PRINTED: 11/28/2023 Health Reaulation & Licensin< Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED ALR-0039 B. WING 11/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5420 CONNECTICUT AVENUE NW BV/MSTAR CHEVY CHASE TENANT D/B/A WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) R 000 Initial Comments Section R000 ROOO An annual licensure survey was conducted on 11/07/2023, 11/08/2023, 11/09/2023 11/13/2023, Director of Nursing/ Designee will complete 11/14/2023 and 11/15/2023, to determine ISP's within 30 days of admission then every compliance with the Assisted Living Law (DC 6 months thereafter. And more frequently Official Code§ 44-101.01 et seq). The Assisted with all significant change in the resident's Living Residence (ALR) provided care for 110 condition. The resident and, if residents and employed 81 personnel, including necessary, the surrogate shall be invited professional and administrative staff. The survey to participate in each reassessment care sample consisted of 32 resident records (including plan. The review shall be conducted by two persons discharged) and 23 employee records an interdisciplinary team that includes (including three Private Duty Aids). the resident's healthcare practitioner (if possible), the resident, the resident's The findings of the survey were based on surrogate, if necessary, and the ALR as observations made throughout the ALR, interviews per state regulation by 03/11/2024. 10% with staff and residents, and reviews of clinical and of all ISP's will be audited per month. administrative records, to include incident reports. Sec. 604a5 Individualized Service Plans R 475 R475 (5) The ISP shall be signed by the resident, or Section 604a5 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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

residents sampled (Residents #6, 7, 9, 12, 13, and

Findings included: 1. On 11/15/2023 at 3:02 PM, a

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.

review of Resident #6's medical record showed that

Executive Director History Metado lector

Resident # 6's ISP will be signed as per

representative of the ALR immediately after a scheduled care plan meeting by

by the resident, or surrogate and a

state regulation after the ISP is reviewed

03/11/2024.

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: if it is i	2. On 11/15/2023 at #7's medical record sideveloped on 05/01// 11/02/2023. The docthat the ISP's were resident and a repression of the ISP's were resident and a repression of the ISP's medical record signed by the resident of the ISP's medical record sideveloped an 07/23/2 show evidence that the signed by the resident of the ISP's medical record sideveloped an 07/23/2 show evidence that the signed by the resident of the ISP's medical record sideveloped on 11/09/20/20/20/20/20/20/20/20/20/20/20/20/20/	9:42 a.m., a review of Resident showed that ISPs were 2023 and revised on ument failed ta show evidence eviewed and signed by the sentative of the ALR. 1:37 PM, a review of Resident howed that an ISP review was 2023. The document failed to be ISP was reviewed and at or a surrogate. 1:38 PM, a review of Resident showed that an ISP was 2023. The document failed to be ISP was reviewed and at or a surrogate. 30 p.m., a review of Resident showed that an ISP was 2023 and revised on 23. The revised ISPs were aftive of the ALR, but failed to be document was reviewed resident or a representative. 10 PM, a review of Resident thowed that an ISP review 0/2023. The document failed he ISP was reviewed and a surrogate and a LR.	F s b	Resident # 7's ISP will be state regulation after the by the resident, or surrog representative of the ALI after a scheduled care plan 03/11/2024. Resident # 9's ISP will be state regulation after the I by the resident, or surrogarepresentative of the ALI after a scheduled care plan 03/11/2024. Resident # 12's ISP will be state regulation after the IS by the resident, or surrogarepresentative of the ALR after a scheduled care plan 03/11/2024. Resident # 13's ISP will be state regulation after the IS by the resident, or surrogate representative of the ALR after a scheduled care plan 03/11/2024. Resident # 16's ISP will be state regulation after the IS by the resident, or surrogate representative of the ALR after a scheduled care plan 03/11/2024. Resident # 16's ISP will be state regulation after the IS by the resident, or surrogate representative of the ALR after a scheduled care plan 03/11/2024.	signed as per ISP is reviewed ate and a R immediately in meeting by signed as per ISP is reviewed ate and a R immediately in meeting by signed as per ISP is reviewed ate and a recting by signed as per ISP is reviewed ate and a rimmediately a meeting by signed as per ISP is reviewed ate and a rimmediately and a rimmediately signed as per ISP is reviewed and a rimmediately and a rimmediately	

