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 _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4666 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

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R 000	Initial Comments 0000 Initial Comments On 5/11/2022 and 5/12/2022, the Department of Health, Health Regulations and Licensing Administration, Intermediate Care Facilities (DOH/HRLA/ICFD), received email notifications from two complainants. The email notification showed that two of the residents' Responsible Parties raised concerns regarding services provided to their loved ones by Livingston Place at Southern Avenue Assisted Living Residence (ALR). Based on the nature of the emails, the State Survey Agency (SSA) initiated an on-site investigations on 5/13/2022, beginning at 9:34 AM, at 4657 Livingston Road, SE Washington, DC to determine compliance with the Assisted Living Residence Regulatory Act of 2000, "DC Code § 44-101.01" and attendant regulations. The surveyors remained on site through 05/19/2022. The complainants alleged the following: [Allegations of Complainant #1] 1. Resident #1 acquired bedbugs at the facility in her apartment. 2. Resident #1's son was required to buy a new bed. 3. The resident's clothing were all washed together, which damaged the light-colored clothing and the dry-cleaned clothing. 4. Resident #1's son was denied financial assistance for the damaged clothing.	R 000	Please start typing your responses here:	

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

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R 000	Continued From page 1 5. Resident #1's son was denied reimbursement for one month's rent. 6. The resident's bank account was charged twice for May 2022's rent. Son reported he left message for management, then contacted the Executive Director after one day of no communication. 7. The resident's son also reported that two staff had stated to him that, "The place is running itself." [Allegations of Complainant #2] 1. The resident's fob is missing. She has lost it twice. 2. Personal items were missing (paper towels, food items). 3. The bed sheets have not been changed for at least 2 weeks. 4. No bath was given; she had a horrible odor. 5. No available transportation for appointments. 6. There was a 7% rent increase. 7. There was no one at the front desk. 8. There was an inability to reach nursing staff by phone most of the time. 9. There were no activities to assist with mental capacity. 10. There was a non-medical employee sitting by the medication cart (2nd floor), which was in the	R 000		

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R 000	Continued From page 2 hallway and no one else was around. The nurse's station is on the 2nd floor. During the course of the investigation, it was determined that other residents in the ALR may be adversely affected by practices identified by the complainants. Therefore, a random sampling of 18 of the 84 residents of the facility was selected to verify the ALR's compliance with the applicable regulatory guidelines. The investigative findings were based on observations, interviews with the complainants, management staff, the residents and residential staff, and a review of administrative records. The investigation determined that the ALR failed to be in compliance with the Assisted Living Residence Regulatory Act of 2000, "DC Code § 44-101.01". The deficient practices are addressed within this report.	R 000		
R 142	10112.1 Financial Agreements 10112.1 The complete terms of all financial provisions in a resident's agreement shall be made available for the resident (or surrogate) to review prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the complete terms of all financial provisions in a resident's agreement, were accurately communicated to the Responsible Parties for two of the two residents in the investigation (Residents #1 and 2). Findings included: I. On 5/13/2022 at 3:18 PM, review of a complaint dated 5/11/2022, revealed that Resident #2's	R 142	10122.1 R142 Financial Agreements 8-3-22 Residents 1 was given a copy of lease their lease agreement. Resident #2 is in hospital currently but have a copy ready to give to her on her return to community. There was no increase in residents 1 or 2 rent since move in. Resident number 1 has a credit of $162 for September rent. Administrator or designee will provide a copy of the resident's agreement including all financial provisions prior to admission to resident /surrogate. Resident and or surrogate will sign acknowledgment that a copy was provided, and acknowledgment will be kept on resident's chart with all moves in beginning 8-1-22 and forward. An Audit of all current resident's financial agreements will be conducted to ensure correct signed and will provide a copy as needed to residents/surrogate by 9-15-22. Administrator and or designee will review all new move in agreements monthly to ensure resident/surrogate received a copy of financial agreement and that acknowledgement was singed.	

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R 142	Continued From page 3 niece, who is the Responsible Party, alleged that the ALR increased the resident's rent by 7% since admission and that the increase was not included in the rental terms. On 5/13/2022 at 5:05 PM, during a telephone interview, Resident #2's Responsible Party indicated that since admission, the resident's monthly rent had increased by 7%, and that the increase had not been included in the terms. When asked to provide a copy of the resident's rental agreement, the Responsible Party stated that the resident should have received the rental increase in the mail and that she would look for the documentation. On 05/16/2022 at 10:37 AM, interview with the Assisted Living administrator (ALA) revealed Resident #2 should not have received any increase in her monthly rental fee since admission, however he would follow-up. The ALA said that he would provide an email that included the attachment (Lease Form) that was sent to the Responsible Party, which showed a move-in date of 11/13/2021. On 05/16/2022 at 1:20 PM, interview with the ALR's Director of Operations revealed Resident #2 did not have a rent increase since admission on 10/7/2021. She said that there was a difference of $27.00 between the Resident Rental Agreement and the Rental Fee Summary, which were both dated and signed by the Responsible Party on 10/07/2021. The Director of Operations said that the $27.00 was a board charge, which brought the monthly room rate to $1,444.00. On 5/16/2022 at approximately 2:00 PM, the Director of Operations provided a copy of Resident #2's Service Agreement Fee Summary,	R 142		

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R 142	Continued From page 4 Rental Fee Summary, and Lease Agreement. a. The Resident Lease dated 10/7/2021 showed the following: Resident #2 was to be charged a total monthly rent of $1417.00. The Rental Agreement term was for a six month period, and then will change to month-to-month following the first six months, commencing on 4/07/2022. The Resident's Lease Agreement was signed and dated by the Responsible Party on 10/07/2021. b. The Service Agreement Fee Summary dated 10/07/2021 showed the following "private pay" amount: Monthly Service Fee - $1417.00 (Core and/or personal care charges), and Board Charges - $27.00, for the total of $1,444.00. The form also contained the following note ["We may change these fees upon thirty days of written notice to you, however, if your level of personal Care Services increases or decreases, the new fees will apply immediately."] The Service Agreement Fee Summary was signed by the Responsible Party on 10/07/2021. c. The Rental Fee Summary dated 10/7/2021 showed the following: Resident #2's total monthly room rate was $1444.00 for a one-bedroom apartment. The resident's responsibility was $1057.00 until funds for the Optional State Supplement Program (OSSP) are received. "Once they are received, the difference of $387.00 times the number of unpaid months will be drafted from your account." In comparison, the Lease Agreement showed the	R 142		

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R 142	Continued From page 5 total monthly rent was $1417.00. The Service Agreement fee summary and the Rental Fee Summary showed the total monthly rent was $1444.00, which was a difference of $27.00. On 5/17/2022 at 2:37 PM, Resident #2's bank statements were reviewed to determine payments to the ALR for rent. The December 2021 bank statement showed zero was deducted for rent. The January 2022, bank statement showed that a double Automated Clearing House (ACH) Network draft of $2114.00 was attempted on 1/12/2022, however the ACH was not paid by the bank. On 1/19/2022, $1,057.00 was paid by ACH. The January 2022 bank statement also reflected a debit card payment of $407.43 on 1/25/2022. The February 2022, bank statement showed an ACH of $1,057.00 was attempted, but not paid. The March and April 2022, bank statements showed the ACH payments of $1,057.00 respectively. A follow-up interview with the Responsible Party by telephone on 5/19/2022 at 12:45 PM, revealed she was still searching for the rent increase letter that she removed from Resident #2's ALR mailbox, however she had not been able to locate it. Another attempt to reach the Responsible Party by telephone to obtain a copy of the rent increase letter was made by the investigators on 6/02/2022. After there was no response, a voicemail was left. It should be noted that at the time of the investigation exit conference on 6/03/2022, no documents had been provided by the Responsible Party or the ALR to show any increase in Resident #2's monthly rent. At the time of the investigation, prior to admission	R 142		

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R 142	Continued From page 6 the ALR failed to ensure that the signed Lease Agreement total monthly rent ($1417.00), coincided with the signed Service Agreement fee summary and the signed Rental Fee Summary, which both stated the total monthly rent was $1444.00. II. Resident #1's responsible party alleged that the rent for the apartment at the ALR was increased after admission. On 05/13/2022, beginning at 5:11 PM, a telephone interview with Resident #1's Responsible Party indicated that the ALR recently increased the monthly rental fee and that he would provide the supporting documentation. The Responsible Party then requested follow-up to verify that the resident was now paying the correct amount for her one-bedroom apartment. On 05/19/2022 at 12:04 AM, the Responsible Party emailed documentations to the investigators. On 05/19/2022 at 9:00 AM, review of the documentations detailed the following: a. An email dated 03/03/2021, from an Aria Management Company representative, asked if Resident #1 needed a studio apartment ($1,323.00) or a one bedroom ($1,417.00). b. An email from the Responsible Party dated 5/19/2022, noted that he checked Resident #1's past bank records since admission and determined that Resident #1 was paying $1417.00 until recently, when the amount was increased to $1444.00 in February 2022. "I am searching for communication as to the reason, but I assumed it was a result of inflation and the pandemic."	R 142		

