STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TEN	WASHIN	NNECTICUT A GTON, DC 20		
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETE IE APPROPRIATE DATE
R 000 Initial Comments		R 000		
House, Assisted Living 06/26/18 through 07/compliance with the ALR provided care for 79 personnel to incluse administrative staff. administrator reported construction worker with bedroom naked from the nature of this incidence of the ALR's in along with a review of completed to determine adequate supervision by the ALR law. On 00 identified systemic fail immediate risk to the residents. The facility on 07/03/18, was issusticense for no new additional records. The survey findings with interviews with resident members, as well as the and clinical records. Listed below are abbrette body of this report. ADL - Activities of Dail ALA- Assisted Living ALR - Assisted Living ALR - Assisted Living DME - Durable Medica QA - Quality Assurance.	Assisted Living Law. The or 73 residents and employs de professional and On 04/13/18, the ALR's d an incident that alleged a was observed in a resident's the waist down. Based on dent, a comprehensive ncident management system of the ALR's investigation was ne if the ALR provided and oversight as required 7/03/18, the survey team allures that posed an health and safety of all was notified and, effective and a 90 day restricted missions. There based on observations, and the review of administrative deviations used throughout the review of administrative deviations used throughout the residence all Equipment elements.			
CPAP - Continuous Po TED - Throbo-Embolic APS - Adult Protective	-Deterrent Services			
RDO - Regional Direct				
Ith Regulation & Licensing Administration of the Provider of t	ion SUPPLIER REPRESENTATIVE'S SIGN/		EVecutive Director	(X6) DATE

Health Regulation & Licensi			*	FORM APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) AND PLAN OF CORRECTION (DENTIFICATION MIMBER)			IPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING_		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CIT	Y, STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TE	ENANT D/B/A CHF 5420 CO		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	DRF COMPLETE
should acknowledge residents may have a impairment. Services offer a balance between least restrictive setting Based on observation review, the ALR failed secured environment the facility. Specifical implement its policies respond timely to state (III) to implement its princidents and allegation of the facility failed to required the use of states follows: Record review of the Monitoring and Responses to the second facility failed the Monitoring and Responses follows:	Physical Service Plan urse Jursing Aide sing Assistant ministration Record pom phy of Care ervices and environment to that a significant number of some form of cognitive s and environment should reen choice and safety in the ng. In, interview and policy d to provide a safe and t for all residents residing in ally, the facility failed (I) to s on door monitoring, (II) to sinvell/exit door alarms, and policies on reporting ions of abuse. In implement its policies that rairwell/exit door monitoring, facility's policy titled, "Door onse Policy," dated at each stairwell/exit door		R 008 Sec. 102b2 Philosophy of Ca I. The facility failed to implement it policies that required the use of stairwell/exit door monitoring. a. The ALA immediately retrained sthe Door Monitoring and Response Stairwell door alarms were reset to a when opened by sending alerts throuthe entire day to the Concierge at the desk and the CNA pagers. b. The Door Monitoring and Response Policy has been revised to reflect the minute response time to exterior doo doors leading to the basement as with other alerts within the ALR. Staff was trained on the revised policy on 9/12. The staff will be trained on the Door Monitoring and Response Policy and during new hire orientation, and as	taff on 6/29/18 Policy, alarm Ighout e front se e 10- 8/24/18 ors and h as /18.
06/06/16, showed that	onse Policy," dated it each stairwell/exit door monitoring device located at	İ	Monitoring and Response Policy and during new hire orientation, and as required.	ually,

Regulation & Licensin	g Admin		F	PRINTED: 08/03/201
Health	istration	T	man	FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN		(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING		
NAME OF REQUIPER OF SUPER (-)				07/13/2018
NAME OF PROVIDER OR SUPPLIER			, STATE, ZIP CODE	
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(X4) I	WASHIN	GION, DC	20015	- New York
PREF X (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	RF DATE
R 008 Continued From pag	e 2	R 008	c. The Business Office Manager	will
the top of the door F	er the policy, "When the		keep an annual education log, list	ting
door was opened or	ajar, the monitor released a	0	the annual monthly trainings. The	
silent alarm which wa	is sent to each Certified	D.	education log will be monitored	•
Nurse Assistant's (Ci	NA) pager and the Front		monthly by the QA Committee for	
Desk Console. The a	larm indicated the location	†		
of the door which wa	s opened, prompting the		completion/compliance. The QA	
resident had entered	access point to verify that no	**	Committee will be monitoring the	
was not to exceed fiv	the stairwell. Response time e minutes."	#3 #3	policy monthly during the QA me	eeting.
the ALR's stairwell ex #3, #4, #5, #6 and #7 observed to utilize the During an interview or Residential Relations facility decided to turn 7:00 AM and 2:30 PM construction workers of frequently, which trigg response by the ALR's the facility had implem measure for stairwell executed and not. The surveyors	ered the need for extra aides. When questioned if ented a secondary safety		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 che the door/stairwell alarms and rese alarm pagers. b. The staff will be trained annuall Silversphere to properly use the al system. Newly hired staff will be	ly 6/29/18 e eck et to ly by
was taken by the Residual Telephone Was taken by the All Staff and contractors is active and ongoing in review of the attendance.	e logs showed that airwell alarm monitoring	The state of the s	trained on policy by ALR. c. All doors leading outside and to basement have been secured and monitored every 2-3 hours.	

Health	Regulation & Licensi	ng Administration		/	FORM APPROVE
STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG:	(X3) DATE SURVEY COMPLETED
		ALR-0039	B WING_		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	/, STATE, ZIP CODE	
BV/MS1	TAR CHEVY CHASE TE	ENANT D/R/A CHE 5420 COI		T 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
R 008	Continued From pa	ge 3	R 008		
	provided on 07/04/1 employees.	8, with a total of 23 of the 79			
	(II) The facility failed stairwell/exit door all policy.	to respond timely to arms in accordance with their			
	implemented alarm the front desk conso stairwell exit door all ALR staff response. the same day at 12:	r-up observations of the ALR's response system located at ple showed at 11:00 AM that a sarmed for 20 minutes without Continued observations on 20 PM showed another at alarmed for 17 minutes sponse.			
	07/06/18 regarding in the receptionist state announcement was in the intercom system responds to reset the also questioned about	with the receptionist on esponse time to the alarm, and 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 sur monitor and respond system.	vey, the ALR failed to to the stairwell exit alarm			
Į.	(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, Neglec Exploitation	et, and
!	Neglect - Exploitation' showed that the staff,	ALR's policy, titled, "Abuse - " "revised in January 2018, "witnessing, suspecting, or abuse, neglect and/or		I. The ALR staff failed to immed report an allegation of sexual about the facility's ALA.	liately use to

Health	Regulation & Licensii	ng Administration			FORM APPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50 0 0 0 0 0 0	ALR-0039	B WING _		07/13/2018
	PROVIDER OR SUPPLIER	£400.00v		(, STATE, ZIP CODE T AVENUE NW	1
BV/MST	AR CHEVY CHASE TE		STON, DC		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
	A review of the ALR 07/03/18 at 10:00 A timeline and sequen 04/06/18 incident: Friday, 04/06/18 - Ti witnessed an alleger #12, reported the incident to the Activition Monday, 04/09/18 - Ti incident to the Activition Monday, 04/11/11 reported the alleged Interviews conducted construction superint parties had made the parties had made th	of the ALR's housekeepers ction worker standing in com partially unclothed. It is investigative findings on M revealed the following are of events surrounding the the housekeeper, who disease of Resident sident to the receptionist.	R 008	a. The receptionist was retrained reporting all allegations, include alleged, to management, regard circumstances. Housekeeper was trained on the appropriate report process after observing a possible abusive situation. The ALR receannual training for the Abuse and Neglect and Reporting policy of 4/26/2018. The ALA was retrait on 7/4/2018 on the Reporting of Abuse, Neglect and Exploitation Resident. Staff members that far adhere to the policy received disciplinary action, per policy. b. The Abuse, Neglect, and Reporting has been revised/updated staff will be retrained on the reviupdated policy. The staff will reannual training and training durinew hire orientation on the Abus Neglect, and Reporting policy. c. The BOM will keep an annual	less of less of less of as 4/13/18 ting le le eived 4/26/18 ad an ned 7/4/18 a of a liled to bring 8/22/18 The 8/31/18 lised/leceive ling se,
f F II	esponsible to: - Seek immediate er Notify the Resident's Notify the Residents Party of the report; Notify local law enfo	nergency care if needed:		education log, listing the annual training. The education log will monitored monthly by the QA Committee for completion/compliance.	

