STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0006	A. BUILDING: _____ B. WING _____	C 10/15/2019

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GRAND OAKS ASSISTED LIVING	5901 MACARTHUR BLVD NW WASHINGTON, DC 20016

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R 000	Initial Comments On 09/03/19, the Department of Health, Health Regulation and Licensing Administration, Intermediate Care Facilities Division (State Survey Agency), received a request to investigate allegations against management at the Assisted Living Residence, to include the Assisted Living Administrator and the Senior Vice President. The complainant, Resident #1, presented a letter dated 08/19/19, in which the Senior Vice President stated that he had investigated the resident's grievances and found no evidence to substantiate the allegations. Based on the nature of the allegations, the State Survey Agency initiated an on-site investigation on 10/03/19 beginning at 3:10 PM, to determine compliance with the Assisted Living Residence Regulatory Act of 2000 and attendant regulations. The complainant alleged the following: Allegation 1: Resident #1 alleged emotional and mental abuse and retaliation by the Assisted Living Administrator. Conclusion: The complaint allegation was partially substantiated. The complaint allegation of emotional and mental abuse could not be substantiated. The allegation of retaliation was substantiated. Allegation 2: Resident #1 alleged exploitation and coercion by the Assisted Living Administrator regarding a request that a new Resident Agreement be signed prior to the resident relocating to a new unit. Conclusion: The complaint allegation could not be substantiated.	R 000		

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R 000	Continued From page 1 The findings of this investigation are detailed throughout the body of this report. Listed below are abbreviations used throughout the report: ALA - Assisted Living Administrator ALR - Assisted Living Residence ALRRA - Assisted Living Residence Regulatory Act of 2000 email - electronic mail F - Fahrenheit RA - Resident Agreement SC - Sales Counselor SSA - State Survey Agency/Department of Health, Health Regulation and Licensing Administration, Intermediate Care Facilities Division	R 000	*Grand Oaks is filing this response for the sole purpose of confirming compliance with requests of Department of Health in receipt of the survey report related to the survey completed on October 15, 2019. This response is not an admission of liability or statement of agreement with respect to issues identified in discussions with the agency but is submitted to demonstrate regulatory compliance.*	
R 354	Sec. 505a3 Representation And Resolution Of Grievances (3) To present grievances and complaints without fear of threat of retaliation and have them acknowledged and acted upon promptly with due respect to the provisions of this act; Based on interview and record review, the ALR failed to ensure that each resident was able to present grievances and complaints without fear of retaliation, for one of one resident who filed a grievance against the ALA and other managers (Resident #1). Findings included: The review of the ALR's Resident Grievance Procedure dated March 2016 revealed, "At no time will any team member of the Community	R 354	**R354 105.05(a)3** A resident shall have the right to present grievances and complaints without fear of threat or retaliation and have them acknowledged and acted upon promptly with due respect to the provisions of this chapter. **I. Corrective Action** The ALA acted to have the complainant sign an updated resident agreement to accomplish the request of internal transfer. At the time of this action, the ALA believed it to be standard business practice to have residents sign a new RA when there is a voluntary unit assignment change for residents that had an existing resident agreement under the previous management company.	

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R 354	Continued From page 2 take any improper action against a resident for making a complaint, whether or not the complaint is valid." A review of the ALR's Resident's Rights dated 04/30/10, revealed a resident shall have the right "to present grievances and complaints without fear of threat of retaliation and have them acknowledged and acted upon promptly with due respect to the provisions law." The ALR failed to adhere to its policies and procedures prohibiting retaliation, as evidenced by the following: On 07/19/19, Resident #1 and the resident's husband (non-resident) filed a formal grievance complaint alleging that the ALR's ALA retaliated and coerced the resident to sign a new RA prior to relocating from one unit/suite to another. Resident #1 objected to signing a new RA, alleging that the ALA unfairly singled out Resident #1 with the request. She and her husband believed this was in retaliation for being outspoken and willing to complain. 1. During an interview with the ALA and the ALR's attorney on 10/04/19 beginning at 9:40 AM, the ALA stated that it was standard business practice to have residents sign a new RA when there is a voluntary unit assignment change and the RA was signed under a different management company. However, further interview revealed that the ALR had identified 12 of 12 residents who relocated to other units without having to sign a new RA with Sibley management. She described this as an accidental oversight and that she had not noticed that those residents had signed their RAs under the previous management company. She then stated that there were no written procedures regarding voluntary unit assignment changes and no process for identifying which residents would need to sign a new RA. The ALA stated that she was working on a policy for future	R 354	The intent of the ALA was not to single out the complainant or to retaliate for previous actions. Subsequently, it came to be known to the ALA, based on auditing, that 12/12 residents had not signed an updated resident agreement when completing internal transfer of units. The ALA immediately took action to remedy this and required all of those outstanding residents to sign updated agreements several weeks before this onsite inspection. The ALR did not find this these actions to represent retaliation by the ALA on the complainant. Notwithstanding these findings, the ALR will provide education and training to the management team and staff on the Resident Grievance Procedure as well as the ALR's residents' rights policy. **II. How to Identify Other** Currently, there are no other grievances or disputes being reviewed for which the ALR could potentially identify retaliation as a factor.	

