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 _____	R 09/11/2023

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

(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 A follow-up survey was conducted on 09/07/2023, 09/08/2023, and 09/11/2023 to determine the facility's compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) that were cited during the 03/14/2023 licensure survey and the 07/19/2023 follow-up survey. The findings of the survey were based on observations, interviews, and review of resident and administrative records. Based on observations, interviews, and record review, the Assisted Living Residence (ALR) failed to maintain environmental safeguards to ensure the safety of each resident, to include pendants with a functioning emergency alert call button, emergency alert pull cords in each resident's bathroom, and the maintenance of a functioning and reliable emergency alert system, for 114 of the 114 residents of the facility. Findings included: On 09/07/2023 at 12:42 pm, the State Survey Agency received a telephone complaint from Resident #3. The resident said that her blood glucose monitoring device was not functioning properly. Resident #3 had used her emergency alert to call pendent seeking assistance; however, as of that time, no one had responded to the alert. At 1:07 pm, interview with the Executive Director/ Assisted Living Administrator (ED/ALA) revealed that approximately two weeks prior to the survey, the Assistant Director of Nursing (ADON) had informed her that the facility's pagers were not working properly. According to the ED/ALA, new pagers had been ordered.	{R 000}	Please start typing your responses here: On going rounding of resident safety checks will be conducted and documented by care staff on every shift for every resident including independents and reviewed daily by DON/ADON. Documentation created by DON/ADON listing all residents with pendants currently. Residents found without pendants will be issued one and documented. DON/ADON to monitor accuracy and include on ISP. Residents that refuse to utilize pendants will continue to be checked on an ongoing basis and refusal documented in chart. Nursing staff educated on importance of safety rounds on all residents and efficient call bell response times along with documentation. DON/ADON has issue enough pagers to be available to all nursing staff for every shift. Sign in and out sheet is located in all nursing station for staff to obtain during all shift.	10/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
WINSTINA WILLIAMS	EXECUTIVE DIRECTOR	10/10/23

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{R 000}	Continued From page 1 The ADON stated that due to the problems with the emergency alert system, staff were instructed to perform room checks "more often" to ensure resident safety. The ED/ALA agreed to find documentation showing evidence that the facility had ordered new pagers. 1. On 09/07/2023 beginning at 3:49 pm, the surveyors interviewed Resident #3 in her unit. The interview was consistent with what she had stated over the telephone. The resident said that the sensor in her glucose monitoring device alerted her to the need to have the device serviced. She pressed her pendant to have nursing staff come for assistance (time not specified); however, it took "close to an hour" for the nurse to arrive. On 09/11/2023 at 12:22 pm, during an interview with the LPN who responded to Resident #3's call alert on 09/07/2023 confirmed that nursing staff did not respond to the call button. Instead, the concierge reportedly called the LPN at 1:00 pm stating that Resident #3 wanted the sensor in her glucose monitoring device changed. The LPN then went to the resident's unit to investigate. 2. On 09/08/2023 at 3:05 pm, Resident #10 was observed seated in a wheelchair near the elevator on the 2nd floor. Upon the surveyor's request, the resident activated her pendant and a red light flashed. After 15 minutes with no response, the surveyor spoke with an RN on duty. The RN said that the pagers were "not working properly." 3. At 3:20 pm, Resident #11 answered the door to his unit. He stated that he did not have a call	{R 000}	Maintenance director to review emergency pull cords in each room to verify functionality of each. Repairs will be made to all that are not functional. Maintenance to complete monthly review of pull cord functionality and battery check of all occupied rooms. Maintenance Director will ensure that there is adequate stock of batteries to replace for pendants and pull cord system.	10/10/23

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{R 000}	Continued From page 2	{R 000}		

pendant. When asked to test the emergency pull cord in the bathroom, the resident pulled it four times; however, the red light did not come on. Resident #11 stated that the pull cord "never" worked for him.

4. At 3:28 pm, Resident #13 pushed the call button on his emergency pendant and the red light flashed. The resident, however, stated: "they don't answer that." At 3:31 pm, a CNA came to the resident's door.

