Health Reaulation & Licensina Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0041	A. BUILDING: _____ B. WING _____	R 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}: Initial Comments		{R 000}	A. With respect to the specific resident(s)/situation cited: Individual service plans have been completed for (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, and 12) to determine the resident's service needs. B. With respect to what systemic measures have been put in place to address the stated concern: Livingston Place (LP) will conduct a pre-admission Individual Service Plan (ISP) for each new admission within 30 days prior to admission to determine the resident's service needs. LP will use the new move in checklist as an audit tool to ensure that all ISP's are completed prior to the date of admission to the community. The Executive Director (ED) or designee will review all documentation and confirm all necessary steps have been completed prior to the resident being admitted. For the next 3 months the ED will review 100% of new admission checklists for completion. During and after the 3 months, the Quality Assurance committee will evaluate the efficacy of the documentation and audits and determine if continued audits are needed and/or if additional actions need to be implemented.	4/14/22

0000 Initial Comments
A follow up survey was conducted on 04/06/2020 and 04/07/2022, to determine the facility's compliance with the Assisted Living Residence Regulations, Title 22-8 DCMR (Public Health and Medicine) Chapter 101 during the 02/04/2022 licensure survey.

The findings of the survey were based on observations, interviews, and review of client/administrative records.

{R 146}, 10113.1 Individualized Service Plans (ISPs) {R 146}

10113.1 An ISP shall be developed for each resident not more than thirty (30) days prior to admission.
Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident had a pre-admission Individual Service Plan (ISP) completed within 30 days prior to admission, for twelve of 13 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12).

Findings Included:

On 02/02/2022, the facility was cited for failing to ensure each resident had a pre-admission Individual Service Plan (ISP) completed within 30 days prior to admission. Based on the Plan of Correction (POC) dated 03/10/2022, the facility stated that the ISP's for each resident will be developed not more than 30 days prior to admission.

1. On 04/06/2022 at 12:30 PM, review of Resident #1's medical record showed that the resident was admitted to the assisted living

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residence on 03/01/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

2. At 12:41 PM, review of Resident #2's medical record showed that the resident was admitted to the assisted living residence on 03/08/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

3. At 12:56 PM, review of Resident #3's medical record showed that the resident was admitted to the assisted living residence on 04/01/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

4. At 1:00 PM, review of Resident #4's medical record showed that the resident was admitted to the assisted living residence on 04/04/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

5. At 1:06 PM, review of Resident #S's medical record showed that the resident was admitted to the assisted living residence on 03/29/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

6. At 1:30 PM, review of Resident #6's medical record showed that the resident was admitted to

C. With respect to how the plan of correction will be monitored:

The Executive Director or designee is responsible for the implementation and continued adherence to the various steps outlined in this plan of correction. Additionally, the ED is responsible for addressing and resolving concerns that may arise related to the implementation and adherence.

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{R 146}; Continued From page 2		1 {R 146}		

the assisted living residence on 03/14/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

7. At 1:37 PM, review of Resident #7's medical record showed that the resident was admitted to the assisted living residence on 03/25/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

8. At 1:42 PM, review of Resident #B's medical record showed that the resident was admitted to the assisted living residence on 03/22/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

9. At 1:50 PM, review of Resident #9's medical record showed that the resident was admitted to the assisted living residence on 03/10/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

10. At 1:58 **PM,** review of Resident #1O's medical record showed that the resident was admitted to the assisted living residence on 03/09/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs.

11. At 2:32 PM, review of Resident #11's medical record showed that the resident was admitted to

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{R 146}	Continued From page 3 the assisted living residence on 04/02/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs. 12. At 2:35 PM, review of Resident #12's medical record showed that the resident was admitted to the assisted living residence on 04/02/2022. Further medical record review failed to show documented evidence that a pre-admission individual service plan was conducted to determine the resident's service needs. On 04/07/2022 at 4:30 PM, the Assisted Living Administrator acknowledged the assisted living residence did not complete a pre-admission Individual service plans for the residents prior to admissions. At the time of the survey, the assisted living residence failed to ensure that pre-admission Individual service plans were conducted for all residents.	{R 146}		
{R 279}	10116.15d Staffing Standards 10116.1Sd A completed criminal background check, performed as required by the District laws and regulations applicable to each individual; Based on interviews and record review, the Assisted Living Residence (ALR) failed to ensure a background check was performed and documented for each employee at the time of initial employment for two of the eight employees (Staff #5 and 7). Findings included:	{R 279}	A. With respect to the specific resident(s)/situation cited: Criminal Background checks were completed for (Employees #5, and 7). Livingston Place will obtain a completed criminal background check, performed as required by the District laws and regulations applicable to each individual and place the report in the employee file at the time of initial employment.	4/14/22

