

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2019
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NAME OF PROVIDER OR SUPPLIER BV/MSTAR CHEVY CHASE TENANT D/B/A CHE	STREET ADDRESS, CITY, STATE, ZIP CODE 5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R 000 Initial Comments

An annual licensure survey was conducted on 06/25/19 through 06/28/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The survey also included the abatement of the plan of correction submitted on 06/10/19, for the 05/13/19 monitoring visit. The ALR provided care for 69 residents and employed 81 personnel, to include professional and administrative staff. A random sample of 17 resident records and 18 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews.

Listed below are abbreviations that appear in the body of this report:

- ADON - Assistant Director of Nursing
- ALA- Assistant Living Administrator
- DON - Director of Nursing
- ISP - Individualized Support Plan
- PDA - Private Duty Aide

R 481 Sec. 604b Individualized Service Plans

(b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on interview and record review, the ALA failed to ensure ISPs included the services to be provided, when, how often, and by whom services will be provided for two of 16 residents in the sample (Resident #1 and #6).

Findings included:

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Uchit Seelaman

TITLE

Administrator

(X6) DATE

8/8/19

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R 481	<p>Continued From page 1</p> <p>According to the 06/10/19 plan of correction for the 05/13/19 monitoring visit, the ALR documented that all ISPs would be reviewed and updated by 06/14/19. The plan further indicated that all ISP's would be reviewed by the healthcare practitioner and resident/surrogate, by no later than 06/21/19. The ALR failed to update all ISPs as indicated in their plan as evidenced below:</p> <p>1. On 06/25/19 at 2:30 PM, review of Resident #1's clinical record revealed a physician's order dated 06/20/19, which showed that the resident was to have skin prep applied to the plantar blister on the left foot every shift. On 06/25/19 at 2:37 PM, review of the ISP dated 06/18/19 lacked documented evidence of when, how often, and by whom wound care services were to be provided to the resident.</p> <p>On 06/25/19 at 2:46 PM, review of Resident #1's nursing note dated 06/20/19 showed that wound care services started on 06/20/19.</p> <p>During an interview on 06/25/19 at 3:51 PM, the ALA confirmed that the resident was receiving wound care services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom wound care services would be provided in all residents' ISPs.</p> <p>At the time of the survey, the ALR failed to provide documented evidence that all ISPs included when, how often, and by whom wound care services would be provided.</p> <p>2. On 06/26/19 at 1:42 PM, review of Resident 6's ISP (undated, however signed by the resident's spouse 06/19/19) showed that the resident had a</p>	R 481	<p>R481</p> <ol style="list-style-type: none"> 1. The ISP for resident ID #1 was corrected on 6/20/19 to include the details of the wound care services being provided. See attachment #1 2. Resident ID#6 no longer resides at the community. <p>The Director of Nursing/designee will conduct a random audit of ten percent of resident ISP's monthly for three months to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed.</p>	
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Nichi Beekman, Administrator 8/8/19

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R 483	<p>Continued From page 3</p> <p>sample (Resident #11).</p> <p>Findings included:</p> <p>According to the 06/10/19 plan of correction for the 05/13/19 monitoring visit, the ALR documented that all ISPs would be reviewed and updated by 06/14/19. The plan further indicated that all ISP's would be reviewed by the healthcare practitioner and resident/surrogate, by no later than 06/21/19. The ALR failed to update all ISPs as indicated in their plan as evidenced below:</p> <p>On 06/28/19 at 10:20 AM, review of Resident 11's medical record showed the following:</p> <ul style="list-style-type: none"> - a nurse's note, dated 03/26/19, that stated which the resident sustained a fall on 03/26/19; - a nurse's note, dated 04/01/19, that stated which the resident underwent metacarpal surgery; and - hospital discharge papers documenting that the resident had right hip surgery on 04/19/19. <p>Review of Resident #11's ISP (undated, however signed by the resident on 06/20/19) failed to show the resident's 03/26/19 fall, the 04/01/19 metacarpal surgery, and the 04/19/19 right hip surgery.</p> <p>At the time of the survey, the ALA failed to provide documented evidence that all ISPs were updated when there were significant changes in residents' health care status.</p>	R 483	<p>R483</p> <p>The ISP for resident ID #11 was updated to reflect the history of the fall on 3/26/19, the metacarpal surgery on 4/1/19, and the hip surgery on 4/19/19. Completion date: 8/7/19. See attachment #2. The Director of Nursing/designee will conduct a random audit of ten percent of resident ISP's monthly for three months (August, September and October 2019) to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed.</p>	
R 821	<p>Sec. 904e8 Medication Storage</p> <p>(8) Residents who self-administer may keep and use prescription and nonprescription medications</p>	R 821		