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STAT.	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	-
		ALR-0039	B WING		07/13/2018	
NAME	OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		-
BV/N	ISTAR CHEVY CHASE T	ENANT D/B/A CHF 5420 CO	NNECTICUT A	VENUE NW		
(X4) PREF TA(FIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	re
RO	008 Continued From pa	ge 5	R 008			71.00
	Protective Services and Ombudsmen a - [Ensure] required with the required tin - [Ensure] an insura - [Ensure] the identiand person making confidential unless of sic] assure no retarmaking the report; a - If the Incident Repreportable, the ALA of the Regional Dire will forward a copy to department." Note: I Allegations of Resid listed. Interviews with the A inconsistencies with the alleged abuse or the following timeline response to the incident the police, who took Note: The police representations of the police representations. - Thursday, 04/12/18 ALA notified Resident abuse. - Friday, 04/13/18 (7) Resident #12's physical post-incident physical	the report is submitted; ty of the Resident, perpetrator the report remains circumstances prevent it; aliation against the person and ort is risk related and/or state (or designee) will send a copy ctor of Operation (RDO), who to the home office legal Under risk related incidents, ent abuse or neglect was LA demonstrated the investigative findings of 104/06/18, as evidenced by the regarding the administrative tent: (6 days post-incident): The ident of alleged sexual abuse by a report of the incident. ort failed to reflect the name. (6 days post-incident): The t #12's son of the alleged days post-incident):				

as "homebound due to dementia" and having "no Health Regulation & Licensing Administration

Health I	Regulation & Licensi	ng Administration			FORM APPROVE
STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
	Water Company of the	ALR-0039	B WING		07//2/2040
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CIT	Y, STATE, ZIP CODE	07/13/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
R 008	Continued From pa	ge 6	R 008		
	recollection" of the i	ncident.			
	- Friday, 04/13/18 (7 notified APS and the alleged incident.	days post-incident): The ALA state licensing agency of the			
15	ALR conducted staff	B (20 days post-incident): The fin-service training on Neglect and Exploitation of			
(evidence that the AL of the incident to the	at there was no documented A had forwarded notification Long-Term Care as required by the ALR's			
T.	alled to implement th	vey, the ALR staff and ALA ne facility's policies on nd allegations of abuse.			
R 292 S	Sec. 504.1 Accommo	odation Of Needs.	R 292	R 292 Sec. 504.1 Accommodation	of
a in th a B no as #* fo wo to or (R	no treatment with re ndividual needs and neir health and physi nd the health or safe ased on record revieusing staff failed: (1 s prescribed for two ample receiving wou 1 and #2); (2) to follor two of two resident ound care services (follow the fall policy ne of one residents in desident #10); (4) to	ate and appropriate services asonable accommodation of preferences consistent with cal and mental capabilities by of other residents; and interview, the ALR to to follow physician orders of two residents in the nd care services (Residents by the wound care policies is in the sample receiving Residents #1 and #2); (3) for the sample who fell ensure special instructions followed for one of one		Needs I. The ALR nursing staff failed to pwound care per physician orders. a. The DON/RN completed a 100% audit for current residents. The audincluded a review of Physician ordewound care for residents #1 and #2 current residents. DON/Delegate provided one-on-one training to all on how to review, verify, and transc Physician's orders (including wound	orovide ochart 8/17/18 it ers for and all nurses 8/31/18 cribe

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Health Regulation & Licensi	ng Administration			FORM	M APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG:	(X3) DAT	E SURVEY
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NAME OF PROVIDER OR SUPPLIER		-		07/	13/2018
			Y, STATE, ZIP CODE		
BV/MSTAR CHEVY CHASE TE	ENANT D/B/A CHE WASHING	GTON, DC	JT AVENUE NW 20015		
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R 292 Continued From pa	ge 7	R 292			
resident in the same	ole (Resident #10); and (5) to		care orders) and record in the MA		0.15.4.4.0
assess a resident's	ability to independently		TAR. DON/Delegate reviewed a	nd	8/31/18
operate DME for on	e of one resident in the		verified orders for all residents		
sample (Resident #	11).		currently receiving wound/skin ca	ıre.	
	•		b. A binder for copies of physician	n orders	8/17/18
Findings included:			will be kept in DON's office. Each		
4 Th. At B			the DON/Delegate will review any	y orders	
1. The ALR nursing	staff failed to provide wound		for wound care and verify		
care per priysician o	rders, as evidenced below:		implementation. All nurses receive	ed	8/31/18
a. Review of Reside	ent #1's current medical		training on the purpose of the bind	ler to	
record on 06/27/18 a	at 11:30 AM showed the		verify that wound/skin care orders	are	
following wound care	orders:		implemented. All nurses received	training	
			on how to review, verify and trans	cribe	
 i. 08/10/17- Cleanse 	left upper arm skin tear with		physician orders (including wound	Leare	
normal saline, pat dr	v. apply bacitracin ointment		orders) and to record completion o	f each	
cover with 4 X 4 gau;	ze, and secure with kerlix		application/treatment on the MAR	/TAR	
daily and PRN.			Training will be completed and	7711.	
Further review of the	record revealed TARs that		documented upon new hire and and	nually	
lacked documented a	evidence the wound care		thereafter.	nuarry	
mentioned above was	s provided on the following		c. The DON/Delegate will audit th		
dates: 08/12/17, 09/0	7/17, 09/17/17, 09/27/17,		physician's orders for wound care	e 	
09/30/17,10/23/17, ar	nd 12/10/17		for complete transposition to the	orders	
			for complete transcription to the T	AK	
ii. 10/25/17- Cleanse	left heel wound with normal		and report findings to the QA Com		
saline, pat dry, peri-w	ound surrounding skin area		monthly to ensure compliance. The	e	
with skin-prep, apply i	odosorb cream to wound		DON/Delegate will print TAR		
bed, cover with 4 X 4	gauze then secure with		documentation reports from Quick	Mar	
kerlix wrap and tape of	lally until healed.		(computer software system) and wi		
Further review of the	record revealed TARs from		review the audit monthly with the (QА	
10/25/17 through 12/3	1/17 that showed the above	i	Committee to ensure compliance w	ith	
mentioned wound care	e order was not transcribed	1	documentation of treatment(s) by n	urses.	
completely to the TAR	s. Continued review of the	1	II. The ALR staff failed to follow th	ı.e	
IARS showed that nur	sing staff documented that		wound care policy.		
they only applied lodos	sorb gel to the left heel		Tourid out o portey.		
daily.	(1977) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995) (1995)		a The Chevy Chase assessed and	<u>. </u>	
E Barda	w		a. The Chevy Chase current policy f	or	
D. Review of Resident	#2's current medical record		Skin & Wound Care was reviewed.		
Regulation & Licensing Administrat FORM	ion			-	
- Orier	6699	40	3K211 If a	ontinuation	shoot A of 41

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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 provided the wound care. wound care orders) and to record 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. 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 & Licens	cina Administration		λ,	PRINTED: 08/03/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
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R 292 Continued From pa	age 9	R 292	200	
Further review of R there was no docur	Resident #1's record revealed umented evidence that the ad the wound management		the log and reviewed daily in the meeting with the IDT. Fall Log witracked, trended, and reported to the Committee monthly.	rill be he QA
on 06/29/18 at 10:3 staff was currently	dent #2's current medical record 30 AM showed that the nursing providing wound care to the t. The wound care services 8.		I. The ALR failed to ensure that instructions from hospital discharg followed. a. Resident #10's hospital orders w	ge were
Wound Care," revis the Wellness Direct were implemented,	ity's policy titled, "Skin & sed in January 2018, showed stor was to assure interventions , documented, and service d 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 hos	o correct / of the 8/24/18 ts to
there was no docum Director followed the outlined above.	desident #2's record revealed mented evidence the Wellness le 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 re orders, including special instruction	office. eview all ns from
AM, the ALA stated to DON was to ensure was followed.	on 07/05/18 starting at 10:30 that the facility's previous that the wound care policy		the hospital/ER, along with the disc summary, and verify implementatio that the resident's MD has been not special instructions/discharge order.	on and tified of rs.
At the time of the su follow the wound car	urvey, the ALR staff failed to are policies.		c. The DON/Delegate will audit dai physician's orders/new orders for compliance with implementing spec	
evidenced below:	ed to follow the fall policy, as		instructions from the hospital/ER an notifying the MD & RP, and report findings to the QA Committee mont	nd
06/26/18 at 12:00 PM large, purple-colored	dent #10's apartment on M showed the resident had a d bruise on the right side of ded down to the neck.		ensure compliance.	my to

	Health Regulation & Licensi	ng Administration		1 /	FORM	M APPROVE
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G:		E SURVEY IPLETED
ļ		ALR-0039	8 WING_		07	/13/2018
	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	011	13/2010
L	BV/MSTAR CHEVY CHASE TE	NANT D/B/A CHE 5420 CON		AVENUE NW		
	PREFIX (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)	D BE	(X5) COMPLETE DATE
	a total of seven time through June 2018. Review of the facility in January 2018, showellness Director winvestigation was convestigation was updated with in was reviewed, and a Further review of recono documented evide followed the fall policy. 4. The ALR failed to instructions from hose followed, as evidence. Observation of Residence Observation of Residence of the review of the note of seven times through June 2018. To a local ER for evaluation of the seven falls. Further review of the note dated 06/24/18 to observed on the floor Lt. front head." The new evidence of the reside	PM revealed the resident felles from December 2017 y's policy titled, "Falls," revised owed that after a fall, the ras to ensure a fall impleted, the resident's ISP terventions, a QA of the fall a fall tracking was completed. Cord revealed that there was rence the Wellness Director by as outlined above. The serve of the tall is the serve of the tall is the serve of the Wellness Director by as outlined above. The serve of the tall is the serve of the serve		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 ordered 5/23/18. b. The resident was assessed by his Nurse Practitioner. Resident #11 wit assessed for the use and operation of mechanical devices and medical deviced during the 6 month ISP, and with an change in condition. All new resident be assessed for the use and operation mechanical devices and medical device prior to admission, at move in, during 30 day ISP, the 6 month ISP, and with change in condition. The DON creat Medical Device Log to track resident the ALR with medical devices. c. The DON/Delegate will audit most the Medical Device Log to ensure the equipment is functional and the resident safely using the equipment.	sessed about and the off on hose PCP's il be fivices ag the off it any led a lits in onthly he	6/26/18
	noted that resident's in	njury was on the right side in the left side as indicated in				1

the note.