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{R 279}	Continued From page 4 During the initial survey conducted on 02/01/2022 through 02/04/2022, the personnel files of four of 14 staff did not have a background check. Review of the plan of correction dated 03/22/2022 showed that the four cited background checks were completed, and that the background check forms were provided to the Department of Health for review. During the follow-up survey on 04/06/2022 beginning at 10:07 AM, the surveyors requested documentation of criminal background checks for employees hired after 02/04/2022. Record review on 04/07/2022 at 12: 52 PM showed that no criminal background check was available for Staff #5 (hired on 02/21/2022) and Staff #7 (hired on 02/15/2022). Interview with ALA Director of Operations (000) on 04/07/2022 at 12:54 PM, revealed that an email was sent to the two staff on 03/15/2022 to request authorization to conduct their background checks, however the employees did not respond. At the time of the survey, there was no evidence the ALR obtained a background check for each employee prior to hire and maintained the record on file.	{R 279}	B. With respect to what systemic measures have been put in place to address the stated concern: Livingston Place will use the new hire checklist as an audit tool to confirm that all criminal backgrounds are completed prior to the initial hire date. The Executive Director (ED) or designee will review all documentation and confirm completion prior to the employee start date. For the next 3 months the ED will review 100% of new employee checklists for completion. During and after the 3 months, the Quality Assurance committee will evaluate the efficacy of the documentation and audits and determine if continued audits are needed and/or if additional actions need to be implemented. C. With respect to how the plan of correction will be monitored: The Executive Director or designee is responsible for the implementation and continued adherence to the various steps outlined in this plan of correction. Additionally, the ED is responsible for addressing and resolving concerns that may arise related to the implementation and adherence.	
{R 281}	10116.15f Staffing Standards 10116.15f A healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to show evidence of a healthcare practitioner written	{R 281}	A. With respect to the specific resident(s)/situation cited: Health Certificates with healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis has been completed for (Life Enrichment Director, Culinary Aide #3, Culinary Assistants #1 and 3).	4/14/22

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certification that each employee was free from communicable diseases, including communicable tuberculosis, for four staff (Life Enrichment Director, Culinary Aide #3, Culinary Assistants #1 and 3).

Findings included:

On 02/02/2022, at 11:18 AM, the surveyors requested documentation to verify certification of employees' health status by a physician, including being free from communicable disease. During the survey, the ALR failed to provide a statement from a healthcare practitioner that 16 of 17 employees were free from communicable diseases.

The plan of correction (POC) dated 03/22/2022 stated that the facility will ensure that a healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis will be obtained and placed in the employee's file at the time of the initial employment.

During the follow-up survey on 04/06/2022 at 11:53 AM, , records were requested for sixteen employees to verify the ALR's compliance with the POC. From the 2/04/2022 survey citation, four of the 16 employees were no longer working at the facility. Six of the health certifications were completed by the ALA's medical director, and six were completed by an outside provider via Zoom. To further review the ALR's compliance, the health certificates for the eight employees hired after 02/04/2022 were requested.

At 4:55 PM, interview with the ALR's Director of Operations (DOO) revealed the facility currently had 58 staff and that each employee's record was

B. With respect to what systemic measures have been put in place to address the stated concern:

Livingston Place will use the new hire checklist as an audit tool to confirm that all Health Certificates with a healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis are completed prior to the initial hire date. The Executive Director (ED) or designee will review all documentation and confirm all necessary steps have been completed prior to the employee start date.

For the next 3 months the ED will review 100% of new employee checklists for completion. During and after the 3 months, the Quality Assurance committee will evaluate the efficacy of the documentation and audits and determine if continued audits are needed and/or if additional actions need to be implemented.

C. With respect to how the plan of correction will be monitored:

The Executive Director or designee is responsible for the implementation and continued adherence to the various steps outlined in this plan of correction. Additionally, the ED is responsible for addressing and resolving concerns that may arise related to the implementation and adherence.

