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 07/19/2023

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 07/17/2023, 07/18/2023 and 07/19/2023, to determine the facility's compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101 during the 03/14/2023 licensure 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: This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submissio n of this Plan of Correctionis not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law	
{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 infestations, for two of seven residents in the facility (Residents #6 and 7). Findings included: The facility was cited during the previous survey for failing to implement effective treatment measures and monitoring systems to eliminate bed bug infestations in the facility. On 06/09/2023, the Assisted Living Residence (ALR) forwarded a Plan of Correction (POC) that showed the Community staff will walk the community daily to monitor for insects. The POC also reflected that the maintenance staff will conduct five random room checks to inspect for infestation weekly. The findings of the room checks will be reported in the monthly Quality Assurance (QA) meeting.	{R 202}	1.Resident #6 and 7 currently resides in the facility. No ill effects noted to the residents. Both rooms have been treated for bed bug infestations on by the pest control company. The residents were temporarily relocated to other rooms for their safety and to ensure the rooms were properly treated. 2. The Maintenance Director or designee will assess all current resident rooms for any bed bugs infestations and report information to the pest control company. 3. The Executive Director or designee will in-service the maintenance director that there must be effective treatment measures and monitoring systems in place to eliminate beg bugs infestations.	8/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: WINSTINA WILLIAMS — TITLE: Executive Director — (X6) DATE: 8/3/2023

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 07/19/2023

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 202}	Continued From page 1 During the follow-up visit on 07/18/2023 beginning at 10:21 am, an environmental walk-through of the facility was conducted with the maintenance staff. At 10:39 am, observations showed that a Pest Patrol Inspector was on-site treating some of the resident's units. According to maintenance staff, the pest patrol inspector was here treating at a least five random units as routine maintenance to include units 431 and 305 for bed bugs and other insects. The inspector was scheduled to provide inspections once a month. Maintenance staff stated to the surveyor team that the random inspections were a part of the POC. The Maintenance staff stated that there had not been any issues of bed bugs in the units recently (within the last month). On 07/19/2023 at 3:05 pm, the maintenance staff was asked about the five weekly random checks that were supposed to be conducted by him and his staff. The maintenance staff stated that he was not aware that he was supposed to be conducting five random checks weekly. The surveyor shared the POC with the maintenance staff regarding the plan for mitigating the spread of bed bugs. Again, he stated that he was not aware that he was supposed to be conducting those checks five times weekly. At 3:34 pm, during the exit conference, the Executive Director (ED) confirmed during an interview that the maintenance staff were to conduct five weekly random checks to monitor for bed bugs. When asked if the random checks were documented, the ED stated that she would have to check with maintenance staff. By the time the exit conference concluded, there was no additional information provided for the surveyors regarding the requested documentation for monitoring the bed bugs. It should be noted that	{R 202}	4. The Maintenance Director or designee will audit 5 random rooms to inspect for any beg bug infestations weekly x 4, then monthly x 3 months. Results of the audits will be reviewed during the Quality Assurance Meeting.	

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 07/19/2023

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 202}	Continued From page 2 during the exit conference, the surveyor mentioned that the system put in place for mitigating the spread of bed bugs seemed to be ineffective. The facility's administrative staff all agreed. At 5:03 pm, the maintenance staff provided the survey with a pest patrol documentation dated 07/18/2023 at the end of the exit. On 07/21/2023 at 10:37 am, a post survey review of the pest patrol invoice dated 07/18/2023 showed that there was a live bed bug on the bed mattress cover, one dead bed bug on a sofa underneath the seat cushion in Resident #6's room. Further review revealed there were many bed bugs/excrements on the ceilings, walls, windows, and blinds in Resident #7's room. At 11:05 am, a post survey interview was conducted with the ED via telephone. According to the ED, the maintenance staff mentioned to her during the follow-up survey period (07/17/2023 - 07/19/2023) that there were active bed bugs in two residents bedrooms. The maintenance staff, who was present during the telephone call with the ED, confirmed that there were bed bugs in Residents #6 and 7 rooms while the surveyors were onsite. When asked why he did not alert the surveyors that there were active bed bugs in two of the rooms, the maintenance staff stated, "my apologies, I should have told you all". The Maintenance staff stated that he knew there were active bed bugs in the residents' rooms on 07/18/2023. At the time of the follow-up visit, the ALR failed to implement effective environmental measures to prevent recurrent bed bug infestations. This is a repeat deficiency. See Statement of	{R 202}		