5. At 3:40 pm, Resident #12 was asked to activate his pendant. At 4:05 pm, the survey team left the resident after there was no response. Observations also showed that when Resident #12's emergency pull cord in the bathroom was tested, the red light did not come on.

At 5:20 pm, in an interview with the ADON stated that each LPN should have a pager; however, there were only two in the building. The ED/ALA, who was present at the time, confirmed that the facility needed more pagers. The survey team informed them that some of the emergency pull cords in bathrooms did not show a red light when pulled and their system required immediate attention.

On 09/11/2023 at 10:40 am, the ED/ALA and her assistant informed the survey team that emergency pull cords in every unit had been tested over the weekend. Emergency call pendants were also assessed. The maintenance director joined the discussion. He stated that batteries had been replaced in some bathroom systems; however, more batteries were needed. In addition, they distributed the pendants that they had to hand and ordered more pendants. The ED/ALA stated that although some residents

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{R 000}	Continued From page 3 said they did not want a pendant; the facility wanted every resident to have a working pendant. She agreed to provide a status report showing the results of the building-wide tests of the emergency alert system. At 11:00 am, a review of the emergency call system analysis revealed the following: Out of 114 bathroom pull cords tested, 77 did not show a red light when pulled (not functional); whereas 37 showed a red light. According to the chart provided, six of the 37 pull cords showing a red light did not activate a beeper (representing a systemic failure). Even though the survey team requested a status report on the emergency alert system, the facility did not provide data showing how many pendants were issued in total (building-wide). Management stated that the pendants had been checked; however, there was no documentation showing the number of pendants that functioned properly. On 09/11/2023 at 4:57 pm, the Regional Director stated that all RNs, LPNs, and CNAs should have a working pager. At the time of the survey, the ALR failed to maintain an effective emergency alert system. This is a repeat deficiency. See deficiency report dated 06/03/2022. In a Plan of Correction received on 08/17/2022, it stated: "Pull cords will be checked monthly with and (sic) a member of leadership will do monthly apartment inspections to monitor for any environmental issues." In addition, a Plan of Correction that was received	{R 000}		

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{R 000}	Continued From page 4 on 08/18/2023 for an investigative report dated 04/19/2023, showed the following: "The DON developed a room check protocol for the nursing staff to increase the monitoring and safety for each resident... The DON or designee will in-service the nursing staff on the room check protocol to increase monitoring and safety for each resident." The completion date given was 08/28/2023.	{R 000}		
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.	R 272	Documentation of resident safety checks on an ongoing basis by care staff to be completed every shift on every resident including independents and reviewed daily by DON/ADON.	
R 583	Sec. 701d1 Staffing Standards. (1) Employ staff and develop a staffing plan in accordance with this act and based upon the following criteria to assure the safety and proper care of residents in the ALR: Based on interviews and recorded reviews, the Assisted Living Residence (ALR) failed to maintain staffing to effectively monitor residents, for 114 of the 114 residents. Findings included: On 09/07/2023, the State Survey Agency received a complaint via email from the Office of Health Care Ombudsman and Bill of Rights against the ALR. According to the email, Resident #1 fell in her room on 09/02/2023 around 10:30 pm, when she lost her balance and fell to the floor. She was unable to get up or reach for her phone. Her emergency alert call pendant was on a table and	R 583	Nursing staff educated on importance of safety rounds on all residents and efficient call bell response times along with documentation.	

