STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING	TALL TALL	07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
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R 000 Initial Comments		R 000		
House, Assisted Livi 06/26/18 through 07/compliance with the ALR provided care for 79 personnel to inclus administrative staff. administrator reporter construction worker who bedroom naked from the nature of this incireview of the ALR's ir along with a review of completed to determine adequate supervision by the ALR law. On 00 identified systemic fair immediate risk to the residents. The facility on 07/03/18, was issufficense for no new admitted.	Assisted Living Law. The or 73 residents and employs ade professional and On 04/13/18, the ALR's ad an incident that alleged a was observed in a resident's the waist down. Based on dent, a comprehensive incident management system of the ALR's investigation was ine if the ALR provided and oversight as required 7/03/18, the survey team illures that posed an health and safety of all was notified and, effective and a 90 day restricted			
Listed below are abbro the body of this report	eviations used throughout			
ADL - Activities of Dail ALA- Assisted Living A ALR - Assisted Living DME - Durable Medica QA - Quality Assurance CPAP - Continuous Po TED - Throbo-Embolic APS - Adult Protective RDO - Regional Direct	Administrator Residence al Equipment e esitive Airway Pressure c-Deterrent Services or of Operations			
h Regulation & Licensing Administrat RATORY DIRECTOR'S OR PROVIDER/	lion SUPPLIER REPRESENTATIVE'S SIGNA	TURE	Executive Director	(X8) DATE

Health Regulation & Licens	sing Administration		٢	ORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
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R 000 Continued From p	age 1	R 000		
H&P- History and ISP- Individualized RN - Registered N DON - Director of PDA -Private Duty CNA - Certified Nu PRN - as needed TAR- Treatment Ac Lt - left mg - milligram ER - Emergency R R 008 Sec. 102b2 Philosof	Service Plan Jurse Nursing Aide rsing Assistant dministration Record	D 009		
K 000 Gec. 10202 Pillios	pny of Care	R 008	R 008 Sec. 102b2 Philosophy of Care	
should acknowledg residents may have impairment. Service offer a balance between the service setty and the service services and the service services and the services are services.			I. The facility failed to implement its policies that required the use of stairwell/exit door monitoring.	
review, the ALR faile secured environment the facility. Specification implement its policies respond timely to st	on, interview and policy ed to provide a safe and nt for all residents residing in ally, the facility failed (I) to es on door monitoring, (II) to airwell/exit door alarms, and policies on reporting tions of abuse.		a. The ALA immediately retrained staff the Door Monitoring and Response Poli Stairwell door alarms were reset to alar when opened by sending alerts through the entire day to the Concierge at the fredesk and the CNA pagers.  b. The Door Monitoring and Response	cy. n out
Findings included:  (I) The facility failed required the use of sas follows:	to implement its policies that stairwell/exit door monitoring,		Policy has been revised to reflect the 10 minute response time to exterior doors a doors leading to the basement as with other alerts within the ALR. Staff was trained on the revised policy on 9/12/18.	nd
Monitoring and Resp 06/06/16, showed th	e facility's policy titled, "Door conse Policy," dated at each stairwell/exit door monitoring device located at		The staff will be trained on the Door Monitoring and Response Policy annual during new hire orientation, and as required.	

Re	egulation & Licensin	ng Admin		Į.	PRINTED: 08	3/03/201
Health STATEMEN	T OF DEFICIENCIES OF CORRECTION	istration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SU COMPLET	RVEY
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R 008 (	Continued From page	ge 2	R 008	c. The Business Office Manager	will	
t	he top of the door I	Per the policy, "When the		keep an annual education log, lis	ting	
C	loor was opened or	alar, the monitor released a		the annual monthly trainings. Th	e	
S	silent alarm which w	as sent to each Certified		education log will be monitored		
,	Nurse Assistant's (C	NA) pager and the Front		monthly by the QA Committee for	or	
L	esk Console. The	alarm indicated the location		completion/compliance. The QA		
8	taff to the identified	s opened, prompting the access point to verify that no		Committee will be monitoring th		
re	esident had entered	the stairwell. Response time		policy monthly during the QA m	ooting	
w	as not to exceed five	/e minutes."		poncy monthly during the QA m	eenng.	
ot th ot D Ri fa 7: co fre the me Re	6/26/18 at 2:27 PM the ALR's stairwell exits and #7 diserved to utilize the uring an interview of the esidential Relations cility decided to turn 00 AM and 2:30 PM onstruction workers equently, which trigg sponse by the ALR' of facility had implent easure for stairwell esidential Relations do not. The surveyor	the initial tour of the ALR on showed disabled alarms on kit doors on Floors #1, #2, 7. Some residents were a stairs versus the elevator. In 06/26/18 at 2:30 PM, the Manager stated that the in off the alarms between 1. This was because the used the stairwells so gered the need for extra is aides. When questioned if mented a secondary safety exit monitoring, the Manager responded they is explained the safety risk foor alarms immediately.		II. The facility failed to respond to stairwell/exit door alarms in accordance with their policy.  a. The ALR staff were immediate retrained on the requirements of answering the door alarms timely (within 10 minutes). Silversphere Security came to the facility to of the door/stairwell alarms and resealarm pagers.  b. The staff will be trained annual Silversphere to properly use the asystem. Newly hired staff will be	ely 6/2 e neck et to  lly by tlarm	29/18
Re 07/ wa "Ef All is a rev in-s	cord review of the //03/18 at 3:18 PM in staken by the Resi fective 06/27/18, all staff and contractor active and ongoing in ew of the attendant service training on staff and contractors.	ALR's training records on indicated the following action dential Relations Manager: I door alarms are activated, is informed and compliance immediately." Record ce logs showed that stairwell alarm monitoring 27/18. Although training	i	trained on policy by ALR.  c. All doors leading outside and to basement have been secured and monitored every 2-3 hours.		4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION	(X3) DATE	
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R 008 Continued From page	ge 3	R 008			
provided on 07/04/1 employees.	8, with a total of 23 of the 79				244
<ul><li>(II) The facility failed stairwell/exit door ali policy.</li></ul>	to respond timely to arms in accordance with their				
implemented alarm in the front desk conso stainwell exit door ala ALR staff response. the same day at 12:2	response system located at ale showed at 11:00 AM that a armed for 20 minutes without Continued observations on 20 PM showed another at alarmed for 17 minutes sponse.				
07/06/18 regarding re the receptionist state announcement was r the intercom system responds to reset the also questioned about	with the receptionist on esponse time to the alarm, of that a general made by the front desk using until one of the employees alarm. The receptionist was at the ALR's door monitoring ist was not familiar with the				
At the time of the sun monitor and respond system.	vey, the ALR failed to to the stairwell exit alarm				
(III) Cross refer to 039 implement its policies allegations of abuse,	90: The ALR staff failed to on reporting incidents and as follows:		R 390 Sec. 509b1 Abuse, Negl Exploitation	ect, and	
Neglect - Exploitation' showed that the staff, having knowledge of a exploitation of a reside report immediately, or	ent have an obligation to as soon as practical."		I. The ALR staff failed to immereport an allegation of sexual at the facility's ALA.		
Regulation & Licensing Administra FORM	tion 88	99 4	GK211	If continuation s	

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPLETED ALR-0039 B WING 07/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5420 CONNECTICUT AVENUE NW** BV/MSTAR CHEVY CHASE TENANT D/B/A CHE WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) R 008 Continued From page 4 R 008 a. The receptionist was retrained on 4/13/18 reporting all allegations, including a. On 04/06/18, one of the ALR's housekeepers alleged, to management, regardless of observed a construction worker standing in circumstances. Housekeeper was Resident #12's bedroom partially unclothed. 4/13/18 trained on the appropriate reporting A review of the ALR's investigative findings on process after observing a possible 07/03/18 at 10:00 AM revealed the following abusive situation. The ALR received 4/26/18 timeline and sequence of events surrounding the 04/06/18 incident: annual training for the Abuse and Neglect and Reporting policy on Friday, 04/06/18 - The housekeeper, who 4/26/2018. The ALA was retrained 7/4/18 witnessed an alleged sexual abuse of Resident on 7/4/2018 on the Reporting of #12, reported the incident to the receptionist. Abuse, Neglect and Exploitation of a Sunday, 04/08/18 - The receptionist reported the Resident. Staff members that failed to incident to the Activities Director. adhere to the policy received Monday, 04/09/18 - The construction worker was disciplinary action, per policy. observed by the ALR staff working on the ALR premises and on the floor where Resident #12 b. The Abuse, Neglect, and Reporting 8/22/18 lived. policy has been revised/updated. The 8/31/18 Wednesday, 04/11/18 - The Activities Director staff will be retrained on the revised/ reported the alleged abuse to the ALA. [Note: updated policy. The staff will receive Interviews conducted with the receptionist and the annual training and training during construction superintendent indicated that both parties had made the ALA aware of the incident new hire orientation on the Abuse, on 04/09/18.1 Neglect, and Reporting policy. b. Further review of the ALR's "Abuse - Neglect -Exploitation" policy revealed that the ALA was c. The BOM will keep an annual responsible to: education log, listing the annual training. The education log will be "- Seek immediate emergency care if needed; monitored monthly by the OA - Notify the Resident's Medical Provider: - Notify the Residents authorized Responsible

Party of the report;

to the alleged abuse:

- Notify local law enforcement for any physical injury, sexual abuse, death or other crime related Committee for completion/

compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Protective Services, and Ombudsmen as - [Ensure] required to with the required tim - [Ensure] an insura - [Ensure] the identit and person making confidential unless of - [sic] assure no retarmaking the report; a - If the Incident Reportable, the ALA (of the Regional Direct will forward a copy to department." Note: LA Allegations of Reside listed.  Interviews with the Alinconsistencies with the alleged abuse on the following timeline response to the incident to the police, who took Note: The police reportation of the police reportati	egation, enlisting Adult the State Regulatory Agency, is needed and required; documentation is completed the frames; ince report is submitted; by of the Resident, perpetrator the report remains circumstances prevent it; eliation against the person and the person against the person and the person against the person a					

