Health Reciulation & Licensmq Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A BUILDING:

(X3) DATE SURVEY COMPLETED

ALR-0041

B WING _ _ _ _ _ _

02/04/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTHERN AVE SPILLC DBA LIVINGSTON AT 4656 LIVINGSTON ROAD, SE

WASHINGTON, DC 20032

(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)

(XS) COMPLETE

R 000: Initial Comments

R 000

0000 Initial Comments
An annual licensure survey was conducted on 02/01/2022, 02/02/2022, 02/03/2022 and 02/04/2022 to determine compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 49 residents and employed 51 personnel, to include professional and administrative staff. A random sample of 16 resident records and 17 employee records were; selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record reviews, and resident and staff interviews.

R 146 10113.1 Individualized Service Plans (ISPs)

R 146

10113.1 An ISP shall be developed for each resident not more than thirty (30) days prior to admission.

Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure each resident had a pre-admission Individual Service Plan (ISP) completed within 30 days prior to admission, for sixteen of 16 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and #16).

Findings Included:

1. On 02/02/2022 at 10:09 AM, review of Resident #1's medical record showed that the resident was admitted to the assisted living residence on 06/03/2021. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

R 146 It is the intent of Livingston Place at Southern Ave to provide safe and appropriate care within the regulations set forth by the DOH.

Livingston Place at Southern Ave (LP) will develop and IPS for each resident not more than 30 days prior to admission to the community.

LP will use the new move in checklist (attached) as an audit tool to ensure that all ISP's are completed prior to the time of admission to the community. The Executive Director or designee will review all documentation and indicate on the audit tool that all necessary steps have been completed prior to the resident being admitted. This will be kept in the resident file.

All new move in check lists will be reviewed by the Executive Director or Designee prior to move in to ensure that all necessary steps have been completed. The ED or Designee will review 100% of these files for the first 30 days. 50% of move ins will be audited by the ED or Designee for the next 30 days. 10% of new move in files will be audited quarterly by the ED or Designee on an ongoing basis after the first 60 days of audits.

Implementation 3/7/2022 Completion of initial 100% audit 3/9/22

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

Cool Coberson

3/0/22

(X6) DATE

Heath Reaulation & Lice	nsina Administration		-110-110-10U	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	3.4-2.5.0 Paye 111.	CONSTRUCTION	COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NOWIBER.	A BUILDING: _		1
	ALR-0041	B WING _ =		02/04/2022
	STREET A	DDRESS, CITY, ST/	ATE, ZIP CODE	
NAME OF PROVIDER OR SUPP	4656 LIV	INGSTON ROA	D, SE	
SOUTHERN AVE SP LLC	DBA LIVINGSTON AT WASHIN	GTON, DC 200		RRECTION (X5)
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	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE
TAG REGULATORY	M. M.		DEFICIENCY)	
R 146 Continued From	m page 1	R 146		
. 2. At 11:59 AM	, review of Resident #S's medical	1		
record showed	that the resident was admitted to			
the assisted liv	ving residence on 07/08/2021.	91		
Further medic	al record review failed to show			
documented e	vidence that a pre-admission			
individual serv	ice plan was conducted to resident's service needs.	1		
determine the	resident's service needs.			
3 At 1:20 PM	review of Resident #2's medical		2.0	
record showed	that the resident was admitted to			
the assisted liv	vina residence on 09/17/2021.			
Further medic	al record review failed to show			
documented e	vidence that a pre-admission			
individual serv	rice plan was conducted to	1		
determine the	resident's service needs.	1		
4. At 2:39 PM	, review of Resident #9's medical	- 1		
record shower	d that the resident was admitted to			
the assisted li	ving residence on 08/26/2021.	- 1		
Further medic	al record review failed to show			
documented e	evidence that a pre-admission	- 1		
individual sen	vice plan was conducted to	1		
determine the	resident's service needs.			
5 Δ+3·02 PM	, review of Resident #10's medical			
record showe	d that the resident was admitted to			
the assisted li	iving residence on 09/18/2021.			
Further medic	cal record review failed to show			
documented of	evidence that a pre-admission			
individual ser	vice plan was conducted to			
determine the	resident's service needs.			
0 11 0 54 014	, review of Resident #11's medica	, 1	*	
6. At 3:51 PM	that the resident was admitted to	·		
record snowe	iving residence on 08/25/2021.		m +:	
Europe modi	cal record review failed to show			
documented	evidence that a pre-admission			
individual ser	vice plan was conducted to			
determine the	e resident's service needs.	l	±3	
I Geremme nu	# ## # # # # # # # # # # # # # # #	1		

