STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0001	A. BUILDING: _____ B. WING _____	01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARMY DISTAFF FOUNDATION INC	6200 OREGON AVENUE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments An annual survey was conducted on 01/22/2020, 01/23/2020 and 01/24/2020 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq). The Assisted Living Residence (ALR) provided care for 40 residents and employed 32 personnel to include professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. The following abbreviation is used throughout the body of the report: ALR - Assisted Living Residence DCMR - District of Columbia Municipal Regulations DON - Director of Nursing EPA - Environmental Protection Agency LPN - Licensed Practical Nurse PSI - pounds per square inch	R 000	This plan of correction is prepared and/or executed because it is required by the Provisions of State Law. The plan of correction is the Army Distaff Foundation and Knollwood's credible Allegation of Compliance.	
R 255	Sec. 502a4 Self-determination, choice (4) With assurance of privacy and the opportunity to act autonomously and share in the responsibility for decisions. Based on observation and interview, the facility failed to ensure that each resident's privacy was protected for one of one resident receiving medications (Resident #16). Findings included: On 01/22/2020 at 11:19 AM, observation of the facility showed a medication cart on the first floor hallway. There was an open laptop on top of the cart, facing two residents' rooms. Closer observation of the cart showed that there was	R 255		

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R 255	Continued From page 1 resident information displayed on the laptop's screen. The LPN, who was responsible for the laptop, was in a resident's room and away from the medication cart. At 11:22 AM when the LPN returned to the medication cart, the surveyor alerted the the nurse to the privacy concern. The LPN responded that the computer system was new and does not allow an easy method to turn off the screen without logging off of the system. Therefore, the laptop was left open to avoid a long process of signing back into the computer system. At 1:37 PM the ALR Director said that the facility would ensure that staff maintained the privacy of resident information going forward. At the time of survey, the ALR failed to ensure that each resident's clinical information was kept confidential.	R 255	R255 1) The private information of Resident #16 was made private immediately to protect the privacy of the resident. 2) Licensed Nurses will be educated to include protecting the privacy of residents' information during medication administration. 3) The Terrace Nurse Coordinator and/or designee will observe 2 licensed nurses' medication administration to include ensuring the license nurse protects the residents' private information during medication administration once a week x4 and then once a month x6. Results will be reported to the Quality Assurance Committee for any further recommendations.	01/22/2020 02/28/2020 Ongoing
R 821	Sec. 904e8 Medication Storage (8) Residents who self-administer may keep and use prescription and nonprescription medications in their units as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure that resident's medications were kept secured in their units for three of six residents' units observed (Residents #1, 2 and 3). Findings included: On 01/22/2020 during the survey's entrance conference, the Director of Nursing stated that there were no residents who self-administered	R 821		

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R 821	Continued From page 2 their medications. 1. At 11:10 AM, observation of Resident #1's unit showed multiple bottles of medications, which were unsecured. At 1:56 PM, review of the nurse's initial assessment of the resident's ability to self administer medications showed that the resident was not capable. 2. At 11:38 AM, observation of Resident #2's unit showed a box of Albuterol Sulfate on a table beside a nebulizer machine. When asked about the medications, the Nurse Coordinator said that the residents family may have brought them to the resident's unit. She stated that the medication would be removed and administered by the nurses. At 2:41 PM, review of the nurse's 45-day medication assessment, dated 12/09/2019, showed that the resident was not capable of self administering medications. 3. At 12:15 PM, observation of Resident #3's unit showed multiple bottles of medications and a weekly pill box that contained pills, which were unsecured. The Director said that one of the nurses would remove the medications. Also, that the resident's family brought in the medication, but the ALR's nurses were responsible for administering them. On 01/23/2020 at 11:42 AM, review of the nurse's 45-day medication assessment, dated 12/06/2019, showed that the resident was not capable of self administering medications. At the time of survey, the ALR failed to ensure	R 821	R1058 1) For Residents #1, #2, and #3 medications were removed from the apartment immediately by staff. 2) Employees will be educated to include medications are to be kept secured in the residents' apartment. 3) The Terrace nurse coordinator and/or designee will check all apartments for medications once a week x4 and then once a month x6 to ensure medications are secured.	01/22/2020 02/28/2020 Ongoing

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R 821	Continued From page 3 that medication that were kept in residents' units only by those who self administered, and were kept secured.	R 821		
R1058	Sec. 1011h Special requirements for ALRs with 17 beds (h) An ALR shall ensure that all food is prepared and served in accordance with Chapters 20 through 24 of Title 23 of the District of Columbia Municipal Regulations and shall organize plumbing facilities to insure that food is processed and served so as to be safe for human consumption. Based on observation and interview, the ALR failed to follow Chapter 24, Subtitle A of Title 25 DCMR, Food and Food Operations Regulations, which was formerly Title 23. Findings included: On 01/23/2020, the inspection of the facility's kitchen was conducted by The Department of Health Food Safety and Hygiene Inspection Services Division. The inspector observed and documented the following violations: 504.1 - The disinfectant with EPA Registration#1836-83-1677 is not on EPA List G. EPA's registered antimicrobial products effective against Norovirus. 1525.1 - The service line dishwashing machine has a data plate for chemical sanitizing specifications, however the unit uses fresh hot water sanitizing. 1812.1 - The dishwashing machine's final rinse cycle pressure was measured a 3 PSI	R1058	R1058 1) Corrections were made for the deficiencies noted by the Department of Health Food Agency and Hygiene Inspector report as recommended. 2) Dining employees will be educated to include following the regulations as outlined in the Food and Food Operations regulations related to the deficient practices. 3) Dining Manager and/or Supervisor will do a walkthrough once a week x4 and then once a month x6 to monitor the facility's compliance of the Food and Food Operation Regulations.	02/14/2020 02/28/2020 Ongoing

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R1058	Continued From page 4 1901.5(d)(2) - The interior of the ice maker on the service line is not being cleaned frequently enough to prevent the accumulation of mold on the metal strip panel. 1903.1 - Lime is built up on the spray arm of the dishwashing machine. 2418.1(b) - The garbage disposal unit (food waste grinder) at the end dishwashing machine is out of order. It should be noted that the facility's Director signed the inspection report for the kitchen at the time of survey. At the time of the survey, the ALR failed to follow Subtitle A of Title 25 DCMR, Food and Food Operations Regulations.	R1058		