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	signed as required l	by regulation.			= 1)	
	At the time of the su all ISPs were signed and a representative	rvey, the ALR failed to ensure d by the resident or surrogate of the ALR.				
	(d) The ISP shall be admission and at lea The ISP shall be upon a significant change. The resident and, if it be invited to participate review shall be conditioner, the resident that includes the practitioner, the residencessary, and the AB Based on interviews. Assisted Living Resident Individualized Serviewed and updated resident's condition si	e reviewed 30 days after set every 6 months thereafter. Itated more frequently if there is in the resident's condition. In the resident's condition. In the in each reassessment. The sucted by an interdisciplinary e resident's healthcare ent, the resident's surrogate, if st.R. and record reviews the lence (ALR) failed to ensure envice Plans (ISP's) were do to reflect changes in the such as falls, and emergency of the 23 residents in the	R483	Section 604d Director of Nursing/ Designee will of ISP's within 30 days of admission the months thereafter. And more freq with all significant change in the rescondition. The resident and, if ne the surrogate shall be invited to participate in each reassessmen plan. The review shall be conducted an interdisciplinary team that incompare the resident's healthcare practition possible), the resident, the resident surrogate, if necessary, and the per state regulation by 03/11/2020 of all ISP's will be audited per months.	t care cted by cludes oner (if ent's	
1 1 18 c	The review of resident 1/09/2023 at 1:00 p.r SPs were not update ondition such as falls s follows:	ts' records starting on m. showed that the residents d to reflect changes in , and emergency room visits		Resident #4's ISP was updated by Director Of Nursing on 12/2/2023 10/17/2023 to show that the reside transported to the hospital from a medical appointment.	from nt was	
R th	esident #4's record s re resident was trans	howed that on 10/17/2023, ported to the hospital from a after expressing a desire				

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AND PLA	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY
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f f f f f r r e e n a a ttt p u C di ai	to jump off a bridge ALR on 10/20/2023 depressive disorder failed to show evide hospitalization, along the resident's "major 2. On 11/14/2023 at Resident #15's reco 6 falls from 11/22/20 further review of the physical therapy evacompleted due to chand transferring. The recommended that the twice a week for 60 of the resident's ISP (6 10/25/2023, failed to (PT) treatment plan. 3. On 11/13/2023 at 3:418's record showed 10/12/2023, 10/07/20 further review of the readmission ISP was esident's admission; evidence that the ISP esident's falls and fail addition, the review of the therapist's treatmer week for 90 days, pdated to reflect the on 11/15/2023 at 3:20	e. The resident returned to the with a diagnosis of major r. A further review of the record ence of the resident's ag with the strategies to address or depressive disorder". 12:15 PM, the review of red showed that the resident had 223 through 06/23/2023. A record revealed that an initial aduation dated 05/03/2023, was sange in the resident's walking a evaluation further the resident receive services days. The continued review of month) review dated reflect the Physical Therapy's 2:23 PM, a review of Resident that the resident fell on 223, and 10/05/2023. The resident's record showed that a sideveloped prior to the however, there was no was updated to reflect the II prevention strategies. In the PT progress showed that ent plan was for three visits. The resident's ISP was not resident's PT services. 2 PM, the above findings were rector of Nursing, who	Director frequency interpressions possions.	esident # 15's ISP was updated by 2/2/2023 by the Director Of Vesignee and will be updated will expendition strategies. In additional wiew of the PT progress show erapist's treatment plan reflect from Physical Therapy. Sident 18's ISP was updated will be updated will b	Vellness / weekly. To falls and fall on, the wed that the ting every on /ellness / weekly. To falls and fall n, the ed that the ing every will f admission And more ange in the ont and, if invited to The udes the r, (if t's	

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PRINTED: 11/28/2023 Health Reaulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING: COMPLETED. ALR-0039 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 (X4VD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R 483 Continued From page 4 Sec.802b R483 At the time of the survey the ALR failed to ensure all ISPs were updated to reflect changes in the residents' condition. The Executive Director/Designee conducted an Inservice training on R 705 Sec. 802b Medical, Rehabilitation, Psychosocial 12/1/2023 with the Sales Coordinators and R 705 Move in Coordinator on Reviewing and Assess. completing Intermediate Care Facilities (b) The ALR shall maintain resident information Division Admission/Annual Medical obtained from a standardized physician's statement Certification form was completed with all approved by the Mayor. The information shall areas addressed, form in it's entirety before include a description of the applicant's current all move ins to CCH. The Executive physical condition and medical status relevant to Director, Director Of Nurse/Designee will defining care needs, and the applicant's psychological and cognitive status, if so, indicated review all forms for New move ins and during the medical assessment. Annually/ on going. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Intermediate Care Facilities Division The Executive Director, DON/Designee Admission/Annual Medical Certification form was will review Resident 9's Intermediate Care completed with all areas addressed, for seven of the Facilities Division Admission/Annual 20 residents in the sample (Residents #1, 2, 4, 5, Medical Certification form will be review 11, 13, and 20). and updated by 1/11/2023 by their Primary Findings included. care Physician. The ALR failed to ensure medical certification forms were completed with all areas addressed as The Executive Director, DON/Designee evidenced below: will review Resident's Intermediate Care Facilities Division Admission/Annual a.) On 11/14/2023 at 2:35 p.m., a review of Resident #9's medical certification form dated Medical Certification form will be review 02/27/2022 showed the physician failed to indicate if and updated by 1/11/2023 by their Primary the resident had or needed a podiatrist. care Physician