Health Reaulation		na Administration			FORM APPROVED			
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		ALR-0041	B. WING	1926	02/04/2022			
NAME OF PROVIDER O	OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE				
SOUTHERN AVE S	SOUTHERN AVE SPILLC DBA LIVINGSTON AT 4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032							
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R 146 Continue	d From pa	ge 2	R 146					
Resident resident residence review fa a pre-adrecte needs. 8. At 11:0 record she	#14's med was admitted on 11/04/2 illed to show nission indicated to determine 3 AM, reviewed that t	10:00 AM, review of ical record showed that the ed to the assisted living 2021. Further medical record w documented evidence that vidual service plan was tine the resident #6's medical he resident was admitted to						
Further m document individual determine	edical reco ted evidenc service pla the reside	sidence on 07/08/2021. rd review failed to show e that a pre-admission n was conducted to nt's service needs.			xc]1			
record sho the assisto Further mo document individual	owed that the diving resection in the diving resection in the dividence of	w of Resident #13's medical ne resident was admitted to sidence on 11/15/2021. The review failed to show that a pre-admission in was conducted to the service needs.						
medical re admitted to 12/30/2021 to show do pre-admiss	cord showed the assist Further nacumented sion individ	ew of Resident #15's ed that the resident was ed living residence on nedical record review failed evidence that a ual service plan was ne the resident's service						
record show the assiste Further me	wed that the d living resi dical record	w of Resident #3's medical e resident was admitted to dence on 10/16/2021. I review failed to show that a pre-admission						

PRINTED: 03/03/2022 FORM APPROVED Health Reaulation & Licensma Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A BUILDING B. WING 02/04/2022 ALR-0041 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4656 LIVINGSTON ROAD, SE SOUTHERN AVE SP LLC OBA LIVINGSTON AT WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XS) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R 146 R 146 Continued From page 3 individual service plan was conducted to determine the resident's service needs. 12. At 11:53 AM, review of Resident #4's medical record showed that the resident was admitted to the assisted living residence on 09/30/2021. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs. 13. At 12:10 PM, review of Resident #7's medical record showed that the resident was admitted to the assisted living residence on 10/09/2021. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs. 14. At 12:58 PM, review of Resident #B's medical record showed that the resident was admitted to the assisted living residence on 10/09/2021. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs. 15. On 02/04/2022 at 1:37 PM, review of Resident #12's medical record showed that the resident was admitted to the assisted living residence on 09/03/2021 . Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

16. At 2:00 PM, review of Resident #16's medical record showed that the resident was admitted to the assisted living residence on 02/02/2022. Further medical record review failed to show

(X4) ID PREFIX TAG

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

ID PREFIX TAG

R 146

R 161

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

(X5) COMPLETE DATE

R 146 Continued From page 4

documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

On 02/04/2022 at 3:08 PM, the Assisted Living Administrator acknowledged the assisted living residence did not complete a pre-admission individual service plan prior to the admissions.

At the time of the survey, the assisted living residence failed to ensure that pre-admission individual service plans were conducted for all residents.