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 07/19/2023

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 202}	Continued From page 3 Deficiencies Report dated 03/14/2023.	{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 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}	1.Resident #6, #7, #12 currently reside in the facility. No ill effects noted to the residents. All rooms have been treated for bed bug infestations on by the pest control company. The residents were temporarily relocated to other rooms for their safety and to ensure the rooms were properly treated. 2. The Maintenance Director or designee will assess all current resident rooms for any bed bugs infestations and report information to the pest control company. 3. The Executive Director or designee will in-service the maintenance director that there must be effective treatment measures and monitoring systems in place to eliminate beg bugs infestations. 4. The Maintenance Director or designee will audit 5 random rooms to inspect for any beg bug infestations weekly x 4, then monthly x 3 months. Results of the audits will be reviewed during the Quality Assurance Meeting.	8/28/23
{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. Based on observations, record reviews, and interviews, the Assisted Living Administrator failed	{R 562}		

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 07/19/2023

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 562}	Continued From page 4 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 in accordance with the ALR's guest policy (Regulation-10110.2n, § 44-105.03). B. 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). C. Establish a mechanism to ensure the facility complies with accepted standards of infection control and Emergency Preparedness requirements (See §§ 44-105.01. R119). D. Establish a mechanism to ensure deficient practices made known to the facility via 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 in accordance with the facility's guest policy, as follows: 2. [Cross reference 10116.15c - R278] On 07/18/2023 beginning at 2:54 pm, review of personnel records showed no evidence that LPN	{R 562}	1. No ill effects were noted to any resident due to the alleged allegations. 2. The current residents in the facility continues to thrive without any issues related to alleged findings. 3. The Regional Director of Operations will inservice the ALA that there must be an effective monitoring mechanism, written policies and procedures developed and implemented to ensure adequate oversight of the ALR as evidence by making sure all guests sign in and out of the ALR, the healthcare workers are properly credentialed and trained, the facility complies with accepted standards of infection control and emergency preparedness requirements and that deficient practices via compliance surveys were abated and systems are implemented to maintain compliance with DC laws and regulations.	8/28/23

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 07/19/2023

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 562}	Continued From page 5 #4 had a current license. 3. [Cross reference 10110.2I-R119] The ALA failed to ensure that the ALR complied with the District of Columbia health guidance on COVID 19/Infection Control, as follows: a. The facility was without a written policy and procedures that outlined circumstance in which staff were required to wear source control, as follows: On 06/01/2023, DOH issued an updated guidance titled: "Coronavirus 2019 (COVID-19): Interim Guidance for Required Personal Protective Equipment (PPE) for Healthcare Facilities" that included the following: "During all COVID-19 Hospital Admission Levels and COVID Emergency Department Visit Levels, all healthcare professionals, regardless of vaccination status, must wear source control: - while inside any area of the healthcare facility for 10 days after they were exposed to COVID-19, - when caring for patients/residents who are moderately to severely immunocompromised (defined as "includes, but is not limited to: people on chemotherapy, people with blood cancers like leukemia, people who have had an organ transplant or stem cell transplant, and people on kidney dialysis), - while in a unit/area in the facility experiencing a confirmed outbreak." Observations on 07/17/2023 beginning at 9:05 am showed some staff in the front foyer area and in the hallways wore surgical masks, some wore N-95 respirators (or similar), while other staff were without source control masks.	{R 562}	4. The Executive Director or designee will audit the visitor logs to ensure all guest signed in and out of the ALR, healthcare workers are properly credentialed and trained, complies with accepted standards of infection control; specifically, asking visitors if they had any COVID-19 symptoms or exposures to someone who was positive within the past 10 days, emergency preparedness requirements and that deficient practices made known via compliance surveys are abated and systems are implemented to maintain compliance with DC laws and regulations weekly x 4, monthly x 3 months. Results of the audits will be reviewed during the Quality Assurance Meeting.	

