Health R	tegulation & Licensino	Administration	744.00		· · · · · · · · · · · · · · · · · · ·
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	f'	X3) DATE SURVEY COMPLETED
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					R
		ALR-0041	B. WING		07/19/2023
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, ST	FATE, ZIP CODE	
		4656	LIVINGSTON RO		
SOUTHE	RN AVE SP LLC DBA L	IVINGSTON AT	HINGTON, DC 2	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATO NTIFYING INFORMATION)	PRY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{R 000}	Initial Comments		{R 000}		
	0000 Initial Comments			i	
	A follow-up survey w 07/18/2023 and 07/1 facility's compliance Residence Regulatio Health and Medicine 03/14/2023 licensure The findings of the s	vas conducted on 07/17/202 9/2023, to determine the with the Assisted Living ons, Title 22-B DCMR (Publ c) Chapter 101 during the e survey. urvey were based on ews, and review of Resider	lic	Please start typing your responses the This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exist or that one was cited correctly. This Plan of Correction is	98
{R 012}	Resid 10102.4 A Licensee health, safety, and w	Operate an Assisted Livingshall be responsible for the elfare of the ALR's resident	,	submitted to meet requirements established by state and federal law  1. No ill effects were noted to an resident due to the alleged allegations.	8/28/23
	interviews, the Assis to establish an effect develop and/or imple procedures to ensure	ns, record reviews, and ted Living Administrator fail live monitoring mechanism, ement written policies and adequate oversight of the dence, as evidenced by the	ı	<ul><li>2. The current residents in the facontinues to thrive without any is related to alleged findings.</li><li>3. The Regional Director of</li></ul>	sues
	signed in and out of	anism to ensure all guests the ALR in accordance with Regulation-10110.2n, §	ı the	Operations will inservice the ALA there must be an effective monit mechanism, written policies and procedures developed and implemented to ensure adequate oversight of the ALR as evidence	oring e e by
	workers are properly 10116.15c, 10116.15 44-107.02 R278, R	677, R678 and R682).		making sure all guests sign in an of the ALR, the healthcare worked are properly credentialed and trathe facility complies with accepted standards of infection control and	ers ined, ed
		anism to ensure the facility ed standards of infection cy Preparedness		emergency preparedness requirements and that deficient practices via compliance surveys were abated and systems are	
ealth Pegula	tion & Licensing Administra	tion		implemented to maintain complia	ance

WINSTINA STATE FORM

with DC laWs and regulations.

Executive Director

DXX212

Health R	equiation & Licensino	Administration				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	ALR-0041	B. WING		R 07/19/2023	
NAME OF D	DOLUBER OD SUSSILIES		DESC CITY ST	ATE ZIR CODE	,	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST. NGSTON ROA	·		
SOUTHE	RN AVE SP LLC DBA I	IVINGSTON AT	TON, DC 2	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{R 012}	Continued From pag	ge 1	{R 012}	4. The Executive Director or		
	requirements (See §	§ 44-105.01. R119).		designee will audit the visitor le		
	D. Establish a mech	anism to ensure deficient	1	to ensure all guest signed in a out of the ALR, healthcare wor		
	practices made know	wn to the facility via compliance		are properly credentialed and	Koro	
		d, and systems implemented to		trained, complies with accepte	d	
		e with applicable District of regulations (See all repeat		standards of infection control;	101	
	deficiencies through			specifically, asking visitors if the had any COVID-19 symptoms		
	Findings included:			exposures to someone who wa		
	Findings included:			positive within the past 10 day	s,	
		0110.2n - R121] The ALA failed	:	emergency preparedness requirements and that deficien	<u>+</u>	
		signed in and out of the ALR In facility's guest policy, as		practices made known via		
	follows:	lacility's guest policy, as		compliance surveys are abate	d and	
				systems are implemented to		
		10116.15c - R278] On g at 2:54 pm, a review of		maintain compliance with DC I and regulations weekly x 4,	aws	
:		nowed no evidence that LPN #4		monthly x 3 months. Results o	f the	
	had a current license	9.		audits will be reviewed at the		
	3. ICross reference	10110.2I-R119] The ALA failed		Quality Assurance Meeting.	İ	
		R complied with the District of dance on COVID 19/Infection				
	a The feelibrase	ithaut a writtan palicy and				
	procedures that outli	ithout a written policy and ned circumstance in which staff ar source control, as follows:				
		Hissued an updated guidance				
	Guidance for Require Equipment (PPE) for included the followin					
				•		