R 161 10113.7a1 Individualized Service Plans (ISPs)

(1) Was invited to participate in the review of the ISP: and Based on record review and interview, the Assisted Living Residence (ALR) failed to ensure that a signed statement confirming that the resident or surrogate was invited to participate in the review of the Individual Service Plan (ISP), as required, for fifteen of 15 residents in the core

sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15).

Findings included:

On 02/02/2022 beginning at 10:09 AM, review of the Individual Service Plan for Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15 showed no documented evidence that the residents and surrogates were invited to participate in the review of their individual service plan.

On 02/04/2022, at 2:00 PM, the Assisted Living Administrator and the Assistant Director of Nursing confirmed that there was no documented R161 It is the intent of Livingston Place at Southern Ave to provide safe and appropriate care within the regulations set forth by the DOH.

Livingston Place at Southern Avenue will at or around the time of an ISP review conducted pursuant to § 604(d) of the Act (D.C. Official Code § 44-106.04(d)), the ALR shall: (a) Obtain from the resident (or surrogate) a signed statement confirming that the resident (or surrogate): (1) Was invited to participate in the review of the ISP; and (2) Did or did not participate in the review of the ISP; or, (b) If the resident has refused to give signed confirmation regarding the same ISP review on two (2) separate occasions, document in the resident's record the date, time, and method of each attempt to obtain the resident's signed confirmations and the name of the ALR personnel who made each attempt.

At the time of move in the resident or surrogate will be provided with a written notice of ISP review that includes the date and time that the ISP review will be performed. This review will be performed at a minimum of 7 days after issuance. The resident or surrogate will be asked to sign the notice and will be provided with a copy of their signed notice. The issuance of this notice will be documented on the move in checklist.

All new move in check lists will be reviewed by the Executive Director or Designee prior to move in to ensure that all necessary steps have

Health Regulation & Licensing Administration STATE FORM

been completed. The ED or Designee will review 100% of these files for the first 30 days. 50% of move ins will be audited by the ED or Designee for the next 30 days. 10% of new move in files will be audited quarterly by the ED or Designee on an ongoing basis after the first 60 days of audits.

Implementation 3/7/2022 Completion of initial 100% audit 3/9/22

Health	Reaulation & Licensn	na Administration	cause a series		
	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 161	Continued From pag	je 5	R 161		
	surrogates were inv individual service pl	ed the residents or the ited to participate in their lans.			
	residence failed to e statement confirmin	ensure that a signed g that the resident or d to participate in the review			
	of the individual sen	vice plan.			
R 279	9 10116.15d Staffing \$	Standards	R 279		
	check, performed as and regulations appl Based on interview a Assisted Living Resid a background check employee at the time	ted criminal background required by the District laws icable to each individual; and record review, the dence (ALR) failed to ensure was documented for each of initial employment for the core sample (Staff #2, 8,			
	Findings included:				
	requested documenta checks for all employ Assisted Living Admir records were maintain	:18 AM, the surveyors ation of criminal background ees in the sample. The nistrator said that the ned electronically and will be by the surveyor team.			
	Living Residence's enthat a screen for pote	PM, review of the Assisted inployee handbook showed ential employees should be onducting reference checks			
6	On 02/03/2022, at 3:3 revealed that the corp	7 PM, the ALA however porate office representative			

