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	ALR-0039	A. BUILDING _____ B. WING _____	07/13/2018

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BV/MSTAR CHEVY CHASE TENANT D/B/A CHE	5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015

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R 000	Initial Comments An annual survey was conducted at Chevy Chase House, Assisted Living Residence (ALR), from 06/26/18 through 07/13/18 to determine compliance with the Assisted Living Law. The ALR provided care for 73 residents and employs 79 personnel to include professional and administrative staff. On 04/13/18, the ALR's administrator reported an incident that alleged a construction worker was observed in a resident's bedroom naked from the waist down. Based on the nature of this incident, a comprehensive review of the ALR's incident management system along with a review of the ALR's investigation was completed to determine if the ALR provided adequate supervision and oversight as required by the ALR law. On 07/03/18, the survey team identified systemic failures that posed an immediate risk to the health and safety of all residents. The facility was notified and, effective on 07/03/18, was issued a 90 day restricted license for no new admissions. The survey findings were based on observations, interviews with residents, employees and family members, as well as the review of administrative and clinical records. Listed below are abbreviations used throughout the body of this report. ADL - Activities of Daily Living ALA- Assisted Living Administrator ALR - Assisted Living Residence DME - Durable Medical Equipment QA - Quality Assurance CPAP - Continuous Positive Airway Pressure TED - Thrombo-Embolic-Deterrent APS - Adult Protective Services RDO - Regional Director of Operations	R 000		

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R 000	Continued From page 1 H&P- History and Physical ISP- Individualized Service Plan RN - Registered Nurse DON - Director of Nursing PDA -Private Duty Aide CNA - Certified Nursing Assistant PRN - as needed TAR- Treatment Administration Record Lt - left mg - milligram ER - Emergency Room	R 000		
R 008	Sec. 102b2 Philosophy of Care (2) The design of services and environment should acknowledge that a significant number of residents may have some form of cognitive impairment. Services and environment should offer a balance between choice and safety in the least restrictive setting. Based on observation, interview and policy review, the ALR failed to provide a safe and secured environment for all residents residing in the facility. Specifically, the facility failed (I) to implement its policies on door monitoring, (II) to respond timely to stairwell/exit door alarms, and (III) to implement its policies on reporting incidents and allegations of abuse. Findings included: (I) The facility failed to implement its policies that required the use of stairwell/exit door monitoring, as follows: Record review of the facility's policy titled, "Door Monitoring and Response Policy," dated 06/06/16, showed that each stairwell/exit door was equipped with a monitoring device located at	R 008	R 008 Sec. 102b2 Philosophy of Care I. The facility failed to implement its policies that required the use of stairwell/exit door monitoring. a. The ALA immediately retrained staff on the Door Monitoring and Response Policy. Stairwell door alarms were reset to alarm when opened by sending alerts throughout the entire day to the Concierge at the front desk and the CNA pagers. 6/29/18 b. The Door Monitoring and Response Policy has been revised to reflect the 10-minute response time to exterior doors and doors leading to the basement as with other alerts within the ALR. Staff was trained on the revised policy on 9/12/18. The staff will be trained on the Door Monitoring and Response Policy annually, during new hire orientation, and as required. 8/24/18	

