R 293			
		cal record showed a					
	summary dated 04/25/2023, which showed that the					1	
	resident was admitted for Heart failure exacerbatio and renal mass. The discharge summary also recommended that resident #3 should receive no						
						1	
	ı	ical soft diet. A revie				1	
		nt ISP dated 02/28/2				1	
		s of Heart failure exac				1	
		iny goals and interve				1	
		erns. The ISP failed ould receive no adde				1	
		t. There was no evide				1	
		ceiving a no added sa				1	
	mechanical salt diet.		,			1	
	b). On 05/24/2023 at	 at 12:03 pm, a review nediate Care Facilitie					
	Admission/Annual M	Medical Certification f	form dated			ļ	
		that the resident had oted that he needed				1	
		Psychiatrist. Residen				1	
	,	2/28/2023 did not ref				1	
		itia, Psychiatric conc				1	
		ons to manage these				1	
		nce in the record of s	•			1	
	_	3's Dementia and Ps	ychiatric			1	
	concerns.					1	
	c). A review on 05/24	.4/2023 at 2:00 pm, c	of Resident				
	#4's medical record	showed an order for	physical				
	therapy (PT). There						
	that the resident had		PT or had				
	an appointment sche	eduled for P1.					
	d). On 05/25/2023 at #5's Intermediate Ca						
	Medical Certification						
	that the resident had						
	Mellitus and an orde						
	diet. Resident #5's c	urrent					
						,	

Health R	Regulation & Licensing	Administration				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ABRAM I	HALL AL OPCO, DBA	ABRAMASSIIFD	N DRIVE, WA STON, DC 20	SHINGTON, DC20012 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
R 293	Continued From pag	ge 2.	R 293			
	ISP dated 05/02/202 of Diabetes Mellitus, concentrated sweets interventions to man no documented evid receiving a no concere). On 05/24/2023 at #8's Intermediate Ca Medical Certification that the resident had and a recommendati. The residents ISP date focus area of falls arreview of the resider showed that the resident had any interventions to elopement risk and fathe records that the records that the rethe Psychiatrist as on place to prevent falls f). On 05/24/2023 at #8's medical records 09/06/2023 for a bila with Computer-aided history of a breast m. 9/2022. There was Resident #8 completed g). On 05/24/2023 at #8's Intermediate Ca Medical Certification	23 did not reflect the diagnosis, a diet order for no is diet or any goals and large these concerns. There was lence that the resident was entrated sweets diet.  1 1:03 pm, a review of Resident are Facilities Admission/Annual of form dated 06/12/2022 showed dia diagnosis of Schizophrenia ion for a Psychiatric follow uplated 10/03/2022 revealed and Elopement risk. Continued into the nursing progress notes dent had repeated falls on 022 and 05/02/2023. Resident and 10/03/2022 did not reflect manage her Psychiatric needs, falls. There was no evidence in resident had followed up with redered or had strategies in				

Health Regulation & Licensing Administration STATE FORM

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING;		COM	IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
ADDAMI	JALL AL ODCO DDA	ADDAM ASSITED 1320 MAIN	N DRIVE, WA	SHINGTON, DC20012		
ABRAIVI	HALL AL OPCO, DBA	WASHING	TON, DC 2	0012		
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R 293	Continued From pag	ge 3.	R 293			
R 293	Further review of the Oncology appointment of the Oncology	e medical record revealed an ent completed on 10/06/2022 1 month. There was no ce showing that Resident #8 cology 1 month later as to 1:20 pm, a review of Resident Care Facilities Admission/Annual form dated 06/06/2022 showed an allergy to latex, codeine, dent #15's current ISP dated effect a focus area or ress her allergy to pork and documented evidence that the latex, codeine, pork, and nuts id.				
	these concerns.					

Health R	Regulation & Licensing	Administration				
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ARRAMI	HALL AL OPCO, DBA	ARRAM ASSITED 1320 MAIN	N DRIVE, WA	SHINGTON, DC20012		
ADRAMI	HALL AL OPCO, DBA	WASHING	TON, DC 2	0012		
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				DEFICIENCY)		
R 293	Continued From pag	ge 4.	R 293			
	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					
		e 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.					
		rvey, the Assisted Living led to ensure that residents had		R375		
		e medical and health services,		Corrective Action to be accomplished		
	psychiatric services,	physical therapy services in		· ·		
		intain the highest practicable		There is only one resident who expired on whose chart has been maintained in the D		
	pnysical, mental, and	d psychosocial well-being.		Nursing office, and in PointClickCare as a		
				moved-out resident. The DON will request the death certificate and place that information		
				inside the existing chart. Resident #17 is a	alive and	
R 375	Sec. 506a4 Privacy	and Confidentiality.	R 375	residing at the ALR. Resident #18 passed a hospital, and his closed chart is maintain	away at   ned in the	
	(4) To bour 4h sign			DON office and in PointClickCare.		
	years after discharge	ecords maintained for up to 3		2. Measures Implemented to ensure it do	es not	
		and attempted record review,		recur		
		Residence (ALR) failed to		Request death certificate of any resident w		
		eceased residents were		pronounced dead at the ALR at the time of from the health entity who certified the dea		
		three years for one of the two of the facility (Resident #16)		include in the closed medical records kept		
	deceased residents	of the facility (Nesident #10)		ALR.		
	Findings included:			3. QA Program Action to Monitor complian	nce with	
	On 05/00/0000 -1 10	UEO ama di mina di la casta da		corrective measures		
		:59 am, during the entrance sted Living Administrator (ALA)		When residents move out or pass away, the		
		ors that there had been two		closed chart will be reviewed by the ALA to that all necessary documentation is compl		
	resident deaths in th	e facility, Residents #16 and		closed record cover sheet will be signed by DON and the ALA.		
	17. On 05/26/2023, t	he surveyor requested to				
			l	4 Date to be completed: June 30, 2023		

Health R	Regulation & Licensing	Administration				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COM	SURVEY PLETED
		ALR-0042	B. WING		05/2	6/2023
	ROVIDER OR SUPPLIER	ABRAM ASSITED 1320 MAIR	PRESS, CITY, ST N DRIVE, WA TON, DC 2	SHINGTON, DC20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
R 375	see Resident #16's attempting to locate Assistant Director of surveyor that the red At 12:44 pm, the ALL was given to the Offi Examiner and that the record to be main At the time of the sur	record for review. After the resident's record, the nursing (ADON) informed the cord could not be located.  A said that the original record ce of the Chief Medical he ALR had not made a copy of intained in the facility.  Tryey, the ALR failed to maintain sed residents for up to three	R 375	R421		
R 421	resident prior to adm resident or surrogate representative of the portions of the contra Based on interviews Assisted Living Resident written agreement for admission, for 12 of (Resident #1, 3, 4, 5 15). Findings included: 1. On 05/25/2023 at #1's clinical record readmitted on 11/29/20 the Resident's Agree resident on 11/29/20 moved in.	Agreements  It must be provided to the dission and signed by the set, if necessary, and a marked ALR. The nonfinancial act shall include the following: and record reviews, the dence (ALR) failed to obtain a reall residents prior to the 20 residents in the sample 1.52 pm, review of Resident evealed that the resident was 1.52 pm, review of Resident evealed that the resident was 1.52, the same day the resident evealed that the resident was 1.53 am, review of Resident evealed that the resident was 1.54 and 1.55 am, review of Resident evealed that the resident was 1.55 am, review of Resident evealed that the resident was 1.55 am, review of Resident evealed that the resident was 1.55 am, review of Resident evealed that the resident was 1.55 am, review of Resident evealed that the resident was 1.55 am 1.55 am, review of Resident evealed that the resident was 1.55 am 1.55 a	R 421	1. Corrective Action to be accomplished The Resident Agreement is a legal docum signed by both the Resident and/or their s and the ALR. We cannot change the date already signed agreements.  2. Measures Implemented to ensure it do recur  The regulation states that the "written cont be provided to the resident prior to admissinged by the resident or surrogate, if nect and a representative of the ALR." Becaus agreement stipulates the care and service will provide and is responsible for, it cannot signed in advance of the date the services provided. The ALR will provide the Reside Agreement in advance of admission to the or surrogate, and will get signed receipt the received it, however, the date of the Reside Agreement will need to be the date service which is the day of admission.  3. QA Program Action to Monitor compliate corrective measures  The Admissions Director will provide a repmonthly QA meeting to include any new at The report will include the date of admission that documents were provided with receip	es not  tract must sion and essary, se the sthe ALR of the swill be ent e residents at they dency es begin,  nce with enter the dmissions. on, date	