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R 008	Continued From pag	je 6	R 008		
	recollection" of the in	ncident			
	- Friday, 04/13/18 (7 notified APS and the alleged incident Thursday, 04/26/18 ALR conducted staff "Reporting of Abuse, a Resident."  It should be noted the evidence that the AL/ of the incident to the Ombudsman's office policy.  At the time of the sunfailed to implement th	days post-incident): The ALA state licensing agency of the (20 days post-incident): The in-service training on Neglect and Exploitation of at there was no documented had forwarded notification Long-Term Care as required by the ALR's			
i i i i i i i i i i i i i i i i i i i	and treatment with real individual needs and physic and the health or safe; Based on record revienursing staff failed: (1) as prescribed for two comple receiving wour #1 and #2); (2) to follow for two of two residents wound care services (For follow the fall policy one of one residents in Resident #10); (4) to establishment #10); (6)	te and appropriate services asonable accommodation of preferences consistent with sal and mental capabilities by of other residents; what and interview, the ALR to follow physician orders of two residents in the aid care services (Residents when the wound care policies in the sample receiving Residents #1 and #2); (3) for	R 292	R 292 Sec. 504.1 Accommodation of Needs  I. The ALR nursing staff failed to produce the wound care per physician orders.  a. The DON/RN completed a 100% audit for current residents. The audit included a review of Physician order wound care for residents #1 and #2 current residents. DON/Delegate provided one-on-one training to all to on how to review, verify, and transce Physician's orders (including wound the second se	rovide  chart 8/17/18 it its for and all nurses 8/31/18 iribe

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operate DME for one sample (Resident #1 Findings included:	ole (Resident #10); and (5) to ability to independently a of one resident in the label.	R 292	care orders) and record in the MAR TAR. DON/Delegate reviewed and verified orders for all residents currently receiving wound/skin care b. A binder for copies of physician will be kept in DON's office. Each of the DON/Delegate will review any office.	8/31/18 e. orders 8/17/18 day
a. Review of Resider record on 06/27/18 at following wound care	staff failed to provide wound rders, as evidenced below: nt #1's current medical t 11:30 AM showed the orders:		for wound care and verify implementation. All nurses received training on the purpose of the binder verify that wound/skin care orders a implemented. All nurses received training on how to review, verify and transcribusing orders (including research)	r to are aining ribe
cover with 4 X 4 gauze daily and PRN.	record revealed TARs that		physician orders (including wound orders) and to record completion of application/treatment on the MAR/T Training will be completed and documented upon new hire and annu-	each AR.
mentioned above was dates: 08/12/17, 09/07 09/30/17,10/23/17, and	vidence the wound care provided on the following 7/17, 09/17/17, 09/27/17, ad 12/10/17.	İ	thereafter. c. The DON/Delegate will audit the physician's orders for wound care or for complete transcription to the TAI	rders R
<ul> <li>saline, pat dry, peri-wo with skin-prep, apply io</li> </ul>	eft heel wound with normal ound surrounding skin area odosorb cream to wound gauze then secure with aily until healed.		and report findings to the QA Comm monthly to ensure compliance. The DON/Delegate will print TAR documentation reports from QuickM (computer software system) and will reprint the confidence of	ar
10/25/17 through 12/31	ecord revealed TARs from 1/17 that showed the above		review the audit monthly with the QA Committee to ensure compliance with documentation of treatment(s) by nur	h

daily.

mentioned wound care order was not transcribed completely to the TARs. Continued review of the

TARs showed that nursing staff documented that

they only applied iodosorb gel to the left heel

II. The ALR staff failed to follow the

a. The Chevy Chase current policy for Skin & Wound Care was reviewed.

wound care policy.

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING ALR-0039 07/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5420 CONNECTICUT AVENUE NW** BV/MSTAR CHEVY CHASE TENANT D/B/A CHE WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) R 292 Continued From page 8 b. A binder for copies of physician orders R 292 7/20/18 will be kept in DON's office. Each day the on 06/29/18 at 10:30 AM, showed the following DON/Delegate will review any orders for wound care orders: 8/31/18 wound care and verify implementation. All 03/15/18- Cleanse right dorsal ankle with normal nurses received training on purpose of binder to verify that wound/skin care orders 8/23/18 saline, apply small amount of saline gel, cover with boarder gauze daily. are implemented. All nurses received training on how to review, verify and Continued review of the record lacked transcribe physician orders (including documented evidence that the nursing staff wound care orders) and to record provided the wound care. completion of each application/treatment on During an interview on 07/03/18 at 2:00 PM, the the MAR/TAR. Training will be completed facility's contract nurse stated that documentation and documented upon new hire and of wound care provided should be in the annually thereafter. residents' records. The contract nurse could not c. The DON/Delegate will audit the verify that wound care services were provided as physician's orders for wound care orders ordered, due to not working with the facility at that and report findings to the OA Committee monthly to ensure that nurses are in At the time of the survey, the ALR nursing staff compliance with the Skin & Wound Care failed to provide wound care services as ordered. Policy. III. The ALR staff failed to follow the Fall 2. The ALR staff failed to follow the wound care policy, as evidenced below: 6/25/18 a. Resident #10 was reassessed by RN and ISP was updated. a. Review of Resident #1's current medical b. The Chevy Chase Fall Policy was record on 06/27/18 at 11:30 AM showed that the 7/20/18 revised. Staff was educated/trained on the nursing staff provided wound care services from revised Fall Policy. Nurses will be 08/10/17 through 12/31/17. 8/31/18 educated/trained on how to evaluate a Review of the facility's undated policy titled. resident at risk for a fall using revised Fall "Wound Management," showed the following: Risk Screening and select a resident- the nursing staff was to institute a weekly wound centered intervention if indicated, DON/ tracking tool: Delegate evaluated all current residents - the resident's ISP was to be updated using Fall Risk Screening. DON/Delegate 8/23/18 immediately with modifications: - the Director of Clinical Services was to review updated resident's ISPs that are at risk for the wound tracking tool weekly; and a fall. - the wound care team was to meet weekly to c. The DON/Delegate created a Fall Log.

review the resident's wound status.

4GK211

Each new fall will be added to

8/24/18

Health Regulation & Licensi	ng Administration			PRINTED: 08/03/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 292 Continued From pa	ige 9	R 292		
there was no docur	esident #1's record revealed nented evidence that the I the wound management re.		the log and reviewed daily in the n meeting with the IDT. Fall Log w tracked, trended, and reported to the Committee monthly.	ill be
on 06/29/18 at 10:3 staff was currently p	ent #2's current medical record 0 AM showed that the nursing providing wound care to the The wound care services		I. The ALR failed to ensure that instructions from hospital discharg followed.  a. Resident #10's hospital orders w	e were
Wound Care," revise the Wellness Directo were implemented, a	y's policy titled, "Skin & ed in January 2018, showed or was to assure interventions documented, and service with current interventions.		reviewed. RN entered late entry to the description of the injury. DON/ Delegate completed a 100% audit of clinical records for current resident review special instructions after ho	of the 8/24/18 s to
there was no docum	sident #2's record revealed ented evidence the Wellness Skin & Wound Care policy		discharge. b. A binder for copies of physician new orders will be kept in DON's o Each day the DON/Delegate will reorders, including special instruction	ffice. view all is from
AM, the ALA stated t	on 07/05/18 starting at 10:30 hat the facility's previous that the wound care policy		the hospital/ER, along with the disc summary, and verify implementation that the resident's MD has been not special instructions/discharge order	on and ified of s.
At the time of the sur follow the wound care	rvey, the ALR staff failed to e policies.		c. The DON/Delegate will audit dai physician's orders/new orders for compliance with implementing spec	
The ALR staff faile evidenced below:	d to follow the fall policy, as		instructions from the hospital/ER ar notifying the MD & RP, and report findings to the QA Committee mont	nd
06/26/18 at 12:00 PM	ent #10's apartment on I showed the resident had a bruise on the right side of ed down to the neck.		ensure compliance.	my to

Health	Regulation & Licensin	ng Administration		1		APPROVE
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	a total of seven time through June 2018.  Review of the facility in January 2018, showed the seven was convertigation was convestigation was convertigated with interview of received the seven was reviewed, and a further review of received through the seven through the seven was reviewed.	o PM revealed the resident felles from December 2017  y's policy titled, "Falls," revised lowed that after a fall, the vas to ensure a fall ompleted, the resident's ISP terventions, a QA of the fall a fall tracking was completed.	R 292	The ALR failed to assess resident ability to independently operate a Comachine.  a. The resident was immediately as by a registered nurse and educated the use and operation of the CPAP, TED Hose. Resident received size Medium TED Hose on 6/27/18 and demonstrated ability to turn on and correctly. Obtained order for CPAP 8/1/18. Order was present for TED	sessed about and the	6/26/18
	no documented evide followed the fall policity of t	dence the Wellness Director cy as outlined above.  e ensure that special spital discharge were sed below:  dent #10's apartment on M showed the resident had a I bruise on the right side of sed down to the neck.		ordered 5/23/18. b. The resident was assessed by his Nurse Practitioner. Resident #11 wi assessed for the use and operation o mechanical devices and medical devicing the 6 month ISP, and with an change in condition. All new resider be assessed for the use and operation mechanical devices and medical devices and medical devicer to admission, at move in, durin 30 day ISP, the 6 month ISP, and wi	PCP's ill be of vices ny nts will n of vices ng the ith any	7/9/18
	a total of seven times through June 2018. To a local ER for evaluof the seven falls.  Further review of the note dated 06/24/18 thousand the floor Lt. front head." The note evidence of the reside the exact location of the noted that resident's interest the sevent form.	PM revealed the resident fell is from December 2017 The resident was transferred uation of head injury for two  record revealed a nursing that documented, "resident is swelling [sic] observed on ote lacked documented ent's orientation status and the fall. It should also be injury was on the right side in the left side as indicated in		change in condition. The DON creat Medical Device Log to track residenthe ALR with medical devices.  c. The DON/Delegate will audit most the Medical Device Log to ensure the equipment is functional and the residual using the equipment.	nts in nthly 8 ne	8/14/18

the note.