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R 583	Continued From page 5 out of reach. She yelled for help for several hours, but no one heard her calls. Resident #1 further reported that no one came to check on her as she lay on the floor all night. The email further stated that on Sunday 09/03/2023 at approximately 10:00 am, a Certified Nursing Assistant (CNA) came into the room and assisted Resident #1 off the floor. On 09/07/2023 at 1:11 pm, the Executive Director (and Assisted Living Administrator, ED/ALA), who said she was unaware that a resident had fallen in her unit on the evening of 09/02/2023 and remained on the floor all night, said "there should be room checks done every two hours." Beginning at 2:18 pm, an interview with a Licensed Practical Nurse (LPN #1) revealed that her shift began at 11:00 pm on 09/02/2023. LPN #1 said she left the facility before her shift ended the next morning. She informed the CNAs that she would be available by telephone. LPN #1 said she received a call from CNA #2 at "around 7:19 am." CNA #2 reported hearing Resident #1's calls for help. The CNA's FOB, however, did not unlock the door to Resident #1's unit. LPN #1 instructed CNA #2 to retrieve a key in order to access the unit. Beginning at 2:49 pm, the interview with CNA #3 revealed that CNA #2's shift was ending at the time that CNA #3 came on duty. CNA #2 had told her that Resident #1 had spent the night on the floor of her unit. When asked, CNA #3 said that staff "we do a 2-hour resident check." Beginning at 4:04 pm, Resident #1 was interviewed in her unit. The resident described the circumstances of the fall and her night on the floor in detail. Her account closely matched what	R 583	Staffing matrix to be reviewed by DON/ADON to ensure appropriateness for the current resident needs, in order to provide safe care. To ensure adequate staffing DON/ADON will provide coverage as needed. DON/ADON to create schedule in compliance with safety standards.	10/10/23

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R 583	Continued From page 6	R 583		

had been alleged in the email received from the ombudsman. Resident #1 confirmed that she could not reach her emergency alert pendant or the telephone. No one heard her cries for help when she first fell and "nobody came to the door and knocked" all night. Resident #1 complained that nurses and security people should be walking around checking on people and she did not understand why no one came to assist her before morning. She stayed on the floor all night. The CNA who assisted her off the floor summoned an LPN who assessed her that morning.

On 09/11/2023 beginning 3:09 pm, interview with CNA #1 revealed that she and one other CNA had worked the evening of 09/02/2023. According to CNA #1, a third CNA had left the building at 6:30 pm, shortly after having arrived. CNA #1 said that they only knocked on the doors of residents that were known to need more assistance. Residents living on the fifth floor, such as Resident #1, were deemed to be more "independent." CNA #1 stated that, as an exception, she assisted a resident on the fifth floor at approximately 9:30 pm. She recalled passing by Resident #1's door at around 9:45 pm and did not hear a cry for assistance.

When asked again about the number of CNAs on duty, she said a third CNA "came in and just left" at 6:30 pm. She further stated that "I checked the schedule and saw there were just two of us" until 11:00 pm. It should be noted that CNA #1 said she left her shift at 10:30 pm. It should be further noted that a review of the staff schedule showed that five CNAs were to have been on duty between 3:00 pm and 11:00 pm on 09/02/2023.

At 3:45 pm, the survey team asked the ED/ALA for employee time sheets that would indicate the

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R 583	Continued From page 7 specific hours that each staff person worked ("clocked in and out") on Friday, 09/01/2023 through Monday, 09/04/2023. However, no additional information was made available for review before the survey ended later that afternoon. At the time of the survey, there was no evidence that the ALR ensured sufficient staffing during the holiday weekend of 09/01/2023 through 09/04/2023.	R 583		

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{R 000}	Initial Comments 0000 Initial Comments A follow-up survey was conducted on 09/07/2023, 09/08/2023, and 09/11/2023 to determine the facility's compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101 that were cited during the 03/14/2023 licensure survey and the 07/19/2023 follow-up survey. The findings of the survey were based on observations, interviews, and review of resident and administrative records.	{R 000}	Please start typing your responses here:	
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 ensure that every employee or contractor's personnel file contained a written statement from a healthcare practitioner confirming that they were free of communicable disease, including tuberculosis, for one of one recently hired employee whose record was reviewed (Delegating Nurse). Findings included: During an interview on 09/07/2023 at 11:58 am, the Executive Director/Assisted Living Administrator (ED/ALA) said the facility had entered into a contract with a delegating registered nurse (RN). The delegating RN did not have a set schedule; however, she was expected to come twice a week for four hours each visit. The delegating RN was also available by telephone as needed.	R 281	All staff files to be reviewed by ED/AED to ensure compliance with healthcare practitioner's written statement on communicable diseases per standards. All staff found to need record will be required to obtain documentation. ED will complete a monthly audit on all current employee files to ensure compliance.	10/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: WINSTINA WILLIAMS — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 10/10/23