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R 008	Continued From page 2 the top of the door. Per the policy, "When the door was opened or ajar, the monitor released a silent alarm which was sent to each Certified Nurse Assistant's (CNA) pager and the Front Desk Console. The alarm indicated the location of the door which was opened, prompting the staff to the identified access point to verify that no resident had entered the stairwell. Response time was not to exceed five minutes." Observations during the initial tour of the ALR on 06/26/18 at 2:27 PM showed disabled alarms on the ALR's stairwell exit doors on Floors #1, #2, #3, #4, #5, #6 and #7. Some residents were observed to utilize the stairs versus the elevator. During an interview on 06/26/18 at 2:30 PM, the Residential Relations Manager stated that the facility decided to turn off the alarms between 7:00 AM and 2:30 PM. This was because the construction workers used the stairwells so frequently, which triggered the need for extra response by the ALR's aides. When questioned if the facility had implemented a secondary safety measure for stairwell exit monitoring, the Residential Relations Manager responded they had not. The surveyors explained the safety risk for not enabling the door alarms immediately. Record review of the ALR's training records on 07/03/18 at 3:18 PM indicated the following action was taken by the Residential Relations Manager: "Effective 06/27/18, all door alarms are activated. All staff and contractors informed and compliance is active and ongoing immediately." Record review of the attendance logs showed that in-service training on stairwell alarm monitoring was conducted on 06/27/18. Although training was provided on 06/27/18, the ALR staff failed to respond to the exit door alarms during subsequent observations with ALR staff was	R 008	c. The Business Office Manager will keep an annual education log, listing the annual monthly trainings. The education log will be monitored monthly by the QA Committee for completion/compliance. The QA Committee will be monitoring the new policy monthly during the QA meeting. II. The facility failed to respond timely to stairwell/exit door alarms in accordance with their policy. a. The ALR staff were immediately retrained on the requirements of answering the door alarms timely (within 10 minutes). Silversphere Security came to the facility to check the door/stairwell alarms and reset to alarm pagers. b. The staff will be trained annually by Silversphere to properly use the alarm system. Newly hired staff will be trained on policy by ALR. c. All doors leading outside and to the basement have been secured and monitored every 2-3 hours.	6/29/18 8/24/18

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R 008	Continued From page 3 provided on 07/04/18, with a total of 23 of the 79 employees. (II) The facility failed to respond timely to stairwell/exit door alarms in accordance with their policy. On 07/06/18, follow-up observations of the ALR's implemented alarm response system located at the front desk console showed at 11:00 AM that a stairwell exit door alarmed for 20 minutes without ALR staff response. Continued observations on the same day at 12:20 PM showed another stairwell exit door that alarmed for 17 minutes without ALR staff response. During an interview with the receptionist on 07/06/18 regarding response time to the alarm, the receptionist stated that a general announcement was made by the front desk using the intercom system until one of the employees responds to reset the alarm. The receptionist was also questioned about the ALR's door monitoring policy. The receptionist was not familiar with the facility's policy. At the time of the survey, the ALR failed to monitor and respond to the stairwell exit alarm system. (III) Cross refer to 0390: The ALR staff failed to implement its policies on reporting incidents and allegations of abuse, as follows: Record review of the ALR's policy, titled, "Abuse - Neglect - Exploitation" revised in January 2018, showed that the staff, "witnessing, suspecting, or having knowledge of abuse, neglect and/or exploitation of a resident have an obligation to report immediately, or as soon as practical."	R 008	R 390 Sec. 509b1 Abuse, Neglect, and Exploitation I. The ALR staff failed to immediately report an allegation of sexual abuse to the facility's ALA.	