Health Reaulation & Licensin a Administration (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED ABUIN NĢ B WING _ _ _ _ _ _ 02/04/2022 ALR-0041 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4656 LIVINGSTON ROAD, SE SOUTHERN AVE SP LLC DBA LIVINGSTON AT WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID COMPLET E (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R 279 ' Continued From page 6 R 279 R279 It is the intent of Livingston Place at said the requested records (background checks) Southern Ave to provide safe and appropriate should be on file at the Assisted Living policies within the regulations set forth by the Residence. The Assisted Living Administrator DOH. said that the search for the criminal background check showed that they were still not available for Livingston Place at Southern Ave will obtain a Staff #2, 8, 10, and 11. completed criminal background check, At the time of the survey, there was no performed as required by the District laws and documented evidence the Assisted Living regulations applicable to each individual and Residence maintained a background check for place the report in the employee file at the time each employee. of initial employment. R 281 R 281 10116.15f Staffing Standards All employee files will be reviewed by the Executive Director or Designee by 3/10/22 to 10116.1Sf A healthcare practitioner's written statement as to whether the employee bears any ensure that all necessary steps have been communicable diseases, including communicable completed. The ED or Designee will review tuberculosis. 100% of these files for the first 30 days. 50% : Based on interview and record review, the employee files will be audited by the ED or Assisted Living Residence (ALR) failed to show Designee for the next 30 days. 10% of employee e vidence that each employee had a written i statement from a healthcare practitioner stating files will be audited quarterly by the ED or I that they were free from communicable diseases, Designee on an ongoing basis after the first 60 for 16 of the 17 staff in the sample (Staff# 1, 2, 3, days of audits. 4, 5, 6, 7, 8, 9, 10, 11, 12, 14), Assistant Director of Nursing (ADON), Assisted Living Administrator (ALA), and the Maintenance Director). Findings included: Implemented 2/28/22 Completion of initial 100% audit 3/9/22 On 02/02/2022, at 11:18 AM, the surveyors requested documentation to verify certification of employees' health status by a physician, including free from communicable disease. The Assisted Living Administrator said that the records were maintained electronically and would be accessible for review by the surveyors team.

On 02/03/2022, at 3:37 PM, the Assisted Living

Heath Reaulation & Licensin	a Administration			PRINTED: 03/03/2022 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0041	B WING_		02/04/2022
NAME OF PROVIDER OR SUPPLIER	4000 1 11 0	DRESS, CITY,	STATE, ZIP CODE	
SOUTHERN AVE SPILLC OBA	LIVINGS ON AT	NGSTON ROSTON, DC-2		
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF IX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
R 281 Continued From page	ge 7	R 281	R281 It is the intent of Livings	ton Place at
Administrator however corporate office repringer records should be on Residence.	ver revealed that the result the result the requested a file at the Assisted Living		Southern Ave to provide safe a policies within the regulations DOH.	and appropriate set forth by the
Administrator confirm certifications request 7, 8, 9, 10, 11, 12, 14	40 AM, the Assisted Living med that the health ted for Staff# 1, 2, 3, 4, 5, 6, 4, the Assistant Director of d the Maintenance Director		LP will ensure that a healthcar written statement as to whethe bears any communicable disease communicable tuberculosis is o placed in the employee file at the employment. All employee files will be review	r the employee ses, including obtained and is he time of initial
the Assisted Living Re accessible record of status and a healthca	vey, there was no evidence esidence maintained an each employee's health re practitioner certification ee from communicable		Executive Director or Designee ensure that all necessary steps less completed. The ED or Designee 100% of these files for the first employee files will be audited by Designee for the next 30 days. 1	by 3/10/22 to have been will review 30 days. 50% y the ED or
be required on an and freedom from tubercu form. Documentation employee's licensed it	nes, including the ALA, shall had basis to document allosis in a communicable shall be provided by the nealthcare practitioner.	R 283	files will be audited quarterly by Designee on an ongoing basis af lays of audits.	y the ED or
Based on interview an Assisted Living Reside	nd record review, the ence (ALR) failed to		mplemented - 2/28/22 Completion of initial 100% audi	it 3/9/22

Assisted Living Residence (ALR) failed to document each employee was free from tuberculosis for eleven of seventeen staff in the sample (Staff #1, 5, 6, 8, 9, 10, 11, #12, the Assistant Director of Nursing (ADON), the

Findings included:

Maintenance Director).