Health Regulation & Licensing Administration STATE FORM

E28X11

4. Date to be completed: June 23, 2023

Health R	egulation & Licensino	Administration			Table 1	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0042	B. WING	<del></del>	05/2	26/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST			
ABRAM H	HALL AL OPCO, DBA	ABRAMASSIIFU	TON, DC 2	SHINGTON, DC20012 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
	the Resident's Agree resident on 02/27/20 moved in.  3. On 05/24/2023 at #4's clinical record readmitted on 05/05/20 the Resident's Agree resident on 05/05/20 moved in.  4. On 05/25/2023 at #5's clinical record readmitted on 04/27/20 the Resident's Agree resident on 04/27/20 moved in.  5. On 05/25/2023 at #6's clinical record readmitted on 02/16/20 the Resident's Agree resident on 02/16/20 moved in.  6. On 05/25/2023 at #7's clinical record readmitted on 12/28/20 moved in.  7. On 05/24/2023 at #8's clinical record readmitted on 12/28/20 moved in.	223. The record showed that ement was signed by the 223, the same day the resident evealed that the resident was 223. The record showed that ement was signed by the 223, the same day the resident was 223. The record showed that evealed that the resident was 223. The record showed that ement was signed by the 223, the same day the resident evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 222. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that evealed that the resident was 223. The record showed that event was signed by the 223, the same day the resident	R 421			

Health R	Regulation & Licensing	Administration				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COM	SURVEY MPLETED
		ALR-0042	B. WING		05/:	26/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
ABRAM I	HALL AL OPCO, DBA	ABKAMASSUFU	N DRIVE, WA	ASHINGTON, DC20012 10012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE	
R 421	Continued From pag	je 7.	R 421			
	#10's clinical record admitted on 01/19/20 the Resident's Agree	11:17 am, review of Resident revealed that the resident was 023. The record showed that ement was signed by the 123, the same day the resident				
	#12's clinical record admitted on 01/10/20 the Resident's Agree	2:03 pm, review of Resident revealed that the resident was 023. The record showed that ement was signed by the 23, the same day the resident				
	#13's clinical record admitted on 05/17/20 the Resident's Agree	t 12:36 pm, review of Resident revealed that the resident was 023. The record showed that ement was signed by the 23, the same day the resident				
	#14's clinical record admitted on 04/27/20 the Resident's Agree	t 10:32 am, review of Resident revealed that the resident was 023. The record showed that ement was signed by the 23, the same day the resident				
	#15's clinical record admitted on 09/06/20 the Resident's Agree	t 12:18 am, review of Resident revealed that the resident was 023. The record showed that ment was signed by the 23, the same day the resident				
	discussed with the A stated that he recent	30 pm, the above findings were dmissions Director (AD), who ly started working as the AD. It moving forward, he will make				

	Administration				
DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
RRECTION	IDENTIFICATION NOMBER	A BUILDING:		CON	-15150
	ALR-0042	B. WING		05/2	6/2023
ER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
AL ORGO DRA A	DDAM ASSITED 1320 MAIN	DRIVE, WA	SHINGTON, DC20012		
. AL OPCO, DBA A	WASHING	TON, DC 20	0012		
CH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
ntinued From pag	e 8.	R 421			
idmissions. In that the resident agreement admissions the time of the sure that the time of the time of the sure that the time of the sure that the time of the sure that the time of the time of the sure that the time of time of the time of time	at interview, he acknowledged eements were not signed prior ession as required. Evey, the ALR failed to ensure greement was signed prior to		D474		
CO4e4 Individue	slined Comittee Dlane	D 471			
s. 604a'i individua	alized Service Plans	K 4/ I	· ·		
or to admission. Sed on interview a sing Residence (Al gistered Nurse (R vice Plan (ISP) pi dents in the sample, 9, 10, 11, 12, 13 dings included: view of the sample o am from 05/24/2 wed no evidence SP prior to reside on 05/24/2023 at medical record so itted on 11/29/20 on 05/24/2023 at medical record so itted on 05/04/20 on 05/24/2023 at medical record so itted on 05/04/20	and record review, the Assisted LR) failed to ensure its N) developed an Individualized rior to admission for 15 of 20 ole (Resident #1, 2, 3, 4, 5, 6, 3, 14, and 15).  ed residents' records starting at 2023 through 05/26/2023 that the ALR's RN developed ent's admission at follows:  1.52 pm, a review of Resident showed that the resident was 022 and an ISP was initiated on of admission.		the ISP cannot be completed prior to adm The 30 day, 6 month and upon significant reviews have been completed. Effective immediately, the RN will complete an ISP admission.  2. Measures Implemented to ensure it do recur  The RN will complete a preliminary ISP do pre-admission assessment for those application who have been approved. Once approved will complete the ISP with the information from the discharge summary, pre-admission assessment, and the ICFD Admission/Anni Medical Certification forms  3. QA Program Action to Monitor compliancorrective measures  The DON will provide a monthly report for which includes all residents, dates of admissions admission and the includes all residents, dates of admissions and the includes all residents, dates of admissions.	ission. change prior to  es not  uring the cants of the RN gathered on hual  nce with  QA ission,	
The control of the co	SUMMARY STA SUMMARY STA CH DEFICIENCY MUST OR LSC IDEI  tinued From page dmissions. In that the resident agree he time of the sur- each resident ag- resident's admission. he time of the sur- each resident agree and Individual (1) An ISP shall It to admission. he don interview and g Residence (Al istered Nurse (R rice Plan (ISP) po- dents in the sample gents in the sample gents in the sample to am from 05/24/2 he am from 05/24/2 he am from 05/24/2 he am from 05/24/2 he am o evidence he prior to reside medical record se itted on 11/29/2 he am o 05/24/2023 at medical record se itted on 05/04/2 he am o 05/04/2	ALR-0042  STREET ADD  1320 MAIN WASHING  SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  tinued From page 8. dmissions. In that interview, he acknowledged the resident agreements were not signed prior he resident admission as required.  The time of the survey, the ALR failed to ensure each resident agreement was signed prior to resident's admission.  604a1 Individualized Service Plans  (1) An ISP shall be developed for each resident on interview and record review, the Assisted of Residence (ALR) failed to ensure its istered Nurse (RN) developed an Individualized vice Plan (ISP) prior to admission for 15 of 20 dents in the sample (Resident #1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, and 15).	ALR-0042  STREET ADDRESS, CITY, STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Tinued From page 8.  In that interview, he acknowledged the resident agreements were not signed prior the resident agreement was signed prior to resident's admission.  R 421  In the time of the survey, the ALR failed to ensure each resident agreement was signed prior to resident's admission.  R 471  In the time of the survey, the ALR failed to ensure each resident agreement was signed prior to resident's admission.  R 471  In the time of the survey, the ALR failed to ensure each resident agreement was signed prior to resident's admission.  R 471  In the time of the survey, the ALR failed to ensure its intered Nurse (RN) developed for each resident roadmission.  In the sample (Resident #1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, and 15).  In the sampled residents' records starting at a tam from 05/24/2023 through 05/26/2023 and no evidence that the ALR's RN developed SP prior to resident's admission at follows:  In 05/24/2023 at 1:52 pm, a review of Resident medical record showed that the resident was intended in 11/29/2022 and an ISP was initiated on 9/2022, the day of admission.  In 05/24/2023 at 1:01 pm, a review of Resident medical record showed that the resident was intended in 11/29/2022 and an ISP was initiated on 11/29/2023 and 11/	ALR-0042  ER OR SUPPLIER  ALR-0042  STREET ADDRESS, CITY, STATE, ZIP CODE  1320 MAIN DRIVE, WASHINGTON, DC 20012  WASHINGTON, DC 20012  SUMMARY STATEMENT OF DEFICIENCIES THOEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  It induced From page 8.  Idmissions. In that interview, he acknowledged the resident agreements were not signed prior re resident admission as required.  It is the time of the survey, the ALR failed to ensure each resident agreement was signed prior to resident's admission.  It is admission.  It is developed for each resident to admission and ed on interview and record review, the Assisted grassidence (ALR) failed to ensure its stered Nurse (RN) developed an Individualized in the sample (Resident #1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, and 15).  It imgs included:  It is a summary in the sample of residents and monotofize/4/2023 through 05/26/2023 wed no evidence that the ALR's RN developed SP prior to resident's admission.  It is a bull by the sampled residents and insignificant are review of Resident medical record showed that the resident was itted on 11/29/2022 and an ISP was initiated on 9/2022, the day of admission.  It is a bull by the sampled residents and insignificant in the sample of the sampled residents and insignificant in the sample of the sampled residents and insignificant in the sample of the sampled residents and insignificant in the sample of the sampled residents and insignificant reviews have been approved. Once approved will complete a preliminary ISP dipreadmission assessment for those application from the discharge summary, pre-admission assessment for those application from the discharge summary. Pre-admission assessment for those application from the discharge summary. Pre-admission assessment for the ICPD Admission/An Medical Certification forms  3. QA Program Action to Monitor compliance of the pre-admission assessment for those application forms  3. QA Program Action to Monitor compliance of the pre-admission assessment for the ICPD	ALR-0042  B WING  ALR-0042  STREET ADDRESS, CITY, STATE, ZIP CODE  1320 MAIN DRIVE, WASHINGTON, DC 20012  WASHINGTON, DC 20012  SUMMARY STATEMENT OF DEPTICENCIES CHORNING INFORMATION)  PREDICTION OF LSC IDENTIFYING INFORMATION)  OR LSC IDENTIFYING INFORMATION)  PREDIX TAG  THE PROVIDERS PLAN OF CORRECTION EACH CORRECTION EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREDIX TAG  PREDIX TAG  PROVIDERS PLAN OF CORRECTION EACH CORRECTION EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREDIX TAG  PREDIX TAG  PROVIDERS PLAN OF CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  R 421  A BUILDING:  PROVIDERS PLAN OF CORRECTION EACH