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R 142	Continued From page 7 On 5/19/2022 at 12:55 PM, interview with the Director of Operations revealed Resident #1 had only paid $1,417.00 for the rental of the one-bedroom apartment from 7/01/2021 until February 2022. She said however that during this same period the resident should have been paying $1,444.00 ($1,417.00 rent plus $27.00 board charge). She further stated that the reason the board charges were not collected from the Responsible Party until February 2022 was unclear. On 5/20/2022 at 11:56 AM, the Director of Operations emailed the investigators that Resident #1's rent was increased to include the $27.00 board charge, effective February 2022. The email stated that her conversation with the ALR's previous representative confirmed that the Responsible Party agreed to pay the $1444.00 rent, effective 02/01/2022, and signed the Automated Clearing House (ACH) Form. The attachment to the email was a Monthly Authorization Fee Authorization form for ACH debits for monthly rental payment. The form was signed by the Responsible Party on 1/18/2022 and the ACH debits were scheduled to begin in February 2022. The Resident Lease dated 6/3/2021 showed the following: (1) The Lease Agreement, dated and signed by the Responsible Party on 06/03/2021 documented that $1417.00 was due monthly for a term of Six (6) months. A prorated payment of $1,322.73 for June 2021 was immediately due, and thereafter the monthly fee of $1417.00 on the first calendar day of the month. (2) The Rental Fee Summary dated 6/03/2021	R 142		

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R 142	Continued From page 8 showed the following: Resident #1's total monthly room rate was $1417.00 for a one-bedroom apartment. A prorated payment of $1,275.29 was due for the first month (June 2021) (3) The Service Agreement Fee Summary form showed the following: The Service Agreement Fee Summary form was left blank. The form only noted "n/a" (not applicable) and was not signed by the ALR representative or the Responsible Party. The Service Agreement which was dated and signed by the Responsible Party on 6/03/2021, showed..."Fees: In addition to your rental fee, you shall pay a monthly fee for Core Services (Board charge) and Personal Care Services, if applicable. Your monthly fee is payable in advance by the first day of each calendar month. We may change your monthly fee for Core Services and for Personal Care Services and any fees for additional services upon thirty days written notice to you." In comparing the two signed documents presented, the Lease Agreement and the Rental Fee Summary, both showed the total monthly rent was $1417.00. No additional fees were charged until Resident #1's rent was increased to include the $27.00 board charge monthly in February 2022, which then brought the total monthly rent to $1444.00. At the time of the investigation, prior to admission the ALR failed to ensure that the signed Lease Agreement total monthly rent ($1417.00) and signed Rental Fee Summary ($1417.00),	R 142		

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R 142	Continued From page 9 coincided with the unsigned Service Agreement Fee Summary (left blank) to clearly define the total monthly rent, including board charges due from the resident's Responsible Party.	R 142		
R 374	10124.8 Medication Administration 10124.8. An ALR shall ensure that all employees and all licensed practical nurses, registered nurses, advanced practice registered nurses, physicians, physician assistants, or certified medication aides responsible for administering or assisting in the administration of medication to a resident while on the ALR's premises, immediately report any medication error or adverse drug reactions to the ALR's available registered nurse and ALA upon discovery. The ALR shall require the ALA or Acting Administrator to report the medication error or adverse drug reaction, to the resident's healthcare practitioner, prescriber, pharmacist, and the resident (or surrogate), as appropriate. Based on observation, interviews and record reviews, the Assisted Living Residences (ALR) failed to ensure employees administering and assisting residents with medications, immediately reported drugs errors to the registered nurse (RN) and the Assisted Living Administrator (ALA) upon discovery and notified the resident's health care practitioner of the error for one of one resident (Resident #3). Findings included: The facility nurse failed to immediately report Resident #3's prescribed medication refusals and errors to the RN and the ALA when aware as evidenced below:	R 374	10124.8 R374 Medication Administration 6-28-22 Director of Nursing of Livingston Place and Reginal director of Clinical Services for Priority Life care educated all Nurse on proper notification/reporting process of resident's medication refusal, missing medication and any medication error to RN, d Health Care practitioner/PCP/NP and resident/ surrogate. All nurses also re-educated on proper medication administration process with emphasis on observing residents take medication and proper medication documentation. A second RN has been hired to start 8-1-22. Director of Nursing or RN Designee will review proper reporting of medication issues and proper medication administration monthly starting in July 2022 at monthly staff/nurse meeting x 3 months. Regional Director of Clinical Services and Operation specialist with priority Life care will educate all member of Leadership on proper reporting procedure and time frame to state regulatory body, PCP and surrogates of all incidents by 8-3-22. Administrator, or RN designee will review monthly with leadership team on proper incident reporting with emphasis on medication incidents x 4 months.	

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R 374	Continued From page 10 On 5/13/2022 at 1:42 PM, a walk-through observation in the resident's apartment showed 5 cups of unidentified punched medications and several packets containing other medications. Observation of the medication packets left in the resident's apartment revealed the medications included (1) Benztropine Mesylate 1 mg in the morning (2) Nifedipine 30 mg in the morning, (3) Florastor 250 mg every day (4) and Olanzapine 10 mg at bedtime. At 1:47 PM, during an interview, Resident #3 said "I don't take it. I told the doctor it does not make me feel any different. He said I don't have to take it." During interview on 5/13/2022 at 1:49 PM, with the Director of Nursing (DON) who accompanied the surveyor's, she said Resident #3 should not have prescription medication in her apartment. The DON said that she would immediately follow-up with the nursing staff to determine why the medications were in the resident's apartment. The DON stated that during her interview with the nurses that were called on site, they said the resident refused the medications and kicked them out of her apartment before they could retrieve them from her. The DON revealed however that the Licensed Practical Nurse (LPN) provided no explanation why the resident's refusal to take the medication when offered was not reported immediately to the RN and the ALA. As a result, the medication refusal had not been reported to a healthcare practitioner, prescriber, or pharmacist. On 5/16/2022 at 2:52 PM, review of Resident #3's diagnoses revealed they included Paranoid Schizophrenia, Age Related Bilateral Cataract, Glaucoma, Bilateral Hearing Loss, and Essential	R 374		

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R 374	Continued From page 11 Hypertension. The May 2022, physician orders included Olanzapine 10 mg, 1 tab at bedtime, Benztropine 1 mg, 1 tab twice daily, Nifedipine ER 30 mg, 1 tab daily, Florastor 250 mg capsule, 1 capsule every day. On 5/16/2022 at 3:05 PM, review of an incident report dated 5/16/2022 revealed that upon discovery of the medication error, the DON wrote an incident report and counseled all nurses on duty. At the time of the investigation, the ALR failed to ensure all nursing professionals responsible for administering or assisting with medication administration to residents reported any medication refusals or errors to the available RN, the ALA, and the health care practitioner upon discovery.	R 374		
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 observations, interviews, and record reviews, the Assisted Living Residence (ALR) failed to report timely, bed bug infestations in the facility apartments to the Department of Health (DOH) for two of three residents (Residents #1 and 3). Findings included: 1. On 5/13/2022 at 5:11PM, interview with	R 383	10125.4a Reporting Complaints To The Director R383 Residents 1 and 3 were not reimbursed for any expense related to bed beg incident per resident policy of Bed Bug addendum that both residents POA signed at time of contract signing. All Staff educated on 6-27-22 by Administrator and leadership department heads on proper notification of Administrator of any incidents that involve resident care. All members of leadership team were educated by regional operational specialist and regional director of clinical services the week of 6-27-22 on verbal report to DOH and submitting a written report in 24 hours. Administrator and or designee will review regulation 10125.4a on a weekly basis with leadership in month of August 2022. Ongoing Administrator or designee will monitor daily for proper reporting to all regulatory bodies occur timely and that verbal and written reports completed.	