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{R 281}	Continued From page 6	{R 281}		

reviewed to determine if it included a current health certificate. Due to the large number of outstanding staff health certificates, the ALR's medical director was able to complete only six. The Director of Operations said that all the employees who did not have a current health certificate were scheduled for a Zoom Assessment and were to notify her when completed. To ensure that the remaining health certificates were completed timely, the ALR contracted with an outside provider to complete the health certificates via Zoom, however the facility was still waiting to receive the completed health certificate forms.

On 04/07/2022, beginning at 10:11 AM, review of health certifications revealed the following:

(a) Zoom (electronic) health certifications were completed for 23 employees. Review of a list presented showed the date that the Zoom certification were scheduled for the employees. The health certificate forms completed via Zoom were not dated and did not include the date of the tuberculin screening.

(b) No health certification was provided for three of the eight staff hired after 02/04/2022: (Life Enrichment Director - Hire 03/14/2022, Culinary Aide #3 - Hire 2/21/2022, Culinary Assistant #3 - Hire 2/15/2022). Also, no health certificate was available for Culinary Assistant #1 - Hire 9/15/2021.

At the time of the survey, there was no evidence the Assisted Living Residence maintained a complete record of a healthcare practitioner certification that each staff was free from communicable disease.

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{R 283}	Continued From page 7	{R 283}		
{R 283}	10116.17 Staffing Standards 10116.17 All employees, including the ALA, shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Documentation shall be provided by the employee's licensed healthcare practitioner. Based on interview and record reviews, the Assisted Living Administrator (ALA) failed to document that each employee was free from communicable tuberculosis (TB) for three of the eight new staff (Life Enrichment Director, Culinary Aide #3, and the Assisted Living Administrator (ALA). Findings included: During the initial survey conducted on 02/01/2022 through 02/04/2022, the facility failed to document that eleven of 17 staff had a current screening for tuberculosis. The plan of correction (POC) dated 03/22/2022 stated that on an annual basis each employee shall document freedom from TB in a communicable form. Several tuberculin screenings were submitted with the POC. Review of the forms on 04/06/2022 beginning at 10:07 AM, showed the remaining tuberculin screening that were not available on 02/04/2022. The previously cited tuberculosis screenings were therefore abated. To verify sustained compliance, the surveyors requested the tuberculin screening reports for the eight new staff hired after 02/04/2022. No tuberculin screening was provided for three of the eight staff (Life Enrichment Director - Hire 03/14/2022; Culinary Aide #3 - Hire 02/23/2022;	{R 283}	C. With respect to the specific resident(s)/situation cited: Documentation has been completed for the (Life Enrichment Director, Culinary Aide #3, and the Assisted Living Administrator (ALA) confirming freedom from tuberculosis in a communicable form by a licensed healthcare practitioner. D. With respect to what systemic measures have been put in place to address the stated concern: Livingston Place will use the employee file checklist as an audit tool to confirm that all employee Health Certificates with a healthcare practitioner's written statement documenting freedom from tuberculosis in a communicable form is completed annually. The Executive Director (ED) or designee will review all documentation and confirm all necessary steps have been completed prior to the employee start date. For the next 3 months the ED will review 100% of employee file checklists for completion. During and after the 3 months, the Quality Assurance committee will evaluate the efficacy of the documentation and audits and determine if continued audits are needed and/or if additional actions need to be implemented.	4/14/22

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{R 283}	Continued From page 8 ALA- Hire 03/11/2022). On 04/07/2022, at 3:30 PM, interview with the Assisted Living Residence Director of Operation confirmed that all the employees, prior to hire and annually should be screened for communicable disease including tuberculosis. At the time of the survey, the ALR failed to document that each employee was free from communicable diseases including tuberculosis.	{R 283}	C. With respect to how the plan of correction will be monitored: The Executive Director or designee is responsible for the implementation and continued adherence to the various steps outlined in this plan of correction. Additionally, the ED is responsible for addressing and resolving concerns that may arise related to the implementation and adherence.	
{R 383}	10125.4a Reporting Complaints To The Director 10125.4a An ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day; and Based on interview and record reviews the Assisted Living Residence (ALR) failed to promptly notify the Director of any incident that substantially affects a resident. The notification shall be made by phone and follow-up with written notification within twenty-four (24) hours or the next business day for ten of the ten residents reviewed (Residents #6, #14, 15, 16, 17, 18, 19, 20, 21, and 22). Findings included: On 03/22/2022, a review of the ALR's plan of correction (POC) dated 03/22/2022 for the 02/01/2022 through 02/04/2022 survey revealed that the ALR will notify the Department of Health (DOH) of any unusual incident that substantially affects a resident. Notifications of unusual	{R 383}	A. With respect to the specific resident(s)/situation cited: The ALA at Livingston Place will notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents will be made by contacting the Department of Health by phone promptly and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day. B. With respect to what systemic measures have been put in place to address the stated concern: The ALA at Livingston Place will review 100% of incident reports to confirm notification is made by phone and follow-up with written notification within twenty-four (24) hours or the next business day for all unusual incidents that substantially affects a resident. The Executive Director (ED) or designee will review all documentation and confirm all necessary steps have been completed.	4/14/22