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

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	if the resident had o physician also failed immunization form. c.) On 11/09/2023 a Resident #11's medio 05/26/2023 showed the resident had or water mammogram, or Papalso failed to indicate screened for demention behavior, (i.e., uncoorequiring occasional stredirection, etc.) d.) On 11/13/2023 at Resident #4's medica 09/25/2023 showed the document the resident reason for the evaluation indicate if the resident colonoscopy, mammotest. The physician also resident #8's medical 08/27/2023 showed the resident present house, respirations and physician failed to documeded a prostate-specific physician also did not in non prescribed drugs, respiration, if the resident medical equipment, and the physician also did not in non prescribed drugs, respiration, if the resident medical equipment, and the physician also did not in the physician also	r needed a podiatrist. The to complete part 2 of the to call certification form dated to be to call certification to the resident's perative, combative, wanders, supervision, constant 11:43 a.m., a review of I certification form dated to the physician failed to the physician failed to the complete to the tobacco, or non-prescribed to the tobacco, or non-prescribed to the physician failed to indicate to the tobacco, or non-prescribed to the physician failed to indicate to the tobacco, or non-prescribed to the physician failed to indicate the physici	Res Div Cer upo	The Executive Director, DON/Devill review Resident 11's Intermedacilities Division Admission/Andedical Certification form will be and updated within by 1/11/2023 Irimary care Physician The Executive Director, DON/Destill review Resident 4's Intermediacilities Division Admission/Annedical Certification form will be d updated by 1/11/2023 by their re Physician Sident 's Intermediate Care Facility is a control of the review and a control of the re	diate Care nual e review by their signee ate Care nual review Primary	
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and the resident's psychological and cognitive status. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician. Medical Certification form will be review and updated by 01/11/2023 by their Primary care Physician.		and medical status	relevant to defining care needs		Facilities Division Admission/Appr	ale Care	
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		and the resident's	psychological and cognitive				
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		status.			and updated by 01/11/2023 by their	Primary	
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		g.) On 11/14/2023	at 2:30 p.m., a review of		care Physician.	- 1	
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		Resident #13's med	dical certification form dated				
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		11/01/2022 showed	the physician failed to indicate if		E M		
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		mammogram, or Pa	apanicolaou test or PSA			- 4	
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			STATE AND STATE AND ADDRESS OF THE ADDRESS OF THE STATE AND ADDRESS OF THE ADDRESS OF THE ADDRESS OF THE ADDRESS OF THE A				
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		On 11/15/2023 at 3	:45 pm, the above findings were				
At the time of the survey, the ALR failed to ensure all parts of the Medical Certification forms were		Medical Certification	n form were not properly		11 7		
all parts of the Medical Certification forms were	(completed with all a	reas addressed as required.			e 1	
all parts of the Medical Certification forms were		At the time of the au					
completed as required by the regulation.	1	all parts of the Medi	cal Certification forms were				
	0	completed as requir	ed by the regulation.				
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Health Reaulation & Licensinc Administration
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		PLE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED	
		ALR-0039	B.WING		11/15/2023	
	ROVIDER OR SUPPLIER	NANT D/B/A 5420 CO		STATE, ZIP CODE AVENUE NW 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLE E DATE	
	11/07/2023, 11/08// 11/14/2023 and 11// compliance with the Regulations, Title 2 Medicine) Chapter Residence (ALR) prand employed 81 per and administrative structure of 32 residence (including three Prival The findings of the subservations made with staff and reside	e survey was conducted on 2023, 11/09/202311/13/2023, 15/2023, to determine e Assisted Living Residence 2-B DCMR (Public Health and 101. The Assisted Living rovided care for 110 residents ersonnel, including professional staff. The survey sample dent records (including two) and 23 employee records	ROOD	Filled out properly and signed by 10116.15f Staffing Standards		
1	statement as to whe communicable disea tuberculosis. Based on observation reviews, the Assisted to ensure all staff hat healthcare practition free from communicatuberculosis, for two facility (Employees # Findings included:	are practitioner's written ther the employee bears any uses, including communicable ons, interviews and record dictiving Residence (ALR) failed did a written statement from a er confirming that they were able diseases, including of the 23 employees in the 11 and 14).	R 281	The Executive Director of the ALR completed an Inservice with the BOI 12/5/2023 to ensure all staff have a written statement from a healthcar practitioner confirming that they w free from communicable diseases, including tuberculosis. A review of 10% of all staff files will be conducted to ensure compliance. This w continue to 03/11/2024 Employee # 10 communicable diseas status form has been reviewed and updated and signed by a healthcare practitioner certifying that the emplowas free from any communicable disease. This was completed on 12/4/2023	e ere ill ses	