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R 383	Continued From page 12 Resident #1's son, who is the Responsible Party, revealed that bed bugs were discovered in the resident's apartment in December 2021, March 2022, and again in May 2022. On 5/17/2022 at 3:18 PM, a review of an email (dated 5/17/22) from Resident #1's Responsible Party showed the resident was moved three times from her one-bedroom apartment to a studio apartment while the bed bug infestations were being treated. a). On 5/17/2022 at 4:00 PM, review of a Pest Control invoice dated 12/30/2021, revealed that bed bug treatment services were requested on 12/27/2021 for Resident #1's apartment. The inspection revealed many live and dead bed bugs. The apartment was treated for bed bugs, as well as the adjacent apartments (226, 328, 326). At the time of the investigation, there was no evidence the bed bug infestation was reported to DOH. b). On 5/17/2022, at 4:13 PM, review of a housekeeping report dated 3/14/2022 revealed that the maintenance supervisor was informed of the bed bugs seen in Resident #1's apartment (228). A Pest Control invoice dated 3/17/2022 showed that on 3/17/2022, Apartment 228, which was previously treated on 12/30/2021, had many live bed bugs on the bed, baseboards, and ceiling. Additionally Resident #3's Apartment (328) was observed to have many live bed bugs, excrements, and casings. Both apartments were treated by the Pest Patrol. The invoice further noted that staff declined preventative treatment of the rooms neighboring to Apartments 228 and 328.	R 383		

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 _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4856 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

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R 383	Continued From page 13 At the time of the investigation, there was no evidence the bed bug infestation was reported to the DOH. c). On 5/17/2022 at 4:32 PM, review of a Pest Control invoice dated 5/09/2022, revealed the Assisted Living Administrator (ALA) requested bed bug treatment in Resident #1's apartment (228) after staff reported seeing bed bugs. The invoice stated that after the 3/17/2022 treatment of apartment 228, on 4/12/2022 further treatment of the apartment for bed bugs was declined. On 5/9/2022 apartments 213, 226, 326, and 328 were inspected and no bed bug activity was seen. On 06/02/2022, at 3:51 PM, an unusual incident received by DOH on 06/01/2022 at 1:25 PM, revealed that on 5/06/2022, staff observed a live bed bug on Resident #1's bed and on the floor. The resident was temporarily relocated to a studio apartment for the period of the bed bug abatement. At the time of the investigation, there was no evidence the bed bug infestation was reported timely to DOH. 2. The facility failed to report timely bed bug infestation in Resident #3 apartment, as evidenced below. a). During the walk through on 5/13/2022 at 1:02 PM, Resident #3 said she put bugs from her apartment in an envelope and gave them to the staff at the front desk "yesterday". The resident said she had bed bugs in her apartment before. On 5/16/2022 at 2:16 PM, interview with the front desk staff confirmed that Resident #3 gave her the envelope and that she gave the bugs to the	R 383		

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SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

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R 383	Continued From page 14 maintenance director. Review of an incident report dated 5/16/22 (1:43 PM) documented bed bug sighting. On 05/16/2022, at 3:55 PM Resident #3 was interviewed in a different apartment. The resident stated that the facility moved her to a different apartment today (05/16/2022) while her apartment was being treated for bedbugs. On 5/17/2022 at 11:52 PM, interview with the Maintenance Director revealed the Bed Bug Protocol was implemented and the resident was relocated from her apartment temporarily while her apartment was being treated. b). On 5/17/2022, at 4:13 PM, review of a Pest Control invoice dated 3/17/2022 revealed that bed bug treatment services were requested on 3/15/2022 for Resident #3's apartment. The invoice revealed that the apartment was treated for heavy bed bug infestation. The staff declined preventative treatment for neighboring Apartment to 328. At the time of the investigation, there was no evidence the bed bug infestation was reported to DOH. On 5/17/2022 at 4:31 PM, interview with the Assisted Living Administrator (ALA) revealed he began working at the facility on 3/28/2022. The ALA said that he had made efforts to ensure incidents were submitted to DOH in accordance with the regulatory requirement. At the time of the investigation, the ALR failed to notify the Director of unusual incidents (bedbugs) that substantially affected residents by phone	R 383		

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R 383	Continued From page 15 promptly and follow- up with written notification within twenty-four (24) hours or the next business day.	R 383		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 000	Initial Comments On 5/11/2022 and 5/12/2022, the Department of Health, Health Regulations and Licensing Administration, Intermediate Care Facilities (DOH/HRLA/ICFD), received email notifications from two complainants. The email notification showed that two of the residents' Responsible Parties raised concerns regarding services provided to their loved ones by Livingston Place at Southern Avenue Assisted Living Residence (ALR). Based on the nature of the emails, the State Survey Agency (SSA) initiated an on-site investigations on 5/13/2022, beginning at 9:34 AM, at 4657 Livingston Road, SE Washington, DC to determine compliance with the Assisted Living Residence Regulatory Act of 2000, "DC Code § 44-101.01" and attendant regulations. The surveyors remained on site through 05/19/2022. The complainants alleged the following: [Allegations of Complainant #1] 1. Resident #1 acquired bedbugs at the facility in her apartment. 2. Resident #1's son was required to buy a new bed. 3. The resident's clothing were all washed together, which damaged the light-colored clothing and the dry-cleaned clothing. 4. Resident #1's son was denied financial assistance for the damaged clothing. 5. Resident #1's son was denied reimbursement	R 000	Please start typing your responses here:	

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R 000	Continued From page 1 for one month's rent. 6. The resident's bank account was charged twice for May 2022's rent. Son reported he left message for management, then contacted the Executive Director after one day of no communication. 7. The resident's son also reported that two staff had stated to him that, "The place is running itself." [Allegations of Complainant #2] 1. The resident's fob is missing. She has lost it twice. 2. Personal items were missing (paper towels, food items). 3. The bed sheets have not been changed for at least 2 weeks. 4. No bath was given; she had a horrible odor. 5. No available transportation for appointments. 6. There was a 7% rent increase. 7. There was no one at the front desk. 8. There was an inability to reach nursing staff by phone most of the time. 9. There were no activities to assist with mental capacity. 10. There was a non-medical employee sitting by the medication cart (2nd floor), which was in the hallway and no one else was around. The nurse's	R 000		

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R 000	Continued From page 2 station is on the 2nd floor. During the investigation, it was determined that other residents in the ALR may be adversely affected by practices identified by the complainants. Therefore, a random sampling of 18 of the 84 residents of the facility was selected to verify the ALR's compliance with the applicable regulatory guidelines. The investigative findings were based on observations, interviews with the complainants, management staff, the residents and residential staff, and a review of administrative records. The investigation determined that the ALR failed to be in compliance with the Assisted Living Residence Regulatory Act of 2000, "DC Code § 44-101.01". The deficient practices are addressed within this report.	R 000		
R 272	Sec. 503.1 Dignity. (1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible. Based on observations, interviews and record reviews, the Assisted Living Residence (ALR) I. - II. failed to ensure the environment was free of pests (bed bugs) for three of the 18 residents in the sample. (Residents #1, 3, and 4) and III. failed to remove pins from call bells in apartment bathrooms to make them accessible for 13 of the 18 observed apartments (Apartments 317, 328, 346, 426, 434, 334, 317, 311, 234, 228, 521, 517, and 524.) Findings included:	R 272	503.1 Dignity R272 Resident 1 , 3, 4 returned to their original rooms once rooms were treated for bedbugs by the end of May 2022. There was no change to rent during treatment of insects per bed bug addendum signed at contract signing. Resident rooms were inspected /audited missing items documented and items will be purchased to meet the furnishing requirements All staff educated by leadership team on 6-27-22 and 7-19 -22 on what to do if see or a resident reports insect in apartment/community specifically bed bugs. Maintenance, Sales and or designee will check each apartment before new residents physically move in to ensure pullcords operable and all items community provide in good work order. A room ready checklist will be utilized and reviewed 24 hours prior to move in by Administrator to ensure apartment is ready for new resident. A member of the maintenance team will inspect any furniture that residents bring into community to ensure free of insects and in good working order. Pull cords will be checked monthly with and a member of leadership will do monthly apartment inspections to monitor for any environmental issues. Community will have monthly pest inspection and treatment of community by an outside vendor and any issues discovered will be addressed and reported promptly as needed to regulatory body. Community will keep a copy of inspection report for verification.	