	Regulation & Licensing				IONWIAFFROVED
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	-0.	ALR-0039	B WING		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY.	STATE, ZIP CODE	1 0111012010
R\//Men	AD CHEVO CHARE TO			AVENUE NW	
DVINIST	AR CHEVY CHASE TE		STON, DC 20		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
R 292	Continued From page	ge 11	R 292		
	resident returned from special instructions, within the first 48 housing any medicines medicine that make lacked documented physician was made instruction. Also, the medications within the returning from the Elmg (a sedative with the drowsiness).  During an interview of resident stated, "Yes came back from the At the time of the surthat Resident #10 follophysician was made instructions from the sto independently operavidenced below:  During an interview of Resident #11 stated the sassess him to see if he machine and [support esident also stated the machine for sleep aprow to adjust the setting Review of Resident #10 Resid	on 07/05/18 at 3:30 PM, the I took my medicines when I ER."  vey, the ALR failed to ensure I lowed, and the resident's aware of, the special hospital.  assess Resident #11's ability rate a CPAP machine as  n 06/26/18 at 12:40 PM, hat he wanted the nurses to be was using his CPAP to stockings correctly. The nat he used a CPAP mea, but he did not know			

Health Regulation & Licensii	ng Administration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	IPLE CONSTRUCTION IG:	(X3) DATE SURVEY COMPLETED
	ALR-0039	B. WING_		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	/, STATE, ZIP CODE	07710/2010
BV/MSTAR CHEVY CHASE TE		NNECTICU GTON, DC	T AVENUE NW 20015	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE
R 292 Continued From pa	ge 12	R 292		**************************************
obstructive sleep ap documented eviden CPAP therapy or TE During an interview ALA stated that she assess the resident the CPAP therapy are Follow-up review of medical record reversible the Regional Director indicated the resider contract nurse to evidence the setting at 6 disrupted loosen the straps on the flow." The Region that the nurse would healthcare practitions therapy evaluation. On nursing note revealer stockings were too bordered.  At the time of the sur Resident #11 was as	on thad a diagnosis of onea. The record lacked ce of a physician order for D support stockings.  on 06/26/18 at 2:30 PM, the would have the nurse to to evaluate his concerns with not support stockings.  Resident #11's updated aled a nursing note written by or dated 06/26/18, which have assessed by the aluate the resident's ability to be CPAP machine and put on gs. The Regional Director resident stated, "the current if his sleep, so he would the mask which decreases hal Director also documented inform the resident's er and request a respiratory continued review of the difference of			
R 390 Sec. 509b1 Abuse, N	eglect, and Exploitation.	R 390	R 390 Sec. 509b1 Abuse, Neglec	t, and
(b)(1) An ALR, emplo person who believes subjected to abuse, n	yee of an ALR, or other that a resident has been eglect, or exploitation shall use, neglect, or exploitation		Exploitation  I. The ALR staff failed to immed report an allegation of sexual abuthe facility's ALA.	iately

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVE
	N'	A BUILDIN	NG:	COMPLETED
		1		
WALE OF THE STATE	ALR-0039	B WING _		07/13/201
NAME OF PROVIDER OR SUPPLIER			Y, STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TEN			T AVENUE NW	
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES	STON, DC		
TAG REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE
R 390 Continued From pag	e 13	R 390	a The recentionist and activity	.: 4' 4/12/1
immediately to the as	ssisted living administrator		a. The receptionist and activit	nes director 4/12/1
who shall take appro	priate action to protect the		were retrained on reporting al	
resident. The ALR's	hall report any allegation of		allegations, including alleged	, to
abuse, neglect, or ex	oloitation brought to its		management, regardless of cit	reumstances, 4/12/1
attention to the Mayo	r and the Adult Protective		Receptionist and activities dir	ector
Services Program, ac	dministered by the Family		received written corrective ac	
Human Development	on of the Department of		regarding abuse of neglect rep	porting.
Based on interview a	nd record review, employees		Housekeeper was trained on the	he 4/26/1
of the ALR failed to (I)	) immediately report		appropriate reporting process	after
allegations of sexual	abuse to the facility's		observing a possible abusive s	
administrator for Resi	ident #12, and the ALA failed		The ALR received annual train	
to (II) take appropriate	action to protect all		Abuse and Neglect and Repor	
residents living in the	ALR.		on 4/26/2018. The ALA was	
Findings (set al.)			7/4/2018 on the Reporting of	
Findings included:			Neglect and Exploitation of a	
I The AI P stoff failed	to immediately report an		Staff members that failed to ac	
allegation of sexual at	ouse to the facility's ALA, in			
accordance with the A	LR law and implement the		policy received disciplinary ac	8/31/1
facility's internal policy	as follows:		policy.	6/31/1
Record review of the A	ALR's policy titled, "Abuse -		b. The Abuse, Neglect, and Re	porting
Neglect - Exploitation"	revised in January 2018		policy has been revised/update	
showed that the staff, '	"witnessing, suspecting, or	iá.	will be retrained on the revised	
naving knowledge of a	buse, neglect and/or		policy. The staff will receive a	
exploitation of a reside	int have an obligation to		training and training during ne	
report immediately, or	as soon as practical."		orientation on the Abuse, Negl	
On 04/06/18 one of th	e ALR's housekeepers		Reporting policy.	cei, anu
observed a constructio	o worker standing in		reporting policy.	
Resident #12's bedroom	m partially unclothed		TIL 1. 1 OC	***
During an interview with	h the housekeener on		c. The business office manager	
07/03/18 at 11:03 AM, 1	the housekeeper explained		an annual education log, listing	
that she knocked on Re	esident #12's door twice		annual training. The education	
When there was no ans	Swer, she proceeded to		be monitored monthly by the Q	
use a key to access the	apartment. The		Committee for completion/com	
housekeeper further de	scribed that upon entry.		•	
sne observed a constru	iction worker standing at			
trie nead of the bed and	Resident #12 was laying			
Regulation & Licensing Administration FORM				**************************************
I-ONIVI	0690	40	3K211	If continuation sheet 14 c

_	Health Regulation & Licensin	ng Administration		,	FORM APPROVE
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN		(X3) DATE SURVEY COMPLETED
١.,		ALR-0039	B WING_		07/13/2018
	NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY	, STATE, ZIP CODE	
	BV/MSTAR CHEVY CHASE TE	WASHING	INECTICUT	AVENUE NW 20015	
	PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	R 390 Continued From pag	ge 14	R 390	II. The ALR failed to take appropria	ate
	unclothed from the v construction worker construction worker The housekeeper im	ction worker was partially waist down. When the noticed the housekeeper, the was overheard stating "shit." mediately closed the door		action to protect all residents from potential abuse.  a. The alleged abuser, who was a th party contractor, was banned from the second	ird 4/12/18
and left the apartment.  a. A review of the ALR's investigative findings on 07/03/18 at 10:00 AM revealed the following timeline and sequence of events surrounding the 04/06/18 incident:			building. Contractor company was contacted regarding incident. Police department was contacted regarding incident and report filed. Family and physician contacted. Department of Health and Ombudsman notified.		
	#12, reported the inc	I sexual abuse of Resident ident to the receptionist.		b. An investigation will be conducte all abuse allegations per the revised investigation policy and procedures. Abuse and neglect policy revised 8/2. The regional director of operations of	22/18.
	Monday, 04/09/18 - Tobserved by the ALR premises and on the lived.	he construction worker was staff working on the ALR floor where Resident #12		notified immediately of all abuse allegations. The regional director of operations will be actively involved all ongoing investigations of abuse a neglect allegations to ensure compliant	with and 8/31/18
	reported the alleged a Interviews conducted construction superinte	3 - The Activities Director abuse to the ALA. [Note: with the receptionist and the endent indicated that both ALA aware of the incident		with policy. Residents will be informabout circumstances that require investigation into abuse allegations, situation could endanger their safety well-being. All residents were interviewed by ALR staff to ensure the staff to e	if the
	the housekeeper ackr was not reported to th housekeeper made a receptionist who was of the housekeeper's wri	on duty that day. Review of tten statement on 07/03/18 hat the housekeeper was		are no other issues surrounding any contractor. c. Investigations will be reviewed by QA Committee monthly to ensure compliance for resident protection as safety per Resident Rights and Abuspolicy. New contractor policy create ensure construction workers will not	nd se ed to

residents' rooms.

REGULATORY OR LSC ID  R 390   Continued From page 1	NT D/B/A CHE  5420 CO WASHIN  IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	B. WING DDRESS, CITY, S NNECTICUT A GTON, DC 20  ID PREFIX TAG	VENUE NW 015 PROVIDER'S PLAN OF CORRECT	07/13/2018
(X4) ID SUMMARY STATEMIN (EACH DEFICIENCY MUSTAG REGULATORY OR LSC ID	NT D/B/A CHE  5420 CO WASHIN  IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	NNECTICUT A GTON, DC 20 ID PREFIX	VENUE NW 015 PROVIDER'S PLAN OF CORRECT	
(X4) ID SUMMARY STATEMI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC ID	WASHIN IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX	015 PROVIDER'S PLAN OF CORRECT	
REGULATORY OR LSC ID  R 390   Continued From page 1	ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECT	
·	15		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE
the receptionist, who was incident, stated the house incident to him and not. The receptionist also state housekeeper shared the #12 and the construction thought they had engage act. The receptionist left (04/06/18) at approximating informed the facility's Adalleged incident on Sund d. Further review of the Exploitation" policy reversesponsible to:  "- Seek immediate emeron - Notify the Resident's Monotify local law enforce injury, sexual abuse, dead to the alleged abuse;  - Investigate the allegatic Protective Services, the sand Ombudsmen as need fensure] required document the required time fraction from the required time fraction from the identity of t	on 07/03/18 at 11:45 AM, as on duty the day of the usekeeper reported the to the ALA/supervisor. Itated that when the eleobservation of Resident on worker, the receptionist ged in a consensual sexual at the facility that day ately 3:00 PM and citivities Director of the day, 04/08/18.  ALR's "Abuse - Neglect - railed that the ALA was regency care if needed; and the ALA was regency care if needed; at the resident of the related on, enlisting Adult State Regulatory Agency, and and required; mentation is completed ames; report is submitted; the Resident, perpetrator report remains matances prevent it; on against the person risk related and/or state resignee) will send a copy of Operation (RDO), who home office legal	1	DEPROIENCE	
Regulation & Licensing Administration FORM			THE RESERVE THE PROPERTY OF TH	