Executive Director

Health Reaulation & LicensInc Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA

AND PLAN OF CORRECTION	ALR-0039	A. BUILDIN	G:	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER	STREET ADD TENANT D/8/A 5420 CON	DRESS, CITY, S	STATE, ZIP CODE AVENUE NW	11/15/2023
PREFIX (EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMP
no healthcare prathe employee was disease. b). The review of pshowed a written scommunicable disno healthcare practice employee was disease. At the time of survifailed to show evida healthcare practifree from communication to show evida healthcare practifree from communication to the shours or the next because of the health an including falls and ereported to the Dep Health's - Administration to the color of the col	seases status: however, there was citioner's signature certifying that a free from any communicable bersonnel record of Employee #14 statement as to the employee's eases status; however, there was citioner's signature certifying that a free from any communicable bey, the facility's personnel records dence of a signed statement from intioner that each employee was icable diseases. In a complaints To The Director of any at substantially affects a cons of unusual incidents shall be go the Department of Health by the shall be followed up by written that each employee was and record reviews, the facility incidents that had the potential to disafety of each resident, emergency room visits were eartment of rator (DOH) and the Assisted and 19), and 25 of 110 lity (Residents #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0, 24, 0, 31,32, 33,34,35,36,37,38, or sand record reviews #21, 22, 23, 24, 0,		Employee # 14 communicable of status form has been reviewed updated and signed by a health 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 12/1/2023 notifying the Executive I Director of Nursing, RN Supervisor designee immediately after an unus incident that substantially affects a So that the state can be notified profile incidents that have the potential to a the health and safety of each resider including falls and emergency room were reported to the Administrator (and the Assisted Living Resident (A Administrator and DON. This trainitiongoing. All unusual incidents have been emathe state after the fact to insure state notification By the Executive Direct This has already been implemented ensure compliance with state regulat 12/12/2023.	on Director, c, or ual resident mptly. ture iffect nt, visits DOH) LR) ng is niled to ive, to

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	227 627	PLE CONSTRUCTION 3	(X3) DATE SURV COMPLET	
	Selection where the	ALR-0039	B. WING_		11/15/20	023
V/MST/	PROVIDER OR SUPPLIER	NANT D/B/A 5420 CON WASHING		AVENUE NW 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) CMPLE DATE
1	the ALR's incident rincidents were not rincident #2 fell a resulted in the resident emergency room (Eight 2. Resident #4 had a 09/29/2023. 3. Resident #7 fell a falls resulted in the rincidency room. 4. Resident #12 had skin tear. 5. Resident #12 had skin tear. 5. Resident #13 had 2/26/23 - 11/01/2023 resident being transported ambulance. 6. Resident #14 had incident of bluish disconding to 15/2022 to 17. Resident #15 had so 06/23/2023. 3. Resident #16 had so 06/24/2023 to 10/03/2023.	inning at 11:00 am, the review of eports showed that the following eported to the Director or the as evidence below: I total of 25 times. One fall ent being transported to the R) via ambulance. I total of seven times. Two of the esident being transported to the two incidents; one bruise and a 12 falls from Two of the falls resulted in the ported to the emergency room I total of the falls and one coloration to the lower back	R 383	Residents #2, #7, #13, #16, and #36 are being reported the fact on 12/12/2023 to elincidents were reported to already implemented the pof unusual incidents to the Executive Directive, DON audit 10% of all unusual incompliance monthly. The started on 12/1/2023 and will be ongoing on prompt DON/ Designee of all incidents of the polymer will be ongoing on prompt DON/ Designee of all incidents.	d by the ALR after insure all unusual the state. ALR has brompt reporting state. N/Designee will incidents to ensure in-service was ill be ongoing.	