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R 272	Continued From page 3 I. [Cross reference to R383) On 05/13/2022 at 1:02 PM, Resident #3 opened the door to her apartment after the surveyor knocked and said, "You're just the people I want to see. We have bugs." She stated that when she smashed the bugs which were on her bed, blood came out. Further interview revealed that the resident also caught two bedbugs earlier during the week, which she wrapped in tissue and gave it to the front desk staff (Business office Assistant). When asked, the resident stated that no one followed-up after she gave the bedbugs to the front desk staff. On 05/13/2022 beginning at 1:05 PM, observations of Resident #3's apartment (328), which is located directly above Resident #1's apartment (228), revealed what appeared to be several bloods spots on the mattress. The Director of Nursing (DON) who accompanied the surveyors, was informed of the observation at that time. Continued observations showed that Resident #3 was temporarily relocated on 05/16/2022, to a different apartment after the findings. On 05/17/2022 beginning at 3:33 PM, interview with the front desk staff confirmed that Resident #3 handed her two tissues with bedbugs which was retrieved from her mattress. One bedbug was still alive. The front desk staff stated that she reported and gave the bedbugs to the Maintenance Director. On 05/17/2022, at 3:55 PM Resident #3 was interviewed in a different apartment. The resident stated that the facility moved her to a different apartment today (05/17/2022) while her apartment was being treated for bedbugs.	R 272		

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R 272	Continued From page 4 During an interview on 05/18/2022 at 1:58 PM, the Maintenance Director stated that he was not aware that Resident #3 reported that she had bedbugs and did not remember if the front desk staff gave him bedbugs that were retrieved from the resident's mattress. II. On 5/13/2022 at 5:11PM, interview with Resident #1's son, who is the Responsible Party, revealed that bed bugs were discovered in the resident's apartment in December 2021, March 2022, and again in May 2022. The resident was relocated from her one-bedroom apartment to a studio apartment each time, while the bed bug infestations were being treated. At the time of the investigation, intermittent bed bug infestation continued to be a concern at the ALR, as evidenced below: a). On 5/17/2022 at 4:00 PM, review of Pest Control invoices dated 12/30/2021, 3/17/2022, and 5/09/2022, revealed that live and dead bugs were observed, and bed bug treatment services were performed in Resident #1's apartment (228). The inspection of apartment 228 on 12/27/2021 revealed many live and dead bed bugs. The apartment was treated for bed bugs, as well as the adjacent apartments (226, 328, 326). b). Review of a housekeeping report dated 3/14/2022 on 5/17/2022 at 4:13 PM revealed that the maintenance supervisor was informed of the bed bugs seen in Resident #1's apartment (228). A Pest Control invoice dated 3/17/2022 showed that on 3/17/2022, apartment 228, which was previously treated on 12/30/2021, had many live bed bugs on the bed, baseboards, and ceiling. Additionally Resident #3's apartment (328) was observed to have many live bed bugs,	R 272		

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R 272	Continued From page 5 excrements and casings. Both apartments were treated by the Pest Control. The invoice further noted that staff declined preventative treatment of the rooms neighboring to apartments 228 and 328. c). On 5/17/2022 at 4:32 PM, review of a Pest Control invoice dated 5/09/2022, revealed the Assisted Living Administrator (ALA) requested bed bug treatment in Resident #1's apartment (228) after staff reported seeing bed bugs. The invoice stated that after the 3/17/2022 treatment of apartment 228, on 4/12/2022 further treatment of the apartment for bed bugs was declined. On 5/9/2022 apartments 213, 226, 326, and 328 were inspected and no bed bug activity was seen. d). On 5/18/2022 at 11:18 AM, DOH received an incident which stated that on 5/18/2022 at 10:30 PM, Resident #4 who lives in apartment 301, told the front desk staff that she woke up with bite marks on her neck. Maintenance inspection revealed bed bugs in the box spring. The nursing assessment revealed six bite marks on the resident. The bed bug protocol was implemented, and the resident was prepared to be transferred to a temporary apartment. On 5/17/2022 at 4:39 PM, interview with the Assisted Living Administrator (ALA) revealed he began working at the facility on 3/28/2022. He stated that it was the goal of the ALR to maintain a bed bug free environment. Furnishing brought from the residents' homes was to be properly inspected before taking it to the apartments to prevent potential hitch-hiking of bed bugs. All staff and residents were encouraged to promptly report any sighting of bed bugs to ensure timely implementation of the extermination protocol.	R 272		

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R 272	Continued From page 6 On 5/18/2022 at 2:37 PM, review of the Resident Service Agreement revealed a Bed Bug Addendum which included the following: "The goal of this Addendum is to protect the quality of the rented unit's environment from the effects of bed bugs. It is the goal to clearly set forth the responsibilities of each of the parties to the rental agreement. Resident acknowledges the Owner/Agent has inspected the unit and is not aware of any bed bug infestation. Resident agrees that all furnishings and personal properties that will be moved into the premises will be free of bed bugs. Resident hereby agrees to prevent and control possible infestation by adhering to the below list of responsibilities. - Check for hitch-hiking bed bugs. - Resident shall report any problems immediately to the Community. Even a few bed bugs can rapidly multiply to create a major infestation that can spread to other apartments. - Resident shall cooperate with pest control efforts. - Resident agrees to reimburse the Community for expenses including, but not limited to attorney fees and pest management fees that the Community may incur because of infestation of bed bugs in the apartment. - Resident agrees to hold the Community harmless from any actions, claims, losses, damages, and expenses that may incur as a result of a bed bug infestation. - It is acknowledged that the Community shall not be liable for any loss or personal property to the	R 272		

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R 272	Continued From page 7 resident because of an infestation of bed bugs. Resident agrees to have personal property insurance to cover losses. Although the bed bug addendum was in place, intermittent bed bug infestation continued to be a concern at the ALR. At the time of the investigation, the ALR failed to have sufficient environmental measures in place to prevent recurrent bed bug infestation and to ensure a safe, clean, and homelike environment. III. During an environmental inspection on 05/13/22, beginning at 12:24 PM each apartment bathroom was observed to have a call bell system mounted on the wall beside the toilet. Further observations of the call bells in apartments 308, 317, 328 and 346 revealed that the pins remained in the system which prevented them from being able to transmit signals to staff to request for assistance. At 12:45 PM, Interview with the maintenance director confirmed the system is inoperable if the pin is left in the system. The maintenance director then stated that all pins will be removed. Observations on 05/16/2022 beginning at 2:47 PM, showed call bell pins were attached to the system in apartment 426, 434, 334, 317, 311, 234 and 228. Observations on 05/18/2022 beginning at 4:21 PM, showed call bell pins were still attached to the system in apartment 521, 517, and 524. On 05/18/2022 at 4:30 PM, the surveyors showed the call bell pins to the ALA who accompanied the surveyors. The ALA then stated that he will	R 272		

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R 272	Continued From page 8 ensure that all pins are removed to ensure all call bells are functional. At the time of the investigation, the ALR failed to ensure that the call bell pins were removed from the call bell system in each resident's bathroom to ensure safety and assistance when needed.	R 272		
R 280	Sec. 503.9 Dignity. (9) To choose activities and schedules consistent with his or her interests, and physical, mental, and psychosocial well-being. Based on interview and record reviews, the Assisted Living Residence (ALR) failed to ensure a choice of activities consistent with the interests and mental status for one of two residents in the investigation (Resident #2). Findings included: On 5/13/2022 beginning at 4:10 PM, a telephone interview with Resident #2's niece, the Responsible Party, revealed that the resident may need memory care stimulation due to her progressive dementia. She stated that the resident needs lots of encouragement to participate and or she may just sit there. The Responsible Party said that during the resident's preadmission assessment, she was told that activities can be planned for her level. Further, the Responsible Party said that the new Assisted Living Administrator (ALA) said the Activities Coordinator, must now offer activities to the resident. On 5/17/2022 at 1:30 PM, interview with the Life Enrichment Director, who is the Activities Coordinator, revealed that she had served in that	R 280	Sec. 503.9 Dignity. R280 An audit of all current residents' charts will be done to ensure a life enrichment assessment has been completed and if not, one will be completed, and service plan updated accordingly by 8-30-22. Activity director or designee will monitor residents' attendance/involvement in activities by maintaining daily attendance records. 8-3-22 Regional Director of Quality Service Leadership team on life enrichment assessment on activities for residents that may have some cognitive impairment and trained Life Enrichment Leader on how to complete the Life Enrichment assessment and to be addressed in residents service plan. Priority Corp Director of Life Engagement will do training with activity director on engagement activities with individuals with cognitive impairment by 8-30-22 Activity Director or designee will meet with each new resident in the first 7 days of move in to complete a life enrichment assessment to understand each resident's social needs, and interest and those needs will be reflective in-service plan. Administrator or designee will monitor daily to Life enrichment program is occurring.	