Health Regulation & Licensing STATEMENT OF DEFICIENCIES				FURIVI APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING_		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TE		NNECTICUT GTON, DC 2	AVENUE NW	
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DIBE COMPLETI
R 292 Continued From page	ge 11	R 292		
resident returned from special instructions, within the first 48 how using any medicines medicine that make lacked documented physician was made instruction. Also, the medications within the returning from the Elimg (a sedative with indrowsiness). During an interview of resident stated, "Yes came back from the latter that Resident #10 follophysician was made instructions from the storing an interview of the surface of the	on 07/05/18 at 3:30 PM, the I took my medicines when I ER." vey, the ALR failed to ensure lowed, and the resident's aware of, the special			
resident also stated th	nea, but he did not know			
on 06/26/18 at 2:00 Pl admitted on 09/04/17, record revealed a H&F	P dated 09/01/17 that			
Regulation & Licensing Administra FORM		90		
	48	⁹⁹ 4G	K211 If a	ontinuation sheet 12 of 4

Health	Regulation & Licensin		CANCEL CONSTRUCT		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED	
	Wike .	ALR-0039	B. WING		07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS. CIT	Y, STATE, ZIP CODE	
BV/MST	'AD CHEVO CHACE TE			IT AVENUE NW	
	AR CHEVY CHASE TE	WASHIN	GTON, DC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
R 292	Continued From page	ge 12	R 292		
:	obstructive sleep ap documented eviden: CPAP therapy or TE During an interview ALA stated that she assess the resident	nt had a diagnosis of onea. The record lacked one of a physician order for iD support stockings. on 06/26/18 at 2:30 PM, the would have the nurse to to evaluate his concerns with and support stockings.			
	medical record reveathe Regional Directo indicated the residen contract nurse to evaluate independently use the TED support stocking documented that the setting at 6 disrupted loosen the straps on the flow." The Region that the nurse would healthcare practitions therapy evaluation. Conursing note revealed	er and request a respiratory ontinued review of the			
i i	Resident #11 was ass	vey, the ALR failed to ensure sessed to ensure he could cPAP machine and TED	#)		
(; ;	(b)(1) An ALR, employ person who believes to subjected to abuse, no report the alleged abu	eglect, and Exploitation. wee of an ALR, or other hat a resident has been eglect, or exploitation shall se, neglect, or exploitation	R 390	R 390 Sec. 509b1 Abuse, Neglect Exploitation I. The ALR staff failed to immedite report an allegation of sexual abut the facility's ALA.	iately
Ith Dogulati	ion & Licensia Administra			THE RECITITY S ALA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG:	(X3) DATE SURVE COMPLETED
	ALR-0039	B WING _		07/13/201
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE	0.110/201
BV/MSTAR CHEVY CHASE TE	ENANT D/B/A CHE 5420 CQ		T AVENUE NW	
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ODEATION .
PREFIX (EACH DEFICIENCY TAG REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE
R 390 Continued From pa	ge 13	R 390	a. The receptionist and activ	ities director 4/12/1
immediately to the a	assisted living administrator		were retrained on reporting	all
who shall take appr	opriate action to protect the		allegations, including allege	
resident. The ALR	shall report any allegation of		management regardless of	ii, to
abuse, neglect, or e	exploitation brought to its		management, regardless of c	ircumstances. 4/12/
Services Program	or and the Adult Protective administered by the Family		Receptionist and activities d	rector
Services Administra	tion of the Department of		received written corrective a	
Human Developmen	nt.		regarding abuse of neglect re	eporting. 4/26/1
Based on interview a	and record review, employees		Housekeeper was trained on	the
of the ALR failed to	(I) immediately report		appropriate reporting process	
allegations of sexual	abuse to the facility's		observing a possible abusive	
administrator for Res	sident #12, and the ALA failed		The ALR received annual tra	
residents living in the	te action to protect all		Abuse and Neglect and Repo	rting policy
residents living in the	ALR.		on 4/26/2018. The ALA was	
Findings included:			7/4/2018 on the Reporting of	Abuse,
<u>g</u> =			Neglect and Exploitation of a	Resident.
I. The ALR staff faile	d to immediately report an		Staff members that failed to a	adhere to the 8/22/
allegation of sexual a	Ibuse to the facility's ALA in		policy received disciplinary a	iction, per
accordance with the	ALR law and implement the		policy.	8/31/1
facility's internal polic	y as follows:			
Record review of the	ALR's policy titled, "Abuse -		b. The Abuse, Neglect, and R	eporting
Neglect - Exploitation	" revised in January 2018		policy has been revised/updat	ted. The staff
showed that the staff.	"witnessing suspecting or	5	will be retrained on the revise	ed/updated
naving knowledge of	abuse, neglect and/or		policy. The staff will receive	annual
exploitation of a resid	ent have an obligation to		training and training during n	
report infinediately, of	r as soon as practical."		orientation on the Abuse, Neg	
On 04/06/18 one of the	he ALR's housekeepers		Reporting policy.	, icot, and
observed a constructi	On worker standing in	-	- reporting poney.	
Resident #12's bedroo	om partially unclothed.	1	a. The husiness - FC	216.6
During an interview w	ith the housekeeper on		c. The business office manage	
∮07/03/18 at 11:03 AM,	the housekeeper explained		an annual education log, listin	
that she knocked on F	Resident #12's door twice.		annual training. The education	
vvnen there was no ar	nswer, she proceeded to		be monitored monthly by the	
use a key to access th	e apartment. The	1	Committee for completion/com	mpliance.
nousekeeper further d	escribed that upon entry,			
the head of the bed an	ruction worker standing at			

Health Regulation & Licensin	ng Administration			FURINI APPROVEL
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	G	COMPLETED
		1		
.v.	ALR-0039	B WING_	Total Community Community and Community Commun	Appendig and a rest of
	ALIV-0003			07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY	, STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TE	NAME DIRECTE 5420 CON	NECTICU1	AVENUE NW	
THE THE STATE OF T		TON, DC		
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTIO	N
PREFIX : (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	DBE COMPLETE
TAG REGULATORY OR LE	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
THE PROPERTY OF THE PARTY OF TH			DEFICIENCY)	
R 390 Continued From page	ge 14	R 390	II. The ALR failed to take appropri	iate
in bed. The construc	ction worker was partially		action to protect all residents from	
unclothed from the	vaist down. When the		potential abuse.	
construction worker	noticed the housekeeper, the		potential aduse.	
construction worker	was overheard stating "shit."		a. The alleged abuser, who was a the	hird 4/12/18
The housekeeper in	mediately closed the door		party contractor, was banned from	
and left the apartme	nt		building. Contractor company was	
			contacted regarding incident. Polic	
a. A review of the AL	R's investigative findings on			
07/03/18 at 10:00 Af	M revealed the following		department was contacted regardin	
timeline and sequen	ce of events surrounding the		incident and report filed. Family at	
04/06/18 incident:			physician contacted. Department of	f
			Health and Ombudsman notified.	
Friday, 04/06/18 - Th	ie hausekeeper, who		b. An investigation will be conduct	ed for
witnessed an alleged	sexual abuse of Resident		all abuse allegations per the revised	
#12, reported the inc	ident to the receptionist.		investigation policy and procedures	-
0 1 0 0000			Abuse and neglect policy revised 8	
Sunday, 04/08/18 - T	he receptionist reported the		The regional director of operations	
incident to the Activiti	les Director.		notified immediately of all abuse	WIII OC
Monday 04/00/19 7	The complement of		allegations. The regional director of	e .
observed by the ALD	he construction worker was staff working on the ALR		operations will be actively involved	
premises and on the	floor where Resident #12			
lived.	moor where itesident #12		all ongoing investigations of abuse	
		5	neglect allegations to ensure compl	
Wednesday, 04/11/18	3 - The Activities Director		with policy. Residents will be infor	med
reported the alleged a	abuse to the ALA. [Note:		about circumstances that require	
Interviews conducted	with the receptionist and the		investigation into abuse allegations.	, if the
construction superinte	endent indicated that both		situation could endanger their safety	y or
parties had made the	ALA aware of the incident		well-being. All residents were	
on 04/09/18.]		1	interviewed by ALR staff to ensure	there
***********************************		1	are no other issues surrounding any	
 b. During an interview 	on 07/03/18 at 11:03 AM,		contractor.	ŀ
tne nousekeeper ackr	nowledged that the incident	1	c. Investigations will be reviewed by	v the
was not reported to th	e ALA/supervisor. The	1	QA Committee monthly to ensure	y tile
housekeeper made a	"complaint" to the	İ	commission for an interest to ensure	,
the housekeeps the	on duty that day. Review of	I	compliance for resident protection a	
at 11:20 Att about the	tten statement on 07/03/18		safety per Resident Rights and Abus	
uncertain whom to ac-	hat the housekeeper was	i	policy. New contractor policy create	
uncertain whom to rep	on the incident to.		ensure construction workers will no	t be in
Ith Regulation & Licensing Administra	lion		residents' rooms.	CHARLES CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
***************************************	ALR-0039	B. WING		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, S	STATE, ZIP CODE	
BV/MSTAR CHEVY CHASE TE		NNECTICUT A		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLET
R 390 Continued From page	ge 15	R 390	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	TO TO THE PARTY OF
the receptionist, who incident, stated the incident to him and The receptionist also housekeeper shared #12 and the construction thought they had enact. The receptionist (04/06/18) at approxinformed the facility's alleged incident on State of the state	ew on 07/03/18 at 11:45 AM, o was on duty the day of the housekeeper reported the not to the ALA/supervisor. o stated that when the d the observation of Resident ctlon worker, the receptionist gaged in a consensual sexual left the facility that day timately 3:00 PM and a Activities Director of the Sunday, 04/08/18. the ALR's "Abuse - Neglect - evealed that the ALA was	Î		
- Notify the Resident - Notify the Resident Party of the report; - Notify local law enfo injury, sexual abuse, to the alleged abuse; - Investigate the alleg Protective Services, and Ombudsmen as - [Ensure] required dowith the required time - [Ensure] an insurant - [Ensure] the identity and person making the confidential unless cir - [sic] assure no retain making the report; an - If the Incident Report reportable, the ALA (coff the Regional Direct will forward a copy to department." Note: Universidents	procement for any physical death or other crime related death or other crime related death or other crime related death or other crime related death or other crime related death or other crime related death or other crequired; proceded and required; proceeded and required; proceded death or completed death or report is submitted; of the Resident, perpetrator of the Resident, perpetrator of report remains roumstances prevent it; death or designed will send a copy that of Operation (RDO), who the home office legal or of other risk related incidents.			
Regulation & Licensing Administra	ation			
FORM	e	899 464	(211 I	f continuation sheet 16 of

