PRINTED: 08/14/2023

AND PL	MENT OF DEFICIENCIES AN QF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIF:CATION NUMBER		PLE CONSTRUCTION G:	X3) DATE SURVEY COMPLETED
		ALR-9002	B WING_		C 07/26/202
NAME O	F PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	V11201202
LISNE	R LOUISE DICKSON HUR		STERN AVE		
(X4) ID PREFI) TAG	LEACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA OEFICIENCY)	ŤE
R 0	00 Initial Comments		R 000		
	Regulation and Licen Intermediate Care Fa Agency), received no the Assisted Living R transferred to the Skill	cilities Division (State Survey lification that the residents of	,		(454) COM-P CA1
	Agency initiated an or on 07/26/2023 beginn compliance with the A Regulatory Act of 200 Administrator and the eight residents of the (ALR) formally in the S	of the report, the State Survey neite inspection of the facility ing 11:47 a.m., to determine ssisted Living Residence 0. Per the Assisted Living Director of Social Work, the Assisted Living Residence Shoemaker Court were moved utification of the ALR wing of		Please start typing your responses he R544 - 1 Corrective Action: The 6-108's for residents 1, 2, 4, 5, 7 and 8 were reissued on Aug 9, 2023 and included the residents right to challenge the facility's decision to discharge, transfe or relocate the resident. Each resident	8/9/20.
	informed the surveyors responsible party was	r and the Administrator s that each resident's notified of the move, all required documents related		was presented with the 6-108 and copies e-mailed to each resident representative. On Aug 10, 2023, the staff of the DC Long Term Care Ombudsman office acknowledged receipt of the re-issued 6-108's.	
	observations, interview	estigation were based on s, and review of records.	12	Members of the DC Long Term Care Ombudsman met in person with residents 1, 2, 4, 5, 7 and 8, to review their right to challenge the discharge. No resident or resident representative	
R 544	Sec. 608d Discharge a	nd Transfer	R 544	initiated a challenge.	1
	involuntary basis, the A written notice to the res planned discharge and discharge in consultatio surrogate, and the healt	hcare provider. Any nall conform to the notice		Systemic Changes: All social work staft were educated on giving proper notice and including the residents right to challenge the facility's decision to discharge, transfer or relocate the resident with all future 6-108s.	

If continuation sheet 1 of 7

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		
		ALR-0002	B WING		C 07/26/2	2023
AME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	UTIEGI.	LUZJ
_		5425 WF9	TERN AVENU			[
ISNER	LOUISE DICKSON HU	RIROME	TON, DG 201			
(X4) IÕ PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF OEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	CAY COMPLETE CAY
R 544	Continued From pa	ge 1	R 544			
	reviews, the Assiste to properly notify the discharge of the AL facility wing of the fielght residents of the #6, and #7). Findings included: On 07/26/2023 at 1. Administrator (ALA) Services informed to 2, 4, 5, 7, and 8 were Nursing Facility (SN asked they further in and/or their represedated 05/01/2023, in could relocate to the 1). Per the requirem written notice requirements of the Alaman of the requirements of the services of the total or the requirements of the services of the servi	ions, interviews, and record ed Living Residence (ALR) failed e Department of Health of the R residents to the skilled nursing activity building for five of the e ALR (Resident #1, #2, #3, #5, and the Director of Social he surveyors that Residents #1, re transferred to the Skilled IF) wing of the building. When indicated that the residents mattives were notified in a letter informing the residents that they e SNF or choose another ALR tents of § 44-1003.02 - (d). The ed by subsection (a) of this a form prescribed by the Mayor		Monitoring: The Director of S Services will track all future 6-1 to assure proper notice is given the inclusion of the residents rito challenge the facility's decisi discharge, transfer or relocate. Director of Social Services will 6-108's reissued should staff fair provide the resident right to challenge. The Director of Social Services will report findings at Quality Assurance Performance Improvement Committee. R 544 - 2 Corrective Action: The 6-108's residents 1, 2, 3, 5, 6 and 7 were reissued on Aug 9, 2023 via electronic form submission per Health website instructions wit subsequent confirmation e-maineceived on submission. Each reissued 6-108 was e-mailed to the Long Term Care Ombudsman wonfirmation e-mail of receipt	for 87	9/2023
	reads: "[y]ou have a decision to discharg	t less than 12-point type that right to challenge this facility's e, transfer, or relocate you. If scharge you from the facility or		obtained for the Ombudsman's office.		
	to transfer you to an should not have to le have 7 days from the inform the Administr community residence staff that you are rec	other facility and you think you eave, you or your representative e day you receive this notice to ator [Residence Director, if a e facility] or a member of the questing a hearing and to ed hearing request form and		Systemic Changes: All social wo staff were educated on using the Health electronic submission for future 6-108s to assure the department's receipt.	DC "	5/2013