Health R	tegulation & Licensing	Administration		A CONTRACTOR OF THE CONTRACTOR		
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	IPLETED
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		ALR-0041	B. WING		07/19/2023	
NAME OF D		CTREET ADD	DECC CITY OF	ATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST.			
SOUTHE	RN AVE SP LLC DBA L	IVINGSTON AT	IGSTON ROATON, DC 2	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
{R 012}	Continued From pag	ge 2	{R 012}		,,	
	   vaccination status. п	nust wear source control:				
ĺ		ea of the healthcare facility for				
		ere exposed to COVID-19,				
		tients/residents who are				
		ely immunocompromised				
		s, but is not limited to: people on le with blood cancers like				
		no have had an organ transplant				i
		nt, and people on kidney				
	dialysis),					
		in the facility experiencing a				
	confirmed outbreak.					
	showed some of the in the hallways wore N-95 respirators (or:	17/2023 beginning at 9:05 am staff in the front foyer area and surgical masks, some wore similar), while other staff were				
	without source contract At 9:51 am, the Assi was asked if staff we replied "no, it's option mask mandate has a might lead the facility masking, the ALA resumed to the facility masking, the ALA resumed to the staff must wear sour make available for resumed to the ALR's COVID-19 policies a COVID-19 policies and COVID-19 procedures showed Guidelines for Infection 6/04/2021) that said state specific manda	sted Living Administrator (ALA) are required to wear masks. She nal." She further stated that "the been lifted. When asked what y to change back to mandatory plied: "if there is an outbreak." of other circumstances when ce control. The ALA agreed to eview the ALR's current and procedures.  Inning at 3:00 pm, a review of a related policies and a policy "H180 Infection Control ions Disease Outbreak" (dated di: "the community will follow ites related to infectious in The ALA had also presented				

neam R	<u>legulation &amp; Licensing</u>	Administration				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	· · · · · · · · · · · · · · · · · · ·	COM	MPLETED
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			D MINO		4	R
		ALR-0041	B, WING		07/19/2023	
NAME OF B	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.	ATE ZID CODE		
NAME OF F	ROVIDER OR SOFFLIER					
SOUTHE	RN AVE SP LLC DBA I	IVINGSTONAT	NGSTON RO	•		
		WASHING	STON, DC 2	0032		
(X4) ID	SÜMMARY STA	ATEMENT OF DEFICIENCIES	JD.	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	OR LSC IDE	NTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	RIATE	DATE
						<u> </u>
{R 012}	Continued From pag	10 3	{R 012}			
(1.012)	Continued From pag	je 3	1110125			
}	titled: "Coronavirus 2	2019 (COVID-19): Mask and				ĺ
]		e" that stated: "This guidance is				
i	not intended for use	in healthcare facilities.				
	Guidance specific to	masks, respirators, and other	Ĭ			:
	PPE in these setting	s can be found at	,			
	coronavirus.dc.gov/l	nealth guidance."				
	,		1			-
	On 07/19/2023 begin	nning at 11:07 am, the ALA	į.			
		he was asked if what she had				
1		ility's current policies. When	1			
		H180 was dated 06/04/2021,	}			
		ALA replied "yes" when asked	İ			Ì
:	if the 06/07/2023 gui	idance from DOH was what led				
		staff that masking was now				
		ed if she was aware that the				
		e from DOH was not intended				
		other healthcare facilities, the				1
		ontinued discussion revealed				l
1		" routinely checked the				
i		osite for updated guidance.				
		A stated that the facility did not				•
		ance dated 02/01/2023 titled:				
İ		COVID-19): Guidance for				
		lities and Assisted Living				
]		DOH Guidance dated				
İ		red PPE in healthcare facilities.	1			
ļ	At 12:40 pm, the Dire	ector of Nursing (DON)				
		idance titled: "Coronavirus	1			<b> </b>
		terim Guidance for Required				
		Equipment (PPE) for				
ĺ		" updated dated 07/18/2023.				
		the guidance showed that it	:			
	continued the require	ement that "all healthcare				
ŀ		dless of vaccination status,	1			
	must wear source co		1			
		in the 06/01/2023 guidance				
		Vhen asked, the DON said it				
ŀ		elieve there could be current				
ŀ	was reasonable to be	eliese filore conto de corrett				
}						