rican	Tregulation & Licensi	ilg Administration			
AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION	(X3) DATE SURVEY
1			A. BUILDING:	**************************************	COMPLETED
		ALR-0039	B WING		07/40/0040
NAME	F PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	TATE ZID OGOE	07/13/2018
	TAR CHEVY CHASE TE		NNECTICUT A		
Bennie		WASHIN	GTON, DC 20		
(X4) ID PREFI) TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ID BE COMPLETE
R 39	O Continued From page	ge 16	- R 390	The state of the s	
	Allegations of Resid	lent abuse or neglect was			
	Interviews with the A	ALA demonstrated			
	inconsistencies with	the investigative findings of n 04/06/18, as evidenced by			
	the following timeline	e regarding the administrative			
	response to the incid	dent:	Į.		
	- Thursday, 04/12/18	6 (6 days post-incident): The	}		
	to the police, who to	ident of alleged sexual abuse ok a report of the incident.			İ
	Note: The police rep alleged perpetrator's	ort failed to reflect the			
	- Thursday, 04/12/18 ALA notified Residen abuse.	(6 days post-incident): The at #12's son of the alleged			
	physician's assessme	cian performed a Il examination. Note: The ent described Resident #12 to dementia" and having "no			
	- Friday, 04/13/18 (7 onotified APS and the alleged incident.	days post-incident): The ALA state licensing agency of the			
	ALR conducted staff i	(20 days post-incident): The n-service training on Neglect and Exploitation of			
	evidence that the ALA of the incident to the L	t there was no documented had forwarded notification ong-Term Care as required by the ALR's			

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STATEMENT OF DEFICIENCIES				FORM APPROV
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING		07/40/004
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, 8	STATE ZIP CODE	07/13/2018
BV/MSTAR CHEVY CHASE TE	ENANT D/B/A CHF 5420 CC	NNECTICUT	AVENUE NW	
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	IGTON, DC 20		- Name of the second
TAG REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
R 390 Continued From pa	ge 17	R 390		
Activities Director or 07/05/18 at 12:23 Pl timeline documented Director did not infor abuse until Wedneson The findings of the Athat the ALR's staff falled to protect all residents fevidenced by: At the time of the instruction comprehensive review management system ALA's investigation withe ALR provided adeoversight as required	LA's investigation showed ailed to immediately notify the of sexual abuse involving take appropriate action to from 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 equate supervision and by the ALR law.			
alleged sexual abuse the alleged perpetrato	on 07/03/18 at 11:03 AM, er, who witnessed the of Resident #12, observed r on the ALR premises on ich was three days after the			
b. During an interview the ALA stated that wri of the investigative pac of the investigative pac evidence that written si	on 07/03/18 at 12:52 PM, tten statements were part ckage. Subsequent review ckage, however, failed to tatements were obtained and the Activities Director.			
During continued interv	riew, the ALA indicated that			
Regulation & Licensing Administrati	on ess		······································	**************************************

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Health Regulation & Licensin	g Administration			ORWINITIOVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
	ALR-0039	B. WING		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	
	7100 001		AVENUE NW	
BV/MSTAR CHEVY CHASE TE	WASHING	TON, DC 2		
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 APPROP DEFICIENCY)	D BE COMPLETE
R 390 Continued From pag	je 18	R 390		
she also spoke with	the superintendent from the			
construction compar	ny, which was verified through		N.	
communication india	ce dated 04/12/18. The email cated that the Activities			
Director, not the ALA	dieu mat me Activities			
superintendent on M	londay, 04/09/18, to alert him			
to the alleged incider	nt involving one of his			
employees. Continue	ed review of that email			;
showed that on 04/09	9/18, the ALR requested the			
construction compan	y to obtain a written			
alleged perpetrator d	illeged perpetrator. The leclined to provide a written	1		
statement on 04/10/1	18 when approached by the			1
superintendent and v	vas subsequently escorted			
off the ALR premises	the same day. An internal			1
memorandum, dated	04/13/18, from the			
construction compan	y and copied to the ALA,	1		Į.
was provided as a pa	irt of the investigative			
package. It should be	noted that this			
within the construction	ted that the supervisors n company, "decided to			Į.
allow (the accused pe	erpetrator] to return [sic] so	1		
[they] could further we	ork with him and the staff to			
determine what happe	ened."			Ì
At the time of the sur	vey, there was no evidence			
that background scree	ening of construction			1
workers had been imp	plemented. During an)		i
that background chac	on 04/13/18, it was alleged			1
that background checks had been completed by the construction company in accordance with the				1
federal standards, how	wever the clearance criteria			
was unknown. Additio	nally, there was no	1		
evidence at the time o	of the survey that the ALR			1
had implemented a sy	stem for monitoring or			
escorting construction	workers by facility staff to			
sateguard all residents	s when work was required			
to be performed in res	idents' apartments. There	1		Į,
been established by the	provided that a system had ne ALA to orient or to			

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Health I	Regulation & Licensii	ng Administration			FORM APPROV	ED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
1110 54	Y OF COMMECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		ALR-0039	B WING		07/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	TATE, ZIP CODE		
BV/MST/	AR CHEVY CHASE TE	NANT D/B/A CHE 5420 CO	NNECTICUT A	VENUE NW		- 8
		WASHIN	GTON, DC 20	015		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	1D	PROVIDER'S PLAN OF CORRECT!		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.DBE COMPLET PRIATE DATE	٤
	1177		1	DEFICIENCY)	_	- 1
R 390	Continued From pa	ge 19	R 390			\neg
	communicate the ex	xpectations of the ALR with	ì			- 1
	construction worker	s assigned to the community.	1			- 1
		-	1			- 1
	Continued interview	with the ALA revealed that				- 1
:	the police report or	port on 04/12/18. Review of	1			- 1
:	that it was incomple	07/05/18 at 1:30 PM showed te, due to missing the	1			-1
ŀ	perpetrator's name.	The ALA stated that the	1			- 1
	housekeeper told he	er that the contractor was				
	nicknamed "Big Mik	e." Further, the ALA indicated	Į.			- 2
	that subsequent to t	he incident, all residents of	- 1			
	hall meeting not to a	ded during a community town				- [
	into their apartment	and to alert the ALR's	l.			- 1
	maintenance staff.					- 1
	Arab at and		1			- 1
	At the time of the sur	rvey, the ALA was not able to	1			1
	meeting had accurre	evidence that the town halled and/or that the ALA had	1			- 1
	informed the ALR co	mmunity, including all	Í			-1
	residents and their re	esponsible parties, of the				-1
	alleged sexual abuse	and the subsequent safety				-
	measures to be put i	n place by the ALR. The ALA	1			
	also failed to obtain f	eedback from other whether additional incidents	ļ			1
	of this nature had oc	curred				
•	c. During a post-surv	ey telephone interview on	1			
	07/23/18 at 1:30 PM,	Resident #12's son stated	1			
1	inat ne was notified o	of the alleged sexual abuse				1
	days after the incider	on 04/12/18, which was six at occurred. As he described	¥			1
ì	the incident, he noted	that the construction				1
V	worker had no reason	n to be in his mother's				1
r	esidence because re	enovations had already been				
	completed in her apa	rtment.				
	Resident #10's con in	idicated that he was told by				
t	he ALA that the hous	dicated that he was told by ekeeper waited until the end	İ			1