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{R 383}	Continued From page 9	{R 383}		

incidents will be made by contacting the DOH by phone promptly and shall be followed up by written notification to the department within twenty-four (24) hours or the next business day.

On 04/06/2022 at 3:46 PM, interview with the ALR's trainer revealed there were resident falls with injuries, emergency room (ER) visits, and hospitalizations after the 02/04/2022 survey. The record of the falls, ER visits and hospitalizations were requested for review.

On 04/7/2022, beginning at 11:08 AM, a review the incidents was initiated (falls, emergency room visits, and hospitalizations) after 02/04/2022 to verify compliance with the reporting requirements.

I. There was no evidence that three resident falls with injuries were reported to the Department of health (DOH).

(a) An incident report dated 02/12/2022 (6:02 PM) stated that Resident #14 was observed on the floor in his apartment. The resident said that he was trying to get into bed when his legs became weak, and he slipped to the floor. The resident was alert and oriented x 4 and denied pain or discomfort.

A 02/13/2022 (11:06 AM) nursing note stated that Resident #14 was observed on the floor of his apartment. The resident was alert and oriented x 4, however complained of pain when pressure was applied to the left foot. There was a red area on the mid left-back, however no complaint of generalized body pain or discomfort, and a mobile x-ray was ordered.

(b) An incident report dated 03/26/2022 (7:14 PM) stated that Resident #6 came to the nursing area

For the next 3 months the ED will review 100% of reportable incidents for completion. During and after the 3 months, the Quality Assurance committee will evaluate the efficacy of the documentation and audits and determine if continued audits are needed and/or if additional actions need to be implemented.

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to inform the licensed practical nurse (LPN) that he fell off the toilet after nodding off. The LPN observed a 3 cm x 4 cm red bruise to the right forehead and a right upper jaw redness with slight swelling under the right eye. The client complained of headache of 2 on a scale of 10. The resident was alert, verbal, oriented and denied nausea, vomiting, dizziness, or lightheadedness, and returned to his room to lie down, refusing to go to ER for evaluation. The primary care physician (PCP) was notified.

(c) An incident report dated 02/06/2022 (4:40 PM) revealed Resident #15 was found by a certified nursing assistant (CNA) lying on her right side on the floor. The resident was alert and verbally responsive. Vital signs were taken. The resident stated that her right arm and shoulder had a little pain but denied pain in the right hip. Noted stated "Will continue to monitor".

II. There was no evidence emergency room visits (ER) /hospitalizations were reported to the DOH for seven residents.

(a) Resident #16 - Review of a discharge summary revealed on 03/30/2022 the resident was transferred to the ER for evaluation after dizziness and an episode of syncope. The resident was evaluated, treated and returned to the facility on 04/02/2022.

(b) Resident #6 Emergency room evaluations - Review of a nursing incident dated 3/26/2022 revealed that resident sustained an injury when he fell from the toilet. The resident refused to go to the ER as ordered by primary care physician (PCP).

(c) A nursing transfer progress note dated

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	ALR-0041	A. BUILDING _____ B. WING _____	R 04/07/2022

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{R 383}	Continued From page 11	{R 383}		

03/27/2022 (7:08 PM) stated that Resident #2 was sent to the ER due to a prolapsed stoma and stoma bleeding. A 10:22 PM nursing progress note revealed that the resident was treated for an infection and returned to the facility on the same day.