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R 280	Continued From page 9 position since March 2022, and that Resident #2 sometimes comes down for the recreational group activities provided for the residents. The Activities Coordinator said that if she observes the resident in the dining room at mealtime, she asks the staff to bring her to the group recreational activities after the meal. There had been no conversation regarding providing individualized recreational activities for the resident in her apartment. Interview with Certified Nursing Assistant (CNA) #1 on 5/17/2022 at 2:13 PM, revealed Resident #2 was encouraged to participate in the recreational activities, however "drifted off" during them. She added that at times the resident refused to attend activities and requested to go to her apartment. Interview with CNA #2 on 5/17/2022 at 2:56 PM revealed when she is assigned to the resident, she may sometimes take her to the group activities. The CNA stated however, that often after a brief period, the resident requested to go to her apartment and sometimes said she was cold. On 5/18/2022 at 4:42 PM, an attempted interview with Resident #2 revealed she slowly responded to questions, however, did not answer the specific questions asked. On 5/17/2022 at 2:47 PM, review of Resident #2's Client Service Plan updated 3/28/2022 revealed the diagnoses included Alzheimer's disease. The Client Service Plan stated that the resident will participate in activities of preference. Interventions to achieve the goal revealed the resident will be invited and escorted to all activities of interest.	R 280		

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	ALR-0041	A. BUILDING: _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 280	Continued From page 10 At the time of the investigation, there was no evidence the ALR assessed the resident to ensure choices and the provision of activities consistent with her interests and mental status.	R 280		
R 460	Sec. 603a3b Financial Agreements (B) Fee for service rates; and Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that the total monthly rent in the lease agreement coincided with the rental fee and the service agreement fee for two of the two residents in the investigation (Residents #1 and 2). Findings included: I. On 5/13/2022 at 5:05 PM, during a telephone interview, Resident #2's Responsible Party indicated that since admission, the resident's monthly rent had increased by 7%, and that the increase had not been included in the terms. When asked to provide a copy of the resident's rental agreement, the Responsible Party stated that the resident should have received the rental increase in the mail and that she would look for the documentation. On 05/16/2022 at 10:37 AM, interview with the Assisted Living administrator (ALA) revealed Resident #2 should not have received any increase in her monthly rental fee since admission, however he would follow-up. The ALA said that he would provide an email that included the attachment (Lease Form) that was sent to the Responsible Party, which showed a move-in date of 11/13/2021.	R460	There was no increase in the monthly rent. The $1322 was the pro-rated amount to move in. The actual rate going forward will be $1417. See attached supporting documents An Audit of all current resident's financial agreements will be done to ensure accurate fee and service rates by 9-15-22. Administrator will educate leadership team on the regulation 603a3b and proper way to complete Service agreement and the fee and rate section as well as educate need for signatures by community representative and resident and or surrogate by 8-3-22. Administrator or designee will review each new lease agreement to ensure rate and fees are accurate signed properly and copies provided to resident and or surrogate.	

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R 460	Continued From page 11 On 05/16/2022 at 1:20 PM, interview with the ALR's Director of Operations revealed Resident #2 did not have a rent increase since admission on 10/7/2021. She said that there was a difference of $27.00 between the Resident Rental Agreement and the Rental Fee Summary, which were both dated and signed by the Responsible Party on 10/07/2021. The Director of Operations said that the $27.00 was a board charge, which brought the monthly room rate to $1,444.00 On 5/16/2022 at approximately 2:00 PM, the COO provided a copy of Resident #2's Service Agreement Fee Summary, Rental Fee Summary, and Lease Agreement. a. The Resident Lease dated 10/7/2021 showed the following: Resident #2 was to be charged a total monthly rent of $1417.00. The Rental Agreement term was for a six-month period, and then will change to month-to-month following the first six months, commencing on 4/07/2022. The Resident's Lease Agreement was signed and dated by the Responsible Party on 10/07/2021. b. The Service Agreement Fee Summary dated 10/07/2021 showed the following "private pay" amount: Monthly Service Fee - $1417.00 (Core and/or personal care charges), and Board Charges - $27.00, for the total of $1,444.00. The form also contained the following note ["We may change these fees upon thirty days of written notice to you, however, if your level of personal Care Services increases or decreases, the new fees will apply immediately."] The Service Agreement Fee Summary was signed by the Responsible	R 460		

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R 460	Continued From page 12 Party on 10/07/2021. c. The Rental Fee Summary dated 10/7/2021 showed the following: Resident #2's total monthly room rate was $1444.00 for a one-bedroom apartment. The resident's responsibility was $1057.00 until funds for the Optional State Supplement Program (OSSP) are received. "Once they are received, the difference of $387.00 times the number of unpaid months will be drafted from your account." When compared, the Lease Agreement showed the total monthly rent was $1417.00, while the Service Agreement and the Rental Fee Summary showed the total monthly rent was $1444.00, which was a difference of $27.00. At the time of the investigation, prior to admission the ALR failed to ensure that the signed Lease Agreement total monthly rent ($1417.00), coincided with the signed Service Agreement fee summary and the signed Rental Fee Summary, which both stated the total monthly rent was $1444.00. II. On 05/13/2022, beginning at 5:11 PM, a telephone interview with Resident #1's Responsible Party indicated that the ALR recently increased the monthly rental fee. On 05/19/2022 at 12:04 AM, the Responsible Party emailed documentations to the investigators. On 05/19/2022 at 9:00 AM, review of the documentations detailed the following: a. An email dated 03/03/2021 from an Aria Management Company representative, asked if Resident #1 needed a studio apartment	R 460		

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R 460	Continued From page 13 ($1,323.00) or a one bedroom ($1,417.00). b. An email from the Responsible Party dated 5/19/2022 noted that he checked Resident #1's past bank records since admission and determined that Resident #1 was paying $1417.00 until recently, when the amount was increased to $1444.00 in February 2022. "I am searching for communication as to the reason, but I assumed it was a result of inflation and the pandemic." On 5/19/2022 at 12:55 PM, interview with the Chief Operating Officer (COO) revealed that Resident #1 had only paid $1,417.00 for rental of the one-bedroom apartment from 7/01/2021 until February 2022. She said however that during this same period the resident should have been paying $1,444.00 ($1,417.00 rent plus $27.00 board charge). She further stated that the reason the board charges were not collected from the Responsible Party until February 2022 was unclear. On 5/20/2022 at 11:56 AM, the COO emailed the surveyor's that Resident #1's rent was increased to include the $27.00 board charge, effective February 2022. The email stated that her conversation with the ALR's previous representative confirmed that the Responsible Party agreed to pay the $1444.00 rent, effective 02/01/2022, and signed the Automated Clearing House (ACH) Form. The attachment to the email was a Monthly Authorization Fee form for ACH debits for monthly rental payment. The form was signed by the Responsible Party on 1/18/2022 and the ACH debits were scheduled to begin in February 2022. The Resident Lease dated 6/3/2021 showed the	R 460		

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R 460	Continued From page 14 following: (1) The Lease Agreement, dated and signed by the Responsible Party on 06/03/2021 documented that $1417.00 was due monthly for a term of Six (6) months. A prorated payment of $1,322.73 for June 2021 was immediately due, and thereafter the monthly fee of $1417.00 on the first calendar day of the month. (2) The Rental Fee Summary dated 6/03/2021 showed the following: Resident #1's total monthly room rate was $1417.00 for a one-bedroom apartment. A prorated payment of $1,275.29 was due for the first month (June 2021) (3) The Service Agreement Fee Summary form showed the following: The Service Agreement Fee Summary form was left blank. The form only noted "n/a" (not applicable) and was not signed by the ALR representative or the Responsible Party. When compared, the two signed documents available, the Lease Agreement and the Rental Fee Summary both showed the total monthly rent was $1417.00. No additional fees were charged until Resident #1's rent was increased to include the $27.00 board charge monthly in February 2022, which then brought the total monthly rent to $1444.00. At the time of the investigation, prior to admission the ALR failed to ensure that the signed Lease Agreement total monthly rent ($1417.00) and signed Rental Fee Summary ($1417.00), coincided with the unsigned Service Agreement	R 460		

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R 460	Continued From page 15 Fee Summary (left blank) to clearly define the total monthly rent, including board charges due from the resident's Responsible Party.	R 460		
R 464	Sec. 603a6 Financial Agreements (6) A provision which provides at least 45 days' notice of any rate increase except if necessitated by a change in the resident's medical condition. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure that at least 45 days' notice was provided to the Responsible Party prior to a rent increase for one of two residents in the investigation (Resident #1). Findings included: On 05/13/2022, beginning at 5:11 PM, a telephone interview with Resident #1's Responsible Party indicated that the Assisted Living Residence (ALR) recently increased the monthly rental fee and that he would provide the supporting documentation. The Responsible Party then requested a follow-up to verify that the resident was now paying the correct amount for her one-bedroom apartment. On 05/19/2022 at 12:04 AM, the Responsible Party emailed documentations to the investigators. On 05/19/2022 at 9:00 AM, review of the documentations detailed the following: An email dated 03/03/2021 from an Aria Management Company representative, asked if Resident #1 needed a studio apartment ($1,323.00) or a one bedroom ($1,417.00). An email from the Responsible Party dated	R 464	603a6 Financial Agreements R464 1. At the time of the lease signing there was an error in booking board charge. Which is a charge that is implemented at the time of lease signing. The facility has corrected the issue moving forward 7-28-22 the Residential Lease agreement was updated to a 45-day notification of any rent increase will be provided to resident/surrogate. Administrator will educate all members of the leadership team by 8-3-22 on Regulation 603a6 that 45-day notice must be given and documented proof to be kept in residents chart with date of notification. Administrator and or designee will monitor monthly for compliance of 45-day notification occurs prior to increase in rental fees.	