	squiation & Licensir	19 Administration			
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
		ALR-0039	B WING		07/13/2018
NAME OF PE	NOVIDER OR SUPPLIER	STREET A	DORESS OF	Y, STATE, ZIP CODE	
m					
BV/MSTAF	R CHEVY CHASE TE			T AVENUE NW	
(VA) ID	OUMANDY OTA		GTON, DC	20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTIES OF THE A	D BE
R 390 (Continued From pag	ge 20	R 390	The state of the s	
At the certain At according to the certain acc	eported it to the recommendation to the ALA eport the incident to and waited two days incident. Resident # olice department who the incident, a shen the police show uestioning her about the time of the surfact the ALA had initiate personnel involves porting of the allegate. There was also insured the timely track and when to report the time of the surface the time of the surface and when to report the time of the surface and when to report the time of the surface and when to report the time of the surface was while the investigated.	reptionist instead of the visor. The resident's son also that the receptionist failed to the administrator/supervisor later before reporting the 12's son mentioned that the as notified before he knew and his mom was startled			
pre	event further incide	nts.			i
	509b3 Abuse, N	eglect, and Exploitation.	R 392	R 392 Sec. 509b3 Abuse, Neglect, a Exploitation	and 8/24/18
alli sh: inc inv	egation of abuse, no all take appropriate idents. The ALR sh estigation and actio	oughly investigate any eglect, or exploitation and action to prevent further all report the results of its ons taken, if any, to the		I. The ALR failed to thoroughly invan allegation of abuse. a. Investigation regarding incident	estigate
Ba	yor. sed on interview an ed (I) to thoroughly	nd record review, the ALR investigate an allegation of		immediately conducted. Constructio company provided documentation o	f
abi pot	use involving Residential abuse while t	ent #12, and (II) to prevent the investigation was in		criminal background checks. Create contractor orientation letter for each	0/51/18
pro	gress for all resider	nts in the facility.		contract worker to sign and adhere to	o. 8/6/18
			1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	(X3) DATE SURV COMPLETED
	ALR-0039	B WING		07/13/201
NAME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CI	TY, STATE, ZIP CODE	07/13/20
BV/MSTAR CHEVY CHASE	TENANT D/B/A CHE 5420 CC	NNECTIC	JT AVENUE NW	
	WASHIN	GTON, DC	20015	
TAG REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEMENCY)	HIDDE SON
R 392 Continued From p	page 21	R 392		W
Findings included:			Requested/received background	
			screening criteria from the	
I. [See also R008	and R390] The ALR failed to		construction company. Created	policy
thoroughly investig	gate an allegation of abuse.		on construction worker's interac	41.
			in the ALR.	110ns 8/9/]
a. On 4/13/18, the	state licensing agency		Advised all residents that they sh	rould
received telephone	notification from the ALA		not be requesting assistance from	1
that the notice was	6/18 incident. The ALA stated		outside contractor. Met with resi	idents
perpetrator was es	investigating this incident, the corted from the premises, and		at town hall on 8/9/18 to discuss	thic
that the resident ha	nd been assessed and		policy. Requested, at town hall,	uns
determined to have	Sustained no harm. The ALA		resident with concerns with	
also stated that the	resident's family had have		construction workers to bring tho	8/31/
made aware of the	incident and that background		concerns to the ALA. Met	se
CHECKS WOULD DE CO	inducted for all construction		individually with and	
workers. The licens	ing agency asked the ALA to		individually with each resident to	
documents.	al investigation and supporting		discuss alleged incident.	
On 04/17/18, the oc	currence report and a copy of			
. The police report we	re received it should be		h The Investigation D. P. a. D.	cedure 8/22/1
noted that no further	documentation was received		b. The Investigation Policy & Prod	cedure 6/22/1
HOTH THE ALA. DUTIN	d the onsite inspection		was revised. All staff was trained	on the
Degirining 00/20/18.	Interviews and record		revised policy on 9/12/18. Staff wi	ll be
reviews snowed that	the response actions taken		educated annually and during new	hire
nie vrv weie liot	Umely based on when the		orientation on the Abuse, Neglect,	and
ALA first became aw	are of the allegation.		Exploitation Policy.	
 b. Additional review of 	of the ALR's investigative		a. The business of	
report revealed that t	he response actions taken		c. The business office manager wil	I
Dy the ALA Were not	complete as evidenced		keep an annual education log, listin	ig the
below;			annual monthly trainings. The edu	cation
A notice	V. 12	- 1	log will be monitored monthly by t	he
however failed to	led on 04/12/18 at 22:21,	1	QA Committee for completion/	
name. The ALA desired	ect the alleged perpetrator's	10	compliance. Maintenance director	will
. Hame. The ALA docu	mented that the alleged	1	meet with each contractor to go over	····
there was no further	as "Big Mike," however	- 0	contractor agreement.	•
perpetrator's lenel no	action to obtain the alleged me from the construction			
company. According to	o record review, the alleged	j		
Regulation & Licensing Administra	o record review, the alleged			

Health	Regulation & Licensi	ng Administration		PR	INTED: 08/03/20 FORM APPROVE
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPI E CONSTRUCTION	3) DATE SURVEY COMPLETED
		ALR-0039	B WING_		26.77 (1.27 (2.07))
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DPESS OITS	r, STATE, ZIP CODE	07/13/2018
	AR CHEVY CHASE TE	NANT D/B/A CHE 5420 CON WASHING		T AVENUE NW	
- 	REGULATORY OR L	TEMENT OF DEFICIENCIES 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 APPROPRIA DEFICIENCY)	(X5) E COMPLETE TE DATE
R 392	Continued From page	ge 22	R 392	II The ALP failed to prove the	· · · · · · · · · · · · · · · · · · ·
	perpetrator was esc	orted off of the ALR premises		II. The ALR failed to prevent potential abuse while the investigation was in	l!
	after refusing to pro-	vide a written statement of the		progress for all residents in the facility	
	alleged perpetrator of construction compar work and was seen of Resident #12 lived. To evidence that the alleged perpetrator's status determination ALR community.	d. It should be noted that the was allowed by the my to return to the ALR to working on the floor where The ALR's investigation failed ALA had coordinated with the employer to make a work based on the safety of the		progress for all residents in the facilty a. The alleged abuser, who was a third party contractor, was banned from the 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.	4/12/18
) 1	complete and timely a accordance with the A report to the state lice	ALA's initial occurrence ensing agency.		b. An investigation will be conducted all abuse allegations per the revised investigation P&P. The regional directions	tor
t	he investigation was videnced by:			of operations will be notified immediated of all abuse allegations. The regional director of operations will be actively involved with all ongoing investigation of abuse and neglect to ensure compliant.	ns
n A tr	omprenensive review nanagement system a LR's investigation wa	ection on 06/26/18, a of the ALR's incident along with a review of the as completed to determine if quate supervision and by the ALR law.		with policy. Residents will be informed about circumstances that require investigation into abuse allegations, if t situation could endanger their safety or well-being. Contractor orientation letter created to present to each visiting	the
ar at st re ev me	formed the ALR coming their family member ouse. During interview ated that a town hall i sidents, however, the idence this occurred.	munity, including residents ers, of the alleged sexual with the ALA, it was meeting was held with the was no documented No additional ributed to the community		contractor detailing rules to abide by while in the community. c. Investigations will be reviewed by the QA Committee monthly to ensure compliance for resident protection and safety per Resident Rights and Abuse	e

and family members.

policy.

PRINTED: 08/03/2018

Health	Regulation & Licensi	ng Administration			FORM APPR	₹OVE
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE	FY
		SSATTI STATION NOINBER:	A BUILDING:		COMPLETED	
		ALR-0039	B WING			22
AME OF	PROVIDER OR SUPPLIER	STREET A	DORESS CITY O	TATE, ZIP CODE	07/13/201	18
3V/MST/	AR CHEVY CHASE TE		NNECTICUT A			
	THE OTHER PERSONS	WASHIN	GTON, DC 20	O15		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	/D	PROVIDER'S PLAN OF COR	RECTION	UE.
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	X5) IPLETE ATE
R 392	Continued From pa	ge 23	R 392			
	b. During interview a	and record review, the ALA				
	railed to obtain feed	back from other residents to				
	had occurred.	litional incidents of this nature	1			
	nad occurred.					
	c. There was no evid	dence that a system had been	İ			
	established by the A	LA to orient or to				
19	community with con-	pectations of the ALR	1			
	the community.	struction workers assigned to				
(d. There was no evid	lence that background	1			
i	mplemented During	ction workers had been an interview with the ALA on				
Ċ	04/13/18, it was alled	ed that background checks	1			
	lad been completed	by the construction company				
	i accordance with fe	deral standards however				
	he clearance criteria	was unknown.				
е	. There was no evid	ence that a system for				
п	nonitoring or escorting	a construction workers by				
16	acility staff had been	implemented to safeguard				
a	partments.	rforming work in residents'				
	T L	Cola Minim				
I.	I nere was no evide	nce that the ALA ensured	I			
w	hen to report unusua	he ALR staff on how and	1			
g. di	nere was no evide	nce that the ALA initiated				
th	e witnessing and rer	th the personnel involved in porting of the alleged sexual	1			
ab	ouse of Resident #12	g of the dileged sexual				
At	the time of the au-	ou the ALD 6-11				
ad	equate safeguards i	ey, the ALR failed to put n place to prevent potential	1			
ab	use while the investi	gation was in progress				
an	a the ALR also failed	to take appropriate				
co	rrective action to pre	vent further incidents.				

_	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
L		ALR-0039	B WING_		07/13/2018
	NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE	07710/2010
	BV/MSTAR CHEVY CHASE TE		NNECTICUT	FAVENUE NW 20015	
	PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	R 471 Continued From pa	ge 24	R 471		
	resident prior to adr Based on record re- failed to develop an of five newly admitte	be developed for each nission. view and interview, the ALR ISP before admission for four ed residents in the sample	R 471	R 471 Sec. 604a1 Individualized Service Plans I. The ALR failed to develop ISP before admission for Residents #2 #4, #11, and #12.	
	(Residents #2, #4, #11, and #12). Findings included: 1. Review of Resident #2's current clinical record on 06/29/18 at 10:30 AM showed that there was no documented evidence that the ALR staff developed an ISP for the resident prior to admission on 01/22/18. 2. Review of Resident #4's current clinical record on 07/02/18 at 10:15 AM showed that there was no documented evidence that the ALR staff developed an ISP for the resident prior to admission on 06/06/18. 3. Review of Resident #11's current clinical record on 07/05/18 at 2:00 PM showed that there was no documented evidence that the ALR staff developed an ISP for the resident prior to admission on 09/02/17.			a. ISP's for resident #2, #4, #11 completed. Resident #12 moved of ALR. b. An ISP will be developed prior admission and 30 days post move for all new residents. ISP's will b updated every 6 months and with significant change in condition. c. DON/Delegate will monitor, review, and track each new admit prior to admission to ensure with requirement. ISP's will be tracke spreadsheet and reviewed daily to ensure they are completed timely.	to e-in e ISP d on
	record on 07/13/18 a was no documented developed an ISP for admission on 12/27/1 During an interview o ALA stated that the fa developed ISPs as re	at #12's current clinical at 2:00 PM showed that there evidence that the ALR staff the resident prior to 17. n 07/06/18 at 10:40 AM, the icility's previous nurse quired. However, the ALA the pre-admission ISPs at			