Health	Regulation & Licens	ing Administration			FORM APPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION	(X3) DATE SURVEY
		IS CONTINUON TO NOTIFICE,	A. BUILDING:		COMPLETED
		ALR-0039	B WING		07/42/2042
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIR CODE	07/13/2018
3V/MST	AR CHEVY CHASE T		NNECTICUT A		
		WASHIN	IGTON, DC 20	015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE COMPLETE
R 390	Continued From pa	age 16	R 390		AND 100 100 100 100 100 100 100 100 100 10
	Allegations of Resi	dent abuse or neglect was			
33	Interviews with the	A1 A dames =			
	inconsistencies with	h the investigative findings of	Ī		
	the alleged abuse on 04/06/18, as evidenced by		1		
	the following timeline regarding the administrative response to the incident:				
	- Thursday 04/12/18 (6 days post incident). The				
	<ul> <li>Thursday, 04/12/18 (6 days post-incident): The ALA reported the incident of alleged sexual abuse</li> </ul>		1		
	to the police, who took a report of the incident				
	alleged perpetrator	port failed to reflect the			
	- Thursday, 04/12/16 ALA notified Reside abuse.	8 (6 days post-incident): The nt #12's son of the alleged			
39	- Friday, 04/13/18 (7	days post-incident):			
10	Resident #12's phys	ician performed a			
	post-incident physica physician's assessm	al examination. Note: The nent described Resident #12			
- 1	as "homebound due	to dementia" and having "no			
ı	ecollection" of the in	ncident.			
-	Friday, 04/13/18 (7	days post-incident): The ALA	1		
r	notified APS and the alleged incident.	state licensing agency of the	İ		
•	meged incident.				
7	Thursday, 04/26/18	(20 days post-incident): The			
	Reporting of Abuse	in-service training on Neglect and Exploitation of			
a	Resident."	riogical and Exploitation of			
It	should be noted that	at there was no documented	1		
е	vidence that the ALA	A had forwarded notification			
0	f the incident to the	Long-Term Care as required by the ALR's			Į
р	olicy.	as required by the ALK's			Ī

i	Health Regulation & Licensi	ng Administration			FORM APPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(V3) DATE OUD) EV
I		IDENTIFICATION NUMBER:	A BUILDING:		(X3) DATE SURVEY COMPLETED
I					
ŀ	7/10 - 7/	ALR-0039	B WING		07/49/0040
l	NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIR COOP	07/13/2018
	BV/MSTAR CHEVY CHASE TE	NANT D/B/A CHE 5420 CO	NNECTICUT A	VENUE NW	
	(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES			
	TAG REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
	R 390 Continued From pa	ge 17	R 390		
	the ALA stated the in Activities Director or 07/05/18 at 12:23 P timeline documented Director did not infor abuse until Wedness.  The findings of the Athat the ALR's staff for ALA of an allegation Resident #12.  II. The ALR failed to protect all residents for evidenced by:  At the time of the instruction of the instruction of the instruction with ALR provided addressight as required at During an interview the ALR's housekeeps alleged sexual abuse the alleged perpetrato Monday, 04/09/18, whincident occurred.  b. During an interview the ALA stated that writed the investigative pactor of the investigative pactor of the investigative pactor of the investigative pactor of the receptionist and form the receptionist and form the receptionist and form the receptionist and form the receptionist and form the receptionist and form the receptionist and form the receptionist and form the receptionist and form the receptionist and form the reception is the form the reception the reception of the investigative pactor of the investigative	LA's investigation showed ailed to immediately notify the of sexual abuse involving take appropriate action to rom potential abuse as dection on 06/26/18, a w of the ALR's incident along with a review of the as completed to determine if quate supervision and by the ALR law.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B. WING		07/42/004
NAME OF PROVIDER OR SUPPLIER		DORESS, CITY, S	TATE ZID CODE	07/13/2018
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R 390 Continued From pag	je 18	R 390		*****
construction comparemail correspondent communication indices. Director, not the ALA superintendent on M to the alleged incider employees. Continue showed that on 04/0/construction companematement from the alleged perpetrator of statement on 04/10/1/superintendent and woff the ALR premises memorandum, dated construction companemas provided as a papackage. It should be memorandum indicated within the construction allow [the accused perpetration of the construction allow [the accused perpetration companemas provided as a papackage. It should be memorandum indicated within the construction allow [the accused perpetration companemas perpetration companemas provided as a papackage. It should be memorandum indicated within the construction allow [the accused perpetration companemas perpetration	londay, 04/09/18, to alert him intrology, 04/09/18, to alert him and review of that email 19/18, the ALR requested the large of the author of the leclined to provide a written 18 when approached by the was subsequently escorted the same day. An internal 104/13/18, from the large of the investigative of the investigative of the investigative of that the supervisors of company, "decided to expetrator] to return [sic] so lock with him and the staff to			
that background scre- workers had been im	plemented. During an an on 04/13/18, it was alleged			

FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ALR-0039 B WING 07/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5420 CONNECTICUT AVENUE NW** BV/MSTAR CHEVY CHASE TENANT D/B/A CHE WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 10 (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRFFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) R 390 Continued From page 19 R 390 communicate the expectations of the ALR with construction workers assigned to the community. Continued interview with the ALA revealed that she filed a police report on 04/12/18. Review of the police report on 07/05/18 at 1:30 PM showed that it was incomplete, due to missing the perpetrator's name. The ALA stated that the housekeeper told her that the contractor was nicknamed "Big Mike." Further, the ALA indicated that subsequent to the incident, all residents of the ALR were reminded during a community town hall meeting not to allow any construction workers into their apartment and to alert the ALR's maintenance staff. At the time of the survey, the ALA was not able to provide documented evidence that the town half meeting had occurred and/or that the ALA had informed the ALR community, including all residents and their responsible parties, of the alleged sexual abuse and the subsequent safety measures to be put in place by the ALR. The ALA also failed to obtain feedback from other residents to identify whether additional incidents of this nature had occurred. c. During a post-survey telephone interview on 07/23/18 at 1:30 PM, Resident #12's son stated that he was notified of the alleged sexual abuse involving his mother on 04/12/18, which was six days after the incident occurred. As he described the incident, he noted that the construction worker had no reason to be in his mother's residence because renovations had already been completed in her apartment. Resident #12's son indicated that he was told by the ALA that the housekeeper waited until the end

of the shift to report the incident and then

Treasur Togalation & Election Administration					FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	**************************************	ALR-0039	B WING	Water Market Control	07/13/2018
NAME	OF PROVIDER OR SUPPLIER	STREET A	DORESS, CIT	Y, STATE, ZIP CODE	VIVIO/2010
BV/A	ISTAR CHEVY CHASE TE			T AVENUE NW	
	H WINDS I LINE	WASHIN	GTON, DC		
(X4) PRE TA	FIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE
R:	390 Continued From pa	ge 20	R 390		
	administrator/super was told by the ALA report the incident to and waited two days incident. Resident # police department wabout the incident, a when the police sho questioning her about the time of the su that the ALA had init the personnel involve reporting of the alleg #12. There was also ensured the timely tr how and when to report the time of the sur adequate safeguards abuse while the investigation.	rvey, there was no evidence isted disciplinary action with ed in the witnessing and ed sexual abuse of Resident no evidence that the ALA aining of the ALR staff on port unusual incidents.  In the witnessing and ed sexual abuse of Resident no evidence that the ALA aining of the ALR staff on port unusual incidents.  In the ALR failed to put is in place to prevent potential stigation was in progress and propriate corrective action to			
	509b3 Abuse, N	leglect, and Exploitation.	R 392	R 392 Sec. 509b3 Abuse, Neglect, a Exploitation	nd 8/24/18
allegation of abuse shall take appropriation incidents. The ALR investigation and at Mayor.  Based on interview failed (I) to thorough abuse involving Research		bughly investigate any seglect, or exploitation and action to prevent further sall report the results of its cons taken, if any, to the and record review, the ALR investigate an allegation of lent #12, and (II) to prevent the investigation was in the facility.		1. The ALR failed to thoroughly invean allegation of abuse.  a. Investigation regarding incident immediately conducted. Constructio company provided documentation of criminal background checks. Created contractor orientation letter for each contract worker to sign and adhere to	n 8/6/18 f d 8/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDI	TIPLE CONSTRUCTION NG:	(X3) DATE SUR'
NAME OF DOOR SOME	ALR-0039	B WING		07/13/20
NAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CIT	Y, STATE, ZIP CODE	7.77720
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	WASHIN	GTON, DC	20015	
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R 392 Continued From pag	je 21	R 392		
Findings included:			Requested/received background	
i i i i i i i i i i i i i i i i i i i			screening criteria from the	
I. [See also R008 ar	nd R390] The ALR failed to		construction company. Created p	oliev
thoroughly investigat	e an allegation of abuse.		on construction worker's interacti	A A
			in the ALR.	ons 8/9/
a. On 4/13/18, the st	ate licensing agency			
received telebuoue u	Otification from the ALA		Advised all residents that they sho	ould
regarding the 04/06/	18 incident The ALA stated		not be requesting assistance from	
triat the police was in	vestigating this incident the		outside contractor. Met with resid	lents
Perpetrator was esco	TIED From the premises and		at town hall on 8/9/18 to discuss the	nis
mat me resident had	Deen assessed and		policy. Requested, at town hall, a	ny
also stated that the	ustained no harm. The ALA		resident with concerns with	8/31
made aware of the in	esident's family had been		construction workers to bring thos	e
checks would be con-	cident and that background ducted for all construction		concerns to the ALA. Met	
workers. The licensing	g agency asked the ALA to		individually with each resident to	
forward their internal i documents.	nvestigation and supporting		discuss alleged incident.	
On 04/17/18, the occu	rrence report and a copy of			
mic police report were	received It chould be		h The Investigation But a second	9/22/
noted that no further d	Ocumentation was received		b. The Investigation Policy & Proce	edure 8/22/
TOTAL CHE ALA, DUTING I	ne ongita increation		was revised. All staff was trained o	n the
Degirining Ub/26/18. In	PRIME and record	, j	revised policy on 9/12/18. Staff wil	be
reviews showed that the	le response actions taken	1	educated annually and during new h	ire
Di die ALA were nor in	nely naced on whom the	1	orientation on the Abuse, Neglect, a	nd
ALA first became awar	e of the allegation.		Exploitation Policy.	
b. Additional review of				
report revealed that the	response actions taken		c. The business office manager will	
by the ALA were not co	milete as evidental	Į,	keep an annual education log, listing	the
below:	Pioto de evidenced	a	annual monthly trainings. The educ	ation
		fi	og will be monitored monthly by th	OH
A police report was filed	on 04/12/18 at 22:24	le	QA Committee for completion/	E
inowever falled to reflect	the alleged perpetrator's		compliance M-interest to	
Figure THE ALA GOCUME	enied that the alleged		compliance. Maintenance director w	/iII
herbetrators name was	"Big Mike " however	į n	neet with each contractor to go over	
uncle was no further act	100 to obtain the alleged	C	ontractor agreement.	
perpetrator's legal name	from the area of	1		
i tamana a lagarriante	record review, the alleged	Ti .		