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R 354	Continued From page 3 transfers. In addition, she denied ever retaliating against Resident #1 and her husband. During a follow-up interview with the ALA on 10/09/19 beginning at 3:02 PM, the ALA stated that "I made an assumption that they (12 of 12 residents who relocated) were already under the new agreement. With [Resident #1], I knew they weren't under a new agreement... I knew there was a history." The investigation findings showed that the ALR expected Resident #1 to sign a new RA although 12 of 12 other residents had relocated without having to sign a new RA. There was no evidence to show that the ALR had an official policy, protocol or practices for new RAs to be signed priot to unit assignment changes; therefore, the ALR had singled out Resident #1 as alleged. 2. On 10/04/19 at approximately 2:00 PM, review of emails showed that the ALA ignored Resident #1's request for written policies, as followed: - On 07/15/19 at 12:00 PM, Resident #1's husband wrote, "Please send me a copy of the written room relocation or transfer policy/process." - 07/15/19 at 2:36 PM, the ALA wrote, "the transfer policy required by the regulation relates to transferring out of the community or a community initiated transfer to another suite. The policy is not in relation to a customer initiated move to another suite." - 07/15/19 at 2:44 PM, Resident #1's husband asked, "Do you have a written policy on what you require of the resident in relation to a customer initiated move to another suite?" - 07/15/19 at 4:00 PM, the ALA wrote, "an updated contract is part of our routine business	R 354	**III. Systemic Changes** Grand Oaks will: • continue to provide training on residents' rights, including retaliation during initial employee orientation. • conduct additional resident rights training specific to retaliation during staff meetings. • update its Abuse and Neglect Education Resource Guide to include a section on Retaliation. **IV. Monitoring Process** Content of the training and staff attendance records will be reviewed by the ALR Quality Assurance Committee during the next 90 days. **V. Date of Completion** The content of the education, staff training, and education resource guide update will take place by January 6, 2020. The Orientation inclusion of the content will be ongoing. The audits will be conducted through April 6, 2020.	01/06/2020 & ongoing

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R 354	Continued From page 4	R 354		

processes. Your wife's paperwork is from [Previous Management Company], not current with Sibley management. We will need to update it for this move. Thank you."

The investigation findings showed that the ALA did not address the husband's request for change of unit assignment policies.

3. The following emails showed evidence that the ALA gave the resident two and a half hours to decide on the purchase of the new unit without honoring a request for a meeting to discuss the RA.

On 07/16/19 at 11:22 AM, Resident #1's husband wrote, "we know your 'routine business processes' in recent years have not always required new RAs for other resident requested moves ...We have four lawyers and the Ombudsman looking at this to provide advice, and hope to hear from them soon ... should you want to make the Resident Agreement an issue, then we will need to set up a meeting with others involved to try and find a mutually agreeable way forward. Let me know how you would like to proceed. Warm regards."
- 07/16/19 at 2:38 PM, the ALA replied, "... we will need a new residency agreement, please let us know if you are interested in [Unit #] by the end of the day. If not, we will proceed with contacting other leads. Take care."

The investigation findings showed that the ALA did not address the request for a meeting and proceeded with other offers.

