STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A	5420 CONNECTICUT 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 licensure survey was conducted on 11/07/2023, 11/08/2023, 11/09/2023 11/13/2023, 11/14/2023 and 11/15/2023, to determine compliance with the Assisted Living Law (DC Official Code§ 44-101.01 et seq). The Assisted Living Residence (ALR) provided care for 110 residents and employed 81 personnel, including professional and administrative staff. The survey sample consisted of 32 resident records (including two persons discharged) and 23 employee records (including three Private Duty Aids). The findings of the survey were based on observations made throughout the ALR, interviews with *staff* and residents, and reviews of clinical and administrative records, to include incident reports.	R000	**Section R000** **Director of Nursing/ Designee will complete ISP's within 30 days of admission then every 6 months thereafter. And more frequently with all significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment care plan. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner (if possible), the resident, the resident's surrogate, if necessary, and the ALR as per state regulation by 03/11/2024. 10% of all ISP's will be audited per month.**	
R 475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all Individualized Service Plans (ISP's) were consistently signed by the resident, or a surrogate, and a representative of the ALR, for six of the 23 residents sampled (Residents #6, 7, 9, 12, 13, and 16). Findings included: 1. On 11/15/2023 at 3:02 PM, a review of Resident #6's medical record showed that an ISP review was conducted on 02/05/2023. The document failed to show evidence that the ISP was reviewed and signed by the resident or a surrogate.	R475	**Section 604a5** **Resident # 6's ISP will be signed as per state regulation after the ISP is reviewed by the resident, or surrogate and a representative of the ALR immediately after a scheduled care plan meeting by 03/11/2024.**	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michael Gaskins TITLE Executive Director (X6) DATE 12/13/23

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R 475	Continued Fram page 1 2. On 11/15/2023 at 9:42 a.m., a review of Resident #7's medical record showed that ISPs were developed on 05/01/2023 and revised on 11/02/2023. The document failed ta show evidence that the ISP's were reviewed and signed by the resident and a representative of the ALR. 3. On 11/14/2023 at 1:37 PM, a review of Resident #9's medical record showed that an ISP review was conducted an 06/16/2023. The document failed to show evidence that the ISP was reviewed and signed by the resident or a surrogate. 4. On 11/15/2023 at 1:38 PM, a review of Resident #12's medical record showed that an ISP was developed an 07/23/2023. The document failed to show evidence that the ISP was reviewed and signed by the resident or a surrogate. 5. On 11/14/2023 at 2:30 p.m., a review of Resident #13's medical record showed that an ISP was developed on 11/09/2022 and revised on 05/07/2023 and 11/10/23. The revised ISPs were signed by a representative of the ALR, but failed to show evidence that the document was reviewed with and signed by the resident or a representative. 6. On 11/13/2023 at 1:10 PM, a review of Resident #16's medical record showed that an ISP review was conducted on 06/20/2023. The document failed ta show evidence that the ISP was reviewed and signed by the resident or a surrogate and a representative of the ALR. On 11/15/2023 at 3:00 PM, the above findings were discussed with the Director of Nursing, who acknowledged that the ISP's were not properly	R 475	**Resident # 7's ISP will be signed as per state regulation after the ISP is reviewed by the resident, or surrogate and a representative of the ALR immediately after a scheduled care plan meeting by 03/11/2024.** **Resident # 9's ISP will be signed as per state regulation after the ISP is reviewed by the resident, or surrogate and a representative of the ALR immediately after a scheduled care plan meeting by 03/11/2024.** **Resident # 12's ISP will be signed as per state regulation after the ISP is reviewed by the resident, or surrogate and a representative of the ALR immediately after a scheduled care plan meeting by 03/11/2024.** **Resident # 13's ISP will be signed as per state regulation after the ISP is reviewed by the resident, or surrogate and a representative of the ALR immediately after a scheduled care plan meeting by 03/11/2024.** **Resident # 16's ISP will be signed as per state regulation after the ISP is reviewed by the resident, or surrogate and a representative of the ALR immediately after a scheduled care plan meeting by 03/11/2024.**	