Health Regulation & Licensing Administration

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DVG211

it continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ALR-0002		B WING	C 07/26/2023		
NAME OF F	ROVIDER OR SUPPLIER	STREET ADO	RESS, CITY, ST	ATE, ZIP CODF	1 077207202	
LISNER	LOUISE DICKSON HUF	RT HOME 5425 WES	TERN AVEN	UE NW		
(X4) ID PREF:X TAG	(EACH DEFICIENCY MIUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NT'FYING INPORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT() (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COME	
	the day you place it is give it to a member of considered the date time limit. In all other be considered the date decision is to relocat think you should not you or your represent the above." - "If you or your represent the decise absence of an emergical control and the decise absence of an emergical commentation of the sandther room within the formation of the sandther room within the formation of the sandther room the formation of the sandther room the sandther room the sandther sa	request form from the facility, in the facility's outgoing mail or of the staff for mailing shall be of mailing for purposes of the cases, the postmark date shall ate of mailing. If, instead, the e you within the facility and you have to move to another room, tative have only 5 days to do assentative request a hearing, it han 5 days after the request is and, in the absence of compelling circumstances, you sore a hearing decision is ion is against you, in the ency or other compelling ill have at least 5 days to be if you are being discharge or facility, and at least 3 days to be facility. If you are being discharged or callity, and at least 3 days to be facility. If you are being discharged or callity, and, at your request, in the Long-Term Care. If you have any questions at tate to call one of the phone for assistance." of 6-108 forms signed by responsible parties provided fent's #1, #2, #4, #5, #7, and	R 544	Monitoring: The Director of Soci Services will track all future 6-108 assure the form is sent via electror submission and the c-mail receipt generated by proper submission. Director of Social Services will tak immediate corrective actions for proper submissions should the 6-40 be sent incorrectly. The Director Social Services will report findings the Quality Assurance and Performance Improvement Committee.	's to nic The c	

DVG211

If continuation sheet 3 of 7

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL'A IDENTIFICATION NUMBER	(X2) MULTIPLE (E SURVEY
			A BUILDING		,	NALCETER
		ALR-0002	8 WING	- ph 1/9 M - A right of committed and collection for property or Mills	07	C /26/2023
AMÉ ÓF P	ROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, STATI	Ê Z/P CODE))
ICNICO I	ALMOS BISKESNILL	5425 WE	STERN AVÉNUE	*		
IONEK	LOUISE DICKSON HU	KI NUME	GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(XS) COMMITTE QATE
R 544	Continued From pa	ge 3	R 544			
	a. A review of Resident #1's 6-108 form showed to residents representative, gave permission via telephone for the transfer on 05/12/2023. The form showed the resident was transferred to SNF on 05/11/2023, one day before the permission was obtained. The copy of the 6-108 form provided did not include the residents right to challenge the facility's decision to discharge, transfer, or relocate the resident, as required by the DC Code § 44-1003.02 (d). b. A review of Resident #2's 6-108 form showed the resident signed the form on 07/18/2023, and the responsible party (RP) was also informed via telephone on the same date. The form indicated the resident was transferred to the SNF on 07/18/202. The copy of the 6-108 form provided did not include the residents right to challenge the facility's decision of discharge, transfer, or relocate the resident, as					
	residents represents for the transfer on 04 the resident was transfer on 04/01/2023. The copdid not include the refacility's decision to othe resident, as requived. A review of Resident.	ent #4's 6-108 form showed the litive, gave permission by phone 4/01/2023. The form indicated insferred to the SNF on by of the 6-108 form provided esidents right to challenge the discharge, transfer, or relocate lired by the DC Code §				
	indicated the residen 07/17/2023, one day the 6-106 form provid	orm on 07/18/2023. The form it was transferred to the SNF on after the transfer. The copy of ded did not include the illenge the facility's decision to or				