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R 281	Continued From page 1 At 2:01 pm, a review of the personnel file maintained for the delegating RN showed a contract the parties signed on 08/29/2023. There was no health certificate found in the personnel record. During a telephone interview on 09/08/2023 beginning at 11:57 am, the delegating nurse said she had not had a physical examination performed. She added, however, that she had an appointment scheduled for that evening. When asked if she had begun performing duties in the facility, she replied "yes," she had begun face to face resident assessments on the premises. At 2:13 pm, the ED/ALA was asked whether the delegating nurse had been determined free of communicable diseases by a healthcare practitioner. The ED/ALA said she had given a form to be completed by the delegating RN's physician. The ED/ALA acknowledged that they had not yet received her health certificate. At the time of the survey, the facility failed to obtain written clearance by a healthcare practitioner stating that the delegating RN was free of communicable disease prior to beginning employment. This is a repeat deficiency. See deficiency reports dated 02/04/2022 and 03/14/2023. In a Plan of Correction that the ED/ALA signed on 06/09/2023 (for the 03/14/2023 annual licensure survey), it stated: "DON, ADON #2, CNAs #3 and 5 will have written documentation that free of communicable disease (sic). Community Human Resources will be conducting an audit of all current employee files to ensure no further infractions and tracking/tickler system will be	R 281		

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R 281	Continued From page 2 utilized to monitor compliance moving forward." The completion date given was 05/31/2023.	R 281		
{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 interviews and record reviews, the Assisted Living Residence (ALR) failed to promptly notify the Department of Health (DOH) by telephone of incidents that substantially affected residents (followed by written notification within 24 hours or the next business day), for 8 of 13 incidents that significantly affected residents in the period 07/19/2023 through 09/07/2023 (Residents #1, 2, 4, 5, 6, 7, 8 and 9). Findings included: A review of incidents that were made known from outside sources or were discovered during the survey process revealed the following: 1). On 09/07/2023, the State Survey Agency received a complaint via email from the Office of Health Care Ombudsman and Bill of Rights against the ALR. According to the email, Resident #1 fell in her room on 09/02/2023 around 10:30 pm, when she lost her balance and fell to the floor. She was unable to get up or reach for her phone. Her emergency alert call pendant was on the table and out of reach. She yelled for help for several hours, but no one heard her calls. Resident #1 further reported that no one came to	{R 383}	Nursing staff educated by ADON on mandatory reporting and standards, proper communication of incident reporting, and proper documentation. Education on policy and procedure for incident reporting and types of incidents to report. Staff trained on proper chain of communication in events of an emergency during regular building hours and after hours. Resident #1 post fall was completed, and ISP has been updated.	

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{R 383}	Continued From page 3 check on her as she laid on the floor all night. The email further stated that on Sunday 09/03/2023 at approximately 10:00 am, a Certified Nursing Assistant (CNA) came into the room and assisted Resident #1 off the floor. The resident called her family to report the incident. She was given Tylenol for right side hip pain and swelling; however, she refused to go to the hospital. On 09/07/2023 at 1:11 pm, the Executive Director (and Assisted Living Administrator, ED/ALA) replied "no" when asked if she was aware that a resident alleged having fallen in her unit on the evening of 09/02/2023 and remained on the floor until the next morning. Beginning at 4:04 pm, Resident #1 was interviewed in her unit. The resident described the circumstances of the fall and her night on the floor in detail. Her account closely matched what had been alleged in the email received from the ombudsman. Resident #1 confirmed that she could not reach her emergency alert pendant or the telephone. No one heard her cries for help and "nobody came to the door and knocked" during the overnight hours and she stayed on the floor all night. The CNA who assisted her off the floor summoned an LPN who assessed her that morning. On 09/11/2023, the Licensed Practical Nurse (LPN #2) who assessed Resident #1 was interviewed beginning at 1:08 pm. When asked who he reported Resident #1's incident to, LPN #2 replied: "I wrote it on a form" which he described as a "24-hour form" that he entered electronically. He later responded "I'm not sure" when asked who reads the 24-hour forms. When asked if he had received training on the facility's Incident Reporting Policy & Procedures, LPN #2	{R 383}		