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R 475	Continued From page 2 signed as required by regulation. At the time of the survey, the ALR failed to ensure all ISPs were signed by the resident or surrogate and a representative of the ALR.	R 475		
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on interviews and record reviews the Assisted Living Residence (ALR) failed to ensure that Individualized Service Plans (ISP's) were reviewed and updated to reflect changes in the resident's condition such as falls, and emergency room visits for three of the 23 residents in the sample (Residents #4, 15 and 18). Findings included: The review of residents' records starting on 11/09/2023 at 1:00 p.m. showed that the residents ISPs were not updated to reflect changes in condition such as falls, and emergency room visits as follows: 1. On 11/13/2023 at 11:43 a.m. a review of Resident #4's record showed that on 10/17/2023, the resident was transported to the hospital from a medical appointment after expressing a desire	R483	**Section 604d** **Director of Nursing/ Designee will complete ISP's within 30 days of admission then every 6 months thereafter. And more frequently with all significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment care plan. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner (if possible), the resident, the resident's surrogate, if necessary, and the ALR as per state regulation by 03/11/2024. 10% of all ISP's will be audited per month.** **Resident #4's ISP was updated by the Director Of Nursing on 12/2/2023 from 10/17/2023 to show that the resident was transported to the hospital from a medical appointment.**	

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R 483	Continued From page 3 to jump off a bridge. The resident returned to the ALR on 10/20/2023 with a diagnosis of major depressive disorder. A further review of the record failed to show evidence of the resident's hospitalization, along with the strategies to address the resident's "major depressive disorder". 2. On 11/14/2023 at 2:15 PM, the review of Resident #15's record showed that the resident had 6 falls from 11/22/2023 through 06/23/2023. A further review of the record revealed that an initial physical therapy evaluation dated 05/03/2023, was completed due to change in the resident's walking and transferring. The evaluation further recommended that the resident receive services twice a week for 60 days. The continued review of the resident's ISP (6 month) review dated 10/25/2023, failed to reflect the Physical Therapy's (PT) treatment plan. 3. On 11/13/2023 at 2:23 PM, a review of Resident #18's record showed that the resident fell on 10/12/2023, 10/07/2023, and 10/05/2023. The further review of the resident's record showed that a preadmission ISP was developed prior to the resident's admission; however, there was no evidence that the ISP was updated to reflect the resident's falls and fall prevention strategies. In addition, the review of the PT progress showed that the therapist's treatment plan was for three visits per week for 90 days. The resident's ISP was not updated to reflect the resident's PT services. On 11/15/2023 at 3:20 PM, the above findings were discussed with the Director of Nursing, who acknowledged that the ISP's were not consistently updated with changes in the resident's conditions.	R483	Resident # 15's ISP was updated on 12/2/2023 by the Director Of Wellness / Designee and will be updated weekly. To reflect the reflect the resident's falls and fall prevention strategies. In addition, the review of the PT progress showed that the therapist's treatment plan reflecting every visit from Physical Therapy. Resident 18's ISP was updated on 12/2/2023 by the Director Of Wellness / Designee and will be updated weekly. To reflect the reflect the resident's falls and fall prevention strategies. In addition, the review of the PT progress showed that the therapist's treatment plan reflecting every visit from Physical Therapy. Director of Nursing/ Designee will complete ISP's within 30 days of admission then every 6 months thereafter. And more frequently with all significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team which **includes the president's healthcare practitioner, (if possible), the resident, the resident's surrogate, if necessary, and the ALR as per state regulation within 90 days.**	

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R 483	Continued From page 4 At the time of the survey the ALR failed to ensure all ISPs were updated to reflect changes in the residents' condition.	R483	Sec.802b The Executive Director/Designee conducted an Inservice training on 12/1/2023 with the Sales Coordinators and Move in Coordinator on Reviewing and completing Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all areas addressed, form in it's entirety before all move ins to CCH. The Executive Director, Director Of Nurse/Designee will review all forms for New move ins and Annually/ on going. The Executive Director, DON/Designee will review Resident 9's Intermediate Care Facilities Division Admission/Annual Medical Certification form will be review and updated by 1/11/2023 by their Primary care Physician. The Executive Director, DON/Designee will review Resident 's Intermediate Care Facilities Division Admission/Annual Medical Certification form will be review and updated by 1/11/2023 by their Primary care Physician	
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so, indicated during the medical assessment. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division Admission/Annual Medical Certification form was completed with all areas addressed, for seven of the 20 residents in the sample (Residents #1, 2, 4, 5, 11, 13, and 20). Findings included. The ALR failed to ensure medical certification forms were completed with all areas addressed as evidenced below: a.) On 11/14/2023 at 2:35 p.m., a review of Resident #9's medical certification form dated 02/27/2022 showed the physician failed to indicate if the resident had or needed a podiatrist. b.) On 11/15/2023 at 1:00 p.m., a review of Resident #S's medical certification form dated 5/26/2023 showed the physician failed to indicate	R 705		