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 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.

Health R	Health Regulation & Licensing Administration								
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUM		(X2) MULTIPLE A, BUILDING:	CONSTRUCTION		(X3) DATE S COM	SURVEY PLETED	
		ALR-0042		B, WING			05/2	26/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE				
ABRAM I	HALL AL OPCO, DBA A	ARKAM ASSILED		N DRIVE, WA TON, DC 20	SHINGTON, DC20012 0012				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGUNTIFYING INFORMATION)	JLATORY	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETE DATE	
R 471	Continued From pag	e 10,		R 471					
	Resident #10's medi resident was admitted	at 11:17 am, a review of cal record showed that ad on 01/19/2023 and a 9/2023, the same day	t the an ISP						
	Resident #11's medi resident was admitted	t 12:08 pm, a review or cal record showed that ed on 11/23/2022 and a 3/2022, the same day	t the an ISP						
	#12's medical record admitted on 01/10/20	t 2:15 pm, a review of I showed that the resid 023 and an ISP was ini e day of the admission	ent was itiated on						
	Resident #13's medi resident was admitte	t 12:36 pm, a review of cal record showed that d on 05/17/2023 and a 8/2023, the day after	the						
	Resident #14's medi- resident was admitte	t 10:40 pm, a review of cal record showed that d on 04/27/2023 and a 8/2023, one day after t	the In ISP						
	Resident #15's media resident was admitte	t 12:18 pm, a review of cal record showed that d on 09/06/2022 and a 9/2022, three days afte	the In ISP						
		on 05/26/2023 at 12:38 iinistrator (ALA) and the Nursing (ADON)							

Health R	Regulation & Licensing	Administration			FORM APPROVE	ΞD
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0042	B. WING		05/26/2023	
	ROVIDER OR SUPPLIER	ARPAM ASSITED 1320 MAIN		SHINGTON, DC20012		
		WASHING	TON, DC 20	0012		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E
R 471	acknowledged that t ISP prior to admission	he RN had not developed an	R 471			
R 475	surrogate, and a rep Based on interview a Living Residence (A resident's Individuali signed by the reside representative of the the sample (Resider 11, 12, 13, 14, and 1 Findings included:  1. On 05/24/2023 at #1's medical record initiated on 11/29/20 the Registered Nurse surrogate.  2. On 05/24/2023 at #2's medical record initiated on 05/26/20 the Registered Nurse surrogate.  3. On 05/24/2023 at #3's medical record initiated on 02/28/20 initiated on 02/28/20	be signed by the resident, or resentative of the ALR. and record review, the Assisted LR) failed to ensure that all zed Service Plans (ISPs) were nt, or surrogate, and a ALR for 15 of 20 residents in at #1, 2, 3, 4, 5, 6, 7, 8, 9, 10,	R 475	1. Corrective Action to be accomplished The DON and ADON have reviewed all r ISPs with the residents and obtained sig from the resident or surrogate to confirm participation and review in addition to the signature of a representative of the ALR.  2. Measures Implemented to ensure it d recur The admissions checklist will be updated include an ISP meeting with the resident surrogate.  3. QA Program Action to Monitor complicorrective measures The QA committee will review at least 10 resident charts monthly to ensure the redocuments are 100% complete. A recommination of the review.  4. Date to be completed: June 30, 2023	natures their oes not I and and/or ance with	

Health R	Regulation & Licensing	Administration					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE S COM	SURVEY IPLETED
		ALR-0042		B. WING		05/2	26/2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	ORESS, CITY, ST	ATE, ZIP CODE		
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R 475	Continued From pag	 je 12.		R 475			
	4. On 05/24/2023 at #4's medical record initiated on 05/05/20 the Registered Nurse surrogate.	showed that an IS 23. The ISP was n	SP was not signed by				
	5. On 05/25/2023 at #5's medical record initiated on 05/02/20 the Registered Nurse surrogate.	showed that an ISI 23. The ISP was n	SP was not signed by				
	6. On 05/24/2023 at #6's medical record sinitiated on 02/17/20 the Registered Nurse surrogate.	showed that an ISI 23. The ISP was n	P was not signed by				
	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.						
7	8. On 05/24/2023 at #8's medical record sinitiated on 10/03/202 the Registered Nurse surrogate.	showed that an ISI 22. The ISP was n	P was not signed by				
	9. On 05/24/2023 at #9's medical record s initiated on 02/03/202 the Registered Nurse surrogate.	showed that an ISF 23. The ISP was n	P was not signed by				
	10. On 05/25/2023 at Resident #10's medic was initiated on 01/1 signed by the Registe	cal record showed 9/2023. The ISP w	that an ISP vas not				