4. During a telephone interview on 10/25/19 at 1:20 PM, Resident #1 stated that she believed that she was being targeted because she had

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R 354	Continued From page 5 filed numerous complaints in the past. A review of the SSA database determined that eight health and safety-related complaints were filed by Resident #1 against the ALR during the period March 2015 - July 2019. There was evidence that during the same period, there were ongoing, written communications from Resident #1's personal attorneys to the ALR, identifying concerns that affected the resident's quality of life. The findings of this investigation showed that Resident #1 had a documented history of complaints against the ALR, for which some allegations were substantiated. 5. The ALA required Resident #1 to sign a new RA prior to obtaining the desired unit, knowing that the resident had objected to several of its provisions in the past, as follows: On 10/08/19 at approximately 12:15 PM, Resident #1 stated that the ALA was aware that she would not sign a new RA because the RA included the adherence to the community guidelines for which she had filed a complaint with the SSA in 2018. A review of the SSA database confirmed that Resident #1 filed a complaint objecting to the community guidelines. Her allegation was investigated and outlined in the SSA's Statement of Deficiencies report, dated 05/08/18, to which the ALR responded. At the time of this investigation, the SSA findings substantiated Resident #1's allegation of retaliation. [Cross-refer to R381]	R 354		

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R 381	Sec. 507 Full Disclosure	R 381		

A resident shall have the right to full disclosure of contract terms and billing practices that are fair and reasonable.
Based on interview and record review, the ALR failed to affirm and protect each resident's right to full disclosure of contract terms that are fair and reasonable, specifically terms that apply to voluntary unit assignment changes, for any resident entering into a contract/ Resident Agreement with the ALR.

Findings included:

The ALR failed to provide full disclosure regarding contract terms applicable to voluntary resident unit assignment changes, as follows:

A. On 07/19/19, Resident #1 filed a grievance with the ALR alleging that she was being required by the ALR's ALA to sign a new RA against her wishes, in order to relocate from her current unit/suite to another suite.

1. An interview with the ALA and the ALR's attorney on 10/04/19 beginning at 9:40 AM, confirmed that Resident #1 and her husband (non-resident) were told that the resident must sign a new RA. They also confirmed that Resident #1 objected to signing a new RA. Further interview revealed that the ALR was without written procedures regarding voluntary unit assignment changes from one unit/suite to another. They stated that due to Resident #1's grievance and rebuttal statement on 08/31/19, the ALR performed an internal audit of resident files and determined that 12 of 12 residents with RAs signed under [Previous Management] had

R381 105.07
A resident shall have the right to full disclosure of contract terms and billing practices that are fair and reasonable.

I. Corrective Action

To assure full disclosure of contract terms and billing practices that are fair and reasonable, Grand Oaks will implement several actions:

- Development of an internal transfer policy that provides a consistent procedure for resident-initiated internal transfers.
- Development of a standard operating procedure for resident apartment waitlists.
- The Grand Oaks Residency Agreement is being reviewed and revised to include language meeting the requirements of the regulation 44-106.02(6): Admission and Discharge policies which include clear and specific criteria for admission, transfer and discharge.
- The ALR has treated this provision to apply to transfers out of Grand Oaks but will add criteria to include internal transfers.

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R 381	Continued From page 7 relocated without signing new RAs. Four of those residents (Residents #2, 4, 5, and 6) were current residents and the remaining eight residents were deceased. Based on the audit, the ALA asked Residents #2, 4, 5, and 6's responsible parties to sign new RAs in September 2019. 2. On 10/04/19 at approximately 2:00 PM, review of email correspondence between the ALA and Resident #1's husband revealed the following: - 07/15/19 at 12:00 PM, Resident #1's husband wrote, "Please send me a copy of the written room relocation or transfer policy/process." - 07/15/19 at 2:36 PM, the ALA wrote, "the transfer policy required by the regulation relates to transferring out of the community or a community initiated transfer to another suite. The policy is not in relation to a customer initiated move to another suite." - 07/15/19 at 2:44 PM, Resident #1's husband asked, "Do you have a written policy on what you require of the resident in relation to a customer initiated move to another suite?" - 07/15/19 at 4:00 PM, the ALA wrote, "an updated contract is part of our routine business processes. Your wife's paperwork is from [Previous Management Company], not current with Sibley management. We will need to update it for this move." - 07/16/19 at 11:22 AM, Resident #1's husband wrote, "we know your 'routine business processes' in recent years have not always required new RAs for other resident requested moves ... should you wish to make the Resident Agreement an issue, then we will need to set up a meeting with others involved to try and find a mutually agreeable way forward. Let me know how you would like to proceed." - 07/16/19 at 2:38 PM, the ALA replied, "we will need a new residency agreement, please let us	R 381	**II. How to Identify Other** At the time this response is being drafted, there are no other residents who have requested internal transfers. However, the ALR will implement the following: • The new Policy and Standardized Operation Procedure will be applied to all other residents' requests for an internal transfer. • The revised Residency Agreement will be used for all new residents moving into the ALR. **III. Systemic Changes** • The revised Residency Agreement will be disseminated to all current residents for review and signature. **IV. Monitoring Process** • Once all the actions (The Internal Transfer Policy, the Standardized Operating	

