Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0041	A. BUILDING: _____ B. WING _____	03/14/2023

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

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R 000	Initial Comments An unannounced annual licensure survey was conducted in conjunction with complaint and unusual incident investigations during the period of 03/07/2023, 03/08/2023, 03/09/2023, 03/10/2023, 03/13/2023 and 03/14/2023, to determine compliance with the Assisted Living Residence (ALR) regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101, and Assisted Living Law DC ST § 44-101.01. The resident census was 109 and 68 personnel were employed by the ALR, to include professional and administrative staff. The survey sample consisted of 33 resident records to include deaths (three) and discharges (two); and 20 employee records. A total of two complaints submitted via the complaint portal/line were investigated during the survey, including: DC~00011777- Admissions - Substantiated. DC~00011491- Provision of nursing services - Unsubstantiated The findings of the survey and investigations were based on observations made throughout the ALR, interviews with staff and residents, and reviews of clinical and administrative records, to include incident reports.	R 000	,A. Resident 4 and 12 rooms were treated. when evidence of bed bugs were found. Resident 4 on 8-17-22 and Resident12 0n 7-12-22 and has no further issues with Bed Bugs since treatment. B. Resident 6 rooms was treated12-14-22, 1-3-23 and was inspected on 2-6-23 as clear of bed bugs When bed bugs found on 3-9-23 by son resident 6 room treated on 4-6-23 All residents are relocated during treatment. Starting May 2023 if bed bugs are found. in a room the Neighboring rooms to each side above and below will be inspected by pest company for any insects (Bed Bugs) Community has a monthly pest inspection. by Pest Patrol LC for all insects (see contract) Community staff will walk community. daily to monitor for insects.	4-26-23
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 observations, interviews and record reviews, the Assisted Living Residence (ALR) failed to implement effective treatment measures and monitoring systems to eliminate bed bug	R 202		

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R 202	Continued From page 1. infestations, for three of the 33 residents in the sample (Residents #4, 6 and 12). Findings included: 1. Resident #4's unit had repeated bed bug infestations in 2022, as follows: a. On 03/08/2023 at 10:35 am, a review of Resident #4's medical records showed a nurse progress note dated 08/17/2022 that documented a skin assessment after the resident complained of bed bugs in her unit. The maintenance department was informed and said the resident would be relocated to another unit while her unit was being treated. On 03/13/2023 at 11:35 am, a review of the pest control technician's email dated 08/17/2022 to the ALR's management staff confirmed that bed bugs and excrement were found in Resident #4's unit. The technician documented that ALR staff informed him that the resident's family member had returned a previously discarded, untreated headboard after the unit was treated for bed bugs in May 2022. 2. On 03/13/2023 at 2:17 pm, a review of the Pest Control invoices for Resident #6's unit showed repeated infestations as follows: a. On 12/14/2022, Resident #6's unit was treated after live bed bugs were found in her unit. Newly hatched bed bugs were seen in the unit on 01/03/2023. The technician recommended that they treat the unit while Resident #6 temporarily relocated. On 02/06/2023, the technician performed a "limited access" inspection, with no bed bug activity seen.	R 202	R202 1.The infestation issue has been addressed and corrected as of 4/28/2023. 2.The Maintenance staff will conduct 5 random room checks to inspect for infestation weekly. The Staffed received an in-service on 4/27/2023 on the identification of Bed Bugs 3.Findings of the room checks will be reported in the monthly QA meeting	4-28-23

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R 202	Continued From page 2. b. On 3/09/2023 at 11:54 am, Resident #6's responsible party notified the State Survey Agency that he saw live bed bugs on the resident's bed and attached a video to the email. The video showed bed bugs crawling on a bed sheet. When interviewed by telephone on 03/10/2023 at 11:25 am, the responsible party said that he had not reported the bed bugs to the ALR on 03/09/2023 because the ALR had not adequately addressed the bed bugs in the past. On 03/10/2023 at 1:00 pm, the Maintenance Director confirmed that he was not aware that Resident #6's responsible party had reported seeing bed bugs on 03/09/2023. 3. On 03/13/2023 at 2:30 pm, a review of the Pest Control invoices for Resident #12's unit showed repeated infestations as follows: a). On 07/12/2022, Resident #12's unit was treated after bed bugs were found in her recliner. b). On 11/08/2022, Resident #12's unit was treated again after bed bugs were seen in a used sofa provided by a relative. A second sofa was seen in the unit with roaches, and newly hatched bed bugs were found on a mattress. On 3/10/2023 at 10:52 am, an interview with the Maintenance Director showed that furnishings brought into the ALR were to be thoroughly inspected before taken to the units to prevent potential hitch hiking of bed bugs. All the staff and residents were encouraged to promptly report any sighting of bed bugs to ensure timely extermination. On 03/13/2023 at 2:37 pm, a review of the Resident Service Agreement showed a Bed Bug	R 202		

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R 202	Continued From page 3. Addendum, which included the following: "The goal of this Addendum is to protect the quality of the rented unit's environment from the effects of bed bugs. Residents agree that all furnishings and personal properties that will be moved into the premises will be free of bed bugs. Resident hereby agrees to prevent and control infestations by adhering to list of responsibilities below: - Check for hitch hiking bed bugs. - Resident shall report any problems at once to the Community. Even a few bed bugs can rapidly multiply to create a major infestation that can spread to other apartments. - Resident shall cooperate with pest control efforts. Although the bed bug addendum was in place, intermittent bed bug infestation continued at the ALR. At the time of the survey, the ALR failed to implement effective environmental measures to prevent recurrent bed bug infestations. This is a repeat deficiency. See Statement of Deficiencies Report dated 02/04/2022.	R 202		
R 272	Sec. 503.1 Dignity. (1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible. Based on observations, interviews, and record	R 272		

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R 272	Continued From page 4. reviews, the Assisted Living Residence (ALR) did not implement effective treatment measures and monitoring systems to eliminate bed bug infestations, for three of 33 residents in the sample (Residents #4, 6, and 12). Findings included: [Cross reference to R202] Beginning on 03/08/2023, interview with residents, review of resident records and interviews with staff revealed there were repeated and ongoing bed bug infestations in the ALR. Some policies and treatments by pest control technicians were documented. However, at the time of the survey, the ALR's interventions were ineffective in preventing recurrent bed bug infestations. This is a repeat deficiency. See Statement of Deficiencies Report dated 06/03/2022.	R 272	272 A. Resident 4 and 12 rooms were treated. when evidence of bed bugs were found. Resident 4 on 8-17-22 and Resident12 0n 7-12-22 and has no further issues with Bed Bugs since treatment. B. Resident 6 rooms was treated12-14-22, 1-3-23 and was inspected on 2-6-23 as clear of bed bugs When bed bugs found on 3-9-23 by son resident 6 room treated on 4-3-23 All residents are relocated during treatment. Starting May 2023 if bed bugs are found in a room the Neighboring rooms to each side above and below will be inspected by pest company for any insects (Bed Bugs) If community suspects a resident to be exposed to bed bugs while out of community that resident's room will be inspected on monthly basis. Community staff will walk community. daily to monitor for insects.	4-28-23
R 282	Sec. 503.11 Dignity. (11) To be free from mental, verbal, emotional, sexual, and physical abuse, neglect, involuntary seclusion, and exploitation; and Based on interviews and recorded reviews, the Assisted Living Residence (ALR) failed to ensure that each resident was free from neglect, for one of the thirty-three residents in the sample (Resident #32). Findings included: 1. The licensed nurse failed to assess resident in accordance with the facility policy when it was determined that Resident #32 sustained a fall	R 282		

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R 282	Continued From page 5. with injury. On 03/07/2023 at 4:00 pm, Resident #32 informed a surveyor that she fell while walking to the bathroom on 01/07/2023 (between 1:15 am and 1:30 am). Resident #32 said that when the Licensed Practical Nurse (LPN) entered her room at 9:00 am to administer medications, she informed the LPN that she fell, and she believed she broke her leg. Resident #32 said that the LPN responded by saying: "For real <resident's name>, you need to go to the Emergency Room (ER)" and told the Resident #32 to call 911 on her own. The LPN did not call 911, per the ALR's Policy and Procedure for Falls. The resident went to the ER after she called her sister for help and the sister called 911. The facility's Policy and Procedures for Falls instructs the nurse to "call family members...". The nurse did not call the residents' family members. Resident #32 said she called her sister for help. Continued interview with Resident #32 revealed that the LPN did not assess her for injuries, per the ALR's Policy and Procedure for Falls. A review of the clinical record lacked evidence of a nursing entry describing the incident and/or a correlating assessment and/or actions taken as a result of gaining knowledge that the resident sustained a fall. There was no evidence that the LPN completed an incident report per the Policies and Procedures for Falls. When the surveyor asked Resident #32 if she informed anyone else, the resident said that she informed Certified Nursing Assistant (CNA) #5,	R 282	R282 a. Resident #32 has been treated and is presently able to ambulate with an assistive device (walker). b. The LPN and CNA involved in the incident have been disciplined. a. In March and ,April 2023 the Clinical Licensed staff and CNA have been in-serviced on the proper procedure for change in condition and return from hospital and MD appointment. b. In April, May, and June of 2023 Clinical staff was/will be in-serviced on the proper follow-up for residents returning from the hospital, doctor's visits i.e., procedure for handling physician orders. c. The 24-hour report will be reviewed by clinical leadership team, daily for unusual incidents with progress notes to ensure compliance. d. Nursing leadership will reviewed and investigated daily for "Missed Medication" Residents have been requested to remain in community during medication pass. e.The findings of missed med audit will be reported during the monthly QA meeting. This will be an ongoing process.	5-31-23 6-15-23