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STATEMEN <sup>®</sup>	Regulation & Licensing T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY MPLETED
		ALR-0042	B. WING	<del>-</del>	05/	26/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
ABRAM H	HALL AL OPCO, DBA	ABRAM ASSILED	N DRIVE, WA	SHINGTON, DC20012 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES  BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
R 475	Continued From pag	ge 13.	R 475			
	resident or a surroga	ate.				
	Resident #11's medi was initiated on 11/2	at 12:08 pm, a review of ical record showed that an ISP 23/2022. The ISP was not tered Nurse (RN), the resident				
	#12's medical recordinitiated on 01/10/20	at 2:15 pm, a review of Resident of showed that an ISP was 23. The ISP was not signed by e (RN), the resident or a				
	Resident #13's medi was initiated on 05/1	t 12:36 pm, a review of cal record showed that an ISP 8/2023. The ISP was not ered Nurse (RN), the resident	*			
	Resident #14's mediwas initiated on 04/2	t 10:40 pm, a review of cal record showed that an ISP 8/2023. The ISP was not ered Nurse (RN), the resident				
	Resident #15's medie was initiated on 09/0	at 12:18 pm, a review of cal record showed that an ISP 9/2022. The ISP was not ered Nurse (RN), the resident				
	Assistant Director of Living Administrator	on 05/26/2023 at 12:38 pm, the Nursing and the Assistant acknowledged that there was SP document as required.				
		vey, the ALR failed to ensure by a resident or surrogate				

Health F	Regulation & Licensing	Administration				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		ALR-0042	B. WING		05/26/2023	
NAME OF PROVIDER OR SUPPLIER  ABRAM HALL AL OPCO, DBA ABRAM ASSITED  STREET ADDRESS, CITY, STATE, ZIP CODE  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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
R 475			R 475			
R 478	and a representative of the ALR.  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 ISP, discharge summary and medical certiforms to update the current ISP based on medical, rehabilitation and psychosocial assessments. They are in the process of ueach ISP with the most current information  2. Measures Implemented to ensure it docrecur  Create a checklist to review the discharge summary, medical certification form and plorders with specific items for use the DON and AL to ensure that the AL records incorthe information from all sources. Any discretivenen sources will be clarified with the parameter provider.  3. QA Program Action to Monitor compliant corrective measures  The QA committee will review at least 10% resident charts monthly to ensure the required documents are 100% complete. A record maintained of the review.  4. Date to be completed: June 30, 2023	fication their  pdating  bes not  mysician //ADON reporate repancies orimary  more with  sof uired	

FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 478 Continued From page 15: R 478 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

Health Regulation & Licensing Administration								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NOWIDER.	A. BUILDING:		COMPLETED			
	ALR-0042		B, WING		05/20	05/26/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATE, ZIP CODE					
ABRAM HALL AL OPCO, DBA ABRAM ASSITED  1320 MAIN DRIVE, WASHINGTON, DC 20012  WASHINGTON, DC 20012								
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION							
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE		
				BEI IOIENOT)				
R 478	Continued From page 16.		R 478					
	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	6/06/2022 failed to reflect any						
	to latex, codeine, po	ventions to address her allergy ork, and nuts.						
	During interview on	05/24/2023 at 2:00 pm, the						
	Assistant Director of	Nursing (ADON) said that she						
		a mental assessment by the ered, and that she will made an						
		n as possible. The ADON also hese concerns should have						
		e resident's current ISP.						
		rvey the ALR failed to ensure all						
		e developed ISP based on their on, and psychosocial						
	assessment.	in, and poyonocoda.						
R 483	Sec. 604d Individual	lized Service Plans	R 483					
	(d) The ISP shall be	e reviewed 30 days after						
	admission and at lea	ast every 6 months thereafter.						
		dated more frequently if there is in the resident's condition.						
	The resident and, if I	necessary, the surrogate shall			ľ			
		ate in each reassessment. The lucted by an interdisciplinary						
	team that includes th	ne resident's healthcare						
	necessary, and the	dent, the resident's surrogate, if						

Health Regulation & Licensing Administration STATE FORM

Health Regulation & Licensing Administration								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		ISERVII IOMISER.						
		ALR-0042	B. WING		05/2	6/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE				
ABRAM HALL AL OPCO, DBA ABRAM ASSITED  1320 MAIN DRIVE, WASHINGTON, DC 20012  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 483	ALR. Based on interview, Assisted Living Resi each resident's Indiv was reviewed I) 30 of every six months, III changes, and IV) the by the resident's hear resident and/or the resident a	and record reviews, the idence (ALR) failed to ensure vidualized Support Plan (ISP) days after admission, II) at least ) updated with significant at the ISPs had been reviewed althcare practitioner, the resident's surrogate, for 15 of the sample (Residents #1, 2, 3, 1, 12, 13, 14, and 15).  Treview each resident's ISP 30 th, as follows:  1:00 pm, a review of Resident showed that the resident was 1023. The ISP was initiated on 123. The ISP was initiated on 123. The ISP was initiated on 124 thereafter.  11:16 am, a review of Resident showed that the resident was 1023. The ISP was initiated on 123. The ISP was initiated on 124 the ISP was initiated on 125 the ISP was initiated 125 the ISP was in	R 483	R483  1. Corrective Action to be accomplished The DON/ADON have reviewed the ISP fresident who has resided with us for at le days. They are completing the 6-month rwell as those of any resident who has has significant change. They are also schedureview meetings with the residents and/or surrogates. Updated ISPs are being shar providers for their review as well.  2. Measures Implemented to ensure it do recur  The DON will ensure that a 30-day post a IDT ISP meeting is conducted and the resident and/or their surrogate and their healthcar will be invited to participate. The same wevery 6 months or more frequently if there change in condition.  3. QA Program Action to Monitor compliate corrective measures  The QA committee will review a report of residents that includes their date of admisensure that ISP's are being reviewed at 3 post admission, at least every 6 months that and upon any significant change in condition ALA will review to ensure that all parties invited to participate and sign.  4. Date to be completed: July 7, 2023	ast 30 reviews, as d a alling ISP r their red with  bes not admission sident e provider rill be done e is a ance with  all ssion to 60-days hereafter, tion. The			

Health R	Regulation & Licensing	Administration			PORI	VI APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
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R 483	no evidence that the e. On 05/24/2023 at #9's medical record admitted on 02/01/2 02/03/2023. There was reviewed therea f. On 05/25/2023 at #10's medical record admitted on 01/19/2 01/19/2023. There was reviewed therea g. On 05/25/2023 at #11's medical record admitted on 11/23/2 11/23/2022. There was reviewed therea h. On 05/25/2023 at #12's medical record admitted on 01/10/2 01/10/2023, however the ISP was reviewed i. On 05/25/2023 at #15's medical record admitted on 09/06/20 09/09/2022, however the ISP was reviewed li). The ALR failed to every six months, as a. On 05/24/2023 at #8's medical record admitted on 10/02/20	a ISP was reviewed thereafter.  12:08 pm, a review of Resident showed that the resident was 023. The ISP was initiated on was no evidence that the ISP after.  11:17 am, a review of Resident dishowed that the resident was 023. The ISP was initiated on was no evidence that the ISP after.  12:08 pm, a review of Resident dishowed that the resident was 022. The ISP was initiated on was no evidence that the ISP after.  2:15 pm, a review of Resident dishowed that the resident was 023. The ISP was initiated on rr, there was no evidence that dishowed that the resident was 023. The ISP was initiated on rr, there was no evidence that dishowed that the resident was 022. The ISP was initiated on rr, there was no evidence that dishowed that the resident was 022. The ISP was initiated on rr, there was no evidence that showed that the resident was 022. The ISP was initiated on rr, there was no evidence that showed that the resident was 022. The ISP was initiated on rr, there was no evidence that				