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R 381	Continued From page 8 know if you are interested in [unit number] by the end of the day. If not, we will proceed with contacting other leads." 3. On 10/04/19 at 3:20 PM, a review of Residents #2, 4, and 5's RAs revealed that they signed new agreements with the current management on 09/23/19, 09/23/19, and 09/20/19, respectively and Resident #1's RA, dated 12/16/10, was signed under the previous management company. None of the RAs reviewed included information or guidance regarding procedures to follow if/when a current resident requests a unit assignment change. 4. On 10/04/19 at 4:35 PM, a review of the ALR's policy on Resident Admissions and Transfers, dated 11/28/18, revealed the following: "This policy does not refer to resident initiated transfers to another suite." At the time of this investigation, the ALR contract failed to disclose a procedure for voluntary unit assignment changes. B. There was evidence that the ALR implemented a waitlist and offered current residents the right to first refusal; however, these practices were not consistently executed, as follow: 1. The ALR's internal investigation report, dated 08/19/19, stated that sales counselors first had to speak with individuals on a waitlist before the ALR could make an offer to Resident #1. 2. During an interview on 10/04/19 beginning at 9:40 AM, the ALA and the ALR's attorney confirmed that initially, the ALR's sales counselors informed Resident #1's husband that there were individuals on a waitlist. At 11:18 AM,	R 381	Procedure for waitlists, the use of the revised Residency Agreement for new residents entering Grand Oaks, and the dissemination of the revised Residency Agreement to all current residents) have been implemented, the CEO, and/or designee, will randomly audit the compliance of the policy requirements, standardized operating procedure, and execution of the revised residency agreements for sixty days. • Results of the compliance audits will be reviewed by the ALR's Quality Assurance team. V. **Date of Completion** The Internal Transfer Policy, the Standardized Operating Procedure for waitlists, the use of the revised Residency Agreement for new residents entering Grand Oaks, and the dissemination of the revised Residency Agreement to all current	

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R 381	Continued From page 9 the Director of Sales (SC #2) stated that the ALR maintained a waitlist in its sales office. SC #2 further stated that current residents had the right of first refusal over people on the waitlist. At 12:30 PM, when asked if current residents had the right of first refusal, SC #1 answered "correct... internal residents get priority." SC #1 confirmed there was a waitlist maintained on a dry erase board in the sales office. 3. On 10/04/19 at 3:20 PM, a review of Residents #2, 4, and 5's RAs, signed 09/23/19, 09/23/19, and 09/20/19, respectively, and Resident #1's RA, signed 12/16/10, revealed no written procedures regarding the management of a waitlist or a current resident's right of first refusal if/when a new unit becomes available. 4. On 10/04/19 at 4:35 PM, a review of the ALR's policy on Resident Admissions and Transfers, dated 11/28/18, revealed that there were no written procedures regarding a current resident's right of first refusal or the management of a waitlist by the sales office. 5. During an interview on 10/07/19 at 3:23 PM, Resident #1 and the resident's husband described conversations in early July 2019 when the husband first expressed interest to the ALR's sales staff for the unit that was available. SC #1 and SC #2 spoke of the need to contact others (non-residents) first, before they could offer the unit to Resident #1. 6. On 10/11/19, the ALA forwarded to SSA documentation via email which showed that three prospective residents had made down payments for admission into the ALR and were on a waitlist for a two bedroom unit, which was the size (two bedroom) that Resident #1 was interested in.	R 381	residents will be completed by January 6, 2020.	01/06/2020 & ongoing

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7. On 10/24/19 during the Exit Conference, the ALA and the ALR's attorney stated that policies and procedures regarding the use of a waitlist and a resident's right of first refusal were under development.

8. For clarification, on 10/25/19 at 1:20 PM, Resident #1 was asked by telephone about her understanding of a waitlist. Resident #1 replied "I wasn't aware of an official policy on a waitlist." When asked if residents had a "right of first refusal," Resident #1 replied "No, I never heard that before."

At the time of this investigation, the ALR contract failed to disclose a procedure for the use of a waitlist and a resident's right of first refusal.

C. The ALR failed to ensure that contract terms disclosed fair and reasonable practices, as follows:

On 07/19/19, Resident #1 filed a grievance with the ALR alleging that the ALA unfairly singled her out (Resident #1) by requiring her to sign a new RA which she found was unreasonable.