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R 282	Continued From page 6. who checked her head and leg. There was no evidence that CNA #5 reported the fall to anyone. On 03/10/2023 beginning at 3:00 pm, an interview with the Assisted Living Administrator (ALA) and the Director of Nursing (DON) revealed that they were not aware of the aforementioned incident. There was no incident report generated at the time of the fall. The DON said that she saw the resident limping (date not specified) and asked her why she was limping. Per the DON, the resident only informed her that she broke her ankle and acknowledged that the cause of the broken ankle was not investigated. At approximately 3:30 pm, during a telephone interview, the LPN confirmed that Resident #32 did inform her that she fell on 01/07/2023, but that she did not assess the resident, did not call 911 or report the fall. 2. The ALR staff neglected to implement measures to manage Resident #32's pain following a fall with fracture. Facility staff failed to obtain prescribed pain medication (Percocet) after Resident #32 returned from the ER with a broken ankle. On 3/13/2023 at 4:49 pm, Resident #32 said that upon discharge from the hospital, she was given a prescription for Percocet (narcotic pain medication). Upon returning to the ALR at 3:30 am on 01/08/2023, she gave the prescription to the overnight nurse. Resident #32 further stated that she asked nurses multiple times for the Percocet; however, she never received it, nor was she offered an alternative for pain management. When interviewed on 03/14/2023 at 2:11 pm, the	R 282		

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R 282	Continued From page 7. DON confirmed that Resident #32 brought a prescription for Percocet with her when she returned from the hospital on 01/08/2023, which was sent to the pharmacy the same day to be filled. On 01/11/2023, the pharmacy informed the nurse that prescriptions for controlled substances such as Percocet could not be filled beyond 72 hours. The DON acknowledged that the resident never received Percocet or an alternative for pain management. A nurse progress note dated 01/11/2023 (1:05 am) revealed that the nurse called the pharmacy to follow up on Resident #32's Percocet prescription that was faxed on 01/08/2023 and was told that the prescription had expired. Review of Resident #32's Medication Administration Record lacked evidence that Percocet was administered. At the time of the survey, the ALR staff failed to ensure that Resident #32 was free from neglect. Staff failed to assess, monitor, and seek emergency services when it was determined the resident sustained a fall with injury, and failed to provide access to prescribed medications or manage pain post fracture. This is a repeat deficiency. See Statement of Deficiencies Report dated 07/12/2022.	R 282		5-31-23
R 292	Sec. 504.1 Accommodation of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents.	R 292		

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R 292	Continued From page 8. Based on interviews and recorded reviews, the Assisted Living Administrator (ALA) failed to ensure each resident received emergency services and medications as prescribed, for one of the 33 residents in the sample (Resident #32). Findings included: I. The ALR failed to ensure residents received appropriate emergency services, as follows: [Cross reference 503.11& 10110.16] On 03/07/2023 at 4:00 pm, Resident #32 informed a surveyor that on 01/07/2023, she fell while walking in her unit. When she told a Licensed Practical Nurse (LPN) that she believed her leg was broken, the LPN did not call 911. The LPN instructed her to call 911 herself. Resident #32 said she telephoned her sister, who came to the ALR, and then called 911 Emergency Services. At approximately 3:30 pm, during a telephone interview, the LPN confirmed that Resident #32 informed her that she fell on 01/07/2023, and she (LPN) did not call 911. At the time of the survey, the ALR failed to call 911 Emergency Services when indicated. II. The ALR failed to ensure each resident received prescribed pain medication timely, as follows: [Cross reference 503.11] On 01/07/2023, Resident #32 fell and was diagnosed with a broken ankle at a hospital Emergency Room (ER). Resident #32 returned to the ALR with a prescription for Percocet, but the medication was never made available. The DON confirmed that the prescription for Percocet was never filled by the pharmacy.	R 292	292 a. Resident #32 has been treated and is presently able to ambulate with an assistive device (walker). b. The LPN and CNA involved in the incident have been disciplined. a. March and April 2023The Clinical Licensed Nurse and CNA have been i in-serviced on the proper procedure for any change in condition. b. April and in May 2023 the Clinical staff have/will be in-serviced on the proper follow-up for residents returning from the hospital and doctor's visits i.e., procedure for handling physician orders. d. Nursing leadership will reviewed and investigated daily for "Missed Medication"(See Attachment). The findings of the incidence reports will be reported during the monthly QA meeting. This will be an ongoing process	5-31-23

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R 292	Continued From page 9. This was verified through a review of the residents' nurse progress notes and medication administration records (MAR). III. The ALR failed to ensure residents received prescribed medications for the management of hypertension, as follows: On 03/13/2023 at 4:49 pm, Resident #32 said that in November 2022, she was prescribed a Clonidine patch weekly in addition to oral medication for blood pressure management. The resident stated that there was a two-week delay in getting the prescription refilled in December 2022. On 3/14/2023 at 2:11 pm, when the DON was asked about Resident #32's Clonidine Patch, she confirmed the delay in getting a refill in December. Beginning at 2:43 pm, a review of Resident #32's record showed a physician order for Clonidine, apply one patch to clean dry skin once a week for hypertension. The 12/2022 MAR showed that a new patch was to be applied weekly, beginning on 12/01/2022. The nurses documented administration on 12/01/2022 and 12/08/2022. The MAR was blank on 12/15/2022 and 12/22/2022, thus verifying that she went two weeks without a Clonidine patch. It should be noted that an entry on 12/22/2022 for Clonidine patch showed "DR" which the key said represented drug refused. At the time of the survey, the ALR's nursing services failed to ensure that Resident #32 received all medications as prescribed. This is a repeat deficiency. See Statement of	R 292		

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R 292	Continued From page 10. Deficiencies Report dated 07/12/2022.	R 292		
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 reviews and interviews, the Assisted Living Residence (ALR) failed to implement its written policy on alcohol use, to include counseling, for one of thirty-three residents sampled (Resident #7). Findings included: On 03/08/2023 at 2:21 pm, review of an incident report showed that on 06/01/2022, Resident #7 became intoxicated in his unit and fell while transferring himself from a toilet to a wheelchair. Resident #7 was transported to an emergency room on 06/01/2022 and discharged the next day. At 2:59 pm, when the Director of Nursing (DON) was asked about Resident #7's fall on 06/01/2022, the DON said that Resident #7 was an alcoholic, and the fall occurred while the resident was intoxicated. This was confirmed through review of Resident #7's Individualized Service Plan (ISP) dated 06/03/2022. On 03/09/2023 at 10:12 am, a review of the ALR use of alcohol restricted policy (Policy B 120), updated on 06/04/2021, showed that: "A Resident who chooses to drink alcohol but fails to abide by these policies or engages in conduct that is	R 293	R293 1.a The facility staff will be in serviced on the Guidance B-120 "Use of Alcohol Restricted" in May 2023 by administrator. b. The residents were/will be educated at May 2023 town hall and in June 2023 by community leadership. b. Resident 7 counseled on alcohol consumption. c. Community Staff will monitor, residents daily for inappropriate alcohol consumption.	5-31-23 6-15-23

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R 293	Continued From page 11. disruptive to the community or a danger to themselves or others shall be counseled regarding their conduct, reminded of the community's rules that permit only temperate alcohol consumption in the privacy of the Resident's own unit, and offered assistance to address their issues with alcohol. The DON, or her designee, shall document the time, date, and content of counseling given to the Resident and the Resident's response to the counseling in the Resident's electronic health record." In a follow up interview with the DON on 03/09/2023 at 1:03 pm, the DON said she was not aware of the alcohol policy, including the requirements for counseling and documentation. The DON further said that Resident #7's record did not reflect that the resident received any counseling on alcohol consumption. At the time of the survey, the ALR failed to ensure that Resident #7 received counseling on alcohol consumption per the facility's policy.	R 293		
R 390	Sec. 509b1 Abuse, Neglect, and Exploitation. (b)(1) An ALR, employee of an ALR, or other person who believes that a resident has been subjected to abuse, neglect, or exploitation shall report the alleged abuse, neglect, or exploitation immediately to the assisted living administrator who shall take appropriate action to protect the resident. The ALR shall report any allegation of abuse, neglect, or exploitation brought to its attention to the Mayor and the Adult Protective Services Program, administered by the Family Services Administration of the Department of Human Development. Based on interviews and record reviews, Assisted	R 390		

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R 390	Continued From page 12. Living Residence (ALR) staff failed to report an incident to the Assisted Living Administrator (ALA), for one of the 33 residents in the sample (Resident #32). Findings included: On 03/07/2023 at 4:00 pm, Resident #32 informed the surveyor that she fell while walking to the bathroom on 01/07/2023 (between 1:15 am and 1:30 am). Resident #32 said that when the Licensed Practical Nurse (LPN) entered her room at 9:00 am to administer medications, she informed the LPN that she fell, and she believed she broke her leg. 1. Resident #32 said that the LPN responded by saying: "For real <resident's name>, you need to go to the Emergency Room (ER)" and told her to call 911. The LPN did not call 911, per the ALR's Policy and Procedure for Falls. The resident went to the emergency room after she called her sister for help and the sister called 911. 2. The Policy and Procedures for Falls instructs the nurse to "call family members...". Resident #32 reported having called her sister. 3. Continued interview with Resident #32 revealed that the LPN did not assess her for injuries, per the ALR's Policy and Procedure for Falls. 4. There was no evidence that the LPN completed an incident report per the Policies and Procedures for Falls. 5. When the surveyor asked Resident #32 if she informed anyone else, the resident said that she informed Certified Nursing Assistant (CNA) #5.	R 390	R390 a. Resident #32 has been treated and is presently able to ambulate with an assistive device (walker). b. The LPN and CNA involved in the incident have been disciplined. a. March and April 2023The Clinical Licensed Nurse and CNA have been i in-serviced on the proper procedure for any change in condition. b. April May and June 2023 the Clinical staff have/will be in-serviced on the proper follow-up for residents returning from the hospital and doctor's visits i.e., procedure for handling physician orders. (see attachment for procures) d. Nursing leadership will review and investigated daily for "Missed Medication"(See Attachment). The findings of the incidence reports will be reported during the monthly QA meeting. This will be an ongoing process.	5/2023 & 6/2023