Health R	Regulation & Licensing	Administration		×		010	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0042		B. WING		05/2	26/2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
ABRAM I	HALL AL OPCO, DBA	ABRAM ASSITED		N DRIVE, WA	SHINGTON, DC20012 0012		
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R 483	Continued From pag	je 19,		R 483			
K 483	b. On 05/25/2023 at #15's medical record admitted on 09/06/20 09/09/2022, however the ISP was reviewed.  III). The ALR failed to resident's ISP after a condition of the police were called transported to an area evaluation. The resident the police were called transported to an area evaluation. The resident of bipolar disorder.  A review of the resident the resident's paddressed with strate a. On 05/24/2023 at #3's medical record stated 04/25/2023, shadmitted for Heart far mass. The discharge the resident should rechanical soft diet. 02/28/2023 failed to failure exacerbation and interventions to in Furthermore, the currents.	12:18 pm, a review of showed that the social thereafter. The review and update a significant change of the served outside and accility. After several to come back into d, and the resident was hospitalized the resident had sent to come back into a hospital for a postent was hospitalized the resident had show documented sychiatric concerns segies to manage the summary recommence in the resident #3's ISF reflect the diagnost and renal mass or manage these commencers.	resident was initiated on idence that the each e, as follows:  If the ALR's 2023, the refused to all attempts to the facility the was eychiatric and a diagnosis on the facility of Resident was and renal mended that is alt, and goals acerns.	R 483			
	resident should recei soft diet.	ve no added sait,	mechanical				

Health Regulation & Licensing Administration

Health R	egulation & Licensing	Administration			TOTAN	AITROVED
STATEMEN"	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDFLAN	of correction	IDENTIFICATION NOMBER.	A, BUILDING	<del>.</del> .		
		ALR-0042	B, WING		05/2	6/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
ADDAMI	HALL AL OPCO, DBA	ARRAM ASSITED 1320 MAIN	I DRIVE, WA	SHINGTON, DC20012		
ADRAWI	TALL AL OFCO, DBA	WASHING	TON, DC 20	0012		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  BE PRECEDED BY FULL REGULATORY	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		NTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
				,		
R 483	Continued From pag	ge 20,	R 483			
		12:03 pm, a review of Resident are Facilities Admission/Annual				
		form dated 02/14/2023 showed				
		Dementia and the physician				
		needed a mental assessment A review of Resident #3's ISP				
	dated 02/28/2023 fa	iled to reflect the diagnosis of				
		ric concerns or any goals and nage these concerns. There was				
		dence in the record of strategies				
	to manage the resid	ents Dementia and Psychiatric				
	concerns.					
		on 05/24/2023 at 2:00 pm, the				
		f Nursing (ADON) said that she				
		a mental health assessment by ordered, and that she will make				
	an appointment as s	soon as possible. The ADON				
		that these concerns should				
	nave been updated	on the resident's current ISP.				
		2:40 pm, a review of Resident				
		are Facilities Admission/Annual form dated 04/21/2023 showed				
		d a diagnosis of Diabetes				
	Mellitus and an orde	er for no concentrated sweets				
		sident #5's current ISP dated reflect the diagnosis of		GMC		
		ne residents current diet order				
		sweets diet or any goals and				
	interventions to mar	nage these concerns.				
		2:06 pm, a review of the ALR's				
		wed that on 05/15/2023 und on the floor in her unit				
	TOSIGETT #O Was TO	and on the hoof in her diffic				

Health Regulation & Licensing Administration

Health R	egulation & Licensing	Administration				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED	
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		ALR-0042	B. WING		05/2	6/2023
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER					
ABRAM I	HALL AL OPCO, DBA	ARRAM ASSILED	TON, DC 20	SHINGTON, DC20012 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
R 483	Continued From pag	ge 21.	R 483			
	near the bathroom.	The resident was unresponsive				
		nd had a pulse. The resident				
		e nurse and transported to the				
		iew of the resident's current ISP				
		23 failed to show evidence that ponsiveness resulting in a				
		addressed with strategies to				
	manage it.					
	e. On 05/23/2023 at	3:15 pm, a review of the ALR's				
		wed the following incidents				
	regarding Resident	<b>#7</b> :				
	• • • •	esident #7 was observed with ss and unsteady gait. The				
	resident said, "I feel	weak, and I went to my room to				
		de balcony." The resident was				
		se and an elevated blood sugar was obtained. The resident				
		ansported to the hospital via				
		s diagnosed with hypoglycemia,				
	and had a contusion	i to the hip.				
		that on 02/07/2023, Resident #7				
	•	twice the previous day. The				
	walker in his room.	when he tried to walk using his				
	3 According to the r	report, on 03/04/2023, Resident				
		om. The resident said he felt				
	dizzy, complained of	f soreness to his right leg and				
	was medicated for the	ne pain.				
	4. On 03/30/2023, R	esident #7 the resident said he				
	felt dizzy. The reside	ent was assessed by the nurse,				
		f 315 mg/DI was noted. The				
		orted to the hospital and ed for an acute head injury.				
	subsequently aumitt	ed for all acute flead flighty.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  ALR-0042  NAME OF PROVIDER OR SUPPLIER  ABRAM HALL AL OPCO, DBA ABRAM ASSITED  ARRAM HALL AL OPCO, DBA ABRAM ASSITED  (A4) ID (A4) ID (A4) ID (A5) I	Health R	egulation & Licensing	Administration			FORIV	APPROVED
NAME OF PROVIDER OR SUPPLIER  ABRAM HALL AL OPCO, DBA ABRAM ASSITED  (EACH DEFICIENCY MUST EPRECEDED BY FULL RESULATIONY TAGS  FOR USE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE_ZIP CODE  1320 MAIN DRIVE, WASHINGTON, DC 20012  WASHINGTON, DC 20012  (MASHINGTON, DC 20012  (EACH DEFICIENCY MUST STATEMENT OF DEFICIENCIES IDDRESS OF THE PRECEDED BY FULL RESULATIONY TAGS  ORL SG DESTRIPTION ON PROMATION OF THE PRECEDED OF THE RESULATIONY TAGS  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 in the progress of the prog	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X				
NAME OF PROVIDER OR SUPPLIER  ABRAM HALL AL OPCO, DBA ABRAM ASSITED  1320 MAIN DRIVE, WASHINGTON, DC 20012  WASHINGTON, DC 20012  (A4)ID  GEACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG  CONTINUED TO THE PROPRIET TO THE PROPRIET OF DEPICIENCES  SUMMAPY STATEMENT OF DEPICIENCY OR LISC IDENTIFYING INFORMATION)  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 fails, however the fails on 01/03/2023, 2/07/2023, were not documented with strategies to manage it. In addition, the ISP has a focus area for fails, however the fails and the even as a recommendation for a Psychiatric follow up. Further review of the residents ISP dated 10/03/2022 showed a focus area of fails and there was a recommendation for a Psychiatric follow up. Further review of Resident #8's nursing progress notes showed that the resident had repeatedly failen 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 to manage the resident's Psychiatric in the patients of the resident of the resident of the psychiatric to manage the resident and repeatedly failen 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	AND PLAN (	JF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED	
ABRAM HALL AL OPCO, DBA ABRAM ASSITED  1320 MAIN DRIVE, WASHINGTON, DC 20012  WASHINGTON, DC 20012  (A4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX FARS  (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 488 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 it. By a care for falls, however the falls on determined and the expectation 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 to manage the resident branch page fallen on 10/14/2022, 12/10/2022			ALR-0042	B. WING		05/2	26/2023
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
MASHINGTON, DC 20012   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY   DPREFIX TAG   CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY   DPREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   COMMETTE   DPREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY)    R 483   Continued From page 22.   S. On 04/02/2023, Resident #7 complained of dizziness. The nurse assessed the resident and noted that his blood sugar was 468 mg/DI. 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 sign 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	ADDAML	ALL AL ORCO DRA	ADDAM ASSITED 1320 MAIN	I DRIVE, WA	SHINGTON, DC20012		
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/Di. 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 it. In addition, the ISP has a focus area for 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 08/12/2022 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, 12/10/0202 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	ADRAWI	MLL AL OPCO, DBA	WASHING	TON, DC 2	0012		
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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	R 483	Continued From page	ge 22.	R 483			
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		5. On 04/02/2023, R dizziness. The nurse noted that his blood resident was transportant was a recipional was	desident #7 complained of assessed the resident and sugar was 468 mg/Dl. The orted to the hospital via desident #7's current ISP initiated to show evidence that the emia, and weakness resulting in readdressed with strategies to on, the ISP has a focus area for Ils on 01/03/2023, 2/07/2023, and with strategies to manage the diagnosis of Schizophrenia form dated 06/12/2022 showed a diagnosis of Schizophrenia ommendation for a Psychiatric view of the residents ISP dated a focus area of falls and attinued review of Resident #8's tes showed that the resident to on 10/14/2022, 12/10/2022 eview of Resident #8's current to on 10/14/2022, 12/10/2022 eview of Resident				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R 483 R 483 Continued From page 23. 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.