1. On 10/02/19, a review of the ALR's internal investigative report, dated 08/19/19, revealed that Resident #1 was the first person to request a unit assignment change who had an RA signed under the previous management company. On 08/31/19, however, Resident #1 filed a rebuttal in which she named 12 other residents in similar circumstances who were not required by the ALA to sign new RAs before they could relocate to a new unit/suite.

2. During an interview with the ALA and the

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ALR's attorney on 10/04/19 beginning at 9:40 AM, they stated that the ALR initiated an internal audit based on Resident #1's 08/31/19 rebuttal. The audit identified 12 of 12 residents who relocated to other units without having to sign a new RA with Sibley management. The ALA described this as an accidental oversight and explained that she had not noticed that the 12 residents had signed the RAs under the previous management company.

3. On 10/04/19 at approximately 10:04 AM, the ALA presented for review a letter dated 09/20/19 addressed to the SSA in which she wrote: "As you know, we have identified those residents who internally transferred with a [Previous Management Company] Agreement still in place. There are four in total...families have the replacement agreement and are expected to provide us with signed copies." The 09/20/19 letter further stated that "Moving forward, we will have all residents who internally transfer sign a Grand Oaks (Management) Agreement..."

4. Continued interview with the ALA and the ALR's attorney on 10/04/19, revealed that current residents with RAs signed under [Previous Management Company] would only be asked to sign a new RA with Sibley management if they were to request a unit assignment change to a different unit. They further acknowledged that there were no written procedures regarding voluntary unit assignment changes.

5. When interviewed on 10/07/19 beginning at 3:03 PM, Resident #1 confirmed that she objected to signing a new RA. At 3:57 PM, the resident complained that her husband's email on 07/16/19, in which he requested a meeting to discuss the issue, was met with a response to

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GRAND OAKS ASSISTED LIVING	5901 MACARTHUR BLVD NW WASHINGTON, DC 20016

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R 381	Continued From page 12 make a decision by the close of the business day (within approximately 2 1/2 hours) or the unit would be offered to someone else. She also complained that they had not received written policies and procedures when the husband requested them by email on 07/15/19. Resident #1 and her husband found it unreasonable to ask her to comply with a policy that didn't exist, especially given that 12 others had not been required to do the same. At the time of this investigation, the findings showed that the ALR failed to ensure full disclosure of contract terms and demonstrate fair and reasonable practices.	R 381	**R392 105.09(b)3** An ALR shall thoroughly investigate any allegation of abuse, neglect, or exploitation and shall take appropriate action to prevent further incidents. The ALR shall report the results of this investigation and actions taken, if any, to the Mayor. **I. Corrective Action** • Grand Oaks will review and revise the Abuse, Neglect, and Exploitation Policy as appropriate. • The Policy will include a Table as an Appendix which will outline the steps required as part of the investigation (e.g. as in this alleged event, interview of the complainant(s), other residents or family members who may have been present during the alleged behavior). • Grand Oaks will review its Grievance Procedure to reassess (1) how events	
R 392	Sec. 509b3 Abuse, Neglect, and Exploitation. (3) An ALR shall thoroughly investigate any allegation of abuse, neglect, or exploitation and shall take appropriate action to prevent further incidents. The ALR shall report the results of its investigation and actions taken, if any, to the Mayor. Based on interview and record review, the ALR failed to thoroughly investigate an allegation of abuse and exploitation, for one of one resident included in the investigation (Resident #1). Findings included: On 09/03/19, the SSA received an email in which Resident #1 alleged emotional abuse, mental abuse, exploitation, and coercion by the ALA. Resident #1 complained that the ALR's internal investigation, dated 08/19/19, failed to substantiate any of the allegations filed by the resident and her husband (non-resident) on 07/19/19. Resident #1 also alleged that the	R 392		