Nichi Beelman, Administrator, 8/8/19

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R 821	<p>Continued From page 4</p> <p>in their units as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure that (I) residents who self administer kept their medications secured from other residents; and (II) only residents who self-administered kept medications in the units, for four of eight residents (Resident #4, 6, 13 and 14).</p> <p>Findings included:</p> <p>I. On 06/25/19 at 11:01 AM, observation of Resident #4's apartment showed a bottle of aspirin on the resident's bedside table. When asked if the resident self-administers medications, Resident #4 responded, "yes." When asked if the resident secures medications when leaving the apartment, Resident #4 replied, "I don't always lock my door. I keep my keys by the door in the basket."</p> <p>When leaving Resident #4's apartment, a mounted, open basket was observed beside the door in the facility's hallway. The basket contained a key ring with two keys.</p> <p>At 3:10 PM, the ADON was informed that the resident kept an apartment key on the outside of the door, and did not show other means of securing medications inside the unit. The ADON replied that the keys would be removed and that the resident would be provided other options to secure medications. It should be noted that on 06/26/19 at 9:45 AM, observation of Resident #4's basket showed that the keys had been removed.</p> <p>II. The ALA failed to ensure that only residents who self-administer kept medications in their</p>	R 821	<p>R821</p> <ol style="list-style-type: none"> 1. Resident ID# 4's room key was removed from the basket by the door at time of survey. The resident and her daughter were re-educated on proper securing of medication in the unit at time of survey. <ol style="list-style-type: none"> a) Resident ID # 13's medication was removed from the bedside table at time of survey. b) Resident ID # 14' s bottle aspirin was removed from the bathroom at time of survey. c) Resident ID # 6 no longer resides at the community. 	
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Nidhi Beekman, Administrator 8/8/19

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R 821	<p>Continued From page 5</p> <p>units, as evidenced by the following:</p> <p>a. On 06/25/19 at 11:23 AM, observation Resident #13's apartment showed a medication cup with a white pill (broken into two pieces) inside sitting on the resident's bedside table. The resident said that the nurse brought the medication the previous night, but the resident forgot to take it.</p> <p>b. At 11:35 AM, observation of Resident #14's apartment showed a bottle of aspirin on the resident's bathroom counter. When asked, Resident #14 said that due to a disability, the nurses administer all of his medications.</p> <p>c. At 11:52 AM, observation of Resident #6's apartment showed multiple medication containers on the table in the family room, on a chair in the hallway, and on the bedside table.</p> <p>At 3:00 PM, the ADON presented a list of the ALR's residents who self-administer. Residents #13 and 14 were not on the list. Resident #6 was on the list, however, the ADON said that the resident's physician wrote an order on 06/21/19 for the facility's nurses to begin to administer the resident's medications.</p> <p>At 3:10 PM, the ADON was informed that there were medications in the Residents #13 and #14's apartments. The ADON replied that the nurses would remove the medications immediately.</p> <p>On 06/26/19 at 10:35 AM, a second observation of Resident #6's apartment showed medications remained on the table in the family room and the hallway chair.</p>	R 821	<p>R821 continued from page 5</p> <p>The Director of Nursing/designee conducted an audit of all resident apartments that self-administer medications. Completion date: July 31, 2019. The residents and staff will be re-educated on safe storage of medications by August 31, 2019. The Director of Nursing/designee will continue to evaluate the resident's ability to maintain safe storage of medications during the 45-day medication assessment. A random audit of the assessments will be conducted monthly for three months (August, September and October). Findings will be reported to the Quality Assurance Committee for follow up as needed.</p>	
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Nicki Beelman, Administrator 8/8/19



GOVERNMENT OF
THE DISTRICT OF
COLUMBIA

CRFMR
Rev. 9/02

**DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION**

Mailing Address
899 North Capitol St., NE
Washington DC 20002
2nd Floor (2224)
202-442-5888

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:	Completion Date
Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction
BV/MStar Chevy Chase Tenant d/b/a Chevy Chase House ALR -0039	5420 Connecticut Ave, NW Washington, DC 20008	06/25/19 - 06/28/19 Follow-up Dates(s):	
C.M. Wilson for P. Vincent Walker	An annual licensure survey was conducted on 06/25/19 through 06/28/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The survey also included the abatement of the plan of correction submitted on 06/10/19, for the 05/13/19 monitoring visit. The ALR provided care for 69 residents and employed 81 personnel, to include professional and administrative staff. A random sample of 16 resident records and 18 employee records were selected for review. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ADON – Assistant Director of Nursing ALA – Assistant Living Administrator ALR - Assisted Living Residence		8/2/19 Wali Seelam ALA Facility Director/Désignee