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 07/19/2023

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 562}	Continued From page 6 At 9:51 am, the Assisted Living Administrator (ALA) was asked if staff were required to wear masks. She replied "no, it ' s optional." She further stated that "the mask mandate has been lifted. When asked what might lead the facility to change back to mandatory masking, the ALA replied: "if there is an outbreak." She did not offer any other circumstances when staff must wear source control. The ALA agreed to make available for review the ALR ' s current COVID-19 policies and procedures. On 07/18/2023 beginning at 3:00 pm, a review of the ALR ' s COVID-19 related policies and procedures showed a policy "H180 Infection Control Guidelines for Infections Disease Outbreak" (dated 06/04/2021) that said: "the community will follow state specific mandates related to infectious respiratory outbreaks." The ALA had also presented a DOH-issued guidance titled: "Coronavirus 2019 (COVID-19): Mask and Respirator Guidance" that stated: "This guidance is not intended for use in healthcare facilities. Guidance specific to masks, respirators, and other PPE in these settings can be found at coronavirus.dc.gov/health guidance." On 07/19/2023 beginning at 11:07 am, the ALA replied "yes" when she was asked if what she had shared were the facility ' s current policies. When informed that policy H180 was dated 06/04/2021, she replied "ok." The ALA replied "yes" when asked if the 06/07/2023 guidance from DOH was what led the facility to inform staff that masking was now optional. When asked if she was aware that the 06/07/2023 guidance from DOH was not intended for use in ALRs and other healthcare facilities, the ALA replied: "no." Continued discussion revealed that a "clinical nurse" routinely checked the coronavirus. Dc website for	{R 562}		

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 07/19/2023

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 562}	Continued From page 7 updated guidance. When asked, the ALA stated that the facility did not have the DOH Guidance dated 02/01/2023 titled: "Coronavirus 2019 (COVID-19): Guidance for Skilled Nursing Facilities and Assisted Living Residences" or the DOH Guidance dated 06/01/2023 for required PPE in healthcare facilities. At 12:40 pm, the Director of Nursing (DON) presented a DOH guidance titled: "Coronavirus 2019 (COVID-19): Interim Guidance for Required Personal Protective Equipment (PPE) for Healthcare Facilities" updated dated 07/18/2023. Immediate review of the guidance showed that it continued the requirement that "all healthcare professionals, regardless of vaccination status, must wear source control" in the three circumstances listed in the 06/01/2023 guidance with the same title. When asked, the DON said it was reasonable to believe there could be current residents who received kidney dialysis; however, this was his third day working in the facility and he could not state with certainty. b. On 01/06/2023, DOH issued an updated guidance requiring all ALRs to: "Ensure that everyone entering the facility is made aware that... visitors who have COVID-19 symptoms or a known close contact with a COVID-19 positive person within the last 10 days, regardless of their vaccination status are not permitted." Observations on 07/17/2023 beginning at 9:05 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 that visitors with symptoms or who had recent contact with a	{R 562}		

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 07/19/2023

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 562}	Continued From page 8 positive person was prohibited from entering. Prior to entering, visitors were asked to sign a form that asked for his or her name, the name and unit number of the person they were visiting, the reason for the visit, the time that they signed in and the time they were leaving the ALR. The form did not request the visitor ' s contact information or ask if the visitor had any COVID-19 symptoms or exposure to someone who was positive within the past 10 days. On 07/19/2023 beginning at 11:07 am, the ALA replied "no" when she was asked if the facility had the DOH Guidance dated 01/06/2023 titled: "Coronavirus 2019 (COVID-19): Guidance for Visitation in Skilled Nursing Facilities and Assisted Living Residences." This is a repeat deficiency. See deficiency reports dated 03/14/2023. In a Plan of Correction, signed 06/09/2023, the ALR stated that: "The front desk staff will be educated by administrator on sign-in process of COVID-19 screening process of visitors (sic) and completion of sign-in information to include name, phone number, address, email ..."	{R 562}		
R 595	Sec. 701d8 Staffing Standards. (8) Assure that each employee has a background check pursuant to federal and District law executed at the time of initial employment. Based on interviews and record reviews, the Assisted Living Residence failed to show evidence that procedures were developed and implemented to ensure compliance with the criminal background check requirements prescribed by 22B DCMR §§ 4700 et seq., for	R 595	1. The non-licensed housekeepers (#1, 2, 3 and 4) will be sent to obtain their fingerprints to obtain "eligibility statements" or similar issued by DC Health to verify that they are cleared to work in a healthcare facility. DOH HR has been contacted by the Executive Director on several occasions to obtain guidance on how to get the non-licensed staff fingerprinted at DOH's approved venue.	8/28/23