Health Regulation & Licens	ing Administration		P	RINTED: 08/03/20 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING_		
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CIT	Y, STATE, ZIP CODE	07/13/2018
BV/MSTAR CHEVY CHASE TO	ENANT D/B/A CHE 5420 COM	NECTICU	T AVENUE NW	
	WASHING	STON, DC	20015	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE COMPLETE
R 392 Continued From pa	ge 22	R 392		
perpetrator was esc	corted off of the ALR premises		II. The ALR failed to prevent potent	tial
after refusing to pro	vide a written statement of the		abuse while the investigation was in	
incident as requeste	ed. It should be noted that the		progress for all residents in the facil	ty.
alleged perpetrator	was allowed by the		a. The alleged abuser, who was a thi	ird 4/12/18
Work and was seen	ny to return to the ALR to working on the floor where		party contractor, was banned from the	he mizno
Resident #12 lived.	The ALR's investigation failed		building. Contractor company was	10
to evidence that the	ALA had coordinated with the		contacted regarding incident. Police	
alleged perpetrator's	s employer to make a work		department was contacted regarding	
ALR community.	based on the safety of the		incident and report filed. Family and	1
ALK community.			physician contacted. Department of	
internal investigation	rvey, the review of the ALA's failed to demonstrate		Health and Ombudsman notified.	
complete and timely	action by the ALA in		b. An investigation will be conducted	for
report to the state lice	ALA's initial occurrence		all abuse allegations per the revised	
op and the state hor	ensing agency.		investigation P&P. The regional dire	ector
<ol> <li>The ALR failed to</li> </ol>	take appropriate action to		of operations will be notified immed	iately
protect all residents f	rom potential abuse while		of all abuse allegations. The regiona	1
the investigation was evidenced by:	being conducted as		director of operations will be actively	/
evidenced by:			involved with all ongoing investigation	ons
At the time of the insp	pection on 06/26/18 a	1	of abuse and neglect to ensure complainth policy. Posidones will be in a	iance
comprehensive review	w of the ALR's incident		with policy. Residents will be inform	ed
management system	along with a review of the	1	about circumstances that require	C.A
ALK'S Investigation wa	as completed to determine if		investigation into abuse allegations, i	t the
the ALK brovided age	quate supervision and		situation could endanger their safety well-being. Contractor prioritation let	or
oversight as required	by the ALK IBW.		well-being. Contractor orientation let- created to present to each visiting	ier
a. There was no evide	ence that the ALA had		contractor detailing rules to abide by	1
informed the ALR com	munity, including residents		while in the community.	1
and their family memb	ers, of the alleged several	j	···· ···························	i
abuse. During interview	w with the ALA it was	1	c. Investigations will be reviewed by t	the
stated that a town hall residents, however, the	meeting was held with ere was no documented		QA Committee monthly to ensure	ine
evidence this occurred	. No additional	1	compliance for resident protection and	. 1
memorandum was dist	tributed to the community	1	safety per Resident Rights and Abuse	1
and family members.			policy.	

6899

policy.

Health Red	ulation & Licensii	ng Administration			FORWAPPROVEL
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ALR-0039	B WING		07/42/2042
NAME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, §	STATE, ZIP CODE	07/13/2018
BV/MSTAR (	CHEVY CHASE TE	NANT D/B/A CHE 5420 CO	NNECTICUT A	AVENUE NW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
R 392 Co	ntinued From pag	ge 23	R 392		
c. Tests contine d. Tests imp	ed to obtain feed intify whether add doccurred.  There was no eviduablished by the Anmunicate the examunity with conscommunity.  There was no eviduening of construction of construction of construction in the examunity with conscening of construction of c	pectations of the ALR struction workers assigned to lence that background ction workers had been an interview with the ALA on led that background checks by the construction company lederal standards, however.			
mon facili all re	itoring or escorting ity staff had been	ence that a system for ng construction workers by implemented to safeguard rforming work in residents'			
the t	ere was no evide imely training of t n to report unusua	nce that the ALA ensured he ALR staff on how and al incidents.			
discip the w	olinary actions with	ence that the ALA initiated th the personnel involved in porting of the alleged sexual 2.			
abuse and ti	uate sateguards i while the invest he ALR also failed	ey, the ALR failed to put in place to prevent potential igation was in progress, d to take appropriate event further incidents.			

Health Regulation & Licensin	ng Administration			TORWALFROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING_		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	01110/2010
BV/MSTAR CHEVY CHASE TE	INANI DIDIA CHE		AVENUE NW	
		TON, DC 2	20015	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
R 471 Continued From pa	ge 24	R 471		
R 471 Sec. 604a1 Individu	alized Service Plans	R 471	R 471 Sec. 604a1 Individualized	1
(a)(1) An ISP shall	be developed for each		Service Plans	•
resident prior to adr	nission.			
Based on record rev	view and interview, the ALR		I. The ALR failed to develop IS	
of five newly admitte	ISP before admission for four ed residents in the sample		before admission for Residents	#2,
(Residents #2, #4, #	11, and #12).		#4, #11, and #12.	
Findings included:			a. ISP's for resident #2, #4, #11	7/31/18
1. Douisus of Decide	-4-401		completed. Resident #12 moved	
on 06/29/18 at 10:30	nt #2's current clinical record  AM showed that there was		of ALR.	4/21/10
no documented evid	ence that the ALR staff		b. An ISP will be developed price	or to
developed an ISP fo admission on 01/22/	r the resident prior to		admission and 30 days post mov	
			for all new residents. ISP's will	T
2. Review of Resider	nt #4's current clinical record		updated every 6 months and with	h
no documented evid	AM showed that there was ence that the ALR staff		significant change in condition. c. DON/Delegate will monitor,	
developed an ISP for	r the resident prior to		review, and track each new adm	it
admission on 06/06/	18.		prior to admission to ensure with	
3. Review of Resider	nt #11's current clinical record		requirement. ISP's will be track	
on 07/05/18 at 2:00 I	PM showed that there was no		spreadsheet and reviewed daily t	
documented evidence developed an ISP for	te that the ALR staff		ensure they are completed timely	y.
admission on 09/02/	17.			
4. Review of Residen	at #12's current clinical	1		
record on 07/13/18 a	t 2:00 PM showed that there			1
was no documented developed an ISP for	evidence that the ALR staff	1		
admission on 12/27/1	7.			
During an interview o	n 07/06/18 at 10:40 AM , the			1
ALA stated that the fa	icility's previous nurse			
was unable to locate	quired. However, the ALA the pre-admission ISPs at			

Health	Regulation & Licensin	ng Administration		5 h	FORM APPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		ALR-0039	B WING_		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AC	ODRESS, CITY	r, STATE, ZIP CODE	
BV/MST.	AR CHEVY CHASE TE			T AVENUE NW	
(X4) ID	SUMMARY STA	WASHING ATEMENT OF DEFICIENCIES	GTON, DC		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
R 471	Continued From page	ge 25	R 471		
	the time of the surve	еу.			
	provide documented	urvey, the ALR failed to devidence that pre-admission ed for Residents #2, #4, #11,			
R 472	Sec. 604a2 Individua	alized Service Plans	R 472	R 472 Sec 604a2	
(2) An ISP shall be developed following the completion of the "post move-in" assessment. Based on record review and interview, the ALR failed to ensure an ISP had been developed after the post move-in assessment for three of five newly admitted residents in the sample (Residents #2, #4, and #11).  Findings included:				I. The ALR failed to ensure an I had been developed after post m in.  a. ISP's for #2, #4, and #11 have completed and reviewed by the Team.	nove- en been 7/31/18
<ol> <li>Review of Resident #2's clinical record on 06/29/18 at 10:30 AM showed that the resident was admitted on 1/22/18, at which time a post move-in assessment was conducted by the facility's nurse. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post move-in assessment.</li> <li>Review of Resident #4's clinical record on 07/02/18 at 10:15 AM showed that the resident was admitted on 06/06/18, at which time a post move-in assessment was conducted by the facility's nurse. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post move-in assessment.</li> </ol>			b. All new residents will receive move-in assessment within 30 d admission. An ISP Log has beel created to track and schedule all assessment due dates. c. The DON/Delegate will moni ISP Log due dates daily to ensur compliance of ISP's to be compliand post move-in assessment will days of move in.	ays of 7/1/18 n ISP tor the re leted	