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R 705	Continued From page 5 if the resident had or needed a podiatrist. The physician also failed to complete part 2 of the immunization form. c.) On 11/09/2023 at 2:31 p.m., a review of Resident #11's medical certification form dated 05/26/2023 showed the physician failed to indicate if the resident had or was in need or a colonoscopy, mammogram, or Papanicolaou test. The physician also failed to indicate if the resident needed to be screened for dementia related to the resident's behavior, (i.e., uncooperative, combative, wanders, requiring occasional supervision, constant redirection, etc.) d.) On 11/13/2023 at 11:43 a.m., a review of Resident #4's medical certification form dated 09/25/2023 showed the physician failed to document the resident's height and indicate the reason for the evaluation. The physician failed to indicate if the resident had or needed a colonoscopy, mammogram, or Papanicolaou (Pap) test. The physician also did not document if the resident used alcohol, tobacco, or non-prescribed drugs. e.) On 11/14/2023 at 4:14 a.m., a review of Resident #S's medical certification form dated 08/27/2023 showed the physician failed to indicate the residents present home address, temperature, pulse, respirations and height and weight. The physician failed to document if the resident had or needed a prostate-specific antigen (PSA) test. The physician also did not indicate if the resident used non prescribed drugs, required prostheses, had an amputation, if the resident was dependent on medical equipment, and had or required dentures. The physician also did not indicate if the resident needed to be screened for dementia or needed a	R 705	The Executive Director, DON/Designee will review Resident 11's Intermediate Care Facilities Division Admission/Annual Medical Certification form will be review and updated within by 1/11/2023 by their Primary care Physician The Executive Director, DON/Designee will review Resident 4's Intermediate Care Facilities Division Admission/Annual Medical Certification form will be review and updated by 1/11/2023 by their Primary care Physician Resident 's Intermediate Care Facilities Division Admission/Annual Medical Certification form will be review and updated by 1/11/2023 by their Primary care Physician.	

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R 705	Continued From page 6 mental health evaluation. f.) On 11/14/2023 at 10:20 a.m., a review of Resident #20's medical record failed to show evidence that a physician completed the Intermediate Care Facilities Division Admission/Annual Medical Certification form to determine the resident's current physical condition and medical status relevant to defining care needs, and the resident's psychological and cognitive status. g.) On 11/14/2023 at 2:30 p.m., a review of Resident #13's medical certification form dated 11/01/2022 showed the physician failed to indicate if the resident had or needed a colonoscopy, mammogram, or Papanicolaou test or PSA. On 11/15/2023 at 3:45 pm, the above findings were discussed with the DON, who acknowledged the Medical Certification form were not properly completed with all areas addressed as required. At the time of the survey, the ALR failed to ensure all parts of the Medical Certification forms were completed as required by the regulation.	R 705	Resident was Discharged from the Community. The Executive Director, DON/Designee will review Resident 13's Intermediate Care Facilities Division Admission/Annual Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician.	