Health	Regulation & Licensin	a Administration		l. k	FORM APPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		ALR-0039	B WING_	The second secon	07/13/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	r, STATE, ZIP CODE	
BV/MST	AR CHEVY CHASE TE		NNECTICU [.] STON, DC	T AVENUE NW 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTII (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
	the time of the survival At the time of the survival At the time of the survival At the time of the survival At the time of the survival At the time of the survival At the time of the survival At the survival At the survival At the post move-in assured the post move-in assured (Residents #2, #4, at Findings included: 1. Review of Resider 06/29/18 at 10:30 At was admitted on 1/22 move-in assessment facility's nurse. Further evealed there was not an ISP had been deveraged there was not at the survival At the survival At 10:15 At was admitted on 06/0 move-in assessment facility's nurse. Further evealed there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged there was not an ISP had been deveraged the survival At the su	ey. Invey, the ALR failed to devidence that pre-admission of for Residents #2, #4, #11, alized Service Plans developed following the cost move-in" assessment. Friew and interview, the ALR SP had been developed after sessment for three of five lents in the sample and #11). Int #2's clinical record on the showed that the resident er review of the record to documented evidence that reloped following the erin assessment. Int #4's clinical record on the showed that the resident evidence that reloped following the erin assessment. Int #4's clinical record on the showed that the resident evidence that was conducted by the er review of the record to documented evidence that eloped following the er review of the record to documented evidence that eloped following the	R 471	I. The ALR failed to ensure an had been developed after post min. a. ISP's for #2, #4, and #11 hav completed and reviewed by the Team. b. All new residents will receive move-in assessment within 30 d admission. An ISP Log has been created to track and schedule all assessment due dates. c. The DON/Delegate will monit ISP Log due dates daily to ensure compliance of ISP's to be compland post move-in assessment with days of move in.	en been 7/31/18 IDT a post lays of 7/1/18 ISP tor the
	resident's post move- 3. Review of Residen	in assessment. t #11's clinical record on			

07/05/18 at 3:00 PM showed that the resident

Health Regulation & Licensia	ng Administration			I ORINIALI KOATD	
I AND FLAN OF CORRECTION I IDENTIFICATION NUMBER: I			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 TE	NANT D/B/A CHE 5420 CON		AVENUE NW		
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 APPROP DEFICIENCY)	D BE COMPLETE	
R 472 Continued From pa	ge 26	R 472			
move-in assessmer facility's nurse. Furt revealed there was an ISP had been de resident's post move During an interview AM, the ALA stated nurse developed ISI	on 07/06/18 starting at 10:40 that the facility's previous Ps as required. However, the ocate the post move-in ISPs				
At the time of the fol ensure ISPs had be	low-up visit, the ALR failed to en developed following the nove-in assessments.	R 481	R 481 Sec. 604b Individualized	Service	
(b) The ISP shall ind provided, when and provided, and how a be provided and acco Based on observation review, the facility fait when, how often, and provided to address significant change in	clude the services to be how often the services will be nd by whom all services will	N 701	I. The ALR failed to document in ISP when, how often, and by who 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.	lom Idress Ient	
Resident #10 with a I right side of the face neck. The observatio	9/18 at 11:30 AM showed arge purplish bruise on the that extended down to the n also revealed that the g oxygen from a compressoren tubing.	1	b. Appropriate members of the II 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 an appropriate resident centered	uring will	

interventions. ISP will include the

Health Regulation & Licensi	ng Administration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING_		07/10/0010
NAME OF PROVIDER OR SUPPLIER	STREET AC		Y, STATE, ZIP CODE	07/13/2018
BV/MSTAR CHEVY CHASE TE	ENANT D/B/A CHE 5420 COI	NNECTICU	T AVENUE NW	
	WASHING	STON, DC	20015	
PREFIX (EACH DEFICIENCY TAG REGULATORY OR L	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)	DRF COMPLETE
R 481 Continued From pa	ge 27	R 481	responsible individuals(s) to con	mnlete
During an interview	on the same day at 11:31 AM,		the service. DON will keep an	mpiete
and was sent to the	that she fell a few days prior ER for evaluation. The		updated incident tracking log. I	DON/
resident also explain	ned that she falls a lot.		RN will keep an ISP log includi	
			documentation of change in	
significant change Is	ent's record revealed a SP dated 06/25/18 that lacked		condition.	
documented eviden	ce of the services to be			
provided, when and	how often the services will be nd by whom all services will		c. The DON will audit the Incid	
be provided to addre	ess the resident's significant		Tracking Log and ISP Tracking	
change in condition	as evidenced by the		track and trend the data outcome	· ·
increased frequency	of falls.		report to QA Committee monthl	
During an interview of	on 07/05/18 starting at 10:30		The QA Committee will determine additional audits or actions are	ine if
AM, the ALA stated t	hat she would ensure that all		required.	
a significant change their ISPs going forw	ed for residents experiencing in condition are included in ard.		required.	
At the time of the sur Resident #10's ISP w resident's frequent fa	vey, the ALR failed to update vith services to address the lls.			
R 483 Sec. 604d Individualiz	zed Service Plans	R 483	R 483 Sec. 604d Individualized	
(d) The ISP shall be	reviewed 30 days after		Service Plans	
The ISP shall be under	st every 6 months thereafter. ated more frequently if there			į.
is a significant change	in the resident's condition		I. The ALR failed to ensure reside	
ine resident and, if no	ecessary, the surrogate		ISPs were reviewed 30 days after	1
shall be invited to part reassessment. The re	rcipate in each eview shall be conducted by		admission, every six months, and updated with a change in conditio	.
an interdisciplinary tea	am that includes the		with the resident/surrogate	111
resident's healthcare i	practitioner, the resident, te, if necessary, and the		participation and IDT review.	
ALR.			1	1
Based on record revie	w and interview, the ALR			1
ralled to ensure reside	nts ISPs were reviewed 30			1

•	Health Regulation & Licensin	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
ŀ		ALR-0039	B WING_		07/13/2018
	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	01/13/2018
	BV/MSTAR CHEVY CHASE TE		NECTICUT STON, DC	T AVENUE NW 20015	
	PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D RF COMPLETE
	R 483 Continued From pag	je 28	R 483		
	residents in the sam #6, #7, #8, #9, #10, a	n, every six months thereafter, ificant changes for ten of 12 ple (Residents #1, #2, #3, #5, and #12).		a. ISP's for Residents #1, #2, #3, #6, #7, #8, #9, #10 and all curre residents were reviewed and up of 7/20/18. Resident #12 move	ent dated as
	on 06/27/18 at 11:30 was admitted on 02/2 record revealed an IS lacked documented e	nt #1's current clinical record AM showed that the resident 25/15. Further review of the 6P dated 06/27/18 which evidence that the resident's		ALR. All ISP's have been disciplined with resident and IDT with approximations. b. An ISP Log was created in or	ropriate
	health care practition. The record also lacke that an ISP review wa prior to 06/27/18.	er or surrogate reviewed it. ed documented evidence as conducted six months		schedule and track revised due of spread them out over the next 6 months. Each week four ISP's veriewed by Medical Director as	will be
	revealed that the residues on 03/21/18. showed that the ALR	he resident's clinical record dent started hospice The record, however, staff did not update the ISP ige until three months later		to ensure all change of condition updates to ensure resident needs being met.	ns and are
	on 06/29/18 at 10:30 A was admitted on 01/22 record revealed an ISF lacked documented ev health care practitione	#2's current clinical record AM showed that the resident 2/18. Further review of the dated 06/29/18 which vidence that the resident's r or surrogate reviewed it.		c. DON/Delegate will audit weel meetings and discuss any issues the QA committee monthly.	
	on 06/29/18 at 1:18 PN	#3's current clinical record If showed that the resident If 5. Further review of the			

record revealed an ISP dated 07/02/18 which

that an ISP review was conducted six months

lacked documented evidence that the resident's health care practitioner or surrogate reviewed it. The record also lacked documented evidence

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	WAL DATE CHOSEN
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	ALR-0039	B WING		
NAME OF SECURISE OF AUTOUR				07/13/2018
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S		
BV/MSTAR CHEVY CHASE TE		NNECTICUT A IGTON, DC 20		
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	1D	PROVIDER'S PLAN OF C	ORRECTION (X5
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE DAT
R 483 Continued From pa	ge 29	R 483		Superior Formula Company
A. Daviero - A.D 11		1		
4. Review of Resid	ent #5's current clinical record			
on 07/02/18 at 11:3	0 AM showed that the residen	t.		
was admitted on Ut	1/01/16. Further review of the			
OF/17/19 which lead	ignificant change ISP dated			
the regidents health	ked documented evidence that	l l		
reviewed it The rea	n care practitioner or surrogate ord also lacked documented	1		
evidence that an IS	P review was conducted six			
months prior to 05/1	7/40 was conducted six			
months prior to 05/1	17/16.			
5 Review of Reside	ent #6's current clinical record	1		
on 07/02/18 at 11:4!	5 AM showed an ISP dated	1		
02/12/18 which lack	ed documented evidence that	1		
it was reviewed by t	he resident's health care	1		
practitioner.	To Took of the Aller Galler			
6. Review of Reside	nt #7's current clinical record	1		
on 07/02/18 at 2:00	PM showed there was no			
documented evident	ce of an ISP review by the	I		
interdisciplinary tean	n since 07/19/16.			
7. Review of Reside	ent #8's current clinical record			
on 07/05/18 at 1:55	PM showed that the resident	1		
was admitted on 12/	07/15. Further review of the			
record revealed an I	SP dated 02/10/18 which	1		
	evidence that it had been			
reviewed by the resid	dent's health care	}		
practitioner, the resid	lent, or the resident's			
surrogate. Also, the	record showed there was no			
documented evidend	te that an ISP review was			
conducted six month				
Review of Reside	nt #9's current clinical record	1		
on 07/05/18 at 10:00	AM showed that the resident	1		
was admitted on 03/3	30/15. Further review of the			
record revealed an IS	SP dated 07/05/18 which	1		
lacked documented a	evidence that it had been	1		
		1		
reviewed by the resid	lent's health care record showed there was			