Health Regulation & Licensing Administration

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 483 R 483 Continued From page 24. 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

practitioner, the resident

the ISP was reviewed by the resident's healthcare

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRFFIX TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 483 Continued From page 25. R 483 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

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:\_\_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 483 Continued From page 26. R 483 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 511 Sec. 606 1 Resident Records R 511

additional agreements.

(1) The resident agreement required by this title, including the "Resident's Rights" statement and any

Based on interview, record review and attempted record review, the Assisted Living Resident (ALR)

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 511 Continued From page 27. R 511 R 511 1. Corrective Action to be accomplished failed to maintain the record of the resident's Resident Agreement for one of the 20 residents in Resident #4 was asked to sign the Residency the sample (Resident #4) and a signed resident's Agreement on 5/25/23 while the survey was being right for one of the 20 residents in the sample conducted and she refused at the time. Staff were attempting to contact her surrogate to have them (Resident #14). assist her with signing, when she went out of the building on personal leave and had an injury that The finding includes: resulted in hospitalization. The resident or her surrogate will be required to sign the Residency a). During the entrance interview with the Assisted Agreement upon her return from short-term rehab. Living Administrator (ALA) on 05/23/2023 at Resident #14 has signed the receipt of Resident's approximately 11:15 am, the ALA was asked for a Riahts. copy of the Resident Agreement, for the residents in the samples. The ALA returned with some 2. Measures Implemented to ensure it does not recur resident's Resident Agreement but indicated that she was unable to locate Resident #4's agreement. The Admissions Director and ALA will review the In a further interview on 5/24/2023 at 2:00 pm. the Financial File of each resident to ensure that all ALA stated she will continue to look for the record documents have been accurately completed and but still could not find it at this time. On 05/26/2023, signed before the resident file is considered complete. the surveyor requested again to see Resident #4's resident agreement for review. 3. QA Program Action to Monitor compliance with corrective measures After attempting to locate the resident's record, the The QA committee will review at least 10% of ALA said the record could not be located. resident charts monthly to ensure the required documents are 100% complete. A record will be b). On 5/25/2023 at approximately 10:32 am, a maintained of the review. review of Resident's # 14 resident agreement dated 4. Date to be completed: June 23, 2023 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.

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 523 Continued From page 28. R 523 R 523 Sec. 607a2 Services to Be Provided R 523 1. Corrective Action to be accomplished (2) Three nutritious and attractive meals and additional snacks, modified to individual dietary The RN has completed a review of each resident's medical record to ensure that a diet order is needs as necessary, on a daily basis. identified and provided the Dining Services Based on observations, interview and record department with an updated list of all residents and reviews, the Assisted Living Residence (ALR) failed their diet orders. to provide meals on a daily basis that were modified 2. Measures Implemented to ensure it does not to the resident's dietary requirements for three of recur the 20 residents in the sample. (Resident #3, 5, and 10) The admissions checklist has been updated to include the diet order communication from Nursing to Dining. The RN will ensure that an updated diet Findings included: order report will be provided to dining services each time there is a new diet order or a diet order On 05/23/2023 at 12:07 pm, the residents were change. observed eating lunch in the dining area. The menu 3. QA Program Action to Monitor compliance with consisted of Pork chops, stuffed peppers, corrective measures cauliflower, carrots, rice, and sauce. There was no alternative menu for modified diet observed during The QA committee will ensure the diet orders lunch time. match the diet order report for each resident chart they review. A record will be maintained of the review. A review of the resident records from 05/24/2023 - 05/25/2023 showed the following 4. Date to be completed: June 30, 2023 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.

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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
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D 500	On the second France and	- 20	D 500			
R 523	Continued From pag	je 29.	R 523			
	c). On 05/25/2023 a	t 11:17 am, a review of				
		ical record showed that the				
		nosis of Diabetes Mellitus with				
		nutritional anemia. A further ediate Care Facilities				
		nedical certification form dated				
		e resident required a regular no				
	concentrated sweets					
		t 1:03 pm, a review of Resident				
		ication form dated 06/06/2022 ident had an allergy to pork and				
	nuts.	dent had an allergy to pork and				
	1100					
		on 05/24/2023 at 10:22 am,				
		that she has Diabetes Mellitus,				
		on a no concentrated sweets				
		the ALR mostly cooks beans, nich she should not be eating				
	due to her condition.					
		2:16 pm, an interview with the				
		vices (DFS) showed that the				
		ware of is a resident with a ther stated that there were no				
	residents on a calori					ľ
		2:16 pm, during an interview				
		ving Administrator (ALA), the				
		er of Resident #10's concern.				
	THE ALA Said that Si	ne would speak with the DFS.				
	At the time of the sur	rvey the ALR failed to provide				
		dified to the resident's dietary				
	needs as necessary					
R 669	Sec. 702b Staff Train	nina	R 669			
	555. 1525 Glair Hall	······································				
	(b) Within 7 days of	femployment, an ALR shall				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:\_ B: WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 669 Continued From page 30. R 669 R669 train a new member of its staff as to the following: 1. Corrective Action to be accomplished Based on record review and interview, the Assisted Each of the employees identified as missing the Living Resident (ALR) failed to ensure that eight of required orientation are completing the mandatory 15 newly hired staff received the required new employee orientation. orientation within seven days of employment (Employees #1, 2, 3, 6, 7, 8, 10 and the Assistant 2. Measures Implemented to ensure it does not recur Director of Nursing). A Mandatory New Employee Orientation will be Findings included: 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 On 05/25/2023 beginning at 9:48 am, review of the within their first 7 days of employment. personnel files showed the following: 3. QA Program Action to Monitor compliance with 1. Review of the ALR's "Employee File Checklist" corrective measures form showed that Assistant Director of Nursing The Business Office Director will supply a report on (ADON) was hired on 01/19/2023. Further review of all staff and contracted personnel monthly for the the checklist form showed a blank space with New QA Committee, which will include the status of all Hire Orientation Form (Completed by end of 1st required orientation and training. A record will be maintained of the review. week) that was not marked as having been completed in section 5. 4. Date to be completed: June 30, 2023 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. 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

Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 669 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. 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

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 669 R 669 Continued From page 32. 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 R 704 Sec. 802a Medical, Rehabilitation, Psychosocial Assess. (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:

Health Regulation & Licensing Administration

FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: \_ B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R 704 R 704 Continued From page 33. R704 1. On 05/25/2023 at 12:18 pm, a review of Resident 1. Corrective Action to be accomplished #15's clinical record showed that the resident was This resident was the very first to be admitted to admitted on 09/06/2022. Further review of the Abrams AL. Since then, the team has been Medical Certification Form showed it was completed verifying that the ICFD Admission/Annual on 06/06/2022, 3 months prior to admission. Medical Certification form is dated no more than 30-days prior to admission. During an interview on 05/26/2023 at 12:40 pm, the 2. Measures Implemented to ensure it does not Assistant Director of Nursing (AD) and the Assistant recur Living Administrator acknowledged that the assessment was not completed within 30 days of The DON and ALA will both review the ICFD Admission/Annual Medical Certification form to admission. The AD said during the interview that he ensure the primary care provider has fully receives the Medical Certification Form and ensures completed it no more than 30 days prior to its completeness within the 30 days window. He scheduled admission. further said that he is new to the position and will 3. QA Program Action to Monitor compliance make sure the documents are accurate moving with corrective measures forward. The QA committee will review at least 10% of At the time of the survey, the ALR failed to ensure resident charts monthly to ensure the required each resident's medical, rehabilitation, and documents are 100% complete. A record will be maintained of the review. psychosocial assessment of each resident was completed within 30 days prior to admission. 4. Date to be completed: June 23, 2023 R 705 Sec. 802b Medical, Rehabilitation, Psychosocial R 705 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

Health Regulation & Licensing Administration

was completed with all

Assisted Living Residence (ALR) failed to ensure each resident's Intermediate Care Facilities Division Admission (ICFD) /Annual Medical Certification form Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING. **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 705 Continued From page 34. R 705 R705 information required for 15 of the 20 residents in the 1. Corrective Action to be accomplished sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15). We have requested updates to the ICFD Admission/Annual Medical Certification form for each of the residents identified from their primary Findings included: care provider. The ALR failed to ensure each resident's (ICFD) 2. Measures Implemented to ensure it does not Admission/Annual Medical Certification Form was completed with all assessment areas addressed as The DON and ALA will both review the ICFD follows: Admission/Annual Medical Certification form to ensure the primary care provider has fully 1. On 05/24/2023 at 1:52 pm, a review of Resident completed it prior to scheduling a move-in, and on annual renewal. #1's (ICFD) Admission/Annual Medical Certification form dated 11/02/2023 showed no documented 3. QA Program Action to Monitor compliance with evidence that the physician assessed if the resident corrective measures had or needed a mammogram, pap smear test, and The QA committee will review at least 10% of prostate-specific antigen (PSA) test, any skin resident charts monthly to ensure the required integrity issues, dental health concerns to include documents are 100% complete. A record will be dentures, tuberculosis status, and if the resident maintained of the review. was exhibiting signs or symptoms suggestive of a communicable disease. The physician also failed to 4. Date to be completed: document a list of the resident's current Requests made to providers by 6/23/23, expected medications, including any supplements and deadline for provider compliance is 07/07/23. 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

Health R	Regulation & Licensing					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0042	B. WING		05/2	6/2023
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ABRAM I	HALL AL OPCO, DBA A	ABRAM ASSILED	N DRIVE, WA	SHINGTON, DC20012 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES  BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
R 705	Continued From page assessed the resident had any allergies, us tetanus, influenza, on non-prescription meet the reason for admission circle if the resident of term medical or nurs would require placer or needed 24-hour indocumented under the attached medication attachment to the document to the document to the document or a clonoscopy. The facility's name and physician documents see attachment, how to the document.  5. On 05/25/2023 at #5's (ICFD) Admission document.  5. On 05/25/2023 at #5's (ICFD) Admission document.  5. On 05/25/2023 at #5's (ICFD) Admission document.	ge 35.  Int's vital signs, if the resident ses tobacco or alcohol, had a present procumental vaccine, uses dication, and failed to include asion. The physician failed to needed continued acute or longuing care or supervision which ment in a hospital/nursing home pursing care. The physician he medication list to see list, however, there was no ocument.  1:45 pm, a review of Resident con/Annual Medical Certification 23 showed no documented sysician assessed if the resident element ad allergies, if they leded a Papanicolaou (pap) test the physician failed to document and present address. The led under the medication list to rever, there was no attachment at the physician assessed if the resident con/Annual Medical Certification 23 showed no documented sysician assessed if the resident less tobacco or alcohol, had a lan influenza vaccine, and if the rescription medication. The ocument if the resident had	R 705			
	6. On 05/24/2023 at	11:16 am, a review of				

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A BUILDING: B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) R 705 Continued From page 36. R 705 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

Health Regulation & Licensing Administration

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) R 705 Continued From page 37. R 705 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

PRINTED: 06/13/2023 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) R 705 Continued From page 38. R 705 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.

to see attachment.

The physician documented under the medication list

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING. **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 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 R 709 Assess. (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)

Health Regulation & Licensing Administration

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 709 Continued From page 40. R 709 R709 Admission/Annual Medical Certification Form was 1. Corrective Action to be accomplished completed with all assessment areas addressed as follows: The DON has requested provider updates to the ICFD) Admission/Annual Medical Certification Form for the 2 residents, so that it matches all other 1. On 05/24/2023 at 12:03 pm a review of Resident medical records. The resident records have been #3's (ICFD) Admission/Annual Medical Certification updated with their known allergies. form dated 02/14/2023 showed no documented evidence that the physician assessed the residents 2. Measures Implemented to ensure it does not for the presence of allergies. The DON and ALA will both review the ICFD 2. On 05/25/2023 at 2:25 pm A review of Resident Admission/Annual Medical Certification form to #5's (ICFD) Admission/Annual Medical Certification ensure the primary care provider has fully completed it prior to scheduling a move-in, and on form dated 04/21/2023 showed no documented annual renewal. evidence that the physician assessed the residents for the presence of allergies. 3. QA Program Action to Monitor compliance with corrective measures In an interview on 05/26/2023 at approximately The QA committee will review at least 10% of 12:40 pm, the Assistant Director of Nursing and the resident charts monthly to ensure the required Assistant Living Administrator acknowledged the documents are 100% complete. A record will be omission of the information and gave no additional maintained of the review. information. In another interview with the 4. Date to be completed: June 23, 2023 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 710 Sec. 802 4 Medical, Rehabilitation, Psychosocial R 710 Assess.