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(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 383}	Continued From page 4 replied: "Not that I can remember." He later stated that "I'm a PRN worker" and he worked " every other weekend." There was no evidence that the facility reported the incident to DOH. 2). The facility failed to report timely that Resident #2 was missing. On 08/25/2023, at 3:57 pm, DC Health received an email from the ALR's Director of Nursing. The email stated that a resident left the facility on 08/24/2023 (time unknown) and did not return. Per the email, "staff performed routine round at 10 pm, and resident not noted to be in her apartment". Per the DON, the Metropolitan police department was informed. The email continued "FYI-The case manager notified me that the resident is at 2210 Adam Place NE. The police went to the day program which turns into turns into an overnight shelter at night. Ms. Jones said that she likes it there. The police officer attempted to return her to the facility. As the officer and her approached the car, she changed her mind and said that she will return "tomorrow." The case manager has been updated." During a telephone interview on 08/25/2023, at 4:10pm, the DON said the resident left in the morning, but was not sure of the time. When asked, the DON said no staff from the facility has gone to the homeless shelter to speak to the resident, but that the case manager has agreed to go see the resident the next day. There was no evidence that the facility timely reported to the DOH, the incident of a missing person on 08/24/2023, as required by the DC ALR regulation, and Law. 3). On 09/11/2023, a review of the ALR's 24-hour report forms showed that on 09/03/2023 at 3:00	{R 383}		

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	ALR - 0041	A. BUILDING: _____ B. WING _____	R 09/11/2023

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{R 383}	Continued From page 5 pm, an LPN on duty documented that he called Resident #4's cell phone for a wellness check. Resident #4 reportedly stated that he was admitted and remained in a local hospital. There was no evidence that the facility reported Resident #4's emergency hospitalization. 4). On 09/11/2023, a review of the ALR's 24-hour report forms showed that on 09/03/2023 at 1:01 am, an LPN on duty documented that while doing rounds at 11:00 pm, Resident #5 was not in the facility. The nurse left a message on the resident's cellphone asking that he contact the facility as soon as possible. There was no additional information documented. There was no evidence that the facility reported that Resident #5 was missing. 5). On 09/11/2023, a review of the ALR's 24-hour report forms showed that on 09/03/2023, an LPN on duty documented that 911 emergency medical services (EMS) were called after Resident #6 complained of abdominal pain and black stools. At 2:00 pm, Resident #6 was transported to a hospital emergency room via ambulance. There was no evidence the facility notified DOH of this incident. 6). According to an incident report that the facility submitted to DOH on 08/18/2023, Resident #7 was discovered on her bathroom floor by an LPN who came to administer morning medications three days earlier, on 08/15/2023. The LPN documented having observed a hematoma on Resident #7's head. Upon further assessment, the LPN dialed 911 and at 05:12 am, emergency personnel arrived and transferred the resident to	{R 383}		

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{R 383}	Continued From page 6 a local hospital. The facility failed to report the incident by telephone immediately and failed to submit written notification to DOH timely. 7). According to an incident report submitted by the facility on 08/04/2023 at 6:56 pm, Resident #8 did not return from day program on 08/03/2023 at 4:00 pm, which was her usual return time. In accordance with the facility's missing persons policy, staff searched the entire building and did not locate her. On 08/04/2023 at 12:32 pm, the Metropolitan Police Department informed the facility that Resident #8 had been found. The facility notified DOH by telephone on 08/04/2023 at 11:44 am, 17 hours after the resident was deemed missing from the facility. 8). According to an incident report submitted by the facility on 08/26/2023 at 6:28 pm, Resident #9 complained on 08/25/2023 at approximately 11:30 am that he was not feeling well. The resident was assessed, and EMS was called. Resident #9 was subsequently transported to a hospital and admitted. There was no evidence that the facility notified DOH immediately by telephone. On 09/08/2023 at 4:05 pm, a review of the facility's Incident Reporting Policy & Procedures (no date) showed: "the staff person who witnesses the event, or is first upon the event, is to report to the Executive Director or of the Community (sic) as soon as possible... If the incident involves a resident, within state regulatory guidelines for reporting, the Executive Director/designees will complete required	{R 383}		