Health Reaulation & Licensinc Administration

STATEMEN	NT OF DEFICIENCIES	Administration (X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
NO PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			OMPLETED
		ALR-0039	B. WING	_	11	/15/2023
	ROVIDER OR SUPPLIER	ENANT D/B/A 5420 CC	DDRESS, CITY, STATE NNECTICUT AV	ENUE NW		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4)ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORP (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETI CATE
R 383	Continued From pa	age 3	R 383			
	9. Resident #17 ha 10/05/2023 to 10/1	d three incidents of falls from 2/2023.				
	10. Resident #18 h in two emergency r	ad 15 incidents of falls resulting oom visits				
	11. Resident #19 h 09/25/2022 to 10/3	ad 14 incidents of falls from 1/2023.				
	12. Resident #21 ha 05/30/2023 to 06/30	ad two incidents of falls from 0/2023.				
	13. Resident #22 ha 08/27/2023 to 12/23	ad five incidents of falls from 3/2022.				
	14. Resident #23 ha 09/17/2022 to 07/30	nd six incidents of falls from 0/2023.				
	15. Resident #24 ha 12/31/2022 to 09/29	d four incidents of falls from /2023.				
	16. Resident #25 ha 07/01/2023 to 09/29	d four incidents of falls from /2023.				
	17. Resident #26 ha 11/19/2022 to 10/20	d three incidents of falls from /2023.				
	18. Resident #27 ha 01/31/2023 to 10/19	d six incidents of falls from 2023.				
	19. Resident #28 had 04/07/2023 to 10//09	d three incidents of falls from /2023.				
2.0	20. Resident #29 had 02/14/2023 to 03/19/	d two incidents of falls from 2023.				
	21. Resident #30 six 09/14/2023 to 10/12/	incidents of falls from 2023.				
2	22. Resident #31 had	I two incidents of falls from				

I WILLIAME	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CU		(VALIA C TOTAL T	COLICEDITORIC		
	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION —		E SURVEY MPLETED
		ALR-0039	B. WING		11	15/2023
	PROVIDER OR SUPPLIER	NANT D/B/A 5420 CC	DDRESS, CITY, STAT	ENUE NW		
(4) ID REFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES STBE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	COMPI COMPI DAT
R 383	Continued From pa	ige 4	R 383			
	12/13/2022 to 01/20	0/2023				
	10/23/2022 to 05/30	ad three incidents of falls from 0/2023. One of the falls led to the sferred via ambulance to the ER	9			
		ad two incidents of falls from 0/2023 with one leading to an sit.				
		d 24 incidents of falls and two sexual abuse incidents.				
	and another inciden	d one unwitnessed fall incident, t of a fall that did not occur on nd the resident was transported ance.			Č mod	
	increased agitation (d one incident regarding i.e., requesting the aide to kill as transported to the hospital on.			4 V. 1	
	was sitting on a stoo	d one incident of a fall where he I and attempted to stand using nable to stand and he then slid			2	
		d one incident of a fall where trash can, lost her balance and				
3	30. Resident #39 had 09/07/2022 to 05/02/	I three incidents of falls from 2023.				
V	31. Resident #40 had where resident's pend of the wheelchair. Th	one incident of a skin tear, dent got stuck on the hand rest				

ND PLAN	FOR DEFICIENCIES (X1) PROVIDER/SUPPL/ER/CL/A IDENTIFICATION NUMBER:		A BUILDING:			E SURVEY OMPLETED
		ALR-0039	B WING		11	/15/2023
	PROVIDER OR SUPPLIER AR CHEVY CHASE TE	NANT D/B/A 5420 CO	DDRESS, CITY, STATI NNECTICUT AVI	ENUE NW		
(X4)ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMP COMP DAT
R 383	Continued From pa	ge 5	R383			
	32. Resident #42 ha 11/04/2023.	d one incident of a fall on				
	33. Resident #43 ha 12/06/2022 to 10/12	d three incidents of falls from /2023.				
	34. Resident #44 ha 05/28/2023 to 09/12/	d two incidents of falls from (2023.	-			
	35. Resident #45 ha the elbow on 03/08/2	d an incident of a skin tear to 2023.				
	36. Resident #46 had resulted in a small pt 11/06/2022.	d an incident of a fall that uncture to the left calf on				
i	policy entitled Incider and Director of Nursing ensure that an incide hours. A further revien the ALR's Administral that an incident is cor	30 PM, the review of the ALR's at Report showed that the ALA ag (DON) are responsible to an treport is completed within 24 w of the policy indicated that for is responsible for ensuring appleted and sent to the State priate form and within the				
C a to	DON and the ALR's A acknowledged that the	e incidents were not reported oth confirmed and stated that				
fa a s	ailed to promptly notil and the DOH by telepi	ey, the ALR's Administrator fy the ALR's Administrator, none of all incidents that a resident, followed by written ours.				

Health Regulation & Licensing Administration