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R 464	Continued From page 16 5/19/2022, noted that he checked Resident #1's past bank records since admission and determined that Resident #1 was paying $1417.00 until recently, when the amount was increased to $1444.00 in February 2022. "I am searching for communication as to the reason, but I assumed it was a result of inflation and the pandemic." On 5/19/2022 at 12:55 PM, interview with the Director of Operations (DOO) revealed Resident #1 had only paid $1,417.00 for the rental of the one-bedroom apartment from 7/01/2021 until February 2022. She said however that during this same period the resident should have been paying $1,444.00 ($1,417.00 rent plus $27.00 board charge). She further stated that the reason the board charges were not collected from the Responsible Party until February 2022 was unclear. The DOO stated that the available records did not show the date the Responsible Party was notified of Resident #1's rent increase. She then stated that the Residential Agreement required at least a 30-day notification. On 5/20/2022 at 11:56 AM, the DOO emailed the investigators that Resident #1's rent was increased to include the $27.00 board charge, effective February 2022. The email stated that her conversation with the ALR's previous representative confirmed that the Responsible Party agreed to pay the $1444.00 rent, effective 02/01/2022, and signed the Automated Clearing House (ACH) Form. The attachment to the email was a Monthly Authorization Fee form for ACH debits for monthly rental payment. The form was signed by the Responsible Party on 1/18/2022 and the ACH debits were scheduled to begin in February 2022. Further review of the email failed to document that the Responsible Party was	R 464		

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R 464	Continued From page 17 notified at least 45 days prior to the rent increase. The Resident Lease dated 6/3/2021 showed the following: (1) The Lease Agreement, dated and signed by the Responsible Party on 06/03/2021 documented that $1417.00 was due monthly for a term of Six (6) months. A prorated payment of $1,322.73 for June 2021 was immediately due, and thereafter the monthly fee of $1417.00 on the first calendar day of the month. (2) The Rental Fee Summary dated 6/03/2021 showed the following: Resident #1's total monthly room rate was $1417.00 for a one-bedroom apartment. A prorated payment of $1,275.29 was due for the first month (June 2021) (3) The Service Agreement Fee Summary form showed the following: The Service Agreement Fee Summary form was left blank. The form only noted "n/a" (not applicable) and was not signed by the ALR representative or the Responsible Party. The Service Agreement was dated and signed by the Responsible Party on 6/03/2021. The Service Agreement showed..."Fees: In addition to your rental fee, you shall pay a monthly fee for Core Services (Board charge) and Personal Care Services, if applicable. Your monthly fee is payable in advance by the first day of each calendar month. We may change your monthly fee for Core Services and for Personal Care Services and any fees for additional services upon thirty days written notice to you."	R 464		

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R 464	Continued From page 18 When compared, the two signed documents available, the Lease Agreement and the Rental Fee Summary both showed the total monthly rent was $1417.00. No additional fees were charged until Resident #1's rent was increased to include the $27.00 board charge monthly in February 2022, which then brought the total monthly rent to $1444.00. At the time of the investigation, there was no evidence that the Responsible Party was provided at least 45 days' notice prior to Resident #1's increase. R 526 Sec. 607a5 Services To Be Provided (5) Laundry and housekeeping service not provided by the resident or surrogate. Based on interview and record reviews, the Assisted Living Residence (ALR) failed to ensure proper laundry services in accordance with the need of one of the two residents in the investigation (Residents #1). Findings Included: On 05/13/2022 beginning at 5:10 PM, interview with Resident #1's son, who is the Responsible Party, revealed that after a bedbug infestation in the Resident's apartment (228), the facility washed all of the resident's clothes together. The light-colored clothing and the dry-cleaned clothes were damaged as a result. On 05/17/2022 beginning at 11:40 AM, interview with the Maintenance Assistant, revealed that he washed Resident #1's dark and light clothes together. He stated that he did not know to	R 464		
		R526	The responsible party (resident 'son) was requested to provide receipts for the damaged clothing. Upon receipt the facility will credit the resident/family. The responsible party was instructed to review the resident Handbook which states the facility will not handle delicate laundry and dry cleaning In addition, the resident/staff was provided training on "The Refusal log for housekeeping which must be signed by both parties Maintenance director gave impromptu training to the maintenance assistant on proper laundry that washed resident #1at the end of May 2022. All staff were educated at June 27 2022 and July 19-22 staff meeting regarding proper laundry procedure by leadership. Maintenance Director and or designee will monitor staff to ensure laundry training occurs prior to assisting with laundry duties.	

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R 526	Continued From page 19 separate the light-colored from the dark colored clothes. On 05/17/2022 beginning at 12:32 PM, interview with the House Keeping Supervisor, revealed that she separated the light-colored clothes from the dark color clothes and placed them in separate bags, and gave the bags to the Maintenance Assistant to take to a commercial laundry. When asked, she stated that she did not instruct on how to wash the resident's clothes. On 05/20/2022 at approximately 12:00 PM, review of the Service Agreement dated 06/03/2021, revealed the ALR will provide one load of personal laundry services each week and as needed. However, at the time of the investigation the ALR staff failed to demonstrate competency on laundry procedures to prevent damage to the residence clothing. At the time of the investigation, the facility failed to provide proper laundry services in accordance with the residence needs.	R 526	LIVINGSTON PLACE LAUNDRY PROCEDURES: 1. LAUNDRY SERVICES WILL BE PERFORMED BY THE NURSING STAFF 2. RESIDENT LAUNDRY WILL BE DONE ON A DESIGNATED SHIFT AND DAY 3. RESIDENT'S CLOTHING WILL BE LAUNDERD ONCE PER WEEK 4. EACH UNIT/FLOOR HAS THEIR OWN WASHER AND DRYER 5. RESIDENT'S LAUNDRY ITEMS ARE DONE SEPARATELY FOR INFECTION CONTROL PURPOSES 6. A LAUNDRY SCHEDULE IS POSTED ON EACH FLOOR 7. A LAUNDRY CHECKLIST WILL BE UTILIZED TO ENSURE THERE IS NO LOSS OF CLOTHING.(SEE ATTACHEMENT)	
R 583	Sec. 701d1 Staffing Standards. (1) Employ staff and develop a staffing plan in accordance with this act and based upon the following criteria to assure the safety and proper care of residents in the ALR: Based on observations, interviews and record reviews, the Assisted Living Residence (ALR) failed to develop and implement a staffing plan to ensure proper housekeeping services in accordance with the Resident Service Agreement, for three of the three residents reviewed (Residents #1, 3 and 4).	R 583	701d1 Staffing Standard (Housekeeping) R583 Two (2) housekeepers have been hired and are in the pre hire process and will be onboarded by end of August 8-30-22. Two (2) housekeepers are schedule on e daily. A schedule for weekly occupied apartment was created to ensure each apartment receives weekly cleaning and a record of date and who cleaned apartment will be kept by 8-3-22. Maintenance Director and Administrator will review housekeeping documentation monthly. Administrator will educate all member of leadership and housekeeping on regulation 701d1 on 8-3-22. Maintenance and or designee will monitor for adequate staffing to ensure residents housekeeping and community housekeeping needs are being met weekly.	