On 02/02/2022, at 11:18 AM, the surveyors requested tuberculin screening for all staff in the

Assisted Living Administrator (ALA), and the

Health Regulation & Licensing Administration STATE FORM

Health Reaulation & LicensinaAdministration

SOUTHERN AVE SP LLC DBA LIVINGSTON AT

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 4656 LIVINGSTON ROAD, SE

WASHINGTON, DC 20032

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

R 283

R 330

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

(XS) COMPLETE DATE

R 283 ' Continued From page 8

sample. The administrator stated that the records were maintained electronically, however would be accessible for the surveyors' review.

On 02/02/2022, at 1:50 PM, tuberculin screening results were provided for Staff #2, 3, 4 and 7. The ALA said screening for tuberculosis was required from all employees at the time of hire.

On 02/04/2022 at 3:22 PM, the ALA confirmed that documentation of tuberculin screenings for Staff #1, 5, 6, 8, 9, 10, 11, #12, the ADON, the ALA, and the Maintenance Director were not available.

At the time of the survey, the ALR failed to maintain documentation that each employee was free from communicable tuberculosis.

R 330 10122 .1 On Site Medication Review

10122.1 The on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code§ 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued.

Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that the Registered Nurse (RN) assessed each resident's response to their medication at least every 45 days, for 15 of the 15 residents' in the core sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15).

Findings included:

R283 It is the intent of Livingston Place at Southern Ave to provide safe and appropriate policies within the regulations set forth by the DOH.

LP will ensure all employees, including the ALA, on an annual basis document freedom from tuberculosis on a communicable form. Documentation shall be provided by the employee's licensed healthcare practitioner on or before their anniversary date each year.

All employee files will be reviewed by the Executive Director or Designee by 3/10/22 to ensure that all necessary steps have been completed. The ED or Designee will review 100% of these files for the first 30 days. 50% employee files will be audited by the ED or Designee for the next 30 days. 10% of employee files will be audited quarterly by the ED or Designee on an ongoing basis after the first 60 days of audits.

Implemented - 2/28/22 Completion of initial 100% audit 3/9/22

Health Regulation & L1cens1ng Administration

FORM APPROVED Health Reaulation & Licensma Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED B WING _ - - - - - - - - -ALR-0041 02/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOUTHERN AVE SP LLC DBA LIVINGSTON AT 4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER 'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XS) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R 330 Continued From page 9 R 330 It is the intent of Livingston Place at R 330 1. On 02/02/2022 at 10:09 AM, review of

- Resident #1's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 davs.
- 2. At 11:59 AM, review of Resident #5's medical record failed to show documented evidence that the assisted living residence's registered nurse

assessed the resident's response to his medications every 45 days.

- 3. At 1:20 PM, review of Resident #2's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to his medications every 45 days.
- 4. At 2:39 PM, Review of Resident #9's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to his medications every 45 days.
- 5. At 3:02 PM, review of Resident #10's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days.
- 6. At 3:51 PM, review of Resident #11's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days.
- 7. On 02/03/2022 at 10:00 AM, review of Resident #14's medical record failed to show documented evidence that the assisted living

Southern Ave to provide safe and appropriate care within the regulations set forth by the DOH.

Livingston Place is contracted with PCA Pharmacy to provide the on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code§ 44-109.03). This shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued.

The Executive Director contracted PCA pharmacy to implement the pharmacy review on 2/28/22. Regular reviews of the resident medications by the contracted RN began on 03/03/22

All resident MARs will be reviewed by the Director of Nursing or Designee by 3/4/22 to ensure that all medication administration orders are correct. The Director of Nursing will receive copies of all MAR reviews performed by the RN contracted by the pharmacy at a minimum of every 45 days.