Health R	egulation & Licensing	Administration			, 01(14	RITIOVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		ALR-0041	B. WING.		R 07/19/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SOUTHE	RN AVE SP LLC DBA I	IVINGSTONAT	NGSTON ROASTON, DC 20			
				PROVIDER'S PLAN OF CORRECTION	NI	A/E>
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(EAGH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
{R 012}	Continued From pag	ge 4	{R 012}			
		ved kidney dialysis; however, y working in the facility and he certainty.				
	guidance requiring a everyone entering the visitors who have Co close contact with a within the last 10 day	OH issued an updated all ALRs to: "Ensure that he facility is made aware that OVID-19 symptoms or a known COVID-19 positive person ys, regardless of their				
i	vaccination status a					
	showed there was nentrance informing was symptoms of COVID contact with a perso could not enter. The survey team that vis recent contact with a prohibited from ente were asked to sign a name, the name and were visiting, the reathey signed in and the ALR. The form did ninformation or ask if symptoms or exposupositive within the page.	•				
i.	replied "no" when sh the DOH Guidance of "Coronavirus 2019 (	nning at 11:07 am, the ALA ie was asked if the facility had dated 01/06/2023 titled: COVID-19): Guidance for Nursing Facilities and Assisted			·	
		ciency. See deficiency reports a a Plan of Correction, signed				

neann r	equiation & Licensing	Administration				_
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:	- Control of the Cont	CUN	IPLETED
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		ALK-0041			U11	19/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADO	RESS, CITY, ST.	ATE, ZIP CODE		:
		4656 LIVIN	IGSTON ROA	AD SE		
SOUTHE	RN AVE SP LLC DBA I	IVINGSTON AT	TON, DC 2	•		
		· · · · · · · · · · · · · · · · · · ·				
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				DEFICIENCY)		
(D.040)			(D. 040)			
{R 012}	Continued From pag	je 5	{R 012}			i
	06/09/2023 the ALR	R stated that: "The front desk				!
		d by administrator on sign-in				:
		9 screening process of visitors				
		of sign-in information to include				i i
		er, address, email"				
j	, , , , , , , , , , , , , , , , , , ,	,				
				4 5		
{R 074}	10108.2 Admissions		{R 074}	Resident #1 currently resides		8/28/23
1				the facility without any ill effects		
	10108.2			medical certification form date 4		
		and record reviews, the		was reviewed by the IDT memb	ers to	
		dence (ALR) failed to ensure		note the missing information.		
]		mediate Care Facilities Division				
		ledical Certification form was		2. The Director of Nursing or		
		equired information for one of		designee will review the medica	al	
		resident in the sample		certification forms prior to a resi		
	(Residents #1).	·		s admission to the ALR to ensu		
				form is completed will all the red		1
	Findings included:			information.	quiiou	Ì
				·	i	
		40 pm, a review of Resident		3. The Executive Director will		
		ation form dated 04/01/2023		inservice the IDT members who	are	
		n failed to check and document				
		gns and did not list the		responsible to ensure the medic		<b>.</b>
	resident's current me	edications.		certification form is completed v		
	O- 0714010000 -1 0 0	20 the effect 5!		all the required information prior	r to	[
		20 pm, the above findings were		admission to the ALR.		
		elegating Nurse (DN). The DN				
		rm was not complete with all		4. The DON or designee will au	dit	
	the required informat	uon.		10% of the new admissions to		
	At the time of the :	visit the ALR failed to ensure		ensure the medical certification		
İ		al Certification form was		is completed with all the require		
				information prior to admission w		1
	completed with all the	e required information.		x 4, monthly x 3 months. Result	s of	Į.
	This is a report defic	siency. See Statement of		the audits will be reviewed at th	е	I
	Deficiencies Report			Quality Meeting.		I
	Policielicies Lebolt (	GELOG UTI 10/2020.		•	!	I
						ļ
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Health R	equiation & Licensing	Administration			,			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIES			CONSTRUCTION	(X3) DATE S	SURVEY PLETED	
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		ALR-0041		B. WING		07/1	9/2023	
NAME OF D	ROVIDER OR SUPPLIER		STREET AND	ADDRESS, CITY, STATE, ZIP CODE				
				IGSTON ROA				
SOUTHE	RN AVE SP LLC DBA I	LIVINGSTON AT		TON, DC 20	The state of the s			
	SLIMMARY STA	ATEMENT OF DEFICIENCIES		QI	PROVIDER'S PLAN OF CORRECTION	V	(X5)	
(X4) ID PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL R	EGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETE DATE	
TAG	OK LSC IDE	NTIFYING INFORMATION)		TAG	DEFICIENCY)	WIL		
	<u> </u>							
{R 119}	Continued From pag	je 6		{R 119}				
{R 119}	10110.2l Required F	Policies and Procedu	res	{R 119}	4			
. 1				·	1.The current residents reside		8/28/23	
	10110.2(I) Emerge				the facility without any ill effection	มร	0/20/23	
	meet the same stan				Control Guidelines for Infection	nie -		
	preparedness as the				Respiratory Disease Outbrea			
	facilities by the Cent Services, at 42 CFR		IVIEUICAIU		policy was revised on 7/21/23			
		=	ropord		show staff are required to we			
	Based on observation reviews, the Assiste	d Living Residence (	'Al R) failed		source control as evidence by			
	to develop and imple				following DC Health's guideling			
	policies and procedu				Signage will be posted at the			
	standards and Distri	ct of Columbia Depa	rtment of		desk and the front doors to no	ote		
	Health (DOH) guida	nce, for 111 of the 1	11 residents		that everyone entering the fac			
	of the facility.		!		is made aware that visitors w			
					have COVID-19 symptoms or	ra		
	Findings included:				known close contact with a			
	1. The facility was w	rithout a written polic	v and		COVID-19 positive person wi			
	procedures that outl				the last 10 days regardless of	rueir		
	were required to we				vaccination status are not			
				:	permitted.			
	On 06/01/2023, DOI				2. There are currently not		110	
	titled: "Coronavirus 2 Guidance for Requir				residents or staff members w	ith		
	Equipment (PPE) fo	r Healthcare Facilitie	's" that		active or suspected COVID-1			
	included the following	g; "During all COVID	)-19		the facility infections.	ļ		
	Hospital Admission	Levels and COVID E	mergency		-	į		
	Department Visit Le	vels, all healthcare			3. The DON or designee will			
	professionals, regard		status,		inservice the facility's staff on			
	must wear source co	ontrol:			revised "H-180 Infection Con	trol		
	- while inside any ar	es of the healthcare	facility for		Guidelines for Infectious	1.9		
	10 days after they w				Respiratory Disease Outbrea			
	day a ditor siloy w				policy noting DC Health's gui			
	- when caring for pa	tients/residents who	are		concerning the staff requirem wear source control in the AL			
	moderately to sever	ely immunocompron	nised		and front desk staff that there			
	(defined as "include				be signage posted at the fror			
	chemotherapy, peor	pie with blood cance	rs like		desk and front doors to note			
					everyone entering the facility			
					made aware that visitors who			