Health Regulation & Licensin	ng Administration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ADAMA DI LINE AND AND AND AND AND AND AND AND AND AND	ALR-0039	B WING		07/13/2018
NAME OF PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	TATE, ZIP CODE	
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R 483 Continued From pa	ge 30	R 483	DEFICIENCY)	Service of the American Service
no documented evid	dence that an ISP review was hs prior to 07/05/18.			
9. Review of Resider record on 07/05/18 resident was admitted review of the record 10/19/17 which lack it was reviewed by the practitioner, the resist surrogate. Also, the documented evidence conducted six months are conducted six months. Continued review of significant change Is lacked documented by the health care programmed in 10. Review of Resider record on 07/13/18 are resident was admitted review of the record move-in ISP dated 1 documented evidence resident's health care the resident's surrogate.	ent #10's current clinical at 1:00 PM showed that the ed on 09/25/13. Further revealed an ISP dated ed documented evidence that he resident's health care dent, or the resident's record showed there was no ce that an ISP review was after 10/19/17. The record revealed a SP dated 06/25/18. The ISP evidence that it was reviewed ractitioner or resident's revealed a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18. The ISP lacked a tax to a post 2/27/18, The ISP lacked a tax to a post 2/27/18, The ISP lacked a tax to a post 2/27/18, The ISP lacked a tax to a post 2/27/18, The ISP lacked a tax to a post 2/27/18, The ISP lacked a post 2/27/18, which documented			
away from the ALR) : back to the facility. T after leaving church,	found at a library (2 miles asking the staff how to get he note also indicated that Resident #12 followed a			
knew how to get to C	cause she thought the man connecticut Avenue. The copped following the man			

when she realized he was not going the right way.
Further review of the record revealed that the
Health Regulation & Licensing Administration
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ä	Health Regulation & Licens	sing Administration		r ₂	FORM APPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY
١		WELLTH TOTAL ON THE CALL	A. BUILDII	NG:	COMPLETED
		ALR-0039	B WING		07/40/0040
1	NAME OF PROVIDER OR SUPPLIES		DDRESS CIT	Y, STATE, ZIP CODE	07/13/2018
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ŀ	dia	WASHIN	GTON, DC		
	(X4) ID SUMMARY ST PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
	TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE PRIATE DATE
	R 483 Continued From p	age 31	R 483		
	ALR staff made Re	esident #12's physician aware			
	of the incident, at v	which time he instructed facility be resident to leave the ALR			
	without supervision	n. The record, however, lacked			
	documented evide	nce that the ALR staff had			
	change in supervis	ated 12/27/18, to address the			
	During an interview	on 07/06/18 at 10:40 AM , the facility's previous nurse			
	reviewed and upda	ted ISPs as required.			
	However, the ALA	was unable to locate the ISPs			
	at the time of the si	urvey.			
	During a post-surve	y interview on 07/23/18			
	starting at 1:00 PM	Resident #12's son stated he		1	
	He also stated that	the ALR had ISP meetings. after the incident on 01/21/18,		1	
	his mother continue	d to leave the facility without		1	
	supervision. When aware of the physic	asked if the ALR made him ian's instructions for his			
	mother to have sup-	ervision when leaving the			1
	facility, the son state recommendation fro	ed, "No, I thought it was a			I
	recommendation in	in the nurse."			ł
	At the time of the su	rvey, the ALR failed to ensure			
	the ISPs for Resider	nts #1, #2, #3, #5, #6, #7, #8, ere updated as required.		15	ľ
	and a top strain 12 we	re apaated as required.			
	R 605 Sec. 701g2 Staffing	Standards.	R 605	R605 Sec.701g2 Staffing Standa	ırds
	(2) Possess curren	t and appropriate licensure		I The ALD Called	
	and certifications as Based on observation	required by law; n, interview, and record		I. The ALR failed to ensure that	
	review, the ALA faile	d to ensure that the PDAs		PDAs working with ALR reside possessed a current license or	nts
	working with ALR res	sidents possessed a current		certification to provide ADL	1
	for one of six PDAs i	n to provide ADL assistance n the sample (PDA #2).		assistance.	
		Janipio (i D/(mz).	1		1

,	Health I	Regulation & Licensin	ng Administration			FORM	MAPPROVE
	STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
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	(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	R 605	Continued From page	ge 32	R 605	a. ALR revised Caregiver (Sitter	()	8/7/18
		Findings included:			policy. ALR updated PDA list t	-	8/31/18
		Resident #1 in her a aide (PDA #6). Durir 11:39 AM, PDA #6 s	26/18 at 11:36 AM showed apartment accompanied by an an interview on 06/26/18 at tated that she was hired by and assisted the resident		include PDA #6. Resident #1 had expired. PDA #2 no longer proving assistance in ALR; unable to obtacopy of valid license.	as ides	
	During an interview on 07/05/18 at 1:40 PM, the ALA verified that Resident #1 received ADL care from a PDA hired by the resident's family. The ALA further stated that Resident #1 needed assistance with getting out of bed, feeding, bathing, and dressing.			b. ALA/Designee will obtain copyalid license for all PDA's prior providing assistance to residents. Responsible party will sign PDA policy upon admission into ALR	to .		
		Who Have Private D the residents in the A and the respective na provided a current co 3:41 PM. Review of t #6, who was previous apartment, was not in	iew of the listing showed a		ALA/Designee will review revise Caregiver (Sitter) Policy with Resident/Responsible Party for residents that currently have PD/and will obtain the Private Careg Agreement. c. QA Committee will review PD List monthly during QA meetings	A's jiver DA	8/31/18
	r C ti	at 2:30 PM lacked do equired CNA certifica on 07/13/18, a certific he DC Health profes:	personnel record on 07/05/18 cumented evidence of the ation. It should be noted that eation search conducted on sional license database CNA certification status 0/31/07.		willing of the cong.		
	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 & Licensin	20 Administration		1, 2		\PPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE S COMPL	
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R 782 Continued From page	ge 33	R 782			
R 782: Sec. 901 1 Respons Personnel		R 782	R782 Sec. 901 Responsibilities ALR Personnel	of the 8	3/24/18
own medications; Based on record rev failed to ensure an ir conducted to determ of self-medicating fo residents who self-medications	riew 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 in assessment had been conducted determine if a resident was capa self-medicating.	to ble of	
#11). Findings included:			a. ALR arranged for RN Consult from Allied Pharmacy to review #11, and all residents that self-		/28/18
on 07/02/18 at 10:15 was admitted on 06/0 record revealed an H indicated the residen self-medicate. The re	ont #4's current clinical record AM showed that the resident 06/18. Further review of the 1&P dated 05/14/18 which t could independently ecord, however, lacked		administer medications. Obtaine orders for residents to self-admin medications from Medical Provide Medical Director.	nister der/	/30/18
documented evidence was conducted to asset self-medicate.	e that an initial assessment sess the resident's ability to		b. DON/Delegate will complete the Initial Assessment of each reside that self-administers prior to/at ti	nt me	
Resident #4 reported	n 07/02/18 at 11:25 AM, that no medication ed from the ALR staff.		of admission and obtain Physicia order to self-administer. Medica director to be consulted about sel	1 lf-	
on 07/02/18 at 3:00 P was admitted on 09/0 revealed a nursing no indicated the resident however, lacked docu	te dated 09/04/17 which self-medicates. The record, mented evidence an initial		medicating resident concerns dur Monthly QA meeting. DON/Del created a Medication Review Log include schedules for review.	egate g to	
assessment was cond resident's ability to sell be noted that the facility	ducted to assess the If-medicate. It should also ity did not have a physician #11 to self-medicate until		 c. DON/Delegate will report statumedication review during Monthl Quality Assurance Meeting. 		

06/29/18, which was approximately eight months

Health Regulation & Licensi	ng Administration			ONWINITIONEL
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION ((X3) DATE SURVEY COMPLETED
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R 782 Continued From pa	ge 34	R 782	CAR III	
after the resident's	admission to the ALR.			
contract nurse could assessment had be the resident's ability contract nurse was when the resident was an initial assessment.	rvey, the ALA failed to ensure it was conducted to of Resident #4 and #11 to			
R 802 Sec. 903 2 On-Site I	Review.	R 802	R802 Sec. 903 On-Site Review	
failed to assess each medications every 4 in the sample (Resid #12). Findings included: 1. Review of Resider 06/27/18 at 11:00 AN was admitted on 02/2 was responsible for a medications. Further revealed that there we the RN reviewed the medications. 2. Review of Residen	iew and interview, the RN in resident's response to 5 days for six of 12 residents ents #1, #2, #5, #6, #7, and it #1's clinical record on a showed that the resident #5/15, and the nursing staff idministering Resident #1's review of the clinical record as no documented evidence		I. RN failed to assess each resident response to meds every 45 days. a. ALR arranged for RN Consultate to complete the 45-day medication reviews for Resident #1, #2, #5, #6 and #7. Resident #12 moved out of 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 resides b. DON/Delegate will be responsible for ensuring resident 45-day medication reviews are completed.	nts 7/31/18 6, f and 4/21/18 8/31/18 ents.
was admitted on 01/2	showed that the resident 2/18, and the nursing staff dministering Resident #2's		DON/Delegate will keep a Medication Review Log	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG:	(X3) DATE SURVEY COMPLETED
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documented evident resident's response 3. Review of Reside 07/02/18 at 11:30 AM was admitted on 08/ was responsible for medications. Further documented evidence resident's response to 4. Review of Resider 07/02/18 at 11:30 AM was admitted on 02/2 was responsible for a medications. Further documented evidence resident's response to 5. Review of Resider 07/02/18 at 2:00 PM was admitted on 02/2 was responsible for a medications. Further documented evidence resident's response to 6. Review of Residen 07/13/18 at 2:00 PM was admitted on 12/2 was responsible for a medications. Further documented evidence resident's response to the following response to the following response to the following resident's response to the following resident resident's response to the following resident reside	r review of the record lacked be the RN reviewed the to medications. Int #5's clinical record on the showed that the resident to 1/16, and the nursing staff administering Resident #5's review of the record lacked be the RN reviewed the to medications. Int #6's clinical record on the showed that the resident 12/18, and the nursing staff administering Resident #6's review of the record lacked the RN reviewed the the RN reviewed the omedications. Int #7's clinical record on showed that the resident 12/14, and the nursing staff administering Resident #7's review of the record lacked the RN reviewed the the RN reviewed the omedications. It #12's clinical record on showed that the resident 7/17, and the nursing staff dministering Resident #12's review of the record lacked the RN reviewed the the RN reviewed the the RN reviewed the RN reviewed the RN reviewed the RN reviewed the RN reviewed the RN reviewed the RN reviewed the RN reviewed the contact the RN reviewed the RN review	R 802	c. DON/Delegate will report sta medication review schedule mon to the QA Committee.	
AM, the ALA stated the ensure that the nurse response to medication	at going forward she would assesses residents' on every 45 days.			
h Regulation & Licensing Administre E FORM	IIION	8899 4	GK211 If 0	continuation sheet 36 of