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R 710	Continued From pag	je 41.	R 710			
				R710		
		nat the applicant is free from		Corrective Action to be accomplished		
		nd from other active, infectious,				
	and reportable comr	nunicable diseases.		The DON and ADON have reviewed every chart to ensure that the provider provided a		
	Rased on interviews	and record reviews, the		response on the ICFD Admission/Annual M Certification Form regarding being free from		
		dence (ALR) failed to ensure		communicable TB and other active, infection	ous and	
		ree from communicable TB and		reportable communicable diseases. For the where the provider did not provide a respor		
		us, and reportable		new test has been completed and documer		
	the sample (Resider	ases for 4 of the 20 residents in		2. Measures Implemented to ensure it doe	s not	
		113 #1, 5, 10 and 15).		recur	S HOL	
	Findings included:			The DON and ALA will both review the ICF		
	The ALR failed to en	sure each resident's	`	Admission/Annual Medical Certification for ensure the primary care provider has fully	rm to	
		acilities Division (ICFD)		completed it prior to scheduling a move-in,	and on	
	Admission/Annual M	ledical Certification Form was		annual renewal.		
		with the following areas not sessment form as noted below:		QA Program Action to Monitor complian corrective measures	ce with	
	1. On 05/24/2023 at	1:52 pm, a review of Resident		The QA committee will review at least 10%		
	#1's (ICFD) Admission	ission/Annual Medical Certification		resident charts monthly to ensure the required documents are 100% complete. A record v		
		23 showed no evidence that the		maintained of the review.		
		that the applicant was free from and other active, infectious, and		4. Date to be completed: June 23, 2023		
	reportable communic			·		
		12:15 pm, a review of Resident on/Annual Medical Certification				
		23 showed no evidence that the				
1		that the applicant was free from				
		nd other active, infectious, and				
	reportable communic	able diseases.				
	3. On 05/25/2023 at	11:17 am, a review of Resident				
	#10's (ICFD) Admiss					
	Certification form dat	ted 01/13/2023 showed no				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING **ALR-0042** 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 710 Continued From page 42. R 710 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 711 Sec. 802 5 Medical, Rehabilitation, Psychosocial R 711 Assess. (5) Current medication profile and projected and other needed medications, treatments, and service; review of nonprescription drugs and review of possible adverse interactions.

Health Regulation & Licensing Administration

Health F	Regulation & Licensing	Administration				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
R 711	Based on record rev Assisted Living Resi the current medication the facility was do Care Facilities Divisi Medical Certification 12, 13, 14, and 15)  Findings included:  1. On 05/24/2023 at #1's ICFD Admission form dated 11/02/20 evidence that the phresident's current mesupplements and vita 2. On 05/24/2023 at #3's ICFD Admission form dated 02/14/202 evidence that the phresidence that the phresident's record showed the medication list to however, there was resident 04/21/202 at #5's ICFD Admission form dated 04/27/202 evidence that the phresident's record showever, there was resident's record showever, there was resident of the medication list to however, there was residented 04/21/202 at #5's ICFD Admission form dated 04/21/202 at #5's ICFD Admission form dated 04/21/202	iews and interviews, the dences (ALR) failed to ensure ons for nine of the 20 residents cumented in the Intermediate on (ICFD) Admission/Annual Form (Resident #1, 3, 4, 5, 10, 1:52 pm, a review of Resident n/Annual Medical Certification 23 showed no documented ysician documented a list of the edications including any amins.  12:03 pm, a review of Resident n/Annual Medical Certification 23 showed no documented ysician assessed if the resident resident ysician assessed if the resident	R 711	R711  1. Corrective Action to be accomplished  We have requested updates to the ICFD  Admission/Annual Medical Certification forr of the residents identified from their primary provider to include a list of the resident's cu medications including any supplements and vitamins.  2. Measures Implemented to ensure it does recur  The DON and ALA will both review the ICF  Admission/Annual Medical Certification forsensure the primary care provider has fully of it prior to scheduling a move-in, and on ansidered and on ansidered and on the corrective measures  The QA committee will review at least 10% resident charts monthly to ensure the required documents are 100% complete. A record of maintained of the review.  4. Date to be completed:  Requests made to providers by 6/23/23, ex deadline for provider compliance is 07/07/2	care irrent d s not  D n to completed ival  ce with  of ired vill be	

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: ALR-0042 B. WING 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 711 Continued From page 44. R 711 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

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) R 711 Continued From page 45. R 711 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 961 Sec. 1002 1 Fire Safety. R 961 (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

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B: WING ALR-0042 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 961 Continued From page 46. R 961 R961 said during an interview that the ALR staff shift 1. Corrective Action to be accomplished 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 The ALA will ensure that fire drills are completed on each shift, each quarter. Additional drills have Friday. The administrator stated that the weekend been completed. staff shift hours were the same as the weekday shift hours. 2. Measures Implemented to ensure it does not recur At 2:13 pm, a review of the facility's Fire Drill report book showed there were only three fire drills An annual checklist of required drills (1 per shift, per quarter) has been created and responsibility conducted between September 2022 to 05/23/2023 assigned. (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 3. QA Program Action to Monitor compliance with corrective measures other fire drills made available for review. This was confirmed through an interview with the Assisted The binder of fire drills including the annual Living Administrator at 2:33 pm. The surveyor schedule, completed forms and training shared with the Assisted Living Administrator that documents will be reviewed by the QA committee fire drills should be conducted quarterly on each at least quarterly. shift. The Assisted Living Administrator stated to the 4. Date to be completed: June 30, 2023 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. R1003 Sec. 1006c Bathrooms. R1003 (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

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE COM	SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER			FATE, ZIP CODE		
ABRAM	HALL AL OPCO, DBA		TON, DC 2	ASHINGTON, DC20012 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	temperature does not Fahrenheit. Based on observation reviews, the Assisted to ensure water temperature and bath and 309) and one direction the First Floor.  Findings included:  On 05/23/2023 begin walk-through of the fishowed the following - At 1:03 pm, the kitcocated in Apartment temperature reading 120.2 °F.  - At 1:09 pm, the kitcocated in Apartment temperature reading 118.8 °F. The survey administrator that hot not exceed 110 °F.  - At 1:17 pm, the dining the kitchen on the first temperature reading to Administrator called to (Employee #13), who the walk-thru in the difloor at 1:23 pm. Emphad water temperature and 117.0 °F in the unthe hot water temperature and 117.0 °F in the unthe hot water temperature and 117.0 °F in the unthe hot water temperature temperature and 117.0 °F in the unthe hot water temperature and 117.0 °F in the	of exceed 110 degrees  ans, interviews and record d Living Residence (ALR) failed beratures did not exceed 110 (°F), for two of the two room sinks in (Apartments #202 ning room hand sink located on  aning at 12:57 am, a acility with the Administrator  thenette and bathroom sinks #202 showed a water that measured 120.0 and  thenette and bathroom sinks #309 showed a water that measured 119.3 and or shared with the water temperatures should  and room hand sink located in the floor showed a water that measured 116.8 °F. The	R1003	R1003  1. Corrective Action to be accomplished The water temperature being delivered to Assisted Living has been changed so that not exceed 110 degrees Fahrenheit.  2. Measures Implemented to ensure it do recur The staff will monitor water temperatures i resident apartments and keep a written reany water temperatures exceed 110 degre Fahrenheit the property management con and the engineer who controls the water dwill be notified and corrective action taken 3. QA Program Action to Monitor compliant corrective measures The log of water temperatures will be revieduring the monthly QA meeting. A record maintained of the review.  4. Date to be completed: June 30, 2023	es not  n cord. If ees npany elivery nce with	

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ALR-0042 B. WING 05/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1320 MAIN DRIVE, WASHINGTON, DC20012 ABRAM HALL AL OPCO, DBA ABRAM ASSITED WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) R1003 Continued From page 48. R1003 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.