Health R	legulation & Licensing	Administration			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		ALR-0041	B. WING		R 07/19/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	100
SOUTHE	RN AVE SP LLC DBA L	IVINGSTONAT	IGSTON ROA		
		WASHING	TON, DC 20		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET
{R 119}	leukemia, people whor stem cell transpla dialysis),  - while in a unit/area confirmed outbreak.'  Observations on 07/showed some staff in hallways wore surgio respirators (or simila without source control of the mask mandate what might lead the mandatory masking, outbreak." She did no circumstances when the ALA agreed to rate ALR's current COV  On 07/18/2023 beging the ALR's covid-1 procedures showed Guidelines for Infection 6/04/2021) that said state specific mandarespiratory outbreaks a DOH-issued guida (COVID-19): Mask a stated: "This guidance healthcare facilities. respirators, and other	in the facility experiencing a  17/2023 beginning at 9:05 am in the front foyer area and in the cal masks, some wore N-95 ir), while other staff were ol masks.  sted Living Administrator (ALA) ere required to wear masks. She onal." She further stated that has been lifted. When asked facility to change back to the ALA replied: "if there is an	{R 119}	COVID-19 symptoms or a know close contact with a COVID-19 positive person within the last 10 days regardless of their vaccina status are not permitted in the fact.  4. The DON or designee will aud 10% of the facility's staff to ensure the staff are wearing their source control as required by DC Healt that the signage is posted at the desk and doors that everyone entering the facility is made away that visitors who have COVID-11 symptoms or a known close corwith a COVID-19 positive persowithin the last 10 days regardles their vaccination status are not permitted weekly x 4, monthly x months. Results of the audits wis submitted to the Quality Assurat Meeting.	tion acility. dit are e n and front are 9 atact n ss of 3 II be