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 07/19/2023

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 595	Continued From page 9 four of the four non-licensed housekeepers whose records were reviewed (HK #1, 2, 3, and 4). Findings included: On 07/19/2023 at 11:50 am, a review of the personnel records of employees who were hired after the 03/14/2023 survey was conducted. Four employees were identified who did not possess any professional license issued through DC Health. Of those four employees, there was no evidence that the facility had obtained "eligibility statements" or similar issued by DC Health for the four unlicensed employees, verifying that they were cleared to work in a healthcare facility. Records showed the following: 1. Housekeeper (HK) #1's personnel record lacked evidence of a DC Health "eligibility statement" clearing him for employment, although the record contained a report dated 06/23/2023, showing that HK #1 passed a background check that was obtained through a private company. HK #1 signed his job description on 06/26/2023. 2. HK #2's personnel record showed the employee signed his job description on 04/25/2023. The record lacked evidence of an "eligibility statement" issued by DC Health, although the record contained a report dated 03/28/2023, showing that HK #2 passed a background check that was obtained through a private company. 3. HK #3's personnel record showed that she signed her job description on 06/27/2023 and had passed a background check that was obtained through a private company. There was no	R 595	2. The Executive Director or designee will review the current non-licensed employees' personnel files to ensure that there is evidence to note compliance with the criminal background checks requirements as evidence by obtaining an "eligibility statement" or similar issued by DC Health. 3. The Executive Director will inservice the Assistant Executive Director or designee to ensure that there is evidence of a background check pursuant to federal and District law executed at the time of initial employment; specifically, obtaining an "eligibility statement" or similar issued by DC Health for unlicensed employees. 4. The Executive Director or designee will audit 50% of new hires' personnel files to ensure that there is an " eligibility statement" or similar issued by DC Health to note if staff are deemed eligible for employment in a healthcare facility weekly x 4, monthly x 3 months. Results of the audits will be reviewed during the Quality Assurance Meeting.	

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 07/19/2023

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 595	Continued From page 10 evidence, however, that an "eligibility statement" or similar was issued by DC Health. . 4. HK #4's personnel record showed the employee signed her job description on 06/26/2023. The record lacked evidence of an "eligibility statement" issued by DC Health, although the record contained a report dated 06/15/2023, showing that HK #4 passed a background check that was obtained through a private company. On 07/19/2023 at approximately 4:00 pm, interview with the Assisted Living Administrator (ALA) revealed that she was no familiar with Chapter 47 or the criminal background check requirements prescribed by 22B DCMR §§ 4700 et seq. The ALA indicated that she would seek additional information from the Human Resources office. At the time of the survey, the Assisted Living Residence failed to ensure that all staff were deemed eligible for employment in a healthcare facility by DC Health following the criminal background check requirements prescribed by 22B DCMR §§ 4700 et seq.	R 595		
{R 605}	Sec. 701g2 Staffing Standards. (2) Possess current and appropriate licensure and certifications as required by law. Based on interviews and record reviews, the Assisted Living Administrator (ALA) failed to ensure that each nurse possessed an appropriate license, for one of the six nurses who were hired and began providing services to residents since the previous (03/14/2023) survey, (Licensed Practical Nurse #4).	{R 605}	1. LPN#4 was removed from the schedule as of 7/19/23. LPN hasn't worked a shift in the ALR since removal from schedule. 2. The Director of Nursing or designee will review the current nursing staff credentials to ensure to ensure they are in active status.	8/2823