Initiated 3/04/22 Completion of initial 100% audit 3/9/22

YYWT11

Health R	eaulation & Ucensm	a Administration			(X3) DATE SURVEY
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
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		ALR-0041	B WING _		02/04/2022
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SOUTHE	RN AVE SP LLC DBA	LIVANGSTON AT	TON, DC 20		
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R 330	Continued From pa	age 10	R 330		
	residence's registe	red nurse assessed the			-
	resident's response days.	to her medications every 45			
	8. At 11:03 AM, rev	riew of Resident #S's medical			
	record failed to sho	ow documented evidence that residence's registered nurse			
	the assisted living	ent's response to her			
	medications every	45 days.			
	9. At 11:04 AM, rev	iew of Resident #13's medical			
	record failed to sho	w documented evidence that			
	the assisted living	residence's registered nurse lent's response to her			
	medications every	45 days.			
	10 At 11:19 AM I	eview of Resident #15's			
	medical record fail	ed to show documented			
	evidence that the a	assisted living residence's ssessed the resident's			
	response to his me	edications every 45 days.			
	11 At 11:35 AM re	eview of Resident #3's medical			
	record failed to she	ow documented evidence that residence's registered nurse			
	the assisted living	dent's response to his			
	medications every	45 days.			
	12 At 11:53 AM. r	eview of Resident #4's medical			
	record failed to sh	ow documented evidence that			
	the assisted living	residence's registered nurse			
	medications every	dent's response to his 45 days.			
1		review of Resident #7's medica	ıl		
	record failed to sh	low documented evidence that			
	the assisted living	residence's registered nurse			
	assessed the resi	dent's response to his			
	medications every	/ 45 days.			

Health Reaulation	& Licensin	a Administration			FORM APPROVED
STATEMENT OF DEFICE	ENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MIN TIE	OLE CONSTRUCTION	
AND PLAN OF CORREC	TION	IDENTIFICATION NUMBER:	A BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
#1		ALR-0041	B WING_	To the energy	02/04/2022
NAME OF PROVIDER OF	SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE	
SOUTHERN AVE SP		100 4656 LIV	INGSTON RO	NAD SE	
	LEG DBA		GTON, DC 2		
(X4) ID SU	MMARY STAT	EMENT OF DEFICIENCIES	ID		1101/77
TAG REGULA	TORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	DIUD BE COMPLETE
R 330 Continued	From page	: 11	R 330		
record falls the assisted assessed (medications) 15. On 02/0 Resident # documented residence's resident's redays. On 02/04/20 Assisted Liveresident's renot assessed At the time of residence's	ed to show diving residents every 45 04/2022 at 12's medical evidence registered esponse to 122 beginning Adminisponses to 124 every 45 of the surveregistered esidents' registered esidents' register	1:37 PM, review of all record failed to show that the assisted living nurse assessed the his medications every 45 ling at 3:18 PM, the strator stated that the otheir medications were days. ey, the assisted living nurse failed to consistently esponse to their			
any unusual resident. Not be made by co by phone prowritten notifica (24) hours or Based on inte Assisted Livin promptly notificate by written hours or the next series and the series of the next series and the series are series and the series are series.	An ALR sha incident that iffications of contacting mptly, and ation to the the next be rview and ig Residence y the Direct notification ext business	all notify the Director of at substantially affects a of unusual incidents shall the Department of Health shall be followed up by a same within twenty-four pusiness day; and record reviews, the ce (ALR) failed to tor by phone and follow within twenty-four (24) as day for one of two a fall (Residents #12).	R 383		

Health Regulation & Licensing Administration

STATE FORM

STATEMENT	eaulation & Licensin FOF DEFICIENCIES OF CORRECTION	A Administration (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED				
		ALR-0041	B WING		02/04/2022				
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032								
(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI- (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE				
R 383	Continued From pa	ge 12	R 383						
	Findings included:								
	Director of Nursing 01/30/2022, staff of floor of his apartmethe evening of the denied falling, how emergency room of Director of Nursing hospitalized for every for dehydration. During further inter PM, the ADON said hospitalized also for status. The ADON occupational and princreased from one hospital.	0:35 AM, the Assistant (ADON) revealed that on bund Resident #12 lying on the ent in the morning and again in same day. The resident ever was transferred to the or evaluation. The Assistant said that the resident was aluation and to receive fluids eview on 02/03/2022, at 3:37 at that Resident #12 remained or a re-evaluation of functional said that the resident's chysical therapy frequency were to two times a week in the							
	Administrator conf	8:55 PM, the Assisted Living irmed that Resident #12's was not reported to the alth/Health Regulation and tration.							
	At the time of the s the ALR reported a Department as rec	survey, there was no evidence an unusual incident to the guired.							