(d) Resident #17 - Hospitalizations: (1) Transferred to the emergency room on 2/26/2022 for evaluation of suspected poly substance abuse and discharged on 02/27/2022. (2) Hospitalization on 04/03/2022, and was admitted for persistent altered mental status requiring sedation and restraints due to suspected drug abuse. Resident was treated for acute toxic encephalopathy and discharged back to the facility on 04/04/2022.

(e) Resident #18 - Resident was hospitalized on 03/21/2022 due to generalized weakness. The resident remained hospitalized until 3/31/2022 for evaluation and treatment of her health conditions.

(f) Resident #19 - (1) Review of discharge instructions revealed the resident was hospitalized on 02/17/2022 for evaluation of shortness of breath with worsening ascites, and was discharged on 02/27/2022. (2) Review of discharge instructions revealed the Resident was again hospitalized on 03/17/2022 for evaluation of shortness of breath due to a low blood level and other chronic medical issues, and was discharged on 03/19/2022.

(g) Resident #20 - Review of a nursing progress note dated 03/07/2022 (7:44 PM) revealed the resident called 911 without staff knowledge. Upon the arrival of the ambulance, the resident complained of severe vertigo and was transported to the nearest accepting emergency department.

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{R 383}	{R 383} ! Continued From page 12 (h) Resident #21 - Evaluated at the ER on 02/18/2022 for poly substance abuse and was recommended for follow-up care. At the time of the survey, the ALR failed to promptly notify the Director of any incident that may substantially affect a resident by phone and follow up with written notification within twenty-four (24) hours or the next business day as required.	{R 383}		

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{R 000}	Initial Comments A follow up survey was conducted on 04/06/2020 and 04/07/2022, to determine the facility's compliance with the Assisted Living Residence Regulations, Title 22-8 DCMR (Public Health and Medicine) Chapter 101 during the 02/04/2022 licensure survey. The findings of the survey were based on observations, interviews, review of client and administrative records.	{R 000}		
{R 677}	Sec. 702b8 Staff Training. (8) Choking precautions and airway obstruction, including the Heimlich Maneuver; and Based on interviews and record reviews, the Assisted Living Residence failed to document compliance with "DC Code, Subchapter VII, Staffing and Training,[§ 44-107.02): (b) Within 7 days of employment, an Assisted Living Residence (ALR) shall train a new member of its staff as to the following: (8) choking precautions and airway obstruction, including the Heimlich Maneuver for three of eight staff reviewed ((Life Enrichment Director, Culinary Assistant #3, and Culinary Aide #3). Findings included: During interview on 02/04/2022 at 3:27 PM, the Assisted Living Administrator (ALA) revealed that the available training records did not include choking and airway obstruction, including Heimlich Maneuvers. Per the plan of corrections (POC) dated 03/22/2022, it states that within 7 days of employment, the ALR will train new staffs on choking precautions and airway obstruction,	{R 677}	A. With respect to the specific resident(s)/situation cited: Choking precautions and airway obstruction, including the Heimlich Maneuver has been completed by the (Life Enrichment Director, Culinary Assistant #3, and Culinary Aide #3). B. With respect to what systemic measures have been put in place to address the stated concern: The ALR at Livingston Place will review 100% of new hire training transcripts before the 7th day of employment to confirm completion of "Choking precautions and airway obstruction, including the Heimlich Maneuver." The Executive Director (ED) or designee will review all documentation and confirm all necessary steps have been completed.	4/14/22

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{R 677}	Continued From page 1 including the Heimlich Maneuver. The training logs submitted with the POC revealed that all previously identified staff were trained after the survey of 2/04/2022. The POC stated that the training was included in the new hire orientation performed within the first 7 days of employment, and that documentation will be placed in the employee file. Interview with the Director of Operations on 04/06/2022 at 3:30 **PM** indicated there were eight new staff hired since 02/04/2022. The ALA revealed that three of the eight staff had not received training on choking precautions and airway obstruction, including the Heimlich Maneuver. Record reviews on 04/07/2022 at 10:32 AM confirmed that three of the eight new staff (Life Enrichment Director, - Hire 3/14/2022, Culinary Assistant - Hire 2/15/2022, and Culinary Aide - Hire 2/21/2022) had not received the training. At the time of the survey, there was no documented evidence that each employee met or possessed training on choking and airway obstruction, including Heimlich Maneuver or received the training within seven days of being hired.	{R 677}	C. With respect to how the plan of correction will be monitored: The Executive Director or designee is responsible for the implementation and continued adherence to the various steps outlined in this plan of correction. Additionally, the ED is responsible for addressing and resolving concerns that may arise related to the implementation and adherence.	
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 insure that food is processed and served so as to be safe for human	R1058		

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consumption.
Based on observations, interview, and record reviews the Assisted living residence (ALR) failed to comply with Chapter 24, Subtitle A of Title 25 DCMR, Food and Food Operations Regulations, formerly: Section 25 -A203 (Certified Food Protection Manager Person in Charge).

