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 0000 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, submission of this Plan of Correction is 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 012}	10102.4. Authority to Operate an Assisted Living Resid 10102.4 A Licensee shall be responsible for the health, safety, and welfare of the ALR's residents. Based on observations, record reviews, and interviews, the Assisted Living Administrator failed to establish an effective monitoring mechanism, develop and/or implement written policies and procedures to ensure adequate oversight of the Assisted Living Residence, as evidenced by the ALA's failure to: A. Establish a mechanism to ensure all guests signed in and out of the ALR 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	{R 012}	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

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

WINSTINA WILLIAMS — Executive Director — 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 012}	Continued From page 1 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, a review of personnel records showed no evidence that LPN #4 had a current license. 3. [Cross reference 10110.2l-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	{R 012}	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 at 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 012}	Continued From page 2	{R 012}		

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 of the 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.

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

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 012}	Continued From page 3 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 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	{R 012}		

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 012}	Continued From page 4	{R 012}		

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 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.

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

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 012}	Continued From page 5 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 012}		
{R 074}	10108.2 Admissions 10108.2 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 required information for one of one newly admitted resident in the sample (Residents #1). 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 failed to check 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. This is a repeat deficiency. See Statement of Deficiencies Report dated 04/13/2023.	{R 074}	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. 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 at the Quality Meeting.	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 119}	Continued From page 6	{R 119}		
{R 119}	10110.2I Required Policies and Procedures 10110.2(I) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR § 483.73. Based on observations, interviews, and record reviews, the Assisted Living Residence (ALR) failed to develop and implement emergency preparedness policies and procedures that comply with Federal standards and District of Columbia Department of Health (DOH) guidance, for 111 of the 111 residents of the facility. Findings included: 1. 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	{R 119}	1.The current residents resides in the facility without any ill effects noted. The "H-180 Infection Control Guidelines for Infectious Respiratory Disease Outbreak" policy was revised on 7/21/23 to show staff are required to wear source control as evidence by following DC Health's guidelines. Signage will be posted at the front desk and the front doors to note 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. 2. There are currently not residents or staff members with active or suspected COVID-19 in the facility infections. 3. The DON or designee will inservice the facility's staff on the revised "H-180 Infection Control Guidelines for Infectious Respiratory Disease Outbreak" policy noting DC Health's guidance concerning the staff requirement to wear source control in the ALR and front desk staff that there must be signage posted at the front desk and front doors to note that everyone entering the facility is made aware that visitors who have	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 119}	Continued From page 7 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. 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."	{R 119}	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 in the facility. 4. The DON or designee will audit 10% of the facility's staff to ensure the staff are wearing their source control as required by DC Health and that the signage is posted at the front desk and doors 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 weekly x 4, monthly x 3 months. Results of the audits will be submitted to 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 119}	Continued From page 8	{R 119}		

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 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.

2. On 01/06/2023, DOH issued an updated guidance requiring all ALRs to: "Ensure that everyone entering the facility is made aware

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 119}	Continued From page 9	{R 119}		

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 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.

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 ..."

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 119}	Continued From page 10 At the time of the re-visit, evidence showed that the facility had not updated its COVID-19 policies and procedures to reflect the most recent guidance issued by DOH.	{R 119}		
R 154	10113.5 Individualized Service Plans (ISPs) 10113.5 A "post move-in" assessment required by § 604 of the Act (D.C. Official Code § 44-106.04) shall be conducted by or on behalf of the ALR within seventy-two (72) hours of a resident's admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Registered Nurse (RN) performed a "post move-in" assessment within 72 hours of admission, for one of one newly admitted resident in the sample (Residents #1). Findings included: On 07/18/2023 beginning at 1:00 pm, a review of Residents #1's records showed that the resident was admitted on 05/04/2023. There was no documented evidence that the ALR's RN assessed the residents within 72 hours of his admission to the ALR. During an interview on 07/18/2023 at 3:10 pm, the ALR ' s delegating Nurse confirmed that there was no assessment performed by the RN within seventy-two (72) hours of the resident ' s admission. At the time of the survey, the ALR failed to ensure the RN performed a "post move-in" assessment within seventy-two (72) hours of admission, as required by § 604 of the Act (D.C. Official Code § 44-106.04).	R 154	1. Resident #1 currently resides in the facility. The “post move-in” assessment was completed on 5/4/23. No ill effects noted. 2. The DON or designee will review the current new admissions to the facility to ensure their “post move-in” assessment was performed by a RN. 3. The Executive Director or designee will in-service the nursing leadership that the “post move-in” assessment is completed by a RN within 72hrs post admission to the facility. 4. The DON or designee will audit 10% of the new admissions to ensure that the “post move-in” assessment is completed by a RN within 72hrs post admission to the facility weekly x 4, monthly x 3 months. Results of the audits will be submitted to the Quality Assurance Meeting.	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 278}	10116.15c Staffing Standards 10116.15c Proof of license, registration, certificate, or other authority for the employee to practice his or her profession in the District, if applicable. 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). 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, double shift 3 pm - 7 am 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.	{R 278}	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. 3. The Executive Director will inservice the human Resource representative 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 submitted to the Quality Assurance Meeting.	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 278}	Continued From page 12 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. 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 ALA failed to develop and implement an effective tickler system, with commensurate monitoring, to ensure that each employee maintained his or her credentials.	{R 278}		
R 326	10120.1 & 2 *Unlicensed Personnel Criminal Background Che 10120.1 No ALR shall employ or contract an unlicensed person for work on the ALR's premises until a criminal background check has	R 326	1. The non-licensed housekeepers (#1, 2, 3 and 4) will be sent to obtain their fingerprints to a venue approved by DC Health so the " eligibility statements" or similar issued by DC Health are collected	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 326	Continued From page 13 been conducted for that person. 10120.2 An ALR shall implement and comply with the criminal background check standards and requirements for unlicensed personnel prescribed by D.C. Official Code §§ 44-551 et seq. and 22-B DCMR §§ 4700 et seq. 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 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. Four employees were identified who did not possess a 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.	R 326	to verify that they are cleared to work in a healthcare facility. 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 submitted to 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 326	Continued From page 14 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 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 326		