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R 000	Initial Comments 0000 Initial Comments An annual licensure survey was conducted on 11/07/2023, 11/08/2023, 11/09/202311/13/2023, 11/14/2023 and 11/15/2023, to determine compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 110 residents and employed 81 personnel, including professional and administrative staff. The survey sample consisted of 32 resident records (including two persons discharged) and 23 employee records (including three Private Duty Aids). The findings of the survey were based on observations made throughout the ALR, interviews with staff and residents, and reviews of clinical and administrative records, to include incident reports.	ROOD	Filled out properly and signed by **10116.15f Staffing Standards**	
R 281	10116.15f Staffing Standards 10116.15f A healthcare practitioner's written statement as to whether the employee bears any communicable diseases, including communicable tuberculosis. Based on observations, interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure all staff had a written statement from a healthcare practitioner confirming that they were free from communicable diseases, including tuberculosis, for two of the 23 employees in the facility (Employees #11 and 14). Findings included: a). The review of personnel record of Employee #10 (Director of Sales) showed a written statement dated 04/15/2023 as to the employee's	R 281	**The Executive Director of the ALR completed an Inservice with the BOM on 12/5/2023 to ensure all staff have a written statement from a healthcare practitioner confirming that they were free from communicable diseases, including tuberculosis.** **A review of 10% of all staff files will be conducted to ensure compliance. This will continue to 03/11/2024** **Employee # 10 communicable diseases status form has been reviewed and updated and signed by a healthcare practitioner certifying that the employee was free from any communicable disease. This was completed on 12/4/2023**	

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

Executive Director 12/13/23

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R 281	Continued From page 1 communicable diseases status: however, there was no healthcare practitioner's signature certifying that the employee was free from any communicable disease. b). The review of personnel record of Employee #14 showed a written statement as to the employee's communicable diseases status; however, there was no healthcare practitioner's signature certifying that the employee was free from any communicable disease. At the time of survey, the facility's personnel records failed to show evidence of a signed statement from a healthcare practitioner that each employee was free from communicable diseases.	R 281	**Employee # 14 communicable diseases status form has been reviewed and updated and signed by a healthcare practitioner certifying that the employee was free from any communicable disease. This was completed on 12/4/2023** 10125.4a CCH nursing staff were in serviced on 12/1/2023 notifying the Executive Director, Director of Nursing, RN Supervisor, or designee immediately after an unusual incident that substantially affects a resident So that the state can be notified promptly. Inservice 12/1/2023.Ensuring all future incidents that have the potential to affect the health and safety of each resident, including falls and emergency room visits were reported to the Administrator (DOH) and the Assisted Living Resident (ALR) Administrator and DON. This training is ongoing. All unusual incidents have been emailed to the state after the fact to insure state notification By the Executive Directive. This has already been implemented to ensure compliance with state regulations on 12/12/2023.	
R 383	10125.4a Reporting Complaints To The Director 10125.4a. An ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day; and Based on interviews and record reviews, the facility failed to ensure all incidents that had the potential to affect the health and safety of each resident, including falls and emergency room visits were reported to the Department of Health's - Administrator (DOH) and the Assisted Living Resident (ALR) Administrator for 10 of the 20 Residents in the core sample (Residents #2, 4, 7, 13, 14, 15, 16, 17, 18, and 19), and 25 of 110 residents in the facility (Residents #21, 22, 23, 24, 25,26,27,28,29,30, 31,32, 33,34,35,36,37,38, 39, 40, 42,43,44,46, 47)	R 383		

Health Reaulation & Licensinc Administration

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R 383	Continued From page 2 Findings included: On 11/07/2023 beginning at 11:00 am, the review of the ALR's incident reports showed that the following incidents were not reported to the Director or the ALR's Administrator as evidence below: 1. Resident #2 fell a total of 25 times. One fall resulted in the resident being transported to the emergency room (ER) via ambulance. 2. Resident #4 had an incident of a fall on 09/29/2023. 3. Resident #7 fell a total of seven times. Two of the falls resulted in the resident being transported to the emergency room. 4. Resident #12 had two incidents; one bruise and a skin tear. 5. Resident #13 had 12 falls from 2/26/23 - 11/01/2023. Two of the falls resulted in the resident being transported to the emergency room via ambulance. 6. Resident #14 had ten incidents of falls and one incident of bluish discoloration to the lower back from 09/15/2022 to 10/29/2023. 7. Resident #15 had incidents/falls from 12/30/2022 to 06/23/2023. 8. Resident #16 had seven incidents of falls from 06/24/2023 to 10/03/2023. One of the falls resulted in an emergency room visit via ambulance.	R 383	**Residents #2, #7, #13, #16, #18, #32, #33, #35, and #36 are being reported by the ALR after the fact on 12/12/2023 to ensure all unusual incidents were reported to the state. ALR has already implemented the prompt reporting of unusual incidents to the state.** Executive Directive, DON/Designee will **audit 10% of all unusual incidents to ensure compliance monthly. The in-service was started on 12/1/2023 and will be ongoing.** **In-service training has already started and will be ongoing on prompt reporting to ED, DON/ Designee of all incident reports.**	