Name of Inspector _____ Date Issued _____



DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

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- CNA – Certified Nurse Assistant
- DFO – Director of Facility Operations
- EP – Emergency Preparedness
- EPP – Emergency Preparedness Program
- PT – Physical Therapist
- PDA – Private Duty Aide

10110 Required Policies and Procedures

10110.01 (k) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR & 483.73;

This regulation is not met as evidenced by:

The ALR failed to develop written policies and procedures to ensure subsistence needs (specifically sewage and waste disposal) during emergency situations, for 69 of 69 residents residing in the facility (Residents#1-69).

On 06/25/19 beginning at 1:04 PM, review of the ALR's EPP dated November 2018 showed no evidence that policies and procedures had been developed to provide for sewage and waste disposal during emergencies.

At 1:33 PM, the DFO said during an interview that the ALR would use red bags in the event there was an emergency in which the sewage and waste disposal both were compromised. When asked if there were policies and procedures outlined in the EPP that specifically addressed sewage and waste disposal, the director of facility operations said "no." The DFO stated that he would develop a policy

10110 Required Policies and Procedures

- a) Chevy Chase House has developed the attached policies and procedures for sewage disposal and waste disposal during emergency situations. See attachment #3, 4. The staff will be educated on the policies by August 31, 2019.

Nicki Seeburn, ALA 8/8/19



DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

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and procedure to address sewage and waste disposal.

At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed all subsistence needs, such as sewage and waste disposal services, during emergency situations.

The ALR failed to develop policies and procedures to track the location of staff and residents during an emergency, for 69 of 69 residents residing in the facility (Residents #1-69).

On 06/25/19 beginning at 1:04 PM, the EP leader (DFO) described during an interview the tracking system used for sheltering in place. When asked about a tracking system during an evacuation outside of the ALR, the EP leader stated that the ALR has a contract with two other providers. The EP leader also stated that head counts of residents would be taken before leaving the ALR. After the residents arrived to their destination, the DFO stated that he would contact all other administrators to inform them of the evacuation.

At 2:50 PM, review of the EPP, dated November 2018, failed to show evidence that the ALR had developed policies and procedures to address the tracking of sheltered residents and staff locations during and after an emergency.

On 06/26/19, between 10:12 AM and 1:01 PM, nine employees (i.e. dining room staff, concierge staff, administrators, ALA, CNAs, PDA, PT staff and housekeeping) were interviewed regarding the ALR's tracking system during an evacuation. Nine of nine

10110 Required Policies and Procedures

b) Chevy Chase House will train all staff on Evacuation Procedures, the use of the Evacuation Resident & Staff Tracking Log and the instructional Evacuation Letter to family will be mailed by August 31, 2018. See attachment #5, 6, 7.

Nick Beelman, ALA 8/8/19



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HEALTH REGULATION & LICENSING
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employees interviewed were not familiar with a tracking system used during an evacuation.

On 6/27/19 at 10:50 AM, a follow-up interview was conducted with the EP leader regarding a written policy and procedure related to tracking residents outside of the ALR during an evacuation. The EP leader stated that a policy and procedure needed to be developed and added to the EPP.

At the time of the survey, the facility failed to document a means of tracking the location of all staff and sheltered clients during and after emergencies.

The ALR failed to ensure each resident's family member had been given information regarding the facility's EPP, for one of one family member interviewed inside the ALR Resident #17's mother).

Findings included:

On 06/25/19, beginning at 1:04 PM, review of the ALR's EPP dated November 2018, showed no information regarding the sharing of its EPP and related policies with residents and involved family members.

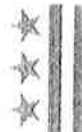
On 06/26/19 at 1:01 PM, Resident #17's mother said during an interview that she had not received any information regarding the ALR's EPP.

On 06/27/19 at 1:36 PM, the EP leader said during an interview that he had not contacted the residents' family

10110 Required Policies and Procedures

c) Chevy Chase House has developed an informational sheet for residents and involved family members which describes procedures of the facility's emergency preparedness plan. The informational sheet is available at the front desk as of August 7, 2019 and will shared with residents and family members by August 31, 2019. See attachment #8.

Lidia Beckman AUA 8/8/19



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

members and/or guardians regarding the ALR's most current EPP information. The EP leader stated that he would create a one page information sheet regarding EP information and distribute the information to the family members.