Health Reaulation & LicensmaAdministration

SOUTHERN AVE SP LLC DBA LIVINGSTON AT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING:

(X3) DATE SURVEY COMPLETED

ALR-0041

WING

02/04/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 4656 LIVINGSTON ROAD, SE

WASHINGTON, DC 20032

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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

(X5) COMPLETE CROSS-DATE

R 000 Initial Comments

An annual licensure survey was conducted on 02/01/2022, 02/02/2022, 02/03/2022 and 02/04/2022 to determine compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 49 residents and employed 51 personnel, to include professional and administrative staff. A random sample of 16 resident records and 17 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews.

R 202 Sec. 501a Standard Of Care

(a) An ALR must care for its residents in a manner and in an environment that promotes maintenance and enhancement of the residents' quality of life and independence. Based on observation and interview, the facility failed to ensure that all staff wore face masks in common areas during the COVID-19 pandemic,

Findings included:

for 51 of 51 residents.

On 02/02/2022 at 9:20 AM, observation revealed Staff #14 was sitting at the front desk. Residents were also seated near the receptionist desk. During this time, the receptionist mask was observed under her chin. At approximately 9:30 AM, the maintenance director walked to the front desk with his mask under his chin. At 1:20 PM, Certified Nurse Assistant (CNA) #3 was observed in the activity room with residents and staff. During this time, CNA #3 was observed without her mask.

R383 It is the intent of Livingston Place at Southern Ave to provide safe and appropriate care within the regulations set forth by the DOH.

LP will notify the Director at the DOH of any unusual incident that substantially affects a resident. Notifications of unusual incidents will be made by contacting the Department of Health by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day.

All incident reports will be reviewed by the Executive Director or Designee by 3/10/22 to ensure that all necessary steps have been completed. The ED or Designee will review 100% of the incident reports for the first 30 days. 50% will be audited by the ED or Designee for the next 30 days. 10% of will be audited quarterly by the ED or Designee on an ongoing basis after the first 60 days of audits.

Completion 3/9/22

R 202 It is the intent of Livingston Place at Southern Ave to provide safe and appropriate care within the regulations set forth by the DOH.

Livingston Place will provide care for its residents in a : manner and in an environment that promotes : maintenance and enhancement of the residents' quality of life and independence in accordance with Sec. 501a Standard Of Care R 202 (a).

An inservice for all staff was held on 3/9/22 to provide additional instruction on proper usage of PPE as related to CDC Covid-19 precautions. Livingston Place employees and residents will adhere to the most restrictive guidelines set forth by the District and/or

alth Reaulation & LicensmaAdministration	CDC.	
	Completed 3/9/22	
	1	
	V.	
	7171	
h Regulation & L1cens1ng Administration DRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE	/FIS SIGNATURE TITLE	(X6) DATE