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R 390	Continued From page 13. CNA #5 checked her head and leg. There was no evidence that CNA #5 reported the fall injury. On 03/10/2023 beginning at 3:00 pm, an interview with the Assisted Living Administrator (ALA) and the Director of Nursing (DON) revealed that they were not aware of the aforementioned incident. There was no incident report generated at the time of the fall. The DON said that she observed the resident limping (date not specified) and asked her why she was limping. According to the DON, the resident only informed her that she broke her ankle. The DON acknowledged that the cause of the broken ankle was not investigated. At approximately 3:30 pm, during a telephone interview, the LPN confirmed that Resident #32 informed her that she fell on 01/07/2023. The LPN also confirmed that she did not assess the resident, call 911 or report the fall. 6. The ALR did not obtain prescribed pain medication after Resident #32 returned from the emergency room with a broken ankle, as follows: On 3/13/2023 at 4:49 pm, Resident #32 said that upon discharge, she was given a prescription for Percocet. The resident said that when she returned to the ALR at 3:30 am, she gave the prescription to the overnight nurse. Resident #32 further stated that she asked nurses multiple times for the Percocet; however, she never received it. When interviewed on 03/14/2023 at 2:11 pm, the DON confirmed that Resident #32 brought a prescription for Percocet with her when she returned on 01/08/2023. The DON said that the prescription went to the pharmacy on the same day to be filled. On 01/11/2023, the pharmacy	R 390		

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R 390	Continued From page 14. informed the nurse that prescriptions for controlled substances such as Percocet could not be filled beyond 72 hours. She then acknowledged that the resident never received the Percocet. A nurse progress note dated 01/11/2023 (1:05 am) confirmed the DON interview. The nurse wrote that she called the pharmacy to follow up on Resident #32's Percocet 5 325 mg prescription that was faxed on 01/08/2023 and was told that the Percocet prescription had expired. Review of the MAR showed Resident #32's prescribed Percocet listed, with no documentation of it being administered. At the time of the survey, the ALR failed to ensure that staff reported Resident #32's fall. Failure to report and investigate the resident's fall that resulted in a fractured ankle, coupled with delayed assessment and access to emergency services and pain medications constitute unreported neglect. This is a repeat deficiency. See Statement of Deficiencies Reports dated 02/04/2022 and 07/12/2022.	R 390		
R 403	Sec. 601b Admissions (b) Prior to admission of a resident, the ALA or designee shall determine that the resident is appropriate for admission to the ALR and that the resident's needs can be met in addition to the needs of the other residents. Based on interview and record review, the Assisted Living Administrator (ALA) failed to	R 403		

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R 403	Continued From page 15. ensure that no resident was admitted without documentation showing that the resident was appropriate for admission, for one of one resident admitted with lower extremity wounds (Resident #27). Findings included: [Cross reference R410a] On 03/08/2023 beginning at 4:30 pm, a review of Resident #27's admissions records and interviews with the Director of Nursing (DON) showed that Resident #27 had skin ulcers identified by staff of the prior facility on 11/17/2022. Resident #27 was admitted to the ALR on 11/28/2022 without sufficient documentation about the status of his skin alteration. On 11/29/2022, the facility's Assistant DON staged one of Resident #27's ulcers as a stage four and transferred the resident to the hospital for further care. The resident was discharged back to the Assisted Living Residence on 12/15/2022 and he discharged himself from the facility on the same day. On 03/10/2023 at 12:38 pm, when the DON was asked about Resident #27's admission to the facility on 11/28/2022, she explained that the Move in Director would not normally request medical or clinical documentation. The DON acknowledged that Resident #27 was not a candidate for admission to the ALR. At the time of the survey, the ALR staff failed to determine whether Resident #27 (who was known to have alterations of the skin on both lower extremities) was appropriate for admission and that his needs could be met by the ALR.	R 403	403 1.Resident #27 no longer resides at facility. RN involved in not completing all pre-move in assessments is gone. 2.Moving forward RN who conducts pre-move in assessment will include skin assessment with written documentation and a pre-move in checklist will be utilized and reveiwed by administrstor prior to move in. 3.Community Pre- Move in process /Assessment was reviewed with leadership team on 4-26-23 4. Administrator will monitor for compliance with use of pre-move in checklist to ensure have documentation. of assessment and resident needs can be met by community. Pre move in checklist will be reviewed at monthly QA	4-26-23

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R 410	Continued From page 16.	R 410		
R 410	Sec. 601e2 Admissions (2) Treatment of stage 3 or 4 skin ulcers. Based on interviews and record reviews, the Assisted Living Residence (ALR) admitted a resident with skin ulcers without first receiving clinical documentation showing the stages of the ulcers for one of the three residents that were discharged in the past seven months (Resident #27). Findings included: On 11/29/2022 at 5:18 pm, the ALR notified the Department of Health that Resident #27 was transported to a hospital emergency room for assessment of wounds on the lower extremities and to "rule out possible sepsis and/or Methicillin resistant Staphylococcus aureus (MRSA)." On 03/08/2023 beginning at 4:30 pm, a review of Resident #27's nursing assessment, nurse progress notes, and other health care records showed the following: The "Livingston Place Pre-Admission Clinical Evaluation Form" initiated 11/17/2022, stated: "skin alteration, right lower leg (front) wound, unable to classify awaiting notes from wound clinic at (hospital)." The Pre-Admission Clinical Evaluation Form also documented "admission date: 11/28/2022"). The "Resident Community Handbook," included a Lease Agreement for a "private, studio" apartment, was signed on 11/28/2022 by Resident #27 and a "Community Representative." Per a nurse progress note dated 11/28/2022 at 8:36 pm: "Resident is currently checking in... Resident is alert and oriented, refused	R 410	410 1.Resident #27 no longer resides at facility. 2.RN will conduct physical assessment of potential new residents that will include skin assessment with written documentation and a pre-move in checklist will be utilized. 3.Community Pre Move in process /Assessment reviewed with leadership team on 4-26-23 4. Administrator will monitor for compliance with use of pre-move in checklist to ensure have documentation. of assessment and resident needs can be met by community. Pre move in checklist will be reviewed at monthly QA	4-30-23

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R 410	Continued From page 17. assessment (including wound, stating that it was cleaned and dressed today at the doctor's office). He went on to say we shall have the opportunity to see it during the next wound change. He did not come with a list of medications but a sizable number of pills... Please, follow up for him to consult with a physician so that we can clarify which medications the physician will want him to be on... I have passed on the papers (photocopies) and medications he came with (specifically wound follow up) to the night nurse)." A Licensed Practical Nurse (LPN) documentation on 11/29/2022 at 2:21 pm read: "Resident status post admit. Alert and oriented x3, upon assessment writer saw dressing on bilateral legs. The writer then asked the resident to look at the wounds that it is important to open, evaluate and stage the wound since he is a new admit. Resident refused for writer to look at the wounds, supervisor Assistant Director of Nursing (ADON) made aware, and she immediately come up to the 4th floor (sic)." Another documentation on 11/29/2022 at 4:27 pm by the Assistant director of nursing (ADON): "This writer was called to the nurses' station by (LPN) who was attempting to perform a full move in assessment on resident as resident initially refused at time of move in yesterday evening... Upon removal (of bandages) resident noted to have stage 4 wound to right leg (and two other wounds) ... Resident reports wound timeline of approximately three 4 months and has been going for weekly wound care at (hospital) and reports last visit last Monday... Right lower extremity wound appears as 5 1/2 inch by 7 3/4-inch wound; wound exhibits signs of infection; purulent yellow drainage, necrotic tissue, and intermittent bleeding noted to wound...Pedal	R 410		

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R 410	Continued From page 18. pulse absent in right lower extremity... resident states he was recently referred to vascular provider due to absent pedal pulse but did not make the appointment... 911 called to transport resident to hospital for further evaluation to rule out sepsis and/or MRSA..." Nurse Progress Note 12/09/2022 at 3:38 pm (Director of Nursing, DON): "Writer spoke with (hospital) case management department... informed them that due to his wounds, he will need a skilled nursing facility. She has agreed to work on placement." Nurse Progress Note 12/15/2022 at 2:01 pm (ADON): "The nursing department was informed by the front desk staff... he was discharged from the hospital and (the resident said) that he would be 'moving out'...Keys were reportedly handed to the front desk concierge... resident was observed moving personal belongings out of the facility..." Continued review of Resident #27's record (including documents that he presented at the time of admission on 11/28/2022) showed no evidence that the facility received written documentation from the wound care specialist or the hospital which provided the sizes/stages and description of the resident's wounds. On 03/10/2023 at 12:38 pm, when the DON was asked about Resident #27's admission to the facility on 11/28/2022, she explained that the move in director would not normally request medical or clinical documentation. When the resident was assessed the following day, he was sent to the hospital because his "wounds looked infected and he did not have any documentations for the wound." The DON also confirmed that on 11/17/2022, she had instructed Resident #27 to obtain a current status report from a hospital or wound clinic.	R 410		

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R 410	Continued From page 19. At the time of the survey, the ALR failed to ensure that prior to admission, Resident #27 (who was known to have ulcers on both lower extremities) provided documentation showing that he did not have stage 3 or 4 skin ulcers.	R 410		
R 421	Sec. 602a Resident Agreements (a) A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following: Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident was provided with a written agreement prior to admission, for five of the 33 residents in the sample (Residents #20, 23, 25, 26 and 28). Findings included: 1. On 03/07/2023 at 3:16 pm, a review of Resident #20's records showed that the resident was admitted on 09/06/2022. Review of the resident's agreement showed that the agreement was signed on the same day, not prior to admission. 2. On 03/07/2023 at 3:30 pm, a review of Resident #26's records showed that the resident was admitted on 07/05/2022. Review of the resident's agreement showed that the agreement was signed on the same day, not prior to the admission. 3. On 03/07/2023 at 4:10 pm, a review of Resident #25's records showed that the resident	R 421	421 1.Unable to correct admitted individuals. 2.The move-in procedure has been reviewed with the Move-In Coordinator and Members of the Leadership Team on 4-26-23 to prevent the reoccurrence. 3.The facility Executive Director will review all contracts with prospective admissions prior to being admitted into the facility. The admission documentation will be reviewed during the monthly QA meeting	4-26-23