Health Regulation & Licensing Administration

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DVG211

If continuation sheel 4 of 7

	OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING:		CC	MPLETED
		ALR-0002	8 WING	₩ Marin	07	C /26/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATE	E, ZIP CODE		
LISNER	LOUISE DICKSON HUR	I MUMB	STERN AVENUE STON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NTEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C LEACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY;	N SHOULD BE E APPROPRIATE	.X5, 50VPLEY: DATE
R 544	Continued From page	e 4	R 544			
		as required by the DC Code §	1, 044			
	44-1003.02 (d).	as redoined by the DC Code 3				
	a A ravious of Decide	ent #7's 6-108 form showed				
1	that the resident's rep by phone for the trans indicated the resident 05/09/2023, one day obtained. The copy of not include the reside facility's decision to di the resident, as requir 44-1003.02 (d).	presentative, gave permission sfer on 05/10/2023. The form twas transferred to the SNF on before the phone consent was f the 6-108 form provided did ints right to challenge the ischarge, transfer, or relocate red by the DC Code §				
	the resident's represe phone for the transfer indicated the resident 05/08/2023, two days obtained. The copy of failed include the resident the resident failed include the resident failed failed failed include the resident failed	at #8's 6-108 form showed that intative, gave permission by on 05/10/2023. The form was transferred to the SNF on before the verbal consent was the 6-108 form provided lents right to challenge the scharge, transfer, or relocate ed by the DC Code §				
E ti C	ensure the residents/re provided with adequate heir rights to challenge lischarge, transfer, or	stigation, the ALR falled to exponsible parties were e notice, informing them of a the facility's decision to relocate the residents, as e District of Columbia §				
S #	dministrator (ALA), an ervices informed the s	110 pm, the Assisted Living and the Director of Social surveyors that Residents #1, were transferred to the				

DVG211

STATE FORM

If continuation sheet 5 of 7

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY
			A BUILDING			
		ALR-0002	B WNG		07	C /26/2023
ME OF P	ROVIDER OR SUPPLIER	STREET AC	ORESS, ÇITÝ STATE	E, ZIP CODE		
SNEO I	OUISE DICKSON HU	RT HOME 5425 WE	STERN AVENUE	NW		
SILK E	COISE DICKSON NO	WASHIN	GTON, DC 2001	16		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AL DEFICIENCY)	HOULD BE	ONE, COMPLS SME
R 544	Continued From pa	ge 5	R 544			
	residents and/or the in a letter dated 05/	ed they further indicated that the air representatives were notified 01/2023, informing the residents cate to the SNF or choose				
	the written notice re section shall be place record and shall be designee and, if the or in part through M	ts of § 44-1003 02(e) copies of equired by subsection (a) of this ced in the resident's clinical transmitted to the Mayor's resident's care is paid in whole edicaid, the Director of the an Services ("DHS"), and the obbudsman.				
	At 1:55 pm, a review showed the following	v of provided resident records g:				
	and the resident war 05/11/2023. There v Department of healt	08 form was dated 05/12/2023, s transferred to the SNF on vas no indication that the h received copies of the written ubsection (a) of this section.				
	and the resident was 07/18/2023. There w Department received	08 form was dated 07/18/2023, stransferred to the SNF on was no indication the discopies of the written notice on (a) of this section.				
6	and the resident was 07/18/2023. There w Department received	08 form was dated 07/18/2023. It ransferred to the SNF on least on indication the discopies of the written notice on (a) of this section.				***
8		08 form was dated 07/18/2023, stransferred to the SNF on was no indication				

STATE FORM

DVG211

If continuation street 6 of 7

	NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER	1	CONSTRUCTION	(X3) DATE SURVE COMPLETE
		ALR-0002	B WNG		C 07/26/20
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	RESS CITY STAT	E. ZIP CODE	
LISNER	LOUISE DICKSON HU	RT HOME 6425 WES	TERN AVENUE	E NW	
		WASHING	TON, DC 200	16	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	Dr.
	the Department received required by subsection the resident was 04/27/2023. There was 04/27/2023. There was 05/09/2023. There was 05	ived copies of the written notice on (a) of this section. Be form was dated 04/27/2023. transferred to the SNF on as no indication the copies of the written notice on (a) of this section. Be form was dated 05/10/2023, transferred to the SNF on as no indication the copies of the written notice on (a) of this section. Indication the copies of the written notice on (a) of this section. Indication the department, but arrevers onsite, during the stigation, the ALR failed to continue to the discharge of the skilled nursing facility wing and on the skilled nursing facility wing and the skilled nursing facility wing an	R 544	DEFICIENCY)	

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If continuation sheet 7 of 7