3. Review of Resident #11's clinical record on 07/05/18 at 3:00 PM showed that the resident

Health	Regulation & Licensin	g Administration			TORWIAFFROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 9:	(X3) DATE SURVEY COMPLETED	
		ALR-0039	B WING_	The second of a second of the	07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	01/10/2010
BV/MST	AR CHEVY CHASE TE	NANCI U/B/A CHE	INECTICUT	AVENUE NW 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETE
R 472	Continued From page	ge 26	R 472		
	move-in assessment facility's nurse. Furth revealed there was a an ISP had been de resident's post move During an interview AM, the ALA stated the nurse developed ISP	on 07/06/18 starting at 10:40 that the facility's previous of as required. However, the ocate the post move-in ISPs			
	At the time of the follensure ISPs had bee	low-up visit, the ALR failed to en developed following the nove-in assessments.		R 481 Sec. 604b Individualized	g
R 481	Sec. 604b Individuali	zed Service Plans	R 481	Plans	Service
	provided, when and I provided, and how ar be provided and acce Based on observation review, the facility fai when, how often, and provided to address to significant change in	elude the services to be now often the services will be not by whom all services will essed. In, interview and record led to document in an ISP of by whom services would be the resident's recent fall (a condition) for one of one e who fell (Resident #10).		I. The ALR failed to document i ISP when, how often, and by wh services would be provided to act the resident's recent fall.  a. Late entry was added for resident to include details of incident the ISP was updated with fall.	nom Idress Ient
	Findings included:			b. Appropriate members of the II	
   	Resident #10 with a la right side of the face t neck. The observation	1/18 at 11:30 AM showed arge purplish bruise on the that extended down to the n also revealed that the g oxygen from a compressor in tubing.		will review all incident reports d the daily clinical meeting. Any incidents will be updated on corresponding ISP. ISP updates include details of incident and ar appropriate resident centered	uring

interventions, ISP will include the

Health Regulation & Licensi	ng Administration			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING_		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CIT	Y, STATE, ZIP CODE	1 0771372018
BV/MSTAR CHEVY CHASE TI	ENANT DIRIA CHE 5420 COI		T AVENUE NW	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCE)	D BE COMPLETE
Resident #10 stated and was sent to the resident also explain Review of the reside significant change It documented evident provided, when and provided, and how a be provided to address change in condition increased frequency.  During an interview of AM, the ALA stated the services to be provided.	on the same day at 11:31 AM, if that she fell a few days prior is ER for evaluation. The ned that she falls a lot.  ent's record revealed a SP dated 06/25/18 that lacked ce of the services to be how often the services will be and by whom all services will ess the resident's significant as evidenced by the of falls.  on 07/05/18 starting at 10:30 that she would ensure that all led for residents experiencing in condition are included in	R 481	responsible individuals(s) to co the service. DON will keep an updated incident tracking log. RN will keep an ISP log includ documentation of change in condition.  c. The DON will audit the Incident Tracking Log and ISP Tracking track and trend the data outcomereport to QA Committee month The QA Committee will determ additional audits or actions are required.	DON/ ing  dent g Log, es, and ly.
Resident #10's ISP v resident's frequent fa  R 483 Sec. 604d Individualit  (d) The ISP shall be admission and at least The ISP shall be upd is a significant change. The resident and, if n shall be invited to par reassessment. The re an interdisciplinary ter resident's healthcare the resident's surroga ALR. Based on record revise	reviewed 30 days after st every 6 months thereafter. ated more frequently if there in the resident's condition. ecessary, the surrogate ticipate in each eview shall be conducted by		R 483 Sec. 604d Individualized Service Plans  I. The ALR failed to ensure resid ISPs were reviewed 30 days after admission, every six months, and updated with a change in condition with the resident/surrogate participation and IDT review.	:

Health	Regulation & Licensi	ng Administration			PRINTED: 08/03/201 FORM APPROVE
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		ALR-0039	B WING_		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 0771372018
BV/MST	AR CHEVY CHASE TE		NECTICUT	T AVENUE NW 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRF COMPLETE
	residents in the sam #6, #7, #8, #9, #10, Findings included:  1. Review of Reside on 06/27/18 at 11:30 was admitted on 02/record revealed an Illacked documented health care practition. The record also lack that an ISP review w prior to 06/27/18.  Continued review of revealed that the res services on 03/21/18 showed that the ALR of the significant charmon 06/27/18.  2. Review of Resident on 06/29/18 at 10:30 was admitted on 01/2 record revealed an IS acked documented except with the significant charmon 06/29/18 at 10:30 was admitted on 01/2 record revealed an IS acked documented except with the significant charmon 06/29/18 at 10:30 was admitted on 01/2 record revealed an IS acked documented except with the significant charmon 06/29/18 at 10:30 was admitted on 01/2 record revealed an IS acked documented except with the same with the significant charmon 06/29/18 at 10:30 was admitted on 01/2 record revealed an IS acked documented except with the same with t	on, every six months thereafter, nificant changes for ten of 12 nple (Residents #1, #2, #3, #5, and #12).  Int #1's current clinical record of AM showed that the resident (25/15. Further review of the SP dated 06/27/18 which evidence that the resident's ner or surrogate reviewed it. led documented evidence has conducted six months the resident's clinical record.	R 483	a. ISP's for Residents #1, #2, # #6, #7, #8, #9, #10 and all curresidents were reviewed and up of 7/20/18. Resident #12 move ALR. All ISP's have been disc with resident and IDT with app signatures.  b. An ISP Log was created in or schedule and track revised due spread them out over the next 6 months. Each week four ISP's reviewed by Medical Director at to ensure all change of condition updates to ensure resident needs being met.  c. DON/Delegate will audit week meetings and discuss any issues the QA committee monthly.	ent odated as ed out of 4/21/18 ed sussed 8/24/18 ropriate  rder to 7/1/18 dates to  will be end IDT ens and es are
٠ ر	on 06/29/18 at 1:18 P	t #3's current clinical record M showed that the resident 2/15. Further review of the			

record revealed an ISP dated 07/02/18 which lacked documented evidence that the resident's health care practitioner or surrogate reviewed it. The record also lacked documented evidence that an ISP review was conducted six months

Healt	Regulation & Licensia	na Administration		1 1	FORM APPROVED
	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T (Y2) MILL TIP	LE CONSTRUCTION	LOVON DATE OUDVEY
AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
i		ĺ	A. BUILDING	·	SOM LETED
		l .	l .		
		ALR-0039	B WING		07/13/2018
NAME C	E 550\/1555 05 01/55				07/13/2010
NAME	F PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
BV/MS	TAR CHEVY CHASE TE	NAKI DIBIA CHE	NNECTICUT GTON, DC 2	AVENUE NW 0015	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	in.	SPANIDEDIS DI AN OF CORDECTI	
PREFIX	( (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	
	Acres and			DEFICIENCY)	
D 40	2 Continued From To	00			····
17.40	3 Continued From pa	ge 29	R 483		
					1
	4 Review of Resid	ent #5's current clinical record			1
	on 07/02/19 at 11:30	O AM showed that the resident	:		
			•		
	was admitted on UB	/01/16. Further review of the			
	record revealed a si	gnificant change ISP dated			1
	05/17/18 which lack	ed documented evidence that			1
	the resident's health	care practitioner or surrogate			
	reviewed it. The rec	ord also lacked documented			
	evidence that an ISI	review was conducted six	9		
	months prior to 05/1	7/18			
	meriate pitor to co, t	7710.			
	5 Review of Pecido	nt #6's current clinical record	3	<b>)</b>	1
		5 AM showed an ISP dated	Į.		ı
	UZI IZI 18 WIIICH IACK	ed documented evidence that			
	it was reviewed by the	ne resident's health care			1
	practitioner.				l l
			1		l l
	<ol><li>Review of Reside</li></ol>	nt #7's current clinical record			
	on 07/02/18 at 2:00	PM showed there was no			
	documented evidence	ce of an ISP review by the	1		
	interdisciplinary tean	cinco 07/10/16	1		Į.
	interdisciplinary team	i since of tarto.	1		
	7 Daviou of Deside	mt 4601a	1		
		ent #8's current clinical record	Ī		
		PM showed that the resident			
	was admitted on 12/0	07/15. Further review of the			
		SP dated 02/10/18 which			
		evidence that it had been			
	reviewed by the resid		Į.		
	practitioner, the resid	lent, or the resident's	i		
	surrogate Also the	ecord showed there was no			
	documented evidence	e that an ISP review was	i i		1
	conducted six month				1
	CONTRACTOR SIX (HOLICI)	a prior to 02/10/16.			1
	O Daview of Barth	-1.40			
	a. Review of Reside	nt #9's current clinical record	1		1
	on 07/05/18 at 10:00	AM showed that the resident	Į.		1
	was admitted on 03/3	30/15. Further review of the			ŀ
	record revealed an IS	SP dated 07/05/18 which	1		1
	lacked documented e	evidence that it had been			Į.
			- 1		

reviewed by the resident's health care practitioner. Also, the record showed there was Health Regulation & Licensing Administration STATE FORM

Health Regulation & Licensing Administration			FURIVIAFFRUVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
ALR-0039	B WING	10,770	07/13/2018
NAME OF PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DV/MOTAR CHEVY CHASE LENANT D/B/A CHE	NNECTICUT AVI		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	D BE COMPLETE
R 483 Continued From page 30	R 483	<del> </del>	
no documented evidence that an ISP review was conducted six months prior to 07/05/18.			
9. Review of Resident #10's current clinical			
record on 07/05/18 at 1:00 PM showed that the resident was admitted on 09/25/13. Further			
review of the record revealed an ISP dated			
10/19/17 which lacked documented evidence that it was reviewed by the resident's health care			1
practitioner, the resident, or the resident's	1		£1
surrogate. Also, the record showed there was no documented evidence that an ISP review was			1
conducted six months after 10/19/17.			
Continued review of the record revealed a significant change ISP dated 06/25/18. The ISP lacked documented evidence that it was reviewed			
by the health care practitioner or resident's surrogate.			
10. Review of Resident #12's current clinical			
record on 07/13/18 at 2:00 PM showed that the resident was admitted on 12/27/17. Further			
review of the record revealed a post			}
move-in ISP dated 12/27/18. The ISP lacked documented evidence that it was reviewed by the			ĺ
resident's health care practitioner, the resident, or			
the resident's surrogate 30 days after admission.			
Continued review of the record revealed a			İ
nursing note dated 01/21/18, which documented	Ĭ		3
that the resident was found at a library (2 miles away from the ALR) asking the staff how to get			
back to the facility. The note also indicated that			
after leaving church, Resident #12 followed a			
"man with a dog" because she thought the man knew how to get to Connecticut Avenue. The			
resident, however, stopped following the man			
when she realized he was not going the right way.  Further review of the record revealed that the			1