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R 421	Continued From page 20. was admitted on 11/07/2022. Review of the resident's agreement showed that the agreement was signed on the same day, not prior to the admission. 4. On 03/08/2023 at 3:34 pm, a review of Resident #28's records showed that the resident was admitted on 12/22/2022. Review of the resident's agreement showed that the agreement was signed on the same day, not prior to the admission. 5. On 03/13/2023 at 4:11 pm, a review of Resident #23's records showed that the resident was admitted on 03/10/2023. Review of the resident's agreement showed that the agreement was signed on the same day, not prior to the admission. On 03/10/2023 at 1:30 pm, the above findings were discussed with the Director of Nursing. She acknowledged that the resident agreements were not signed prior to the resident admission as required. At the time of the survey the ALR failed to ensure that each resident agreement was signed prior to the resident's admission. This is a repeat deficiency. See Statement of Deficiencies Report dated 07/12/2022.	R 421		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to develop Individual Service Plans (ISPs) for all	R 471		

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R 471	Continued From page 21. residents prior to admission, for three of the 33 residents sampled (Residents #20, 23 and 25). Findings included: 1. On 03/07/2023 at 3:16 pm, a review of Resident #23's medical record showed that the resident was admitted to the ALR on 03/10/23. Further medical record review did not show documented evidence that a preadmission ISP was conducted to determine the resident's service needs. 2. On 03/07/2023 at 3:16 pm, a review of Resident #20's medical record showed that the resident was admitted to the ALR on 09/06/2022. Further medical record review did not show documented evidence that a preadmission ISP was conducted to determine the resident's service needs. 3. On 03/07/2023 at 4:10 pm, a review of Resident #25's medical record showed that the resident was admitted to the ALR on 11/07/2022. Further medical record review failed to show documented evidence that a preadmission ISP was conducted to determine the residents' service needs. On 03/10/2023 at 1:19 pm, the above findings were discussed with the Director of Nursing. She acknowledged that the ISPs were not developed prior to the resident admission as required. At the time of the survey, the ALR failed to ensure that preadmission ISPs were developed to determine the service needs for each resident. This is a repeat deficiency. See Statement of Deficiencies Report dated 07/12/2022.	R 471	471 1.Unable to correct already Residents # 20,23, and 25. 2.All prospective Admission ISPs will be completed no more than 30 days prior to admissions and the "Mayor's form (H&P) will be is complete prior to the pre-admission assessment. 3.Newly admitted resident information will be reviewed/discussed in the monthly QA meeting	ongoing

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R 475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all Individualized Service Plans (ISP's) were consistently signed by the resident or a surrogate and a representative of the ALR, for six of 33 residents sampled (Residents #1, 3, 4, 12, 20 and 28). Findings included: 1. On 03/09/2023 at 3:49 pm, a review of Resident #12's medical record showed that an ISP review was conducted on 05/10/2022. The ISP was signed by the Registered Nurse (RN) but failed to show evidence that the ISP was signed by the resident or a surrogate. 2. On 03/13/2023 at 1:37 pm, a review of Resident #3's medical record showed that an ISP review was conducted on 05/10/2022. The ISP was signed by the Registered Nurse (RN) but failed to show evidence that the ISP was signed by the resident or a surrogate. 3. On 03/13/2023 at 3:02 pm, a review of Resident #4's medical record showed that a 30-day ISP review was conducted on 07/04/2022. The ISP was signed by the Registered Nurse (RN) but failed to show evidence that the ISP was signed by the resident or a surrogate. 4. On 03/08/2023 at 1:37 pm, a review of Resident #1's medical record showed that an ISP was developed on 05/19/2022 and revised on 06/23/2022. The document failed to show evidence that the ISP was reviewed and signed by the resident and a representative of the ALR.	R 475	475 Residents # 1,3,4,12,20 and 28 ISP have been signed. During the scheduled ISP conference, the Resident /Responsible party and or Surrogate and staff will review and sign the document. Resident will be physically present during the conference so a signature can be obtained on ISP. ISP will be emailed/mailed for participants not physically present during care conference with instruction to return signed to community within 14 days. The ISP will be placed in binder which will be accessible to staff for review and updating. The staff will be informed of the location of the binder 5/3/2023. New ISPs will be reviewed at monthly QA to ensure signed by resident.	

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R 475	Continued From page 23. 5. On 03/07/2023 at 3:16 pm, a review of Resident #20's medical record showed that an ISP was developed on 09/08/2022. The document showed that the ISP was reviewed and signed by the resident, however there was no evidence that a representative of the ALR signed the document. 6. On 03/08/2023 at 03:37 pm, a review of Resident #28's medical record showed that the resident was admitted to the ALR on 12/22/2022. Preadmission ISP was developed on 12/12/2022 and reviewed on 01/04/2023. The ISP was signed electronically by the RN, but failed to show evidence that the ISP was signed by the resident or a surrogate. On 03/10/2023 at 1:15 pm, the above findings were discussed with the DON. She acknowledged the ISPs were not signed as required. At the time of the survey the ALR failed to ensure all ISPs were signed by a resident or surrogate and a representative of the ALR	R 475		
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident,	R 483	R483 1.Residents # 1,2,4,6,7,11,12,16,19,26, and 29 deficiencies acknowledged. ISP current with ISP updates. 2.An audit of all current Resident ISPs will be conducted to ensure current and timely by clinical leadership by 5-31-23 A tickler will be utilized to help track ISP reviewed at 30 days, significant change. and every 6months 3.ISP tickler will be reviewed. at monthly QA meeting for compliance	5-31-23

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R 483	Continued From page 24. the resident's surrogate, if necessary, and the ALR. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Individual Support Plan (ISP) was reviewed 30 days after admission, at least every six months, updated with significant changes, and that the ISPs had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate, for 11 of 33 residents sampled (Residents #1, 2, 4, 6, 7, 11, 12, 16, 19, 26, and 29). Findings included: I. The ALR failed to review each resident's ISP 30 days after admission, as follows: a. On 03/07/2023 at 3:30 pm, a review of Resident #26's medical record showed that the resident was admitted on 07/05/2022. However, the ISP was reviewed on 09/24/2022, two months after the admission date. b. On 03/09/2023 at 11:00 am, a review of Resident #2's medical record showed that the resident was admitted on 03/22/2022. However, the ISP was reviewed on 06/23/2022, three months after the admission date. II. The ALR failed to update each resident's ISP every six months, as follows: a. On 03/09/2023 at 2:01 pm, a review of Resident #29's medical record showed that the resident was admitted on 09/03/2021 and the ISP was reviewed 06/23/2022. There was no evidence that the ISP was reviewed since 06/23/2022.	R 483		

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R 483	Continued From page 25. b. At 3:49 pm, a review of Resident #12's medical record showed that the resident was admitted on 11/06/2021 and the ISP was reviewed on 06/23/2022. There was no evidence that the ISP was reviewed since 06/23/2022. c. On 03/10/2023 at 10:23 am, a review of Resident #11's medical record showed that the resident was admitted on 02/01/2022 and the ISP was reviewed on 06/23/2022. There was no evidence that the ISP was reviewed since 06/23/2022. d. On 03/07/2023 at 3:30 pm, a review of Resident #26's medical record showed that the resident was admitted on 07/05/2022 and the ISP was reviewed on 09/24/2022 (one month later). There was no evidence that the ISP was reviewed since 09/24/2022. e. On 03/08/2023 at 1:37 pm, a review of Resident #1's medical record showed that the resident was admitted on 09/15/2021 and the ISP was reviewed 06/23/2022. There was no evidence that the ISP was reviewed since 06/23/2022. f. On 03/08/2023 at 3:37 pm, a review of Resident #7's medical record showed that the resident was admitted on 10/21/2021 and the ISP was reviewed 06/03/2022. There was no evidence that the ISP was reviewed since 06/03/2022. g. On 03/09/2023 at 11:40 am, a review of Resident #16's medical record showed that the resident was admitted on 07/08/2021 and the ISP was reviewed on 06/23/2022. There was no evidence that the ISP was reviewed since 06/23/2022.	R 483		

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R 483	Continued From page 26. h. On 03/09/2023 at 11:47 am, a review of Resident #19's medical record showed that the resident was admitted on 04/22/2022. The ISP was dated 04/24/2022. There was evidence that the ISP was reviewed since 04/24/2022. i. On 03/09/2023 at 10:35 am, a review of Resident #4's medical record showed that the resident was admitted on 10/08/2021 and the ISP was reviewed 03/29/2022. There was no evidence that the ISP was reviewed since 03/29/2022. III. The ALR failed to review and update each resident's ISP after the resident experienced a significant change, as follows: a. On 03/09/2023 at 10:35 am, a review of Resident #4's medical record showed a progress note dated 08/17/2022, which showed that the resident received a skin assessment secondary to her complaint of bedbugs in her unit and subsequently relocated to another unit for extermination purposes. Resident #4's current ISP dated 03/29/2023 did not reflect the resident was moved from her unit in August 2022 due to bedbug concern. During an interview at 1:15 pm, the Director of Nursing (DON), who assisted the surveyor with the record review said that Resident #4's incident of bedbugs should have been updated on the resident's current ISP. b. On 03/13/2023 at 3:47 PM, a review of the Resident #6's ISP showed the resident was admitted on 06/03/2021 and the ISP was updated on 06/23/2022. The ISP documented that Resident #6's skin was being monitored due to a	R 483		

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R 483	Continued From page 27. bed bug exposure in June 2022. However, there was no documented evidence that the ISP was reviewed in December 2022 after a new exposure to bed bugs in her unit. On 03/13/2023 at 3:46 pm, an interview with the ADON (#1) showed that the ISP had not been revised since the earlier survey which prompted the ALR to develop the 06/23/2022 ISP. When asked what date the document should have been updated, the ADON #1 replied, "I'm not sure but the support is current." On 03/13/2023 at 4:10 pm, a review of the ALR's ISP policy dated 06/04/2021, showed the following: "ISP policy will be the basis for the provision of all services." On 03/13/2023 at 4:22 pm, an interview with the Assisted Living Administrator (ALA) confirmed that their policy required that every ISP, including Resident #6's should reflect current services based on significant changes. At the time of the survey, the aforementioned ISPs lacked documented evidence that they were reviewed either 30 days after admission, at least every six months, and/or updated to address significant changes. This is a repeat deficiency. See Statement of Deficiencies Report dated 07/12/2022.	R 483		
R 562	Sec. 701a Staffing Standards. (a) An ALR shall be supervised by an ALA who shall be responsible for all personnel and services within the ALR.	R 562		