realitis	<u>equiation &amp; Licensino</u>	Administration				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		A1 D 0044	B. WING		1	₹
		ALR-0041			[ <b>V/</b> /	19/2023
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SOUTHERN AVE SPILIC DHA LIVINGSTON AT			TON, DC 2			
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(X4) ID		ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
			<u> </u>			
{R 119}	Continued From pag	je 8	{R 119}			
	On 07/10/2022 bodie	nning at 11:07 am, the ALA				1
		he was asked if what she had				
		ility 's current policies. When	ŀ			1
		H180 was dated 06/04/2021,	•			i .
		ALA replied "yes" when asked				
		idance from DOH was what led	·			[ ]
1		staff that masking was now				}
		d if she was aware that the				[
		e from DOH was not intended			•	
		other healthcare facilities, the				<b> </b>
		ontinued discussion revealed				1
		" routinely checked the				
		osite for updated guidance.				
-		A stated that the facility did not				l i
l		ance dated 02/01/2023 titled:				i i
1		COVID-19): Guidance for				
		lities and Assisted Living				l
1		OOH Guidance dated				]
		red PPE in healthcare facilities.				
	OUTO TEOLO TOI TOQUII	real i E il i localdicare identices.				
	At 12:40 nm, the Dire	ector of Nursing (DON)				ľ
		idance titled: "Coronavirus				ļ <u>[</u>
		iterim Guidance for Required				
		Equipment (PPE) for			-	]
		" updated dated 07/18/2023.				
		the guidance showed that it				
- 1		ement that "all healthcare				
1	professionals regard	dless of vaccination status,				
	must wear source co					
}		in the 06/01/2023 guidance				
		When asked, the DON said it				
		elieve there could be current				
		ed kidney dialysis; however,				
		working in the facility and he				
ì	could not state with o					
.	SPAIN HOLDING WILLIE					
	2 On 01/06/2023 De	OH issued an updated	;			
ľ		II ALRs to: "Ensure that				
j		e facility is made aware				
	orosposio esternig tri	o many to make diffe				
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Health R	equiation & Licensino	Administration		TARA MANAGAMAN AND AND AND AND AND AND AND AND AND A	7 0 1 1.1	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY IPLETED
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		ALR-0041	B, WING_			₹ 19/2023
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NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
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{R 119}	Continued From page	je 9	{R 119}			
	that visitors who he known close contact person within the last vaccination status at Observations on 07/showed there was nentrance informing waymptoms of COVID contact with a person could not enter. The survey team that visit recent contact with a	ave COVID-19 symptoms or a twith a COVID-19 positive st 10 days, regardless of their re not permitted."  17/2023 beginning at 9:05 am o signage posted at the risitors that people with 0-19 or who had been in close in who was COVID-19 positive receptionist did not inform the itors with symptoms or who had a positive person were				
	recent contact with a positive person were 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.					
	replied "no" when sh the DOH Guidance of "Coronavirus 2019 (6	nning at 11:07 am, the ALA e was asked if the facility had dated 01/06/2023 titled: COVID-19): Guidance for Jursing Facilities and Assisted				
÷	dated 03/14/2023. In 06/09/2023, the ALR staff will be educated process of COVID-19	ciency. See deficiency reports a Plan of Correction, signed a stated that: "The front desked by administrator on sign-in 9 screening process of visitors of sign-in information to include er, address, email"				

Health R	Health Regulation & Licensing Administration						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
COUTUE	DN 445 00 110 DD 41	MINISTON AT 4656 LIVIN	IGSTON RO	AD, SE			
SOUTHE	RN AVE SP LLC DBA L	WASHING	TON, DC 2	0032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	/D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
{R 119}	Continued From pag	e 10	{R 119}				
	facility had not update	visit, evidence showed that the ted its COVID-19 policies and the most recent guidance					
R 154	10113.5 A "post mov 604 of the Act (D.C. be conducted by or c seventy-two (72) hou Based on interviews Assisted Living Resident Registered Nurse move-in" assessment for one of one newly sample (Residents # Findings included:  On 07/18/2023 begin Residents #1's reconwas admitted on 05/0 documented evidence the residents within 7 ALR.  During an interview of ALR 's delegating Non assessment performed a within 8 performed a within seventy-two (72) hours within seventy-two (72) within seventy-two (72) within seventy-two (72) within seventy-two (72) hours within seventy-two	re-in" assessment required by § Official Code § 44-106.04) shall on behalf of the ALR within ars of a resident's admission.  and record reviews, the dence (ALR) failed to ensure e (RN) performed a "post at within 72 hours of admission, admitted resident in the 1).  Ining at 1:00 pm, a review of ds showed that the resident 04/2023. There was no e that the ALR's RN assessed 72 hours of his admission to the area confirmed that there was remed by the RN within ars of the resident 's admission.  In or/18/2023 at 3:10 pm, the curse confirmed that there was remed by the RN within ars of the resident 's admission.  In ory, the ALR failed to ensure the post move-in" assessment 2) hours of admission, as the Act (D.C. Official Code §	R 154	1. Resident #1 currently resides if facility. The "post move-in" assessment was completed on 5/4/23. No ill effects noted.  2. The DON or designee will reviet the current new admissions to the facility to ensure their "post move assessment was performed by a 3. The Executive Director or designill in-service the nursing leaders that the "post move-in" assessment completed by a RN within 72hrs padmission to the facility.  4. The DON or designee will audit 10% of the new admissions to enthat the "post move-in" assessment that the "post move-in" assessment admission to the facility weekly x monthly x 3 months. Results of the audits will be submitted to the Quantity Assurance Meeting.	ew -in" RN. gnee chip ent is cost t sure ent is cost 4,	8/28/23	
	At the time of the sur the RN performed a 'within seventy-two (7 required by § 604 of	vey, the ALR failed to ensure post move-in assessment 2) hours of admission, as			,		