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{R 383}	Continued From page 7 reporting of resident incidents to any state regulatory authorities, as required by state law." Continued review of the policy and procedures failed to show how a staff person should report an incident to the Executive Director. On 09/08/2023 at 2:30 pm, when asked about incident reporting policies, the Assistant Director of Nursing (ADON) said CNAs should notify the nurse on duty who, in turn, should notify her of any incident. The ADON also stated that she had been on medical leave until 09/05/2023. At the time that the ED/ALA presented the Incident Reporting Policy & Procedures, she also presented two "Nursing Inservice Training" signature sheets, dated 06/07/2023 and 06/08/2023. The signature sheets did not indicate the topic of the training(s) or who presented the training(s). When asked at 5:28 pm, the ED/ALA stated the signature sheets were for training on the Incident Reporting policies. [Note: Even though LPN #2's signature was on the 06/07/2023 signature sheet, LPN #2 stated on 09/11/2023 at 1:10 pm that he did not recall receiving training on said policies.] On 09/11/2023 at 9:57 am, interview with the ED/ALA revealed the policy and procedures should say "the staff person who witnesses the event, or is first upon the event, is to report to the Executive Director or leadership of the Community..." At 2:24 pm, in a follow-up interview with the ADON, she stated that the 24-hour online report forms were initiated "recently" (while she was on medical leave). Her understanding was that nurses used them to inform administrators of activities during their shift, and not to report	{R 383}		

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{R 383}	Continued From page 8 incidents. She further stated that submitting a 24-hour report online did not generate an alert that might bring attention to an incident. At 3:32 pm, in a follow-up interview with the ED/ALA, she confirmed that the 24-hour online report forms were relatively new. She had trained the facility's "leadership" on the new form and thought that "the DONs have done training for the LPNs." The ED/ALA agreed to find documentation of the ate [Note: The ADON was out on medical leave over the weekend of 09/02/2023, 09/03/2023, and 09/04/2023, and reported having received no notifications regarding incidents in the facility.] The ED/ALA stated that she would prefer to receive a telephone call or email because that would be "more direct." She confirmed that staff were not instructed to use the 24-hour report form as a means of reporting incidents. "Normally, a nurse would call the ADON; however, if the ADON is unavailable, then they would call me or (her assistant)." She said she had not reviewed the 24-hour forms from the weekend of 09/02/2023, 09/03/2023, and 09/04/2023, adding: "I do not pull it (the 24-hour report) every day. There could be a delay in the information shown in the report. For example, something entered yesterday would not necessarily be visible if I pulled it today." At the time of the survey, the ALR failed to establish and implement a system to ensure that DOH receives prompt notification by telephone, followed by written notification within 24 hours. This is a repeat deficiency. See deficiency reports dated 02/04/2022, 06/03/2022, 03/14/2023, 04/19/2023, 04/20/2023, 08/17/2023, and 08/18/2023.	{R 383}		

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{R 383}	Continued From page 9 In a Plan of Correction that was received on 08/18/2022, it stated: "All staff educated on 06-27-2022 by Administrator and leadership department heads on proper notification of Administrator of any incidents that involve resident care. All members of the leadership team were educated by regional operational specialist and regional director of clinical services... on verbal report to DOH and submitting a written report in 24 hours.... Ongoing Administrator or designee will monitor daily for proper reporting to all regulatory bodies occur timely (sic) and that verbal and written reports completed." In a Plan of Correction that the ED/ALA signed on 06/09/2023 (for the 03/14/2023 annual licensure survey), it stated: "Administrator educated Leadership team on incident reporting protocol to include documentation and calling DOH. Ongoing any incidents that occur will be reviewed daily with leadership team to ensure all proper notification and documentation occur." The completion date given was 05/31/2023.	{R 383}		