Findings include:

1. On 04/06/2022, at 2:25 PM, observation of the dining room showed Culinary Aide #1 mopping the dining room. When asked about the food Service manager, the aide said the cook had left for the day, however, that Culinary Aide #2 was in the kitchen.

At 2:28 PM, interview with Culinary Aide #2 in the kitchen revealed that Culinary Assistant #1, (the cook) had been in charge, however, her shift was 6:30 PM to 1:30 PM and had ended for the day. She said that due to staff calling out, she and Culinary Aide #1 were the only two staff left on duty. When asked about the written menu for dinner, the staff checked the bulletin board and said that it had been there earlier, but was no longer posted. Culinary Aide #2 also showed the surveyor the food stored in the warmer to be served for dinner.

At 2:50 PM, a personnel document submitted with the ALR's plan of correction dated 03/22/2022 was reviewed. The document showed that both the Food Service Director and a Culinary Staff who were observed working during the 02/01/2022 to 02/04/2022 survey were no longer employed by the facility.

An interview with the Assisted Living Administrator (ALA) at 3:05 PM revealed that due

A. With respect to the specific resident(s)/situation cited: 4/14/22

1.) The ALR hired a dining director on 4/18/22 and confirmed the individual holds an active and Certified Food Protection Manager.

2.) The ALR replaced the two large skillets with heavily scarred Teflon-coated interiors.

B. With respect to what systemic measures have been put in place to address the stated concern:

Livingston Place (LP) will take monthly inventory of all cooking surfaces and confirm they are maintained in good condition to prevent potential contamination during food preparation.

LP will use the dining supplies inventory checklist as an audit tool to confirm all cooking surfaces and confirm they are maintained in good condition to prevent potential contamination during food preparation. The Executive Director (ED) or designee will review all documentation and confirm all necessary steps have been completed prior to the resident being admitted.

Health Regulation & Licensing Administration

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R1058	Continued From page 3 to the scheduled staff call outs, he asked Culinary Assistant #2 to report for the evening shift. The ALA confirmed that the previous food service director was no longer an employee, and had been gone for approximately two weeks. The ALA said that a Culinary Aide/Cook, who had sometimes relieved in the absence of the food service director had also left the position. On 04/07/2022 at 11:35 AM, an interview with Culinary Assistant #2 preparing the lunch meal revealed he once had a Food Protection Manager Identification Card, however it had expired. When asked about the written menu, he stated that it had been previously posted on the bulletin board, however, was no longer there. He then showed the surveyor the food he was preparing for lunch. At 12:55 PM, the ALA said that he was responsible for the overall supervision of the food service department, however, he was not a Certified Food Protection Manager. He said that he would check with all food service staff and provide a copy of all current staff certifications. At the time of the survey, no documentation was provided to verify a Food Protection Manager was employed to provide supervision of the culinary operation when food was being prepared and served. 2. Observation in the food production area on 04/06/2022 at 2:31 PM, revealed two large skillets with heavily scarred Teflon-coated interiors. An interview with the food service staff indicated that the skillets were still used for cooking. When informed at 2:48 PM of the skillets, the ALA said that culinary staff had not informed him that the skillets were worn, and that new ones would be ordered.	R1058	For the next 3 months the ED will review 100% of new admission checklists for completion. During and after the 3 months, the Quality Assurance committee will evaluate the efficacy of the documentation and audits and determine if continued audits are needed and/or if additional actions need to be implemented. C. With respect to how the plan of correction will be monitored: The Executive Director or designee is responsible for the implementation and continued adherence to the various steps outlined in this plan of correction. Additionally, the ED is responsible for addressing and resolving concerns that may arise related to the implementation and adherence.	

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At the time of the survey, the ALR failed to ensure cooking surfaces were maintained in good condition to prevent potential contamination during food preparation.

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