Health R	tegulation & Licensing	Administration				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	E CONSTRUCTION	(X3) DATE S	SURVEY PLETED
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	ROVIDER OR SUPPLIER	IVINGSTON AT 4656 LIVIN	RESS, CITY, ST.	AD, SE	<u>,                                      </u>	
OOOTTIL	THE OF LEG OBA !	WASHING	TON, DC 2	0032		,, , _ , _ ,
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{R 278}	or other authority for her profession in the Based on interviews Assisted Living Adm that each nurse post for one of the six nurproviding services to (03/14/2023) survey  Findings included:  On 07/18/2023 at 2:: personnel record ma Nurse (LPN) #4 shot date of 06/30/2023. LPN #4 was hired 05 staffing schedule shollows:  07/04/2023, double so 07/05/2023, 11 pm - 07/06/2023, double so 07/07/2023, 11 pm - as well as shifts on 0 07/11/2023, 07/14/2 addition, LPN #4 was	icense, registration, certificate, the employee to practice his or District, if applicable.  and record reviews, the inistrator (ALA) failed to ensure sessed an appropriate license, rese who were hired and began presidents since the previous (Licensed Practical Nurse #4).  54 pm, a review of the initialized for Licensed Practical wed a license with an expiration The record also showed that 5/26/2023. The July 2023 nurse towed LPN #4 scheduled, as shift 3 pm - 7 am shift 3 pm - 7 am	{R 278}	1. LPN#4 was removed from the schedule as of 7/19/23. LPN has worked a shift in the ALR since refrom schedule.  2. The Director of Nursing or deswill review the current nursing starcedentials to ensure to ensure the in active status.  3. The Executive Director will insect the human Resource representate ensure that the nursing staff creater active while they are employed the ALR; if not, the employee muremoved from the schedule.  4. The Executive Director or designated and the schedule and the schedule are active while they are employed the ALR; if not, the employee muremoved from the schedule.  4. The Executive Director or designated and the schedule and the schedule are active will audit 50% of new hired nursing to ensure their credentials are active weekly x 4, monthly x 3 months, of the audits will be submitted to Quality Assurance Meeting.	signee aff ney are ervice tive to lentials ed at lest be gnee ng staff tive Results	8/28/23
	LPN #4 confirmed the license. She explained money to begin the a	18 pm, telephone interview with at she was without a current ed that she did not have the renewal process. She said she LR as recently as 07/15/2023.				

Health Regulation & Licensing Administration							
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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{R 278}	Continued From pag	je 12	{R 278}				
	Administrator (ALA) expired license, she 06/15/2023 notifying that her license woul asked the nurse to "I once it has been ren pm, the ALA replied day was LPN #4 rem schedule. She then a worked with resident July 2023.  This is a repeat deficion 03/14/2023 for fai Nursing Assistant (C in the District of Colu Plan of Correction (s the human resources auditing all employed infractions and will be ensure compliance. A moving forward to reviewed and (sic) meeting."  At the time of the reand implement an effortmensurate monit	was asked about LPN #4 's presented a letter dated LPN #4 that they were aware december 06/30/2023. The letter bring your updated LPN license ewed." At approximately 4:20 "today" when asked on what noved from the nursing acknowledged that LPN #4 had is without a current license in cliency. When the ALR was cited liling to ensure that a Certified NA #5) was certified to practice imbia, the facility submitted a igned 06/09/2023) that stated is "representative is currently in files to ensure no further ecompleted by 05/31/2023 to A training tickler will be utilized monitor compliance and be conthly quality assurance wisit, the ALA failed to develop fective tickler system, with toring, to ensure that each december of the control of the					
R 326	Background Che 10120.1 No ALR sha unlicensed person fo	nsed Personnel Criminal Il employ or contract an Ir work on the ALR's premises	R 326	1. The non-licensed housekee (#1, 2, 3 and 4) will be sent to obtain their fingerprints to a ve approved by DC Health so the eligibility statements" or similar	nue "	8/28/23	
	until a criminal backg	round check has		issued by DC Health are collected			