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R 392	Continued From page 13 08/19/19 investigative report contained factual errors. On 10/02/19 at approximately 4:00 PM, review of the ALR's internal investigative report, dated 08/19/19, revealed that the investigative report failed to include interviews with key individuals, as follows: A. The internal investigative report included the following statement: "We did not interview [Resident #1] or [her husband] regarding their allegations given the depth of information they provided in documents they submitted." 1. When interviewed on 10/04/19 beginning at 9:40 AM, the ALA and the ALR's attorney stated that the ALR's lead investigator "should have interviewed the complainant." The attorney further noted that the ALA usually investigates allegations of abuse; however, the ALR had the Vice President conduct this investigation because it involved the ALA. 2. When interviewed on 10/07/19 beginning at 3:03 PM, Resident #1 confirmed that neither she nor her husband were interviewed. On 10/09/19, the ALA confirmed that interviewing all complainants was part of the investigation process. At the time of this investigation, there was no evidence that the ALR interviewed Resident #1 and her husband. B. Resident #1's 07/19/19 grievance included an allegation that the ALA made an "unlawful, unsupportive, verbally abusive and retaliatory threat" against Resident #1 at a Resident and Family Council meeting and that the ALA had	R 392	escalated to DC Health are handled (this is to remedy the conclusion by the ALR that DC Health would handle the investigation directly); and (2) the internal escalation process. • Copies of any revised Policy, Appendix, and/or Grievance Procedure will be provided to DC Health by the completion target date. The ALR reserves the right to not produce information collected that otherwise may be afforded legal protection under local and federal laws. II. **How to Identify Other** There are currently no other allegations of abuse, neglect, or exploitation under review by this ALR. III. **Systemic Changes** Once the Policy, Appendix, and Grievance Procedure are reviewed and revised, education will be provided	

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made similarly abusive statements at past meetings. There was no evidence that the ALR investigated this allegation, as follows:

On 10/02/19, a review of the ALR's internal investigative report, dated 08/19/19, revealed no evidence that attendees of the Resident and Family Council meetings, such as other residents, residents' involved family members and/or representatives from the DC Long-Term Care Ombudsman's office, were interviewed. The investigative report did, however, include the following: "In her four plus years of tenure at Grand Oaks, we have not received any complaints from the other 400 plus residents and their family members... (the ALA) meets each challenge at Grand Oaks with a smile... is a role model for our mission... We cannot substantiate this allegation that her behavior is bullying and disrespectful as alleged."

At the time of this investigation, there was no evidence that the ALR interviewed persons who attended the Resident and Family Council meetings.

C. The investigation failed to address Resident #1's allegation that the ALR had allowed voluntary unit assignment changes by other residents in the past without requiring those other residents to sign a new RA with Sibley management, as follows:

1. On 10/02/19, a review of the ALR's internal investigative report, dated 08/19/19, revealed that it reflected Resident #1's grievance regarding her being forced to sign a new RA whereas others had voluntarily changed units in the past and were not forced to sign new RAs. Continued review revealed: "Previously, when the

to the ALR management team to assure compliance.

IV. **Monitoring Process**
Results of the compliance audits will be reviewed by the ALR's Quality Assurance team.

V. **Date of Completion**
Any revisions to the Policy, Appendix, and Grievance Procedure will be completed by January 6, 2020. 01/06/2020 & ongoing

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R 392	Continued From page 15 association with [Previous Management Company] was terminated, a new Grand Oaks Residency Agreement was put into place. Grand Oaks made the business decision that all residents moving into apartments after [Previous Management Company] left, would enter into the revised residency agreement with Grand Oaks... To date, there have not been any residents residing under the [Previous Management Company] agreement that have requested internal transfers to other Grand Oaks apartments. [Resident #1] is the first case of this." This investigation's findings showed that, contrary to the ALR's assertion, Resident #1's request was not the first. Other residents had changed unit assignments without signing a revised RA, and the internal investigative report failed to identify the need to establish relevant written policies and procedures. 2. On 08/31/19, Resident #1 and her husband submitted a rebuttal to the ALR's investigative report. Their document identified the names, dates, and applicable unit/suite numbers of 12 residents whose unit assignment changes occurred after the change in management companies in March 2013. They asserted that those 12 residents had not been required to sign new RAs with Sibley management at the time. 3. In a letter sent to the SSA on 09/20/19, the ALA wrote: "we have identified those residents who internally transferred with a [Previous Management Company] Agreement still in place. There are four in total... Moving forward, we will have all residents who internally transfer, sign a Grand Oaks (Management) Agreement..." When interviewed on 10/04/19 beginning at 9:40	R 392		

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AM, the ALA and the ALR's attorney acknowledged that their internal audit had identified residents who changed unit assignments with a [Previous Management Company] RA and were not required to sign a new RA. During a follow-up interview on 10/09/19 at 3:02 PM, the ALA explained that she "made an assumption that they (other residents) were already under new agreements. With [Resident #1], I knew they weren't under a new agreement... I knew there was a history." On 10/24/19, the ALA confirmed during the Exit Conference that the ALR's internal audit was conducted after, and in direct response to having received Resident #1's 08/31/19 rebuttal to the 08/19/19 investigative report.