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 07/19/2023

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 605}	Continued From page 11 Findings included: On 07/18/2023 at 2:54 pm, a review of the personnel record maintained for Licensed Practical Nurse (LPN) #4 showed a license with an expiration date of 06/30/2023. The record also showed that LPN #4 was hired 05/26/2023. The July 2023 nurse staffing schedule showed LPN #4 scheduled, as follows: 07/04/2023, double shift 3 pm - 7 am 07/05/2023, 11 pm - 7 am 07/06/2023, 3 pm - 7 am (double shift) 07/07/2023, 11 pm - 7 am as well as shifts on 07/08/2023, 07/10/2023, 07/11/2023, 07/14/2023, and 07/15/2023. In addition, LPN #4 was scheduled to work on 07/19/2023, 07/20/2023, 07/21/2023, 07/24/2023, 07/25/203, 07/28/2023, 07/29/2023, and 07/30/2023. On 07/19/2023 at 3:18 pm, telephone interview with LPN #4 confirmed that she was without a current license. She explained that she did not have the money to begin the renewal process. She said she had worked in the ALR as recently as 07/15/2023. At approximately 4:00 pm, when the Assisted Living Administrator (ALA) was asked about LPN #4 ' s expired license, she presented a letter dated 06/15/2023 notifying LPN #4 that they were aware that her license would expire 06/30/2023. The letter asked the nurse to "bring your updated LPN license once it has been renewed." At approximately 4:20 pm, the ALA replied "today" when asked on what day was LPN #4 removed from the nursing schedule. She then acknowledged that LPN #4 had worked with residents without a current license in July 2023.	{R 605}	3. The Executive Director will inservice the human representatives to ensure that the nursing staff credentials are active while they are employed at the ALR; if not, the employee must be removed from the schedule. 4. The Executive Director or designee will audit 50% of new hired nursing staff to ensure their credentials are active weekly x 4, monthly x 3 months. Results of the audits will be reviewed during the Quality Assurance Meeting.	

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 07/19/2023

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 605}	Continued From page 12 This is a repeat deficiency. When the ALR was cited on 03/14/2023 for failing to ensure that a Certified Nursing Assistant (CNA #5) was certified to practice in the District of Columbia, the facility submitted a Plan of Correction (signed 06/09/2023) that stated the human resources "representative is currently auditing all employee files to ensure no further infractions and will be completed by 05/31/2023 to ensure compliance. A training tickler will be utilized ... moving forward to monitor compliance and be reviewed and (sic) monthly quality assurance meeting." At the time of the re-visit, the ALR failed to develop and implement an effective tickler system, with commensurate monitoring, to ensure that each employee maintained his or her credentials.	{R 605}		
{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 each resident's Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all information required for one of one newly admitted resident in the sample (Residents #1).	{R 705}	1. Resident #1 currently resides in the facility without any ill effects. The medical certification form date 4/1/23 was reviewed by the IDT members to note the missing information. 2. The Director of Nursing or designee will review the medical certification forms prior to a resident's admission to the ALR to ensure the form is completed will all the required information.	8/28/23

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 07/19/2023

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 705}	Continued From page 13 Findings included: On 07/17/2023 at 2:40 pm, a review of Resident #1's Medical Certification form dated 04/01/2023 showed the physician did not measure and document the resident ' s vital signs and did not list the resident ' s current medications. On 07/18/2023 at 3:20 pm, the above findings were discussed with the Delegating Nurse (DN). The DN acknowledged the form was not complete with all the required information. At the time of the re-visit the ALR failed to ensure Resident #1's Medical Certification form was completed with all the required information.	{R 705}	3. The Executive Director will inservice the IDT members who are responsible to ensure the medical certification form is completed with all the required information prior to admission to the ALR. 4. The DON or designee will audit 10% of the new admissions to ensure the medical certification form is completed with all the required information prior to admission weekly x 4, monthly x 3 months. Results of the audits will be reviewed during the Quality Assurance Meeting.	