Health Regulation & Licens	ing Administration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	GDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
	IDENTIFICATION NOWIGER:	A. BUILDIN	NG:	COMPLETED
	ALR-0039	B. WING_		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CIT	Y, STATE, ZIP CODE	1 07/13/2016
BV/MSTAR CHEVY CHASE TO			T AVENUE NW	
	WASHIN	GTON, DC		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	D.BE COMPLETE
R 483 Continued From pa	age 31	R 483	T	
ALR staff made Re	esident #12's physician aware			
of the incident, at w	which time he instructed facility		1	
staff not to allow the	e resident to leave the ALR			
without supervision	. The record, however, lacked noe that the ALR staff had			
updated the ISP, da	ated 12/27/18, to address the		i	
change in supervisi	on.		<b>N</b>	
During an interview	on 07/06/40 -1-40-40 ANA II			
ALA stated that the	on 07/06/18 at 10:40 AM , the facility's previous nurse			
reviewed and update	ted ISPs as required.			
However, the ALA w	vas unable to locate the ISPs			
at the time of the su	ırvey.			
During a post-surve	y interview on 07/23/18			
starting at 1:00 PM,	Resident #12's son stated he			
was not aware that t	the ALR had ISP meetings.			
his mother continue	after the incident on 01/21/18, d to leave the facility without			
supervision. When a	sked if the ALR made him			
aware of the physicia	an's instructions for his			
facility the son state	ervision when leaving the ed, "No, I thought it was a			
recommendation fro	m the nurse."			
At the time of the sui	rvey, the ALR failed to ensure			
#9. #10. and #12 we	nts #1, #2, #3, #5, #6, #7, #8, re updated as required.			1
, , , , , , , , , , , , , , , , , , , ,	o apadiou do required.			
R 605 Sec. 701g2 Staffing	Standards.	R 605	R605 Sec.701g2 Staffing Standa	ırds
(2) Possess current	t and appropriate licensure		I TIL ALD OU	
and certifications as	required by law;		I. The ALR failed to ensure that	
based on observation	n, interview, and record		PDAs working with ALR resider	nts
working with ALR res	to ensure that the PDAs idents possessed a current		possessed a current license or	
license or certification	n to provide ADL assistance		certification to provide ADL	
for one of six PDAs in	n the sample (PDA #2).	4	assistance.	)

r	Health I	Regulation & Licensir				1 010	WINI I NOVEL
	STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY MPLETED
L	- Total		ALR-0039	B WING_	***	07	/13/2018
l	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		10/2010
	BV/MST/	AR CHEVY CHASE TE	NANT DIRIA CHE 5420 CON	INECTICUT	AVENUE NW		
L	110000		WASHING	TON, DC			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE
	R 605	Continued From page	ge 32	R 605	a. ALR revised Caregiver (Sitte	er)	8/7/18
		Findings included:			policy. ALR updated PDA list	-	8/31/18
		Observation on 06/2	26/18 at 11:36 AM showed		include PDA #6. Resident #1 h	as	
		Resident #1 in her a	partment accompanied by an		expired. PDA #2 no longer prov	vides	
		11:39 AM, PDA #6 s	ng an interview on 06/26/18 at tated that she was hired by		assistance in ALR; unable to ob	stain	
		the resident's family with feeding.	and assisted the resident		copy of valid license.		
		During an interview	on 07/05/18 at 1:40 PM, the		b. ALA/Designee will obtain co	pv of	
		ALA verified that Res	sident #1 received ADL care		valid license for all PDA's prior		
		from a PDA hired by ALA further stated th	the resident's family. The at Resident #1 needed		providing assistance to residents		
		assistance with getting	ng out of bed, feeding,		Responsible party will sign PDA		
		bathing, and dressing	g.		policy upon admission into ALF	₹.	
		The ALA maintained	a list entitled, "Residents		ALA/Designee will review revis	sed	8/31/18
		Who Have Private D	uty Aides," which indicated		Caregiver (Sitter) Policy with		
		and the respective na	LR who received PDA care ames of the PDAs. The ALA		Resident/Responsible Party for		
		provided a current co	py this list on 07/13/18 at		residents that currently have PD	A's	
		3:41 PM. Review of t #6. who was previous	he listing showed that PDA sly observed in Resident #1's		and will obtain the Private Care	giver	
	i	apartment, was not in	ncluded on the list.		Agreement.		
	(	different PDA (PDA#	iew of the listing showed a		0.1.0		
		Resident #1.	z) was indicated for		c. QA Committee will review PI		
		Review of PDA #210 5	ersonnel record on 07/05/18		List monthly during QA meeting	gs.	
	8	at 2:30 PM lacked do	cumented evidence of the				
	r	equired CNA certifica	ation. It should be noted that				
	t	he DC Health profes:	ation search conducted on signal license database				
	٧	rerified that PDA #2's vas "expired" as of 10	CNA certification status				
	P	at the time of survey, PDA#2 possessed a DL assistance for Re	the ALA failed to ensure valid certification to provide esident #1.				

Health Regulation & Licensi	ng Administration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	ALR-0039	B. WING_	The state of the s	07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	01710/2010
BV/MSTAR CHEVY CHASE TE	WASHING	INECTICUT	TAVENUE NW 20015	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETE
R 782 Continued From pa	ge 33	R 782		1116107-811-32-33-32-32-32-32-32-32-32-32-32-32-32-
R 782: Sec. 901 1 Respon Personnel	sibilities Of The ALR	R 782	R782 Sec. 901 Responsibilities ALR Personnel	of the 8/24/18
own medications; Based on record refailed to ensure an conducted to determ of self-medicating for	view and interview, the ALA nitial assessment had been nine if a resident was capable or two of two newly admitted nedicate (Residents #4 and		I. The ALR failed to ensure an inassessment had been conducted determine if a resident was capa self-medicating.	to
#11). Findings included:			a. ALR arranged for RN Consult from Allied Pharmacy to review #11, and all residents that self-	
on 07/02/18 at 10:19 was admitted on 06/ record revealed an I indicated the resider self-medicate. The re-	ent #4's current clinical record 5 AM showed that the resident 06/18. Further review of the 1&P dated 05/14/18 which nt could independently ecord, however, lacked be that an initial assessment		administer medications. Obtains orders for residents to self-admin medications from Medical Provi Medical Director.  b. DON/Delegate will complete	nister der/
was conducted to as self-medicate.	sess the resident's ability to		Initial Assessment of each reside that self-administers prior to/at ti	ent
Resident #4 reported	on 07/02/18 at 11:25 AM, If that no medication led from the ALR staff.		of admission and obtain Physicial order to self-administer. Medical director to be consulted about self-administer.	l lf-
on 07/02/18 at 3:00 f was admitted on 09/0 revealed a nursing no indicated the residen	nt #11's current clinical record PM showed that the resident 04/17. The record also ote dated 09/04/17 which t self-medicates. The record,		medicating resident concerns dur Monthly QA meeting. DON/Del created a Medication Review Lo include schedules for review.	legate
assessment was con resident's ability to se be noted that the faci order for the Residen	umented evidence an initial ducted to assess the elf-medicate. It should also lity did not have a physician t #11 to self-medicate until approximately eight months		c. DON/Delegate will report state medication review during Month Quality Assurance Meeting.	

	Requiation & Licensin				
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	Water to the top while the	ALR-0039	B WING_		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	OTDCET AL	Donne out		O / / TO/AUTO
	, it will be to the control of the c			, STATE, ZIP CODE	
BV/MST	AR CHEVY CHASE TE	WASHING	NNECTICU <sup>*</sup> STON, DC	「AVENUE NW 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
R 782	Continued From pag	ge 34	R 782		
	after the resident's a	admission to the ALR.			
;	contract nurse could assessment had bee the resident's ability contract nurse was rewhen the resident with the time of the sur an initial assessment.	rvey, the ALA failed to ensure t was conducted to of Resident #4 and #11 to			
R 802	Sec. 903 2 On-Site F	Review.	R 802	R802 Sec. 903 On-Site Review	
	(2) Assess the resid	dent's response to			
	medication; and	tomes responde to		I. RN failed to assess each reside	ent's
*		ew and interview, the RN		response to meds every 45 days.	ALC S
	failed to assess each	resident's response to		response to meds every 45 days.	
	medications every 45	days for six of 12 residents ents #1, #2, #5, #6, #7, and		a. ALR arranged for RN Consultato complete the 45-day medication reviews for Resident #1, #2, #5, #	n
	Findings included:			and #7. Resident #12 moved out	of
	06/27/18 at 11:00 AM was admitted on 02/2 was responsible for a medications. Further	t #1's clinical record on showed that the resident 5/15, and the nursing staff dministering Resident #1's review of the clinical record as no documented evidence		ALR. Medications were reviewed verified by resident Primary Care Provider/Medical Director. ALR arranged for RN's to complete 45 Med Reviews for all current residuals.	8/31/18
į.	the RN reviewed the r medications.	resident's response to		b. DON/Delegate will be respons	ible
(	06/29/18 at 10:30 AM was admitted on 01/2	t #2's clinical record on showed that the resident 2/18, and the nursing staff dministering Resident #2's		for ensuring resident 45-day medication reviews are completed DON/Delegate will keep a Medication Review Log.	d.

Health Regulation & Licensing	Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING _		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TEN	IANT D/B/A CHE 5420 CON		AVENUE NW	
PRÉFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE
documented evidence resident's response to 07/02/18 at 11:30 AM was admitted on 08/0 was responsible for a medications. Further documented evidence resident's response to 4. Review of Resident 07/02/18 at 11:30 AM was admitted on 02/1 was responsible for a medications. Further idocumented evidence resident's response to 5. Review of Resident 07/02/18 at 2:00 PM s was admitted on 02/0 was responsible for admedications. Further idocumented evidence resident's response to 6. Review of Resident 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications. Further indocumented evidence resident's response to 07/13/18 at 2:00 PM s was admitted on 12/27 was responsible for admedications.	review of the record lacked e the RN reviewed the medications.  It #5's clinical record on showed that the resident wide, and the nursing staff dministering Resident #5's review of the record lacked e the RN reviewed the medications.  It #6's clinical record on showed that the resident 2/18, and the nursing staff dministering Resident #6's review of the record lacked e the RN reviewed the medications.  It #7's clinical record on showed that the resident 4/14, and the nursing staff dministering Resident #7's review of the record lacked the RN reviewed the medications.  #12's clinical record on showed that the resident 4/17, and the nursing staff dministering Resident #12's review of the record lacked the RN reviewed the medications.  #12's clinical record on showed that the resident #12's review of the record lacked the RN reviewed the medications.	R 802	c. DON/Delegate will report sta medication review schedule mo to the QA Committee.	