At the time of the investigation, there was no evidence that Resident #1's allegation was thoroughly and accurately investigated.

D. The ALR's internal investigation failed to examine Resident #1's right of first refusal or the practice within the sales office of using a waitlist for prospective residents, as follows:

1. The ALR's investigative report contained contradictory information regarding the waitlist and Resident #1's right to first refusal. In one section of the report, it stated that Resident #1 had the right to first refusal. Elsewhere in the report, however, it showed that SC #1 and SC #2 told the husband that they had to offer the unit/suite to prospective residents on a waitlist prior to offering it to Resident #1.

2. On 10/04/19, interviews with SC #1 and SC #2 revealed that they had a waitlist and they had shown the unit/suite first to prospective residents prior to offering it to Resident #1. Interviews with

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R 392	Continued From page 17 Resident #1 and the ALA revealed that the prospective residents on the waitlist had declined the unit, prior to the offer made to Resident #1. The statement in the report regarding having the right to first refusal therefore, was inaccurate. The SSA investigation determined that the ALR's internal investigative report presented an inaccurate statement that Resident #1 was given the right of first refusal. II. As evidenced above, the ALR's internal investigation, dated 08/19/19, included the following misrepresentations: - The ALR's investigation stated that Resident #1 was the first resident with a [Previous Management Company] RA to request a unit assignment change. This was later proven to be inaccurate, through information provided by Resident #1 as well as the ALR's internal audit that was conducted after Resident #1 submitted a rebuttal on 08/31/19; and, - The ALR's investigation concluded: "At that juncture, however, the interested applicants were told that a Grand Oaks resident had the right to first refusal." This was later proven to be inaccurate, through interviews with SC #1 and SC #2. In addition, the ALR's investigative report dismissed "without merit" Resident #1's grievance that the ALR failed to engage in full disclosure as required by the ALRRA. This was proven to be inaccurate. [See R381] At the time of this investigation, there was no evidence that the ALR investigated Resident #1's grievance thoroughly.	R 392		

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R 426	R 426 Sec. 602a5 Resident Agreements (5) Unit assignment and procedures if changes occur; Based on interview and record review, the ALR's contract/ Resident Agreement failed to include provisions for identifying unit assignments and procedures in the event of unit changes, for any resident entering into a contract/ Resident Agreement with the ALR. Findings included: On 07/19/19, Resident #1 objected to signing a new RA, alleging that the ALA unfairly singled out Resident #1 with the request and had not required 12 other residents who previously relocated to sign new RAs with Sibley management. 1. On 10/04/19 beginning at 9:40 AM, an interview with the ALA and the ALR's attorney stated that there 12 residents with previous management company RAs had relocated without signing new RAs. Four of those residents (Residents #2, 4, 5, and 6) were still residents of the ALR. The ALA further stated that she subsequently asked their responsible parties to sign new RAs in September 2019. 2. On 10/04/19 at 3:20 PM, a review of Residents #2, 4, and 5's RAs revealed that they signed new agreements with the current management on 09/23/19, 09/23/19, and 09/20/19, respectively and Resident #1's RA, dated 12/16/10, was signed under the previous management company. None of the RAs reviewed included information or guidance regarding procedures to follow if/when a current resident requests a unit assignment change.	R 426	**R426 106.02 (a)(5)** A written contract must be provided to the resident prior to admission and signed by the resident or surrogate, if necessary, and a representative of the ALR. The nonfinancial portions of the contract shall include the following: (5) Unit assignment and procedure if changes occur. **I. Corrective Action** As a corrective action, Grand Oaks will implement to following: • The Grand Oaks Residency Agreement is being reviewed and revised to include language meeting the requirements of the regulation 44-106.02(a)(5): Unit Assignment and Procedures if changes occur. **II. <u>How to Identify Other</u>** At the time this response is being drafted, there are no other residents who have requested internal transfers to affect unit assignment. However, the ALR will implement the following:	

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3. On 10/11/19 at 3:10 PM, the ALA stated that she had not realized that the other residents who voluntarily changed units had RAs signed under the previous management company.