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R 583	Continued From page 20 Findings included: On 05/13/2022, at 10:32 AM, interview with the Assisted Living Administrator (ALA) revealed that the ALR was currently licensed to provide services to 150 residents, however the current census was 84 residents. The ALA indicated that light housekeeping and laundry services were included in the Resident Service Agreements and that the Housekeeping Department consisted of the Housekeeping Supervisor and two additional staff. On 05/17/2022 at 1:18 PM, interview with the Housekeeping Supervisor revealed the ALR was staffed with a full-time housekeeper from 8:30 AM to 5:00 PM, and two other housekeeping staff each worked part-time, 3 days a week (a total of 24 hours/week). Housekeeping Aide #1 worked Sunday, Monday, and Thursday, and Housekeeping Aide #2 worked Tuesday, Friday, and Saturday. Further discussion with the Housekeeping Supervisor revealed that she was the only housekeeping staff on duty on Wednesdays. The Housekeeping Supervisor said that usually the housekeeper assignment is 17 to 18 apartments. When asked who responded to housekeeping needs when the staff were not on duty, she stated that it would be the Certified Nursing Assistant (CNA) whomever was available. The supervisor was asked to provide the housekeeping records and stated that she gave them to the Director of Operations. On 5/17/2022 at 2:37 PM, a Housekeeping Aide was observed in an apartment cleaning and mopping the floor. On 5/18/2022 at 9:32 AM, the Housekeeping Supervisor was observed cleaning the activity room located on the first floor.	R 583		

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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 583	Continued From page 21 On 5/19/2022 at 2:13 PM and 2:56 PM respectively, interviews with CNAs #1 and 2 revealed that if bed making is required, the bed would be made by the CNA. Both stated that Residents #1 and 3 can make their own beds. On 5/19/2022 beginning at 3:02 PM, the housekeeping logs provided by the ALA for November 2021 through May 2022 were reviewed. Resident #1 was admitted to the facility on 6/3/2021. The record provided the following regarding housekeeping Services: November 2021 - No weekly service on 11/09/2021 and 11/29/2021 December 2021 - No weekly service after 12/13/2021. A Pest Control invoice dated 12/30/2021, revealed that bed bug treatment services were requested on 12/27/2021 for Resident #1's apartment (228). The inspection revealed many live and dead bed bugs. January 2022- Weekly service on 1/30/2022 February 2022 - Weekly service on 2/18/2022, 2/21/2022 and 2/28/2022 March 2022 - Weekly service on 3/7/2022 and 3/14/22, thereafter no housekeeping records were available for the other weeks in March. The housekeeping report dated 3/14/2022 revealed that the maintenance supervisor was informed of the bed bugs seen in Resident #1's apartment (228). A Pest Control invoice dated 3/17/2022 showed that on 3/17/2022, apartment 228, which was previously treated on 12/30/2021, had many live bed bugs on the bed, baseboards, and	R 583		

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R 583	Continued From page 22 ceiling. April 2022 - Weekly service on 4/12/2022, 4/19/2022, and 4/26/2022. May 2022 - Weekly service on 5/5/2022; 5/11/2022 housekeeping assignment noted that resident moved from apartment 228 to apartment 308. A Pest Control invoice dated 5/09/2022, revealed the ALA requested bed bug treatment in Resident #1's apartment (228) after staff reported seeing bed bugs. b). Resident #3 was admitted to the facility on 8/25/2021. Records showed the following regarding housekeeping services: On 5/18/2022 beginning at 11:46 AM, review of the provided weekly housekeeping logs from November 2021 to May 2022 revealed the following dates for Resident #3: - November 2021 - 11/2, 11/16, and 11/23, 2021 - No service was requested; on 11/30/2021 service was provided. - December 2021 - Service was provided on 12/8/21 and 12/14/2021 - January 2022 - 1/25/2022 - No answer to housekeeper attempt - February 2022 - Service was provided on 2/17/2022 Review of a Pest Control invoice dated 3/17/2022 showed Resident #3's apartment (328) had many live bed bugs, excrements, and casings. The resident was relocated to another apartment temporarily while her apartment was treated and	R 583		

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R 583	Continued From page 23 cleaned. - April 2022 - Service was provided on 4/26/2022 - May 2022 - No routine housekeeping service was documented, however on 5/12/2022, Resident #3 discovered bed bugs in her apartment (328) and reported them to the front desk staff. On 5/13/2022 at 1:02 PM, the resident announced to the surveyors that she had bugs in her apartment. At 1:05 PM, the surveyors observed what appeared to be several blood spots on the resident's mattress. The surveyors then reported the spots to the Director of Nursing, who accompanied them to the resident's apartment. On 5/17/2022, the resident was relocated to another apartment temporarily while her apartment was treated by Pest Control and cleaned. c). Resident #4 was admitted to the facility on 10/08/2021. Records revealed the following information regarding the resident: On 5/18/2022 at 11:18 AM, the Department of Health (DOH) received an incident which stated that on 5/18/2022 at 10:30 AM, Resident #4 who lives in apartment 301, told the front desk staff that she woke up with bite marks on her neck. The maintenance inspection revealed bed bugs in the box spring. The nursing assessment revealed six bite marks on the resident. The bed bug protocol was implemented, and the resident was prepared to be transferred to a temporary apartment. Review of Resident #4's housekeeping services provided is documented below: - November 2021 - Service provided on 11/2,	R 583		

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R 563	Continued From page 24 11/8, 11/16, 11/23, and 11/30/2021 - December 2021 - Service provided on 12/8/21 and 12/14/2021 - January 2022 - Service provided on 1/25/2022 - February 2022 - No housekeeping service records - March 2022 - No housekeeping service records - April 2022 - Service provided on 4/19/2022 No additional records were provided to show that light housekeeping services were offered to the resident. On 5/19/2022 at 3:35 PM, the ALA was asked again about the weekly housekeeping schedules that were missing. The ALA said he would follow-up on the status. He later stated that there were no housekeeping service records in December after 12/14/2021 and in January 2022 because there had been a COVID outbreak at the ALR in December which had affected staffing. On 05/19/2022 at 3:45 PM, review of the Resident Service Agreement revealed that the Core Services monthly rental fee included laundry and housekeeping. The ALR agreed to provide one load of personal laundry and laundering of bed and bath linens on a weekly basis or as needed. Housekeeping services included weekly light housekeeping (vacuuming, dusting and bathroom cleaning). The Resident Apartment Cleaning policy also stated that Weekly Light Housekeeping services shall be provided. Residents will be responsible for the day-to-day cleaning of their apartments (i.e., making beds,	R 563		

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R 583	Continued From page 25 washing dishes, etc.) unless specified in the Individualized Service Plan (ISP). There was also an operational guideline which stated that the bed should be stripped and remade as often as indicated in the residents' ISP. At the time of the investigation, there was no documented evidence that the ALR developed and implemented a staffing plan to ensure housekeeping and laundry services in accordance with the Resident Service Agreement.	R 583		
R1023	Sec. 1008c Bedrooms, (c) An ALR shall ensure that each resident has an adult size bed with clean comfortable mattress and extra linens. Additional furnishings, such as nightstand, desk, chair, mirror, waste basket, etc., shall be made available, subject to residents wishes and tastes. Beds in double occupancy bedrooms must be at least 3 feet apart. Residents may choose to provide their own furnishings after being made aware of the furnishings that the facility is required to provide. All furnishings must meet the Fire Safety Code and be maintained in good repair. Based on observation, interview and record review, the Assisted Living Residence (1) failed to ensure each resident had an adult size bed, and additional furnishings, such as a nightstand, desk, chair, mirror, waste basket, etc., subject to residents wishes and tastes, and (2) failed to offer resident's the opportunity to choose to provide their own furnishings after being informed of the furnishings that the facility is required to provide. Findings Included:	R1023	R1023 In June and July of 2022 an audit of all current residents' rooms was conducted to ensure each resident had the appropriate furniture needed for regulation 1008e and educated on what furniture community can provide. By 8-14-22 a model room with furniture that community can provide will be set up to show prospective resident. Any pieces of furniture that a resident did not have during the audit conducted in June and July have been ordered and goal is items will be in place by 9-15-22. Administrator will educate all member of the leadership team on regulation 1008c on items each apartment is required to offer by 8-03-22 A rent Ready checklist and move in check in list will be used moving forward for all new residents to ensure each apartment has furniture that is required and that any furnishes residents choose to bring are inspected by a member of the maintenance team to ensure in good repair and meet fire safely code.	