At the time of the survey, the ALR to ensure the residents' family members were made aware of the facility's EPP once the plan had been developed.

The ALR failed to develop written policies and procedures that address arrangements and/or agreements the ALR had with other facilities or other entities during an emergency, for 69 of 69 residents residing in the ALR (Residents #1-69).

On 06/25/19, beginning at 1:04 PM, the EP leader said during an interview that in the event residents have to be evacuated, the residents would be relocated to at least two other agencies located within a three to five mile radius.

At 2:05 PM, review of the ALR's EPP, dated November 2018, showed no evidence that policies and procedures had been developed to address arrangements and/or agreements the made with other outside entities during an emergency.

On 06/26/19 at 11:05 PM, the EP leader said during a follow-up interview that he was certain that the ALR had a policy and/or contract agreement with two outside agencies. The EP leader stated that he would check with his other team members to see if they had the contract agreements. There was no additional information given to the surveyor by the time the survey ended on 06/28/19.

10110 Required Policies and Procedures

- d) Chevy Chase House has secured reciprocal agreements with Hillhaven Nursing and Rehab, Adelphi, MD as well as Sunrise of Chevy Chase, Chevy Chase, MD. See attachment #9,10.

Nidia Beedman, ACA 8/8/19

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At the time of the survey, there was no evidence that the facility's EPP included written procedures and/or contract agreements to follow if the residents required relocation during an emergency.

e. The ALR failed to develop policies and procedures that described its role in providing care during major disasters or federal emergencies in alternate care sites, for 69 of 69 residents residing in the ALR (Residents #1-69).

On 06/25/19 beginning at 1:04 PM, the EP leader said during an interview that there was no policy currently in place regarding the 1135 waiver.

On 06/26/19 at 11:11 AM, review of the ALR's EPP, dated November 2018, failed to show evidence that the ALR had developed policies and procedures to address the role of the ALR under a waiver declared by the Secretary of Health and Human Services (public health emergencies) or in the provision of care and treatment at an alternate care site identified by emergency management officials when the President of the United States, in accordance with section 1135 of the Stafford Act, declares a major disaster or emergency.

At the time of the survey, there was no evidence that the facility's EPP addressed the provision of care at alternate sites during declared national emergencies.

f. The ALR failed to show evidence that it trained all staff and

10110 Required Policies and Procedures

e) Chevy Chase House has developed the attached policy and procedure that describes its role in providing care during major disasters or federal emergency in an alternative care site. The policy will be reviewed with staff, residents and mailed to family members by August 31, 2019. See attachment #11.

Nidia Sedeman, ALA 3/2/19

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residents on initial emergency preparedness training (i.e. risk assessments, policies and procedures and communication plan), for 69 residents, 10 of 81 employees, 1 PT, and 1 family member.

Findings included:

On 06/25/19, between 10:12 AM to 12:05 PM, several residents and employees (i.e. residents, server, concierge, ADON, ALA, housekeeper, CNA and PT) were interviewed regarding the ALR's EPP. According to the residents and employees, all had some knowledge of what to do in case of a fire. When asked if they all had received initial training the ALR's overall emergency plan to include the risk assessments, policies and procedures and the communication plan, the residents and employees all said they had not received any training on the ALR's EPP.

On 06/26/19, between 10:24 AM to 1:10 PM, the dining room supervisor and a family member were interviewed regarding to ALR's EPP. The dining room supervisor had knowledge of what to do in case of a fire, but had no knowledge of the ALR's overall EPP and had not received any training on the EPP. The family member said during an interview that she frequently visits her mother weekly. When asked if she had received any information pertaining to the ALR's EPP, the family member replied "no."

On 06/27/19 at approximately 11:30 AM, a follow-up interview was conducted with the DFO regarding initial and ongoing training on the ALR's EPP for the residents and

10110 Required Policies and Procedures

- f) Chevy Chase House will in-service staff and residents on the Emergency Preparedness Plan used by the community by August 31, 2019. This training will take place with all new hires and new residents, annually and reinforced during monthly Staff and Resident meetings.

Nicki Beelman, ALA 8/8/19



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staff. The DFO stated that some of the staff had received training on what to do in case of a fire. When asked if the residents and staff received training on the ALR's overall EPP, the DFO said "no." The director of facility operations stated that he would train staff and the residents as soon as possible.

At the time of the survey, there was no documented evidence that staff and residents received initial training on the ALR's EPP.

Nicki Seeburn, ACA 8/8/19