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R 562	Continued From page 28. Based on observations, record reviews, and interviews, the Assisted Living Administrator failed to establish an effective monitoring mechanism, develop and/or implement written policies and procedures to ensure adequate oversight of the Assisted Living Residence, as evidenced by the ALA's failure to: A. Establish a mechanism to ensure all guests signed in and out of the ALR and did not stay longer than the ten-day maximum allowed in the facility guest policy (Regulation-10110.2n, § 44-105.03). B. Establish written policies and procedures regarding illicit drug use in the facility (Reg. - 10110). C. Establish a mechanism to ensure the implementation of the facility alcohol use policy (Reg.10110.2j.- R117). D. Establish a mechanism to ensure that the Department of Health (DOH) received prompt notifications of unusual incidents of all allegations of neglect and ensure investigations were conducted (Reg-10125.2 - R380 and 383). E. Establish a mechanism to ensure that healthcare workers are properly credentialed and trained (Reg. 10116.15c, 10116.15e - R280) (§ 44-107.02. - R278, R677, R678 and R682). F. Establish a mechanism to ensure the facility complies with accepted standards of infection control and Emergency Preparedness requirements (See §§ 44-105.01. R119). G. Establish a mechanism to ensure deficient practices made known to the facility via	R 562	R562 1Residents # 1 ,19 ,16 and 30 have been counseled regarding "overnight visitation". 2.Residents in the facility were informed of Policy A-485: Guest Policy in May 2023 and June and will be reviewed on a quarterly basis. The facility also developed an "Overnight Request protocol" for the residents to fill out requesting and identifying who will be staying overnight. The staff in the facility will also be performing 5 random room checks for unauthorized visitors nightly. 3.The finding of the Random room checks will be presented in the monthly QA meeting. 5. Administrator will review overnight. guest policy/protocol at time of contract signing with responsible party and resident. 562 1An Illicit drug / Alcohol protocol has been implemented that include counselling, referrals to the necessary facilities for Detox and clinical intervention as prescribed MD. 2.Staff will be educated in May 2023 and in June 2023 on the Illicit Drug Use / Alcohol Protocol. Resident health status continues to be monitored by the Clinical staff along with room checks for known offenders to prevent further occurrences.	5/2023 & 6-15-23 6-15-23

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R 562	Continued From page 29. compliance surveys were abated, and systems implemented to maintain compliance with applicable District of Columbia laws and regulations (See all repeat deficiencies throughout the report). Findings included: 1.[Cross reference 10110.2n - R121] The ALA failed to ensure all guests signed in and out of the ALR and did not stay longer than the ten-day maximum allowed per the facility's guest policy, as follows: On 03/10/2023 at 11:00 am, during interview, Resident #1 said Visitor #1 had been in the unit for two days prior to her death on 01/24/2023. Later that day, a review of the facility's visitors logs for the month of January 2023 showed that Visitor #1 did not sign the visitor logbook. On 3/9/2023 at 2:06 pm, Resident #19 was seen in the dining room with a small child, and at 2:06 pm, two children were seen in the resident's unit. On 03/13/2023 at 12:30 pm, a review of the visitors logs for 03/09/2023 and 03/10/2023 showed no documented evidence that the children had been signed in and out of the facility. On 03/07/2023 at 4:38 pm, it was brought to the surveyor's attention that Resident #16 recently had a visitor who had stayed longer than 10 days in the unit. Interviews with the resident and the ALA on 03/09/2023 confirmed the information, and the ALA presented an Overnight Visitor Request form as documentation. On 03/09/2023, it was brought to the surveyor's attention that Resident #30 had exceeded 10 nights of visitation by a guest. On 03/13/2023 at	R 562	R562 3.Documentation of the Room Checks/ Interventions will be presented in the monthly QA meeting. 4.Signs have been posted at all 5 entrance doors notifying all visitors and residents' illegal drugs not allowed. 5. Administrator will review illicit drug and alcohol protocol with all new residents at time of contract signing and with current residents at May 2023 Resident Town Hall, monthly x2 then quarterly. R562 1.Resident #32 informed staff 71/2 hours after the incident of the fall. The Nurse failed to call 911 and alert Nursing Leadership as well as the Administrator. The Licensed Nurse in question has been disciplined. 2.The facility staff have been re-educated on the procedures for "Change in Condition" and Proper Timely Notification to DOH" and "Investigative Procedures". Incident reports will be reviewed daily by leadership at morning meeting. 3. All Incident reports will be reported/reviewed at monthly QA meeting.	6-15-23

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R 562	Continued From page 30. 11:30 am, the ALA confirmed that Resident #30 often had weekend visitors and had consistently submitted Overnight Visitor Request forms for review and approval. She added that the resident knew about the maximum 10 days allowed annually. The ALA then acknowledged that the policy had not been enforced. At 2:37 pm, review of the Overnight Visitor Request forms showed that visitors with Resident #30 had visited a total of 42 days during the period of November 2022 through February 2023. 2. [Cross reference 10110.1- R106] Reviews of incident reports and nurse progress notes showed that the ALR staff were aware that some residents used illicit drugs. The facility, however, remained without a written policies and procedures regarding illicit drug use, as follows: On 03/07/2023 beginning at 4:16 pm, a review of Resident #31's nurse progress notes and hospital records showed evidence that facility staff were aware that the resident had used heroin on 10/18/2022, 10/19/2022 and 10/23/2022. Resident #31 died of a heroin overdose in his unit on 10/26/2022. According to an incident report dated 01/24/2023, Resident #1 was transported to a hospital emergency room (ER) after informing staff that he drank a gallon of wine and smoked phenyl cyclohexyl piperidine (PCP). Per a facility incident report dated 01/27/2023, someone who was visiting Resident #1 died while in the resident's unit. According to the report, the visitor was pronounced dead on the scene by Emergency Medical Services (EMS) technicians due to a drug overdose.	R 562	562 Incident with Resident #32 was reviewed 1.Leadership was in-serviced on protocol for incident reporting by administrator in May and including proper documentation and calling DOH. The incident reports will be reviewed for accuracy and proper notification daily by community leadership team. 3.The Findings of the incident reports will be reviewed at monthly QA meeting. 562 CPR CNA 5, administrator, Dining Service Director and Sales Director will be trained by 5-18-23 on CPR An audit of all current staff training records will be completed by 5-31-23 by community HR leadership team CPR class has been scheduled for May 11th and 18th 2023 by Red Cross instructor. Administrator, Assistant Administrator and or designee will use a tickler to monitor staff training CPR training and will be reviewed monthly at Quality Assurance meeting.	5-31-23

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R 562	Continued From page 31. On 03/01/2023 at 3:23 pm, the Assisted Living Administrator (ALA) was asked about policies and procedures on illicit drug use within the building. The ALA confirmed that the facility did not have written policies and procedures that would inform and guide staff on how to respond to the suspicions or discovery of illicit drug use within the community. On 03/09/2023 at 11:41 am, the Assistant Assisted Living Administrator informed the survey team that the ALR does not have written policies and procedures about drug use by the residents. 3. [Cross reference 10110.2j- R117] A review of the ALR's incident report log and Resident #7's Individual Service Plan (ISP) and nurse progress notes showed evidence that the facility did not implement its alcohol policy, as follows: On 03/08/2023 at 2:21 pm, review of an incident report showed that on 06/01/2022, Resident #7 became intoxicated in his unit and fell while transferring himself from the toilet to a wheelchair. Resident #7 was transported to the ER on 06/01/2022 and released the next day. At 2:59 pm, when the Director of Nursing (DON) was asked about Resident #7's fall, the DON said that Resident #7 was an alcoholic, and the fall occurred while the resident was intoxicated. This was confirmed through review of Resident #7's ISP dated 06/03/2022. It should be noted however, that the 06/03/2022 ISP did not reflect the need to ensure that Resident #7 received counseling on alcohol consumption, as written in the facility's alcohol policy. It should be further noted that on 03/09/2023 at 1:03 pm, the DON said she was not aware of the alcohol policy. 4. [Cross reference 10125.2- R380] The ALA failed to ensure the Department of Health (DOH)	R 562	562 1. Life enrichment Staff has been educated on the proper protocol for the handling of items of consumption for future activities. 2. Community staff will be in-serviced in May 2023 on Universal and, standard precautions and proper food handling The Activities involving food preparations will be reviewed with Dining Director. 3.Activity Director will present planned activities daily at morning meeting. 4. Activity program will be reviewed at monthly QA. 562 Policy Review 1. Community Operation Guidelines will be reviewed by 5-18-23 2. Operational Guidelines as well as other community protocols in the facility will be reviewed on annual basis. The signatures of all leadership will be reflected in each binder. 3.The QA meeting participants will oversee process.	