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STATE FORM

PRINTED: 03/03/2022

Health Reaulation & Licen	isma Administration			FORM APPROV
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	CVO MILL TIPL		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0041	B. WING	******	02/04/2022
AME OF PROVIDER OR SUPPLIE	R STREET			02/04/2022
	SIREL	ADDRESS, CITY, ST	TATE, ZIP CODE	
OUTHERN AVE SP LLC O		VINGSTON ROA		
(X4) ID SUMMARY S	STATEMENT OF DEFICIENCIES	ID ID		
TAG REGULATORY OF	NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER 'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE COMPLET
R 202 Continued From p	page 1	R 202		
On 02/02/2022 at	1:22 PM, interview with CNA #3			
revealed that she	Was not wearing a mask	1		
because she was	drinking her coffee On	1/2		
02/03/2020 at 2:30	0 PM, interview with the			
Maintenance Direc	ctor revealed that a mask			
should have been	worn and that staff had been	1		1
trained accordingly				
				1
On 02/03/2022 at 3	3:57 PM, review of theAssisted			*
Living Residence p	protective personal equipment			
(FFE) protocol reve	ealed masks were to be worn			
in the facility.	== == == ===	I		
At the time of the si	urvey, the facility's staff failed in all common areas.			
677 Sec. 702b8 Staff Tr		R 677		
(8) Choking precau	itions and airway obstruction ,	4		
including the Heimlig	Ch Maneuver and	I		
Based on interview :	and record reviews the			
Assisted Living Resid	dence failed to document			
compliance with "DC	Code, Subchapter VII	1		
Statting and Training	1.[§ 44-107.02] Jh) Within 7	1		
days of employment,	an Assisted Living	1		
Residence shall train	a new member of its staff	- 1		
as to the following: (8	8) choking precautions and	1		
airway obstruction . i	including the Heimlich			
Maneuver for nine of	fourteen staff (Staff# 2 4	1		
5, 6, 7, 8, 10,11, and	12).	II.		
Findings included:				
On 02/02/2022, the A	assisted Living Administrator			
was requested to prov staff identified in the s	vide training record for the			
	oumpie.	10		

STATEMENT	or DEFICIENCIES CORRECTION	St a Administration (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
,,,,,		ALR-0041	B. WING	- NE NE	02/04/2022
	OVIDER OR SUPPLIER	4656	ET ADDRESS, CITY, LIVINGSTON RO HINGTON, DC	DAD, SE	
(X4) ID PREFIX TAG	CACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
		0	R 677	R 677 It is the intent of Livin	ngston Place at

R 677 Continued From page 2

the Assisted Living Administrator revealed most I records were maintained electronically and that additional training may be in the system. The training records (training logs and training certificates) reviewed, did not include choking and airway obstruction, including Heimlich Maneuver.

Review of the DC Code [44-1-7.02 (b)] at 4:09 PM, "Within 7 days of employment an assisted living residence shall train a new member of its staff as to the following: (8) Choking precautions and airway obstruction, including the Heimlich Maneuver." There was no record provided to show Staff# 2, 4, 5, 6, 7, 8, 10,11, and 12 received the training.

At the time of the survey, there was no documented evidence that each employee met or possessed training on choking and airway obstruction, including Heimlich Maneuver or received the training within seven days of being hired.

R 677 It is the intent of Livingston Place at Southern Ave to provide safe and appropriate care within the regulations set forth by the DOH.

Livingston Place at Southern Ave will ensure compliance with Sec. 702b8 Staff Training. R 677 (8) Choking precautions and airway obstruction, including the Heimlich Maneuver; DC Code, Subchapter VII, Staffing and Training, [§ 44-107.02]: (b) Within 7 days of employment, an Assisted Living Residence shall train a new member of its staff as to the following: (8) choking precautions and airway obstruction, including the Heimlich Maneuver by including the required training in the new hire orientation performed with in the first 7 days of employment. Documentation of this training will be placed in the employee file.

Instruction on proper techniques to be used when someone is choking, or has an airway obstruction, including Heimlich Maneuver, was provided on 3/9/22 to all staff. Please see attached documentation.

All employee files will be reviewed by the Executive Director or Designee by 3/10/22 to ensure that all necessary steps have been completed. The ED or Designee will review 100% of these files for the first 30 days. 50% employee files will be audited by the ED or Designee for the next 30 days. 10% of employee files will be audited quarterly by the ED or Designee on an ongoing basis after the first 60 days of audits.

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If continuation sheet 3 of 3