Health Regulation & Licensing Administration							
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
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		ALR-0041	B. WING		07/19/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.	ATE, ZIP CODE	<del> </del>		
		4656 LIVI	NGSTON RO	AD, SE			
SOUTHE	RN AVE SP LLC DBA	LIVINGS ION AT WASHING	STON, DC 2	0032			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
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			-	DEFICIENCY)			
R 326	Continued From pa	ge 13	R 326				
	- '	_		to verify that they are cleared	io		
	been conducted for	that person.		work in a healthcare facility.			
	10120 2 An Al R sh	all implement and comply with		2. The Executive Director or			
		ound check standards and		designee will review the curre	ot		
		licensed personnel prescribed		non-licensed employees' pers			
	by D.C. Official Cod	le §§ 44-551 et seq. and 22-B		files to ensure that there is			
	DCMR §§ 4700 et s	eq.		evidence to note compliance v	vith		
	Based on interviews	and record reviews, the		the criminal background check			
	Assisted Living Res	idence failed to show evidence	1	requirements as evidence by			
		re developed and implemented		obtaining an "eligibility statement	ent"		
		ce with the criminal background		or similar issued by DC Health			
		prescribed by 22B DCMR §§	1				
		ur of the four non-licensed		3. The Executive Director will	] ]		
		se records were reviewed (HK	İ	inservice the Assistant Execut	ive		
	#1, 2, 3, and 4).		Director or designee to ens		that		
	Findings included:			there is evidence of a backgro			
	i manigo moragoa:			check pursuant to federal and			
	On 07/19/2023 at 1	1:50 AM, a review of the		District law executed at the tin	ne of		
		f employees who were hired	Ì	initial employment; specifically			
		survey. Four employees were		obtaining an "eligibility stateme			
		ot possess a professional	or similar issued by DC Heal		ı for		
		gh DC Health. Of those four		unlicensed employees.			
		as no evidence that the facility			1		
		ility statements" or similar n for the four unlicensed	1	4. The Executive Director or			
		g that they were cleared to work		designee will audit 50% of nev			
	in a healthcare facili			hires' personnel files to ensure			
		-3.	ł	there is an "eligibility statemer			
	Records showed the	e following:		similar issued by DC Health to			
		•		if staff are deemed eligible for			
		() #1's personnel record lacked		employment in a healthcare fa			
		ealth "eligibility statement"		weekly x 4, monthly x 3 month Results of the audits will be	15.		
		ployment, although the record		submitted to the Quality Assur	ance		
		lated 06/23/2023, showing that		Meeting.	ance		
		ckground check that was		Meeting.			
	his job description of	orivate company. HK #1 signed in 06/26/2023					
	ma lon describrion o	TO COLLUZUEU.					
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Health Regulation & Licensing Administration							
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY MPLETED	
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R 326	2. HK #2's personne signed his job descrirecord lacked evider issued by DC Health a report dated 03/28 passed a backgrounthrough a private corpassed by DC Health a report dated 06/15 passed a backgrounthrough a private corport dated 06/15 passed a backgrounthrough a private corport dated 06/15 passed a backgrounthrough a private corport dated 06/15 passed a backgrounthrough a private corport dated that she was the criminal backgrounthrough a private corport dated that she was the time of the sur Residence failed to edeemed eligible for efacility by DC Health	I record showed the employee option on 04/25/2023. The core of an "eligibility statement", although the record contained /2023, showing that HK #2 d check that was obtained mpany.  I record showed that she iption on 06/27/2023 and had d check that was obtained mpany. There was no evidence, gibility statement" or similar ealth.  I record showed the employee iption on 06/26/2023. The core of an "eligibility statement", although the record contained /2023, showing that HK #4 d check that was obtained mpany.  proximately 4:00 pm, interview ing Administrator (ALA) is no familiar with Chapter 47 or and check requirements CMR §§ 4700 et seq. The ALA ould seek additional information ources office.  vey, the Assisted Living ensure that all staff were employment in a healthcare following the criminal quirements prescribed by 22B	R 326				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE S	SURVEY PLETED
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ALR-0041 B. WING		9/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
4656 LIVINGSTON ROAD, SE		
SOUTHERN AVE SPILLC DBA LIVINGSTON AT WASHINGTON, DC 20032		
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOUL TAG CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	) BE	(X5) COMPLETE DATE
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 all incidents that substantially affected a resident, followed by written notification within 24 hours, for five of the 33 residents in the sample (Residents #8, 12, 31, 32 and 33).  Findings included:  1. Prior to the survey, the DOH received notification that on 10/19/2022 at 1:44 pm, a facility nurse found Resident #31 "incoherent and unable to move the lower extremities." The resident admitted to having snorted heroin, and Narcan was administered. On 10/26/2022 at 2:19 pm, the facility notified the DOH that the resident died of a heroin overdose in his unit.  On 03/07/2023 beginning at 4:16 pm, a review of Resident #31's medical records revealed that been three similar incidents, as follows:  On 10/18/2022 at 11:35 pm, a nurse documented having found Resident #31 with slurred speech and drooling. The resident told the nurse he had taken heroin.  On 10/221/2022 at 3:23 pm, a nurse documented telephoning 911 emergency services after finding Resident #31 face down on the floor in his unit.	f 6, 12 acility. hance ration to request 5's unit he tion to ring Also, for 32 s/p on he ensure ly affect l written ext  ervice ader ly affect l written	8/28/23