On 10/15/19 beginning at 9:30 AM, review of the RAs for the other residents revealed the following:
Resident #2 RA signed 09/23/19, relocated on 09/09/16;
Resident #3 RA signed 09/04/12, relocated 10/15/12 (ALR still under Sunrise management);
Resident #4 RA signed 09/13/19, relocated 02/09/17;
Resident #5 RA signed 09/13/19, relocated 03/05/16;
Resident #6 RA signed 09/13/19, relocated 08/01/16;
Resident #7 RA signed 06/29/04, relocated 11/2014 (deceased);
Resident #8 RA signed 10/14/11, relocated 08/2013 and 09/2016 (deceased);
Resident #9 RA signed 07/14/11, relocated 03/2014 (deceased);
Resident #10 RA signed 10/03/11, relocated 02/2014 (deceased);
Resident #11 Record unavailable (alleged unit assignment change 08/2016; now deceased);
Resident #12 RA signed 02/03/11, relocated 03/2014 (deceased);
Resident #13 RA signed 12/21/07, relocated 08/2013 (deceased); and,
Resident #14 RA signed 02/17/11, relocated 03/2014 (deceased).
Review of the above-listed RAs showed that the RA document failed to include provisions for identifying unit assignment and the procedures in the event of a unit change.

- The revised Residency Agreement (incorporating the language meeting 44-106.02(a)(5)) will be used for all new residents moving into the ALR.

III. Systemic Changes

The revised Residency Agreement (incorporating the language meeting 44-106.02(a)(5)) will be disseminated to all current residents for review and signature.

IV. Monitoring Process

Once the use of the revised Residency Agreement for new residents entering Grand Oaks is in place, the CEO, and/or designee, will randomly audit that the section for unit assignment and procedures have been followed for any resident who has requested an internal transfer for the next 90 days. Results of the compliance audits will be reviewed by the ALR's Quality Assurance team.

V. Date of Completion

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R 426	Continued From page 20 At the time of the investigation, the ALR failed to ensure that RAs included written procedures regarding unit assignment and changes thereto.	R 426	The use of the revised Residency Agreement for new residents entering Grand Oaks, and the dissemination of the revised Residency Agreement to all current residents will be completed by January 6, 2020.	01/06/2020 & ongoing
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation and interview, the ALR failed to ensure that the hot water temperature did not exceed 110° F, in three of three hand sinks inspected (Resident #1's unit, the Country Kitchen and public restroom on the 4th floor). Findings included: On 10/07/19, the SSA received an incident report from Resident #1 via email. According to the report, Resident #1 alleged that the water temperature in her bathroom measured at 140°F. On 10/07/19 at 5:43 PM, Resident #1 stated that after turning on the bathroom sink and placing her hands under running water at 1:30 AM, she quickly had to remove them because the water was scalding hot. She further stated that she immediately applied ice to her left hand to prevent a burn. When she used a candy thermometer to measure the water, it measured at 140°F. [Note: Immediate observation of the resident's left and right hands revealed no indication of burns.] 1. Observations on 10/07/19 beginning at 5:51 PM, showed that the hot water temperature	R1003	**R1003 110.06 (c)** An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled using thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. **I. Corrective Action** At the time of the inspection, the Grand Oaks maintenance team provided immediate correction on the spot. **II. How to Identify Other** The Director of Facilities audited the water temperature logs leading up to the incident and provided appropriate follow up actions.	

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R1003	Continued From page 21 measured at 120.6°F in Resident #1's kitchen sink. [Note: The resident requested that the surveyor not go into the bathroom.] Water in the 4th floor North Country Kitchen measured at 117.4°F and water in the 4th floor north public restroom measured at 117.1°F. 2. During an interview on 10/07/19 at 7:30 PM, the Security Guard, who is responsible for overnight water management, stated that he had just adjusted the mixing valve to lower the water temperature down to 110°F. Follow-up observation on 10/07/19 at 7:34 PM, showed that the hot water temperature now measured at 103°F in Resident #1's kitchen sink. Resident #1's bathroom sink measured at 104°F. The 4th floor North Country Kitchen measured at 102.3°F and the 4th floor north public restroom measured at 101.9°F. At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110°F.	R1003	Additionally, the Director of Facilities had a third-party contractor inspect and make adjustments to the hot water system. **III. Systemic Changes** The Director of Facilities updated the Water Temperature Testing Procedures to include ensuring that temperatures are taken on multiple floors in both resident areas and common spaces. **IV. Monitoring Process** The Director of Facilities, and/or designee will audit the water temperature log daily for the next 30 days and then weekly ongoing. The Executive Director, and/or designee will conduct random audits of the water temperature log for the next 90 days. **V. Date of Completion** November 12, 2019 and ongoing	11/12/2019 & ongoing