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R 562	Continued From page 32. received prompt notifications of all allegations of neglect and ensure investigations were conducted, as follows: On 03/07/2023 at 4:00 pm, Resident #32 informed the surveyor that she fell while walking to the bathroom on 01/07/2023 between 1:15 am and 1:30 am. Further discussion showed that Resident #32 informed a nurse 7 1/2 hours later and a Certified Nursing Assistant (CNA) of the fall. Interviews and record reviews showed that the nurse did not assess the resident. Per the resident, the nurse instructed her to call 911. No facility staff assisted in calling 911. Resident #32 went to the emergency room after she called her sister for help in calling the emergency services (911). On 03/10/2023 beginning at 3:00 pm, an interview with the ALA and DON revealed that they were not aware of the aforementioned incident prior to the survey. They also confirmed that no incident report was generated and DOH was not notified of Resident #32's fall and fractured ankle. In addition, the ALR did not investigate the incident in accordance with the "Incident Reporting" Policy, dated 06/04/2021. 5. [Cross reference 10125.4a - R383] The ALR did not notify the DOH timely of all incidents that affected residents and investigate the incidents, as follows: Per an incident report sent to the DOH on 10/26/2022, Resident #31 died of a heroin overdose in his unit. An earlier incident report, received by the DOH on 10/19/2022, stated that the resident informed a nurse that he had snorted heroin. On 03/07/2023 beginning at 4:16 pm, a review of the resident's medical records showed	R 562	562 Covid 1. The Facility resumed Covid 19 prevention and mitigation protocol. 2. The front desk staff will be educated by administrator on sign in process of Covid19 screening process of visitors, and completion of sign-in information to include name, phone number, address, email, and name and room# of the person visiting. A binder of said information will be kept and maintained by front desk staff. 3. The QA committee will review the binder monthly for compliance at meeting.	5-31-23

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R 562	Continued From page 33. that there were three separate incidents (dated 10/18/2022, 10/21/2022 and 10/23/2022) involving Resident #31 using heroin that were not reported to the DOH. The ALR did not investigate the resident's death. Review of the ALR's incident reports showed that 911 emergency services were called when Resident #33 was found unresponsive in his unit on 01/10/2023. The ALR reported to DOH that 911 was called, however, the ALR did not report to DOH that the resident was declared deceased upon assessment by the EMS technicians, either by telephone promptly or by written follow up. On 03/10/2023 at 4:23 pm, the ALA acknowledged that the incident should have reflected that Resident #33 died. In addition, the ALR did not investigate the incident. Survey finding revealed that at least two cases of bedbug infestation were documented after the DOH Surveyors were in the facility in July 2022. Exterminator service invoices showed that they treated one unit for bed bug infestation on 11/08/2022 and 12/14/2022. Neither of the two infestations were reported to DOH or investigated. According to an incident report, Resident #1 called 911 emergency services on 01/23/2023. A visitor was unresponsive. Emergency services and Metropolitan Police investigated. On 01/24/2023, DOH received written notification. The incident, however, was not reported by telephone. In addition, the ALR did not investigate the incident. 6. [Cross reference 10116.15c - R278] On 03/08/2023 beginning at 3:22 pm, review of personnel records showed no evidence that CNA	R 562		

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R 562	Continued From page 34. #5 had a current certification. At 4:22 pm, CNA #5 confirmed with the surveyor and the ALA that she did not possess a current certification. 7. [Cross reference Sec. 702b8 - R677, Sec. 702b9 - R678 and Sec. 702c3 - R682] The ALA failed to ensure all staff received trainings in areas of First Aid and CPR, infection control and Alzheimer's/Dementia, as follows: On 03/07/2023 and 03/08/2023, the Assisted Living Administrator (ALA), Certified Nursing Assistant (CNA #5), the Food Services Director (FSD) and the Director of Sales and Marketing (DSM) were seen onsite, performing duties. On 03/08/2023 beginning at 3:22 pm, a review of the employee's records showed no evidence that the four employees were trained and certified in First Aid and CPR, as required by the ALR's policies on orientation training. On 03/08/2023 at 10:27 am, nine residents were observed going into the activity room. Observations showed that the staff did not ask the residents to wash their hands or perform hand hygiene, before the group began preparing cake pops. Continued observations showed four residents passing a bowl around the table, each pouring batter into a cup. The bowl was then set aside and left uncovered for approximately 20 minutes. Without inspecting the batter, the Activities Coordinator (AC) retrieved the batter and filled the cups for the other five residents. Later that afternoon, some the residents were observed eating cake pops. On 03/08/2023 at 2:53 pm, an interview with the AC revealed that she planned all the activities and gathered the supplies under the direction of the Assistant ALA. The AC said that she was not aware that the residents should have performed hand hygiene or donned gloves prior to taking part in food preparation.	R 562		

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R 562	Continued From page 35. When asked whether the cake batter could be left on the counter uncovered, AC replied that she was not sure and would ask the Assistant ALA. At 3:10 pm, the Assistant ALA said that the Director of Food Services (DFS) previously had informed her that he (DFS) should help in coordinating recreational activities when they involved mixing, cooking and storage. The DFS, who was present at the time, confirmed that when activities include mixing, baking, etc., he should aid with the coordination to ensure food safety and sanitation. On 03/09/2023 at 10:10 am, review of the ALR's food services policy dated 01/18/2021 revealed that all food and services will be supervised by the DFS when served to the residents. In addition, staff must ensure that universal precautions (hand washing) should be implemented. The Assistant Director and the DFS confirmed that all staff must ensure and maintain universal precautions for all food supplied by the ALR. On 03/08/2023 beginning at 9:45 am, a Certified Nursing Assistant (CNA) #5 and the Director of Nursing (DON) were seen in the ALR providing services to the residents. Beginning at 3:22 pm, review of the of the personnel files for CNA #5 and the DON failed to show evidence that the required training had been received. At 4:19 pm, an interview with the Assistant ALA confirmed that CNA #5 and the DON had not received annual training covering cognitive impairments. 8. [Cross reference 10110.2I-R119] The ALA failed to ensure that the ALR complied with the Federal Emergency Preparedness policies and procedures and District of Columbia health	R 562		

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R 562	Continued From page 36. guidance on COVID 19/Infection Control, as follows: On 03/08/2023 beginning at 10:30 am, a review of the ALR's Emergency Management Plan (EMP, dated 01/15/2021) showed it was approved by the governing body on 03/02/2021. The list for "key contacts" in the EMP began with the names and phone numbers of an ALA and a DON who were no longer employed. On 03/08/2023 at 2:36 pm, when asked about the EMP, the ALA confirmed that the plan had not been reviewed and updated since 2021 nor had the contact information been kept current. On 01/06/2023, DOH issued guidance to all ALR's on COVID 19 prevention and mitigation. Observations on 03/07/2023 at 9:00 am and 12:29 pm, and again on 03/08/2023 at 9:07 am showed there was no signage posted at the entrance informing visitors that people with symptoms of COVID 19 or who had been in close contact with a person who was COVID 19 positive could not enter. The receptionist did not inform the survey team on either day that visitors with symptoms or with recent contact with a positive person were prohibited from entering. Interviews with the receptionist and ALA on 03/08/2023 at 9:10 am and 2:37 pm, respectively, confirmed that the ALR had not informed visitors of the COVID 19 requirements. In addition, review of the February 2023 visitors log showed the ALR did not obtain each "visitors' full names, phone number, full home address, email, name and room number of the person they are visiting..." as required by the guidance.	R 562		
R 596	Sec. 701d9 Staffing Standards.	R 596		

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R 596	Continued From page 37. (9) Assure that members of the staff appear to be free from apparent signs and symptoms of communicable disease, as documented by a written statement from a healthcare practitioner. Based on observation, interview and record review, the Assisted Living Administrator (ALA) failed to ensure that all staff had a written statement from a healthcare practitioner stating that they were free from communicable disease, for four of 20 personnel records reviewed (Certified Nursing Assistant #3, Certified Nursing Assistant #5, Assistant Director of Nursing #2, and Director of Nursing). Findings included: On 03/08/2023 beginning at 9:45 am, two Certified Nursing Assistants (CNAs #3 and 5), Assistant Director of Nursing #2 and the Director of Nursing were observed assisting and/or providing services to the residents in the ALR. Beginning at 3:22 pm, review of the personnel records for CNAs #3 and five, Assistant Director of Nursing #2 and the Director of Nursing showed no documented evidence of a written statement from a healthcare practitioner indicating that the employee was free from communicable disease. At 4:19 pm, an interview with the ALA confirmed that all of the employees identified did not have current written statements from a healthcare practitioner indicating that they were free from communicable disease. At the time of survey, the ALA failed to ensure that each employee's personnel record included a signed statement from a healthcare practitioner verifying freedom from communicable disease.	R 596	1. The DON, ADON#2, CNA#3 and #5 have been instructed to have written evidence that are free of communicable disease by 5-16-23 2. HR community leadership will audit all current employee record to ensure that are no further infractions, and a tickler will be used to monitor compliance. 3.Findings of audit will be presented in monthly QA and training tickler will be reviewed at monthly QA meeting	5-31-23

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R 600	Continued From page 38.	R 600		
R 600	Sec. 701d13 Staffing Standards. (13) Complete the training required by section 702 and 12 additional hours of training, annually, conducted by a nationally recognized organization that possesses experience in training staff in dementia care, such as the Alzheimer's Disease and Related Disorders Association, on managing residents who are living with cognitive impairments. Based on observations, staff interviews, and a review of the personnel records, the Assisted Living Residence (ALR) failed to ensure that the Assisted Living Administrator (ALA) completed the required training on dementia care, for the one of one administrator sampled. Findings included: On 03/08/2023 beginning at 9:45 am., the Assisted Living Administrator was observed providing services in the facility. Beginning at 3:22 pm, a review of the personnel file for the ALA failed to show documented evidence of the required dementia care training. At 4:19 pm, an interview with the ALA confirmed that she had not received the 12 hours of annual training (i.e., dementia care, such as the Alzheimer's Disease and Related Disorders Association), as required. At the time of the survey, the ALR failed to ensure that the ALA received 12 hours of dementia care training.	R 600	R600 The ALA/ED is in the process of completing the necessary Dementia Training. Projected completion date 5-31-23 Moving forward a Training tickler will be used to monitor all staff annual training compliance to include Administrator 12 hours of dementia and related diagnosis. Tickler will be reviewed at monthly Quality assurance meeting.	5-31-23
R 605	Sec. 701g2 Staffing Standards.	R 605		

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R 605	Continued From page 39. (2) Possess current and appropriate licensure and certifications as required by law. Based on observations, interview and record reviews, the Assisted Living Administrator (ALA) failed to ensure that all staff possessed appropriate certification for one of the 20 employees reviewed (Certified Nursing Assistant #5). Findings included: On 03/08/2023 beginning at 9:45 am, a Certified Nursing Assistant (CNA) #5 was seen in the ALR providing services to the residents. Beginning at 3:22 pm, a review of CNA #5's personnel record lacked evidence of current certification. On 03/08/2023 at 4:22 PM, during an interview, CNA #5 confirmed with the surveyor and the facility administrator that she did not have a current certificate to practice as a certified nursing assistant. The facility administrator failed to ensure that CNA #5 possessed appropriate credentials to provide healthcare services to residents of the ALR.	R 605	3-8-23 CNA 5 was removed from providing direct care and will not return to care until can provide copy of current CNA certification. An audit of all current CNA and Nurse personal file will be audited to ensure all license/certifications are current. Moving forward a training/certification tickler will be used to monitor training/certifications/License and will be reviewed monthly at Quality. Assurance meeting. HR community leadership will maintain tickler.	5-31-23
R 652	Sec. 702a1 Staff Training. (1) Be certified as a nurse's aide. Based on observations, interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all staff possessed appropriate certification for one of the 20 employees sampled (Certified Nursing Assistant #5). Findings included:	R 652	3-8-23 CNA 5 was removed from providing direct care and will not return to care until can provide copy of current CNA certification. Community HR leader will audit of all current CNA and Nurse personal file ensure all license/ certifications are current. Moving forward a training/certification tickler will be used to monitor training/certifications/License and be reviewed monthly at QA meeting	5-31-23