_He	alth Regulation & Licensi	ng Administration			FORM	APPROVE
STA	TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		E SURVEY PLETED
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PR	EFIX (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 APPROPE DEFICIENCY)	D BE	(X5) COMPLETE DATE
R	802 Continued From pa	ige 36	R 802			***************************************
	each resident's res aforementioned res	urvey, the RN failed to assess ponse to medications for the sidents in the sample.				
R	803 Sec. 903 3 On-Site	Review.	R 803	R803 Sec. 903 On-Site Review		
	self-administer his of Based on record refailed to assess the continue to self-administer his of five of five self-medicate (Resident). Findings included: 1. Review of Reside 06/29/18 at 1:18 PM was admitted on 03/record revealed a Hidocumented the resident's ability	view and interview, the RN resident's ability to safely ninister medications every 45 residents in the sample who dents #3, #8, #9, #10, and of the showed that the resident 12/15. Further review of the RP dated 03/11/15 that ident could independently on. The record, however, evidence the RN assessed to continue to self-medicate.		I. The RN failed to assess the resident's ability to self-administ medications every 45 days. a. ALR arranged for RN Consult to complete the 45-day medication reviews for resident's who self-administer medications. Resident ability to self-administer medications was observed RN Consultants. IRN notified Physician/Medical Director for clarification of ordeself-medicators. DON/Delegate obtained Physician order for resist to continue to self-administer medication.	tants on it's itions DON/	6/28/18 8/31/18
	07/05/18 at 2:00 PM was admitted on 12/0 record revealed a H8 documented the resinadminister medication lacked documented 6	ont #8's clinical record on showed that the resident 07/15. Further review of the AP 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 incl residents that self-administer medications.	self- ery 45	

3. Review of Resident #9's clinical record on 07/05/18 at 10:00 AM showed that the resident

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Health Regulation & Licensing Administration				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	FORM APPROVED		
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	ALR-0039				07/13/2018		
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	D BE COMPLETE PRIATE DATE			
R 803	Continued From page	ge 37	R 803				
		/30/15. Further review of the		c. DON/Delegate will report sta			
		&P dated 04/11/17 that		medication review schedule monthly			
		sident could self-administer ndently. The record, however,		to the QA Committee.			
	lacked documented	evidence the RN assessed					
	the resident's ability	to continue to self-medicate.					
	4. Review of Reside	nt #10's 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 a H&P dated 08/05/13 that					ì		
	documented the res	ident could self-administer					
medications independently. The record, however,							
lacked documented evidence the RN assessed the resident's ability to continue to self-medicate.							
5. Review of Resident #11's clinical record on 07/05/18 at 3:00 PM showed that the resident					1		
	was admitted on 09/	04/17. Further review of the			1		
	record revealed that	there was no documented			l		
	evidence the RN ass	sessed the resident's ability to	1		ĺ		
	06/28/18. It should al	icate from 09/12/17 through lso be noted that the facility					
	did not have a physic	cian order for the resident to	į		1		
	self-medicate until 06	3/29/18, which was					
	approximately eight r admission to the facil	months after the resident's					
	During an interview o	on 07/05/18 starting at 10:30					
	con, the ALA stated tr ensure that the nurse	nat going forward she would assesses the residents'					
	ability to continue to s	self-medicate every 45 days.	1		1		
ļ	At the time of the sun the residents' ability to	vey, the RN failed to assess o continue to self-medicate.					
•	This is a repeat defici	ency.			1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED		
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	R 953	Continued From pag	ge 38	R 953		
	R 953	Sec. 1001b General	Conditions.	R 953	R 953 Sec. 1001b General Condition	ons
		equipment, grounds good repair and ope Based on observation failed to ensure the finstalled equipment values (Residents (Residents Finding included: An environmental ins 06/26/18 at 11:13 AM closet on the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring, did residents good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the fourth finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the finelectrical wiring good to the fi	n and interview, the ALR acility's grounds were safe, was operable, and individual cod repair for 73 of 73 #1-73).		I. Utility closet on fourth floor not contain a lock to ensure the sa of all residents living in the ALR. a. ALR staff installed lock on electrical closet. b. All doors have been assessed need for lock. All needed locks habeen attained and installed. c. Maintenance team will continut to monitor door locks for safety dur their weekly walk-through.	8/1/18 for ve
	t t s	facility, including walk chimney, gutters, down surfaces, and access structurally sound, sa Based on observation determined that the fathe exterior of its build structurally sound and Findings included: Observation on 06/26/ that the ALR's walkwall ireas and missing piethe front sidewalk to the trance. The surveyor	ure that the exterior of its ways, yards, porches, respouts, paintable ory buildings are maintained nitary, and in good repair, and interview, it was icility failed to ensure that ling was maintained in good repair. 18 at 10:26 AM showed by had several cracked ces of flagstone noted from the facility's front door		R 971 Sec. 1003a General Building Exterior I. ALR's walkway had several crack areas and missing pieces of flagston. a. Flagstone walkway project completed as of 8/1/18. b. Exterior has been reviewed by AL for any safety concerns on 8/1/18. Nadditional safety concerns were found. c. Maintenance team will review safe of exterior building monthly.	e. 8/1/18 R o d.

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		ALR-0039	B WING		07/13/2018
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stone throughout the walkway, creating a trip hazard for residents, visitors, and staff. Continued observation showed separation of individual blocks of the flagstone with no evidence of grout in between some of the blocks, resulting in an uneven surface. Another observed area contained an exposed drain pipe missing the cover and with very little surrounding stone, creating a potential trip hazard for residents, visitors, and staff. During an interview on 06/28/18 at 10:15 AM, the Director of Maintenance stated that a contractor was scheduled to come to the ALR that day to inspect the walkway and an update on the status of the repair would be provided to the surveyors. On 06/29/18 at 3:38 PM, the Director of Maintenance explained that two proposals had been collected from vendors to replace the flagstone walkway as soon as possible. On 07/02/18 at 12:15 PM, the Director of Maintenance stated that the contractors were on the premises and had started to repair the walkway. Follow-up observations conducted on 07/02/18 and 07/03/18 at 12:15 PM showed the contractors repairing the walkway on both days Subsequent observations on 07/05/18 and 07/06/18 at 9:10 AM revealed that the repair of the walkway was still in progress and the potential		R 971			
R1003	trip hazards remained Sec. 1006c Bathrooms		R1003	R 1003 Sec. 1006c Bathrooms	
	the not water at all tap	re that the temperature of s to which residents have the use of thermostatically es or by other means,		I. ALR failed to ensure that the water temperature did not exceedegrees.	e hot

ı	Health	Regulation & Licensing	ng Adminisation			FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
-			ALR-0039	B WING_		07/13/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADI			STREET AC	DRESS, CITY	, STATE, ZIP CODE	0771072010	
L	BV/MST/	AR CHEVY CHASE TE	NANT D/B/A CHE 5420 COM WASHING		T 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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE	(X6) COMPLETE DATE
ľ	R1003	Continued From pag	ge 40	R1003		-	TALLOW
including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation and interview, the ALR failed to ensure that the hot water temperature			a. Hot water heater temperature below 110 degrees.b. Facility Maintenance Director	Director to			
		#718, #616, #617, #4	degrees Fahrenheit in six of spected (Apartments 404A, #412, and #214).		maintain daily log of temperatur		
	Findings included:			c. Maintenance team will do weekly			
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 the following hot water temperatures recorded at the bathroom hand sink in each specified location:			temperature checks. Any room f with excessive heat, hot water he will immediately be reset to appropriate temperature while st and resident are informed not to utilize until temperature is within approved range.	eater aff			
	-	Apartment #616 = 11 Apartment #404A = 1 Apartment #412 = 11	5.3 degrees Fahrenheit 5.7 degrees Fahrenheit 11.9 degrees Fahrenheit 3.7 degrees Fahrenheit 2.5 degrees Fahrenheit				
	a tř tř	it 2:20 PM and 2:40 F ne hot water tempera	PM, respectively, showed tures at the hand sinks in partments were between a Fahrenheit.				
	tn de	ie water temperature	ey, the ALR failed to ensure s did not exceed 110 six of the apartment				