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 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 all incidents that substantially affected a resident, followed by written notification within 24 hours, for five of the 33 residents in the sample (Residents #6, 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 10/21/2022 at 3:23 pm, a nurse documented telephoning 911 emergency services after finding Resident #31 face down on the floor in his unit.	{R 383}	1. Resident #31 and #33 no longer resides in the facility. Resident # 6, 12 and 32 currently resides in the facility. No ill effects noted. The Maintenance Director submitted written notification to DC Health for the maintenance request treatment in resident #12 and #6's unit due to bed bug observations. The ADON submitted written notification to DC Health for the incident involving resident #1's visitor on 1/24/23. Also, for the incident involving resident #32 s/p fall resulting in a fractured ankle on 1/7/23. 2. The DON or designee will review the current residents in the facility to ensure that all incidents that substantially affect the resident had a telephone call immediately to DOH followed by written notification within 24hrs or the next business day to DOH. 3. The DON or designee will inservice the administration and clinical leader that all incidents that substantially affect the resident had a telephone call immediately to DOH followed by written notification within 24hrs or the next business day to DOH.	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 383}	Continued From page 16 The resident sustained injuries and was taken to a hospital emergency room for evaluation and treatment. On 10/23/2022 at 9:11 pm, a nurse documented telephoning 911 emergency services after finding Resident #31 unresponsive in his unit. According to a hospital discharge report dated 10/24/2022, the resident was treated for "heroin overdose." There was no evidence that the DOH received notification of the three aforementioned incidents involving heroin use by the resident. 2. On 03/08/2023 at 12:31 pm, a review of the ALR's incident report log showed that on 01/10/2023, at 8:45 am the Certified Nursing Assistant (CNA) informed the fourth-floor nurse that the resident was seen kneeling face down on his bed. The CNA and nurse went back to Resident #33's room, checked for carotid and femoral pulses. When they realized no pulse was found, CPR was immediately initiated while another nurse called 911. The DOH was not notified of the incident promptly via telephone. On 03/10/2023 at 4:23 pm the Assisted Living Administrator (ALA) was interviewed regarding their procedure for reporting incidents to the DOH. The ALA stated that serious incidents should be reported immediately to the DOH, followed by written notification within 24 hours. When asked about Resident #33's incident where he was found faced down in his bedroom with no pulse and 911 was called, the ALA said the DOH should have been called right away. 3. On 03/13/2023 beginning at 1:25 pm, a review of invoices and emails regarding bed bug treatment services revealed incidents of bed bugs	{R 383}	4. The DON or designee will audit 10% of the incidents reported to ensure that any incident that substantially affect the resident had a telephone call immediately to DOH followed by written notification within 24hrs or the next business day weekly x 4, monthly x 3 months. Results of the audits will be submitted to 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 383}	Continued From page 17	{R 383}		

that were not reported to the DOH, as follows.

a). Review of an invoice dated 11/8/2022 revealed that maintenance requested treatment in Resident #12's unit when the resident reported seeing bed bugs. The Department of Health was not notified.

b). Review of invoice dated 12/14/2022 revealed that maintenance requested treatment of Resident #6 unit after live bugs were seen. The technician observed many live bed bugs, excrement, and casings. The resident was relocated to another unit. The Department of Health was not notified.

4. On 01/27/2023, the DOH received notification of the death of Resident #1's visitor. Per the information received, on 01/24/2023 the ALR's staff observed Emergency Medical Services (EMS) personnel going toward Resident #1's unit. The ALR staff went to check on the resident and was informed by the EMS personnel that "the room was currently a crime scene because of a visitor being pronounced dead due to an overdose, and that no one would be allowed to come into the room." The ALR did not notify the DOH promptly by telephone and did not submit any written notification the next day.

5. The ALR failed to ensure that resident emergency room visits with significant injury were reported to the DOH as follows:

[Cross reference R282] On 03/07/2023 at 4:00 pm, Resident #32 informed the surveyor that she fell while walking in her unit on 01/07/2023. She informed a Certified Nursing Assistant (CNA #5) and a Licensed Practical Nurse (LPN) that she believed her leg was broken, but neither the CNA

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 383}	Continued From page 18	{R 383}		

nor the LPN reported the fall. Resident #32's sister called 911 emergency services, after the resident called her. The resident was assessed at an area hospital and diagnosed with a fractured ankle.

There was no evidence that Resident #32's emergency room visit, and diagnosed fractured ankle were reported to the DOH.

On 03/08/2023 beginning at 11:30 am, a review of the ALR's "Incident Reporting" policy, dated 06/04/2021, showed the following instruction: "Serious reportable incidents or other unusual incidents that substantially affect a resident shall be reported to the Director of DC Health by phone promptly and shall be followed up by written notification to the Director within 24 hours of (sic) the next business day."

At the time of the survey, 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.

This is a repeat deficiency. See Statement of Deficiencies Reports dated 02/04/2022, 04/07/2022 and 06/03/2022.