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R 652	Continued From page 40. On 03/08/2023 beginning at 9:45 am, a Certified Nursing Assistant (CNA) #5 was observed in the ALR providing services to the residents. Beginning at 3:22 pm, a review of CNA #5's personnel record lacked evidence of current certification. On 03/08/2023 at 4:22 PM, during an interview, CNA #5 confirmed with the surveyor and the facility administrator that she did not have a current certificate to practice as a certified nursing assistant. The facility administrator failed to ensure that CNA #5 possessed appropriate credentials to provide healthcare services to residents of the ALR. Cross reference to R 605	R 652		
R 677	Sec. 702b8 Staff Training. (8) Choking precautions and airway obstruction, including the Heimlich Maneuver; and Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed ensure each employee was trained on choking precautions and airway obstruction, i.e., Cardiopulmonary Resuscitation (CPR), including the Heimlich Maneuver, for four of 20 employees (Certified Nursing Assistant #5, Assisted Living Administrator (ALA), Food Services Director and Director of Sales and Marketing). Findings included: On 03/08/2023 beginning at 9:45 am, observations showed that Certified Nursing Assistant (CNA#5), ALA, Food Services Director	R 677	CNA 5, administrator, Dining Service Director and Sales Director will be trained by 5-16-23 on CPR and Heimlich maneuver. An audit of all current staff training records will be completed by 5-8-23 to ensure staff are trained on Heimlich Maneuver/CPR certified. CPR class has been scheduled for May 11th and May 18th with Red Cross. Administrator, Assistant Administrator and or designee will use a tickler to monitor staff training CPR/Heimlich Maneuver and will be reviewed monthly at Quality Assurance meeting.	5-31-23

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R 677	Continued From page 41. and Director of Sales and Marketing provided services to the residents in the ALR. At 3:22 pm, a review of personnel records for CNA #5, ALA, Food Services Director and Director of Sales and Marketing lacked evidence of current training on choking precautions and airway obstruction (i.e., CPR), including the Heimlich Maneuver. At 4:19 pm, an interview with the ALA confirmed that all of the employees identified should have a current First Aid and CPR certificate due to the status of being a full-time employee. At the time of the survey, there was no documented evidence that each employee met or possessed training on choking and airway obstruction (i.e., CPR), including Heimlich Maneuver. This is a repeat deficiency. See Statement of Deficiencies Report dated 02/04/2022.	R 677		
R 678	Sec. 702b9 Staff Training. (9) Infection control. Based on observations, interview, and record reviews, the Assisted Living Residence (ALR) failed to ensure all staff demonstrated knowledge of food safety and hand hygiene policies, for one of 20 staff sampled (Activity Coordinator (AC #1). Findings included: On 03/08/2023 at 10:27 am, nine residents were observed going into the activity room. Observations showed that the staff did not ask the residents to wash their hands or perform hand hygiene, before the group began preparing cake pops.	R 678	R678 5-3-23 Activity director will be educated on proper handwashing prior to anyone including residents handling food. Beginning in May of 2023 Activity Director will include Dining Director or dietary member that is safeserv food certified, when a resident activity includes food making/cooking to ensure proper infection control and food handling occurs. A member of Leadership team members will monitor community daily to ensure proper hand hygiene is being followed with emphasis on food handling during activity programing.	

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R 678	Continued From page 42. cake pops. Continued observations showed four of the residents passing a bowl around the table, each pouring batter into a cup. The bowl was then set aside and left uncovered for approximately 20 minutes. AC #1 retrieved the batter and without inspecting the bowl, filled the cups of the other five residents. Later that afternoon, the residents were observed eating cake pops. At 2:53 pm, an interview with AC #1 showed that she planned all the activities and gathered the supplies under the direction of the Assistant Executive Director (AED). The AC #1 stated that she was not aware that the residents should have performed hand hygiene or donned gloves prior to participating in food preparation. When asked whether the cake batter could be left uncovered on the counter, AC #1 replied that she was not sure and would ask the AED. At 3:10 pm, the AED stated that the Director of Food Services (DFS) previously had informed her that he (DFS) should assist in coordinating recreational activities when they involved mixing, cooking and storage. The DFS, who was present at the time, confirmed that when activities include mixing, baking, etc., he should assist with the coordination to ensure food safety and sanitation. On 03/09/2023 at 10:10 am, a review of the facility's food services policy dated 01/18/2021 showed that all food and services will be supervised by the food services director when served to the residents. In addition, staff must ensure that universal precautions (hand washing) be implemented. The Assistant Director and the Food Service Director confirmed that all staff must ensure universal precautions for all food supplied by the facility.	R 678		

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R 678	Continued From page 43. At the time of the survey, the ALR failed to ensure that staff engaged in food preparation activities demonstrated knowledge of food safety and hand hygiene practices, in addition to ensuring that the Director of Food Services was involved and/or assisting with activities that involved meal preparation, to ensure hand washing and other food safety and sanitation protocols are followed.	R 678		
R 682	Sec. 702c3 Staff Training. (3) Four hours covering cognitive impairments in an in-service training approved by a nationally recognized and creditable expert such as the Alzheimer's Disease and Related Disorder Association; and Based on observations, interview, and record reviews, the Assisted Living Residence (ALR) failed to ensure all employees had a minimum of four (4) hours of annual training covering cognitive impairment for two of 20 employees reviewed (Certified Nursing Assistant (CNA) #5 and the Director of Nursing). Findings included: On 03/08/2023 beginning at 9:45 am, a Certified Nursing Assistant CNA #5 and the Director of Nursing (DON) were observed in the ALR providing services to the residents. Beginning at 3:22 pm, a review of the personnel files for CNA #5 and the DON lacked evidence that either employee engaged in cognitive impairment training. During an interview at 4:19 pm, the Assisted Living Administrator (ALA) confirmed that CNA #5 and the DON had not received the four hours of	R 682	3-8-23 CNA number 5 was removed form providing direct care. CNA will not Provide direct care until 4hours of cognitive impairment/dementia annual training is complete. Director of Nursing resigned 5-19-23. An Audit of all current care staff training will be completed by 5-31-23 to ensure. all staff have 4 hours of cognitive impairment dementia training. All staff Training compliance/requirements will be reviewed at monthly QA meeting.	5-31-23

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R 682	Continued From page 44. annual training covering cognitive impairment. At the time of the survey, the ALR failed to ensure that CNA #5 and the DON received training on cognitive impairment.	R 682		
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so, indicated during the medical assessment. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that a standardized physician's statement, approved by DC Health, was completed with all the required information, for seven of 33 residents sampled (Residents #3, 4, 20, 23, 25, 26 and 28). Findings included: 1. On 03/07/2023 at 3:16 pm, a review of Resident #20's medical certification form dated 08/25/2022, lacked documented evidence that the physician screened the resident for communicable disease, tuberculosis, or dementia; there was no determination if the resident had dentures, or needed a Mammogram, Papanicolaou (pap) test, or Colonoscopy. Additionally, the form did not indicate if the resident had ever been hospitalized for a mental health condition.	R 705	Resident 3,4,20,23,25,26, and 28 physician statements/medical certificate unable to correct as occurred in the past. 4-27-23 Regional Director of Clinical re-educated all Clinical leadership, administrator, Sales Director and Assisted administrator that every resident must have a medical certificate completed in its entirety. No section of can be left blank and must prior to physical move in. Starting in May of 2023 a Move in check list will be utilized with each new move in to ensure have completed medical certificate prior to move in Moving forward the Clinical RN will sign bottom of each medical certificate to verify it was reviewed and completed in entirety prior to move in. Every new resident's medical certificate will be reviewed monthly during QA meeting	5-31-23

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R 705	Continued From page 45. 2. On 03/13/2023 at 4:10 pm, a review of Resident #23's medical certification form, dated 02/24/2023, showed no information whether the resident wears dentures, or the need for a Prostate specific Antigen (PSA) or Colonoscopy. 3. On 03/07/2023 at 4:10 pm, a review of Resident #25's medical certification form, dated 10/24/2022, showed no assessment information regarding the need for dementia screening. 4. On 03/07/2023 at 3:30 pm, a review of Resident #26's medical certification form, dated 06/16/2022, showed no assessment information regarding amputation, prosthesis, dentures, required laboratory services, or prescribed medications. 5. On 03/08/2023 at 3:24 pm, a review of Resident #28's medical certification form dated 12/12/2022, showed no assessment information about the need for a PSA or Colonoscopy, and if the resident was or was not exhibiting signs or symptoms suggestive of communicable disease. 6. On 03/09/2023 at 4:00 pm, a review of Resident #3's medical records showed no medical certification form. 7. On 03/09/2023 at 10:35 am, a review of Resident #4's medical records showed no medical certification form. On 03/09/2023 at approximately 4:30 pm, the above findings were shared with the Director of Nursing, who confirmed the findings. At the time of the survey, the ALR failed to ensure that the physician completed the standardized physician's statement, with all areas assessed.	R 705		