Health Regulation & Licensing Administration						
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The hos treat O tele, Res a horresid involved in the notification of the notification	pital emergency itment.  n 10/23/2022 at 9 phoning 911 emerident #31 unrespondent was treated are was no evident fication of the throwing heroin use on 03/08/2023 at 13's incident report 10/2023, at 8:45 a pistant (CNA) information was seen they realized rediately initiated and they realized rediately initiated and they realized rediately initiated and they realized rediately initiated and they realized rediately initiated and they realized rediately initiated and they realized rediately initiated and they realized rediately initiated and they realized reporting stated that seriounted immediately en notification with the Resident #33's down in his becalled, the ALA so called right award of 103/13/2023 begings and emails resident emails rediated emails rediated and emails rediated in 103/13/2023 begings and emails rediated and emails r	ed injuries and was taken to a room for evaluation and  9:11 pm, a nurse documented ergency services after finding ionsive in his unit. According to report dated 10/24/2022, the for "heroin overdose."  Ice that the DOH received ee aforementioned incidents by the resident.  12:31 pm, a review of the log showed that on am the Certified Nursing med the fourth-floor nurse that in kneeling face down on his urse went back to Resident for carotid and femoral pulses. To pulse was found, CPR was while another nurse called not notified of the incident ine.  13 pm the Assisted Living was interviewed regarding their ing incidents to the DOH. The just incidents should be to the DOH, followed by thin 24 hours. When asked incident where he was found droom with no pulse and 911 said the DOH should have	{R 383}	4. The DON or designee will au 10% of the incidents reported to ensure that any incident that substantially affect the resident telephone call immediately to D followed by written notification v 24hrs or the next business day x 4, monthly x 3 months. Result the audits will be submitted to the Quality Assurance Meeting.	had a OH vithin weekly s of	

Health Regulation & Licensing Administration						A AT T NOVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY MPLETED
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{R 383}	Continued From pag	ge 17	{R 383}			
	that were not reporte	ed to the DOH, as follows.				
	that maintenance ree #12's unit when the e bugs. The Departme b). Review of invoice that maintenance ree #6 unit after live bug observed many live to casings. The residen The Department of F  4. On 01/27/2023, the the death of Residen information received observed Emergency personnel going tows staff went to check o informed by the EMS currently a crime sce pronounced dead du one would be allowe ALR did not notify the	poice dated 11/8/2022 revealed quested treatment in Resident resident reported seeing bed ent of Health was not notified.  It dated 12/14/2022 revealed quested treatment of Resident s were seen. The technician bed bugs, excrement, and it was relocated to another unit. Health was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified.  It delth was not notified and was seen because of a visitor being to an overdose, and that no do to come into the room." The end of the promptly by telephone notification the next				
·	reported to the DOH [Cross reference R28 Resident #32 informe while walking in her u informed a Certified I and a Licensed Pract	ts with significant injury were				

neam n	reduiation & Ficensing					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
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SOUTHERN AVE SPILLC DBA LIVINGSTON AT WASHINGTON, DC 20032						
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	ı			DEFICIENCY)		İ
tD noon	O	40	ID 0003			<u>†                                      </u>
{R 383}	Continued From pag	je 18	{R 383}			1
	nor the LPN reported	d the fall. Resident #32's sister				1
		cy services, after the resident				
		lent was assessed at an area				
		sed with a fractured ankle.				
	. •					
	There was no evider	nce that Resident #32's				
	emergency room vis	it, and diagnosed fractured				
	ankle were reported					
						i
	On 03/08/2023 begit	nning at 11:30 am, a review of				
i		Reporting" policy, dated				
		the following instruction:				:
		ncidents or other unusual				
		intially affect a resident shall be				
		tor of DC Health by phone				
		e followed up by written				
		rector within 24 hours of (sic)				
	the next business da	iy."				j
	At the time of the a	new the Appleted Living				
ļ		rvey, the Assisted Living led to promptly notify the				
		h (DOH) by telephone of all				
Ī		intially affected a resident.				
		otification within 24 hours.				}
	IOHOWEG DY WILLELI II	omication within 24 Hours.				<b> </b>
	This is a repeat defin	ciency. See Statement of				
ľ		dated 02/04/2022, 04/07/2022				<b> </b>
	and 06/03/2022.	. da.ta 02/0-112022, 0-110112022				ļ <b>!</b>
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