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R1023	Continued From page 26 1. On 05/13/2022 at 11:39 AM, observations of Resident #5's apartment (421) showed a bed was the only furniture in the room. The living/dining room had bags of clothes, two TV trays and additional items on the floor. The bedroom had clothes that were piled in a basket and in her closet. Continued observations revealed the apartment did not have furnishing such as a dresser, nightstand, desk, chair, waste basket and shower curtain. Interview with the resident at 3:22 PM revealed the facility loaned her a bed and she was not aware that the facility was able to provide her with furnishing. She then stated that she requested a shower chair but was given a portable toilet instead. [Admission date: 12/10/2021] 2. At 11:50 AM, observation of Resident #2's apartment (317) showed the resident's dresser had a missing drawer. There was a bag filled with clothes on the bedroom floor. On 05/19/2022 at 12:45 PM, interview with the resident's niece, who is the Responsible Party revealed the resident had to provide her own furniture and was not made aware that the facility was able to provide her with furnishing such as a dresser. She then stated that she would like the facility to provide additional furnishing for Resident #2. [Admission date: 10/07/2021] 3. On 05/13/2022 at 11:56 AM, observations of Resident #6's apartment (336) revealed the resident slept on a cot. The living/dining room was only furnished with a high table and two chairs that were also high, and the closet had a built-in dresser. Continued observations revealed the apartment did not have an adult size bed, nightstand, desk, comfortable chair, and clean linens. Interview with the resident at the same	R1023	Resident #5 provided with trash can, mirror and shower curtain. Resident #2 POA was made aware of items community offers in June 2022 and will obtain furniture once niece returns audit. Resident #6 community gave a new bed and disposed of cot.	

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R1023	Continued From page 27 time, revealed he moved in without any furniture and had to provide his own. The resident stated that it is difficult to tie his shoes when he sits in the chair because it is too high. Continued interview revealed that the resident was not made aware that the facility was able to provide him with furnishing such as a bed, nightstand, desk, comfortable chair, and linens. He then stated that he would like the facility to provide additional furnishing especially a bed and a standard size chair. [Admission date: 4/07/2022] 4. At 12:09 PM, observations of Resident #7's apartment (346) showed a bed without any linens on the mattress. A large screen television and a wall mount were observed placed on the mattress. On the floor next to the bed were pillows and linens. The living/dining room was furnished with a recliner chair, one small end table and a stool. The closet had a built-in dresser. Continued observations revealed the apartment did not have furnishing such as a nightstand, desk, and waste basket. Interview with the resident at the same time, revealed that the facility provided him with a bed "three or four" days after he moved in and informed them that he did not have a bed. The resident said he sleeps in the recliner chair that his friend gifted him, because his bed did not have any linens on it. The resident also stated that he was waiting for maintenance to mount his television on the wall. Continued interview revealed that the resident was not made aware that the facility was able to provide him with furnishing such as a bed, nightstand, desk, chair, and a shower curtain at the time of move in. He then stated that he would like the facility to provide additional furnishing, mount his television and make his bed. [Admission date: 4/23/2022]	R1023	Resident # 7 TV mounted on wall and furniture request form completed and item ordered.	

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R1023	Continued From page 29 8. On 05/19/2022 at 11:23 AM, observation of Resident #11's apartment (243) showed the resident's television was positioned on the floor and he had no nightstand. Several boxes of items were also on the floor. Interview with the resident at the same time, revealed he had to purchase his own furniture and was not made aware that the facility was able to provide him with furnishing. The resident said that he would like the facility to mount his television on the wall, and that he also needed a mirror, chest of drawers, and a nightstand. [Admission date: 8/18.2021] 9. On 05/16/2022 at 4:12 PM, observations of Resident #12's apartment (334) revealed there was no table or desk. Several items were on the floor and the trash can was turned upside down to support her radio. Observation of the resident's closet showed the rack was positioned low, therefore the resident's clothes hung low onto the floor. Interview with the resident at the same time, revealed she had to provide her own furniture and was not made aware that the facility was able to provide her with furnishing. She then stated that she would like the facility to raise the rack in the closet and would like additional furnishing, such as a table with a leaf and a desk. [Admission date: 9/27/2021] 10. (Cross Reference to R0272, II) On 05/13/2022, at 5:10 PM, interview with Resident #1's son, who is the responsible party, revealed he was asked to purchase a new bed when the resident acquired bedbugs. He stated that he furnished the resident's apartment (228) and was not made aware that the facility was able to provide her with furnishing. On 05/16/2022 at 4:36 PM, observation of	R1023	Resident #11 TV has been mounted and furniture requested has been ordered and will be in place by 8-30-22. Resident #12 Rack in closet not able to be raised. Furniture missing has been ordered and will be in place by 8-30-22. Resident #1 son provided new bed resident wanted and is now aware of furniture that community can provide.	

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R1023	Continued From page 28 5. On 05/13/2022 at 2:12 PM, observation of Resident #9's apartment (428) showed the resident was watching TV. The TV and several boxes of items were on the floor. Interview with the resident at the same time, revealed she had to provide her own furniture and was not made aware that the facility was able to provide her with furnishing. The resident stated that she would like the facility to mount her television on the wall and would like additional furnishing, such as a desk. [Admission date: 11/05/2021] 6. At 2:25 PM, observations of Resident #8's apartment (426) showed the living/dining room was only furnished with a chair and a stool. A television was on a small folding TV tray, a small lamp was on the floor, and the closet had a built-in dresser. Observation of the bathroom showed the light was not working in the bathroom. Continued observations revealed the apartment did not have furnishing such as a nightstand and desk. Interview with the resident at the same time, revealed he was promised furniture, however no furniture was provided. He then stated that he would like light in the bathroom and for the facility to provide additional furnishing such as a nightstand and a desk. [Admission date: 12/21/2021] 7. On 05/19/2022 at 11:18 AM, observations of Resident #10's one bedroom apartment (240) revealed there was no nightstand, dresser, or mirror. Interview with the resident at the same time, revealed she and her husband shared the apartment. She said that she had purchased some furnishing, but still needed a nightstand, mirror, and a dresser for storage. The resident stated that she was not informed that the facility could offer furniture items for her apartment. [Admission date: 7/08/2021]	R1023	Resident #9 TV has been mounted on wall and decline table. Resident #8 Light in Bathroom was replaced, and table ordered. Resident #10 Room has a built-in dresser in room furniture requested Mirror and nightstand will be in place by 8-30-22	

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R1023	Continued From page 30 Resident #1's apartment (228) showed the apartment was being organized for the resident to return after the abatement of the bedbug infestation. During a follow-up interview on 05/18/2022 at 10:29 AM, Resident #1's son revealed that the facility asked him to purchase a desk and a chair approximately two weeks after she moved in. He stated that facility did not furnish the resident's apartment and he was not made aware that the facility was able to provide her with furnishing. At 11:10 AM, Resident #1's son forwarded an email dated 06/07/2021, from a previous ALA. Review of the email revealed the ALA asked, "<Resident #1's son> can you bring in a chair so your mother can eat at the table in her room? I'm told she prefers breakfast in her room and must sit on her bed to eat." Interview with the ALA on 05/13/2022 at approximately 12:00 PM, revealed that he was not aware that residents needed furniture. He stated that the facility will provide furniture such as a bed, dresser, nightstand, table, and chairs. During an interview on 05/17/2022 at 11:00 AM, the Director of Operation (DOO) revealed that the facility gave the residents the opportunity to purchase their own furniture to make it their own and personable. [Admission date: 6/03/2021] 11. On 05/18/2022 at 4:31 PM, observation of Resident #13's apartment (521) showed the apartment was not furnished with a table or chair. Interview with the resident at the same time, revealed she had to provide her own furniture and was not made aware that the facility was able to	R1023	Resident #13 Lamp given, and Chair and Mirror ordered and will be in place no later 8-30-22	

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R1023	Continued From page 31 provide her with furnishing. She then stated that she would like additional furnishing, such as a table, chair, lamp, and a mirror. [Admission date: 4/04/2022] 12. On 05/18/2022 at 4:45 PM, observation of Resident #14's apartment (524) showed the living/dining room was cluttered with boxes and bags. A shelf table was the only furniture observed in the living/dining room. Interview with the resident at the same time, revealed he was told to "bring his own furniture from home." and was not made aware that the facility was able to provide him with furnishing. He then stated that he has not had any assistance with unpacking and needed help. He said he would know what furniture is needed once he gets help. [Admission date: 12/30/2021] 13. On 05/19/2022 beginning at 10:20 AM, a walk-through of the vacant apartments showed there were no furnishings. Interview with the ALA at the same time revealed the facility did not have any apartments that were move in ready with furniture. At the time of the investigation, there was no evidence that the ALR ensured each resident had an adult sized bed with a clean comfortable mattress and required furnishings and informed each resident of furnishing that the ALR is required to provide.	R1023	Resident #14 belongings unpacked as requested in July of 2022	