Health Regulation & Licensin	ng Administration		1 2	FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	ALR-0039	B. WING_	***************************************	07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE	A CONTRACTOR OF THE CONTRACTOR
BV/MSTAR CHEVY CHASE TE		NNECTICUT	T AVENUE NW 20015	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
R 802 Continued From page	ge 36	R 802		to the state of th
each resident's resp aforementioned resi	rvey, the RN failed to assess onse to medications for the dents in the sample.			
R 803 Sec. 903 3 On-Site I	Review.	R 803	R803 Sec. 903 On-Site Review	
self-administer his o Based on record rev failed to assess the continue to self-adm days for five of five re self-medicate (Resid #11).  Findings included:  1. Review of Resider 06/29/18 at 1:18 PM was admitted on 03/2	iew and interview, the RN resident's ability to safely inister medications every 45 esidents in the sample who lents #3, #8, #9, #10, and at #3's clinical record on showed that the resident 12/15. Further review of the		I. The RN failed to assess the resident's ability to self-administ medications every 45 days.  a. ALR arranged for RN Consulto complete the 45-day medication reviews for resident's who self-administer medications. Resident ability to self-administer medications was observed RN Consultants. RN notified Physician/Medical Director for clarification of order	tants 6/28/18 on at's ations DON/ 8/31/18
record revealed a H8 documented the resident administer medication lacked documented expenses and the record revealed a H8 documented expenses are record revealed a H8 documented expenses are record revealed a H8 documented expenses are record revealed a H8 documented expenses are record revealed a H8 documented expenses are record revealed a H8 documented expenses are record revealed a H8 documented the residual record revealed a H8 documented the residual record revealed a H8 documented the residual record revealed a H8 documented the residual record record revealed a H8 documented the residual record record revealed a H8 documented the residual record reco	P dated 03/11/15 that dent could independently n. The record, however, evidence the RN assessed o continue to self-medicate.		blrector for clarification of orde self-medicators. DON/Delegate obtained Physician order for resi to continue to self-administer medication.	
07/05/18 at 2:00 PM: was admitted on 12/0 record revealed a H& documented the resic administer medication lacked documented e the resident's ability to	nt #8's clinical record on showed that the resident 17/15. Further review of the P dated 11/14/15 that dent could independently n. The record, however, evidence the RN assessed to continue to self-medicate.		b. DON/Delegate will be respons for ensuring resident reviews for administration are completed eve days. DON/Delegate will keep a Medication Review Log that incresidents that self-administer medications.	self- ery 45 1

07/05/18 at 10:00 AM showed that the resident

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		ALR-0039	B WING _		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE	
BV/MST/	AR CHEVY CHASE TE	MANILUIDIA GRE		AVENUE NW	
(X4) ID	SIIMMARYSTA	TEMENT OF DEFICIENCIES	STON, DC		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE COMPLETE
R 803	Continued From page	ge 37	R 803		
	record revealed a H documented the res medications independented documented the resident's ability	/30/15. Further review of the &P dated 04/11/17 that ident could self-administer ndently. The record, however, evidence the RN assessed to continue to self-medicate.  nt #10's clinical record on		c. DON/Delegate will report stamedication review schedule moto the QA Committee.	
	07/05/18 at 1:00 PM was admitted on 09/ record revealed a Hidocumented the resimedications independented documented.	showed that the resident 25/13. Further review of the &P dated 08/05/13 that ident could self-administer idently. The record, however, evidence the RN assessed to continue to self-medicate.			
	07/05/18 at 3:00 PM was admitted on 09/6 record revealed that evidence the RN ass continue to self-medio6/28/18. It should all did not have a physicself-medicate until 06	nonths after the resident's			
(	AM, the ALA stated the nurse	on 07/05/18 starting at 10:30 hat going forward she would assesses the residents' self-medicate every 45 days.			
t	At the time of the sur he residents' ability to	vey, the RN failed to assess o continue to self-medicate.			
7	This is a repeat defici	ency.			

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Health Regulation & Licens	ing Administration		FO	RM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY
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	ALR-0039	B WING_		7/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY	, STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE T		NNECTICU <sup>®</sup> GTON, DC	T AVENUE NW 20015	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 953 Continued From pa	age 38	R 953		
R 953 Sec. 1001b General	al Conditions.	R 953	R 953 Sec. 1001b General Condition	S
equipment, ground good repair and op Based on observat failed to ensure the installed equipment living units were in residents (Resident Finding included:  An environmental in 06/26/18 at 11:13 A closet on the fourth electrical wiring, did	ion and interview, the ALR facility's grounds were safe, was operable, and individual good repair for 73 of 73		I. Utility closet on fourth floor of not contain a lock to ensure the safe of all residents living in the ALR.  a. ALR staff installed lock on electrical closet. b. All doors have been assessed fineed for lock. All needed locks have been attained and installed. c. Maintenance team will continue to monitor door locks for safety during their weekly walk-through.	8/1/18 for ee
facility, including wa chimney, gutters, do surfaces, and acces structurally sound, s Based on observation determined that the the exterior of its buistructurally sound ar Findings included:  Observation on 06/2 that the ALR's walkwareas and missing pi	sure that the exterior of its lkways, yards, porches, ownspouts, paintable sory buildings are maintained anitary, and in good repair. In and interview, it was facility failed to ensure that lding was maintained in good repair.  6/18 at 10:26 AM showed may had several cracked seces of flagstone noted from		R 971 Sec. 1003a General Building Exterior  I. ALR's walkway had several cracke areas and missing pieces of flagstone.  a. Flagstone walkway project completed as of 8/1/18.  b. Exterior has been reviewed by ALF for any safety concerns on 8/1/18. No additional safety concerns were found.  c. Maintenance team will review safet.	8/1/18 k
the front sidewalk to entrance. The survey	the facility's front door vors noted eight to ten oken or missing pieces of		<ul> <li>c. Maintenance team will review safet of exterior building monthly.</li> </ul>	y

realth Regulation & Licensing Administration									
STATE AND P	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED				
		ALR-0039	B WING_		07/13/2018				
NAME	OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CIT	Y, STATE, ZIP CODE					
BV/MSTAR CHEVY CHASE TENANT D/B/A CHE  5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015									
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D RE COMPLETE				
R 97	hazard for residents observation showed blocks of the flagsto in between some of uneven surface. And contained an expose cover and with very libraring a potential transfer of Maintenan was scheduled to coinspect the walkway of the repair would be On 06/29/18 at 3:38 Maintenance explaine been collected from vilagstone walkway as 07/02/18 at 12:15 PM Maintenance stated to the premises and had walkway.  Follow-up observation and 07/03/18 at 12:15 contractors repairing Subsequent observation of 107/06/18 at 9:10 AM in the walkway was still the premises was still to the premise of 100 AM in the walkway was still to the premise of 100 AM in the walkway was still to the premise of 100 AM in the walkway was still to the premise of 100 AM in the walkway was still to the premise of 100 AM in the walkway was still to 100	e walkway, creating a trip , visitors, and staff. Continued separation of individual ne with no evidence of grout the blocks, resulting in an other observed area and drain pipe missing the little surrounding stone, rip hazard for residents,  on 06/28/18 at 10:15 AM, the nee stated that a contractor me to the ALR that day to and an update on the status are provided to the surveyors. PM, the Director of ed that two proposals had vendors to replace the soon as possible. On the Director of that the contractors were on distarted to repair the seconducted on 07/02/18 of PM showed the the walkway on both days, ions on 07/05/18 and revealed that the repair of in progress and the potential	R 971						
R1003	trip hazards remained  Sec. 1006c Bathroom		R1003	R 1003 Sec. 1006c Bathrooms					
	the not water at all tap	re that the temperature of is to which residents have y the use of thermostatically es or by other means,		I. ALR failed to ensure that the h water temperature did not exceed degrees.					

Health	Regulation & Licensin	g Adminisuation			FORW APPROVEL				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	UMRER.		(X3) DATE SURVEY				
1			A. BUILDIN	IG:	COMPLETED				
		ALR-0039	B WING_		07/42/2040				
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY	STATE ZIP CODE	07/13/2018				
BV/MSTAR CHEVY CHASE TENANT D/B/A CHE  STREET ADDRESS, CITY, STATE, ZIP CODE  5420 CONNECTICUT AVENUE NW									
WASHINGTON, DC 20015									
(X4) ID PREFIX TAG	REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE				
R1003	Continued From pag	ge 40	R1003						
including control at the source, so that the water				a. Hot water heater temperature	set to 8/1/18				
	temperature does not exceed 110 degrees Fahrenheit,			below 110 degrees.					
Based on observation and interview, the ALR				In Faulting Mail					
failed to ensure that the hot water temperature				b. Facility Maintenance Director to					
did not exceed 110 degrees Fahrenheit in six of the six bathrooms inspected (Apartments				maintain daily log of temperature checks.					
	#718, #616, #617, #4	404A, #412, and #214).		onesis.					
Findings included:			c. Maintenance team will do wee	ekly					
				temperature checks. Any room found					
During the environmental inspection on 06/26/18 at 11:13 AM, the hot water temperature measured 116.6 degrees Fahrenheit at the hand sink in the bathroom of Apartment #718. Further observations conducted on the same day showed				with excessive heat, hot water he	eater				
				will immediately be reset to					
				appropriate temperature while st and resident are informed not to	aff				
the following hot water temperatures recorded at the bathroom hand sink in each specified location:			utilize until temperature is within	,					
			approved range.	1					
					ļ				
-Apartment #617 = 115.3 degrees Fahrenheit -Apartment #616 = 115.7 degrees Fahrenheit -Apartment #404A = 111.9 degrees Fahrenheit -Apartment #412 = 113.7 degrees Fahrenheit -Apartment #214 = 112.5 degrees Fahrenheit									
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				N.	ĺ				
	Follow-up observation	ns on 06/28/18 and 06/29/18							
at 2:20 PM and 2:40 PM, respectively, showed the hot water temperatures at the hand sinks in									
	the aforementioned as	partments were between							
	109.5 and 110 degree	s Fahrenheit.							
	At the time of the surv	ey, the ALR failed to ensure							
the water temperatures did not exceed 110 degrees Fahrenheit in six of the apartment									
	bathrooms inspected.	ery or the abartment			1				
			Į		1				