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R 705	Continued From page 46. Failure to obtain an applicant's current physical condition and medical status on the standardized form is a repeat deficiency. See Statement of Deficiencies Report dated 07/12/2022.	R 705		
R 961	Sec. 1002 1 Fire Safety. (1) An ALR shall be in compliance with Chapter 22, New Residential Board and Care Occupancies, Life Safety Code of the National Fire Protection Association; and Based on record review and interview, the Assisted Living Residence (ALR) failed to ensure fire drills were conducted quarterly on each shift; and document an administrative review of each fire drill report form. Findings included: 1.On 03/08/2023 beginning at 10:10 am, a review of the facility's Fire Drill report forms showed there was one form completed for each month from March 2022 through August 2022. Each of the monthly drills had a 2023 date. For March, however, someone marked over the three, changing it from 2023 into 2022. However, the other months, April, May, June, July, August all showed 2023 dates. When the forms were placed overtop each other and held up to the light, they showed the exact same markings and signature by the Maintenance Director. The only information that was not an exact match was the monthly date. At 3:09 pm, when the Maintenance Director was asked about the fire drill forms that showed April 2023 through August 2023 dates, he confirmed that they were all the same form which had been photocopied.	R 961	R961 4-27-23 Maintenance Director obtained clean fire drill logs to use moving forward instead of using a photocopy. Administrator will re-educate Maintenance Director and the rest of community leadership on proper way to document fire drills by May 5-13-23. Ongoing Fire logs will be reviewed. at monthly QA meetings to ensure accurate and form completed in entirety and signed.	5-13-23

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	ALR-0041	A. BUILDING: _____ B. WING _____	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 961	Continued From page 47. He explained that it was done to "get caught up." The dates on each form did not represent actual fire drill dates but were dates taken from a 2022 fire drill schedule, added after the fact. He further said that "no one looks at" the fire drill forms, "they are for me." When asked about a space at the bottom of the form that was designated for an administrator's signature, he repeated that no other persons looked at the drill report forms. 2. The fire drill report form had two spaces designated for signatures near the bottom of the page. One line was marked "Administrator." There was no signature on the line marked Administrator on any of the forms reviewed by the survey team. At 2:43 pm, when the Assisted Living Administrator (ALA) was asked about the space marked "Administrator," she confirmed that the ALA was expected to review and sign each form. She then acknowledged that she had not reviewed any of the fire drill report forms presented to surveyors. 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. In addition, there was no evidence that the ALA had reviewed each drill report form and signed off at the bottom, as expected by their written emergency plan.	R 961 971	1.Garbage hanging from dumpsters removed. Brown Garbage dumpsters emptied on 3-9-23 by sanitation company. Red dumpster emptied. 5-3-23 by sanitation company and red dumpster added to sanitaation contract for routine emptying. b. Administrator/Maintenance Director will review proper garbage disposal at May 2023 at all staff meeting and with Residents at May 2023 resident council/town hall meeting. c. Maintenance Director and or maintenance Assistant will monitor dumpster daily to ensure emptied and no garbage on the ground.	5-10-23
R 971	Sec. 1003a General Building Exterior (a) An ALR shall ensure that the exterior of its facility, including walkways, yards, porches, chimney, gutters, downspouts, paintable surfaces, and accessory buildings are maintained structurally sound, sanitary, and in good repair.	R 971		

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R 971	Continued From page 48. Based on observations and interviews, the Assisted Living Residence (ALR) failed to maintain the facility's exterior trash collection area in a proper sanitary condition. Findings included: On 03/07/2023 at 11:14 am, four trash collection dumpsters were observed in the parking lot at the rear of the ALR, as follows: a). Two brown dumpsters had full trash bags protruding above the top, which prevented the lids from closing. Several trash bags were on the ground next to the brown dumpsters. b). There was a red dumpster that was filled with trash. The red dumpster also had a trash bag hanging on the outside. At 03/10/2023 at 4:30 pm, the Maintenance Director was asked about trash services. He said that the current trash contractor managed the brown dumpsters. When asked about the red dumpster, the maintenance Director stated that the previous trash contractor left it when the ALR changed trash contractors in June 2022. The Maintenance Director further stated that the previous vendor was asked multiple times to remove the red dumpster but refused. [Note the brown dumpsters had been emptied after the 03/07/2023 observations.] During the time of the interview, the red dumpster remained full of trash. At the time of the survey, the ALR failed to ensure that equipment (dumpsters) for collecting trash outside were always maintained.	R 971		

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R 982	Continued From page 49.	R 982		
R 982	Sec. 1004b General Building Interior (b) An ALR shall ensure that floors and stairways provide a clean, slip-resistant, and safe surface, free of tripping hazards. Based on observations and interviews, the Assisted Living Residence (ALR) failed to ensure each floor was free of trip hazards, and uncollected trash for 109 of 109 residents residing in the ALR. Findings included: 1. On 03/07/2023 at 11:16 am, the cover of a floor drain located in the fifth-floor laundry room was observed recessed approximately one inch below the floor surface which created a potential trip hazard. During an interview at 12:10 pm, the Maintenance Director said he was aware of the trip hazard and had scheduled the repair. (Note: observation on 03/09/2023 at 3:38 pm showed that the floor drain had been repaired.) At the time of the survey, there was no evidence the ALR ensured that the laundry room floor was free of potential trip hazards. 2. On 03/07/2023 at 12:00 pm, in the second-floor trash room, there were ten bags of trash stacked on the floor. In addition, a bag of trash was protruding from the trash chute, preventing the chute door from closing. Posted instructions on the wall outside the trash room door requested residents to place all trash in the chute and not on the floor. At 12:10 pm the Maintenance Director said that the trash chute was full, which prevented the	R 982	R982 1. Shower trip hazard was for repaired 3-8-23. b. Maintenance Director and or designee will walk community daily to ensure community free of trip hazards. 2. a. Trash was removed from the floor and the trash chute was unclogged and community Sanitation company missed pick up sanitation company contacted to ensure trash pickup per contract schedule 2 x week on Tuesday and Fridays. on 3-7-23 sanitation Company missed pick up 3-7-23 . rescheduled pick up 3-9-23 and trash receptacles emptied. b. Administrator/Maintenance Director will review proper garbage disposal at May 2023 all staff meeting and with Residents at May 2023 resident council/town hall meeting. c. Maintenance Director and or Assistant will monitor garbage. reciprocals daily with emphasis on garbage chute.	5-31-23

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R 982	Continued From page 50. trash chute door on the second floor from closing. As a result, residents put the trash on the floor of the trash room. At the time of the survey, the ALR failed to implement an effective system for managing trash.	R 982		5-31-23
R1058	Sec. 1011h Special requirements for ALRs with 17 beds (h) An ALR shall ensure that all food is prepared and served in accordance with Chapters 20 through 24 of Title 23 of the District of Columbia Municipal Regulations and shall organize plumbing facilities to ensure that food is processed and served so as to be safe for human consumption. Based on observations and interviews, the Assisted Living Residence (ALR) failed to follow the District of Columbia Municipal Regulations (DCMR) to ensure the proper sanitization of dishes and utensils and that food was safely prepared and served to the residents. Findings included: On 03/07/2023 starting at 12:31 pm, during the kitchen inspection, observations showed the following: 1) The water temperature at the handwashing sink located on the cooking line measured 77 degrees Fahrenheit. 2) There was a cooked pasta stored in the walk-in refrigerator that was not dated. The Director of Food Services (DFS) discarded the pasta during the inspection.	R1058	1 a. 5-9-23 Maintenance Director adjusted the water temperature at hand sink. b. Starting 5-1-23 Maintenance Director and or Dining Director will monitor hand sink temperature weekly x 4 weeks to ensure temperature maintained at or above 100 degrees. Fahrenheit c. ongoing the Maintenance and or Dining Director will monitor all water temperatures in kitchen on a monthly basis with documentation kept. 2. a.3-7-23 undated pasta was discarded by Dining director. b. dining director will review with all dietary staff on dating food. c. Dining director or a designee will monitor food for dates daily. 3. a. Day of inspection 3-7-23 Dining Director removed dented cans. b. A member of dietary staff will monitor food cans weekly for dented food cans c. Dining Service Director will re-educate all kitchen staff on monitor food cans for dents and not using any can dented	

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R1058	Continued From page 51. 3) There were two dented tin cans stored on a can rack intended for use, which were removed by the DFS. 4) There were stains and scratches observed on all the five colored chopping boards in the kitchen. 5) Observations showed that dishes were washed without sanitizer. During the kitchen inspections, a facility staff was observed washing dishes in the kitchen using the mechanical dishwasher. After the dishes were washed, observations showed that soap remained on the washed dishes. When asked, the staff said that because the dishwashing machine is not working properly the dishes will be rewashed and sanitized in the three-compartment sink. The staff said that there is a sanitizer at the third sink (labeled a sanitizer sink), where he rinsed the dishes. The manufacturer's instructions posted on the wall above the three-compartment sink states that dishes should be sanitized with a quaternary ammonium solution of 100-200 Parts Per Million (PPM) concentration. The surveyor requested a test strip, which the DFS provided. A test of the solution on the third sink labeled "Sanitizer", showed no color change on the strip, which indicated, per the manufacturer's information, that there was no sanitizer. Inspection of the sink showed there was no sanitizer solution hooked up to the dishwashing system. When asked, the DFS confirmed that currently, the ALR is out of sanitizer and would receive the sanitizer the next day. The DFS said that in the meantime, the ALR would use single-use plates, cups, and forks. It should be noted that observations showed residents ate with single-use forks, cups, and plates during dinner on 03/07/2023 and breakfast on 03/08/2023.	R1058	4. a. 5-3-23 Dining Director ordered new chopping boards and scratched. chopping boards were discarded. b. Dining Director will educate all dietary staff on chopping board care. c. Dining Director or designee will monitor monthly to all kitchen tools with emphasis on chopping boards in good work order. 5. Paper utensils were used till. Sanitizer received for Mechanical. Dishwasher. 3-9-23 b. Dining Director will re-educate all dietary staff on proper sanitation of dishes by 5-16-23 c. Ongoing Dining director or a member of leadership team will do random checks of kitchen for proper sanitizing	5-31-23

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R1058	Continued From page 52. The DFS acknowledged all the findings and stated that these points had been covered in his food safety manager training. 6. The kitchen was reinspected on 03/08/2023 beginning at 11:35 am. The water temperature at the handwashing sink located on the cooking line measured 79 degrees Fahrenheit, which was below the 100 degrees Fahrenheit minimum allowed. At the time of the survey, the ALR failed to follow District of Columbia Municipal Regulations for food safety. This is a repeat deficiency. See Statement of Deficiencies Report dated 02/04/2022 and 04/07/2022.	R1058		