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R 383	Continued From page 3 9. Resident #17 had three incidents of falls from 10/05/2023 to 10/12/2023. 10. Resident #18 had 15 incidents of falls resulting in two emergency room visits 11. Resident #19 had 14 incidents of falls from 09/25/2022 to 10/31/2023. 12. Resident #21 had two incidents of falls from 05/30/2023 to 06/30/2023. 13. Resident #22 had five incidents of falls from 08/27/2023 to 12/23/2022. 14. Resident #23 had six incidents of falls from 09/17/2022 to 07/30/2023. 15. Resident #24 had four incidents of falls from 12/31/2022 to 09/29/2023. 16. Resident #25 had four incidents of falls from 07/01/2023 to 09/29/2023. 17. Resident #26 had three incidents of falls from 11/19/2022 to 10/20/2023. 18. Resident #27 had six incidents of falls from 01/31/2023 to 10/19/2023. 19. Resident #28 had three incidents of falls from 04/07/2023 to 10//09/2023. 20. Resident #29 had two incidents of falls from 02/14/2023 to 03/19/2023. 21. Resident #30 six incidents of falls from 09/14/2023 to 10/12/2023. 22. Resident #31 had two incidents of falls from	R 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	A. BUILDING _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A	5420 CONNECTICUT 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 383	Continued From page 4 12/13/2022 to 01/20/2023 23. Resident #32 had three incidents of falls from 10/23/2022 to 05/30/2023. One of the falls led to the resident being transferred via ambulance to the ER. 24. Resident #33 had two incidents of falls from 09/22/2022 to 06/30/2023 with one leading to an emergency room visit. 25. Resident #34 had 24 incidents of falls and two incidents of alleged sexual abuse incidents. 26. Resident #35 had one unwitnessed fall incident, and another incident of a fall that did not occur on the ALR property, and the resident was transported to the ER via ambulance. 27. Resident #36 had one incident regarding increased agitation (i.e., requesting the aide to kill him.) The resident was transported to the hospital for a mental evaluation. 28. Resident #37 had one incident of a fall where he was sitting on a stool and attempted to stand using his walker but was unable to stand and he then slid to the floor. 29. Resident #38 had one incident of a fall where she bumped into the trash can, lost her balance and fell to the floor. 30. Resident #39 had three incidents of falls from 09/07/2022 to 05/02/2023. 31. Resident #40 had one incident of a skin tear, where resident's pendent got stuck on the hand rest of the wheelchair. The fall occurred on 02/05/2023.	R 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	A. BUILDING _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A	5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015

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R 383	Continued From page 5 32. Resident #42 had one incident of a fall on 11/04/2023. 33. Resident #43 had three incidents of falls from 12/06/2022 to 10/12/2023. 34. Resident #44 had two incidents of falls from 05/28/2023 to 09/12/2023. 35. Resident #45 had an incident of a skin tear to the elbow on 03/08/2023. 36. Resident #46 had an incident of a fall that resulted in a small puncture to the left calf on 11/06/2022. On 11/14/2023 at 12:30 PM, the review of the ALR's policy entitled Incident Report showed that the ALA and Director of Nursing (DON) are responsible to ensure that an incident report is completed within 24 hours. A further review of the policy indicated that the ALR's Administrator is responsible for ensuring that an incident is completed and sent to the State Agency on the appropriate form and within the required time. During an interview on 11/08/2023 at 2:20 PM, the DON and the ALR's Administrator both acknowledged that the incidents were not reported to them or to DOH. Both confirmed and stated that additional training is required for the staff. At the time of the survey, the ALR's Administrator failed to promptly notify the ALR's Administrator, and the DOH by telephone of all incidents that substantially affected a resident, followed by written notification within 24 hours.	R383		