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R 008	Continued From page 4 a. On 04/06/18, one of the ALR's housekeepers observed a construction worker standing in Resident #12's bedroom partially unclothed. A review of the ALR's investigative findings on 07/03/18 at 10:00 AM revealed the following timeline and sequence of events surrounding the 04/06/18 incident: Friday, 04/06/18 - The housekeeper, who witnessed an alleged sexual abuse of Resident #12, reported the incident to the receptionist. Sunday, 04/08/18 - The receptionist reported the incident to the Activities Director. Monday, 04/09/18 - The construction worker was observed by the ALR staff working on the ALR premises and on the floor where Resident #12 lived. Wednesday, 04/11/18 - The Activities Director reported the alleged abuse to the ALA. [Note: Interviews conducted with the receptionist and the construction superintendent indicated that both parties had made the ALA aware of the incident on 04/09/18.] b. Further review of the ALR's "Abuse - Neglect - Exploitation" policy revealed that the ALA was responsible to: "- Seek immediate emergency care if needed; - Notify the Resident's Medical Provider; - Notify the Residents authorized Responsible Party of the report; - Notify local law enforcement for any physical injury, sexual abuse, death or other crime related to the alleged abuse;	R 008	a. The receptionist was retrained on reporting all allegations, including alleged, to management, regardless of circumstances. Housekeeper was trained on the appropriate reporting process after observing a possible abusive situation. The ALR received annual training for the Abuse and Neglect and Reporting policy on 4/26/2018. The ALA was retrained on 7/4/2018 on the Reporting of Abuse, Neglect and Exploitation of a Resident. Staff members that failed to adhere to the policy received disciplinary action, per policy. b. The Abuse, Neglect, and Reporting policy has been revised/updated. The staff will be retrained on the revised/ updated policy. The staff will receive annual training and training during new hire orientation on the Abuse, Neglect, and Reporting policy. c. The BOM will keep an annual education log, listing the annual training. The education log will be monitored monthly by the QA Committee for completion/ compliance.	4/13/18 4/13/18 4/26/18 7/4/18 8/22/18 8/31/18

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R 008	Continued From page 5 - Investigate the allegation, enlisting Adult Protective Services, the State Regulatory Agency, and Ombudsmen as needed and required; - [Ensure] required documentation is completed with the required time frames; - [Ensure] an insurance report is submitted; - [Ensure] the identity of the Resident, perpetrator and person making the report remains confidential unless circumstances prevent it; - [sic] assure no retaliation against the person making the report; and - If the Incident Report is risk related and/or state reportable, the ALA (or designee) will send a copy of the Regional Director of Operation (RDO), who will forward a copy to the home office legal department." Note: Under risk related incidents, Allegations of Resident abuse or neglect was listed. Interviews with the ALA demonstrated inconsistencies with the investigative findings of the alleged abuse on 04/06/18, as evidenced by the following timeline regarding the administrative response to the incident: - Thursday, 04/12/18 (6 days post-incident): The ALA reported the incident of alleged sexual abuse to the police, who took a report of the incident. Note: The police report failed to reflect the alleged perpetrator's name. - Thursday, 04/12/18 (6 days post-incident): The ALA notified Resident #12's son of the alleged abuse. - Friday, 04/13/18 (7 days post-incident): Resident #12's physician performed a post-incident physical examination. Note: The physician's assessment described Resident #12 as "homebound due to dementia" and having "no	R 008		

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R 008	Continued From page 6 recollection" of the incident. - Friday, 04/13/18 (7 days post-incident): The ALA notified APS and the state licensing agency of the alleged incident. - Thursday, 04/26/18 (20 days post-incident): The ALR conducted staff in-service training on "Reporting of Abuse, Neglect and Exploitation of a Resident." It should be noted that there was no documented evidence that the ALA had forwarded notification of the incident to the Long-Term Care Ombudsman's office as required by the ALR's policy. At the time of the survey, the ALR staff and ALA failed to implement the facility's policies on reporting incidents and allegations of abuse.	R 008		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; Based on record review and interview, the ALR nursing staff failed: (1) to follow physician orders as prescribed for two of two residents in the sample receiving wound care services (Residents #1 and #2); (2) to follow the wound care policies for two of two residents in the sample receiving wound care services (Residents #1 and #2); (3) to follow the fall policy for one of one residents in the sample who fell (Resident #10); (4) to ensure special instructions from the hospital were followed for one of one	R 292	R 292 Sec. 504.1 Accommodation of Needs I. The ALR nursing staff failed to provide wound care per physician orders. a. The DON/RN completed a 100% chart audit for current residents. The audit included a review of Physician orders for wound care for residents #1 and #2 and all current residents. DON/Delegate provided one-on-one training to all nurses on how to review, verify, and transcribe Physician's orders (including wound	8/17/18 8/31/18

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resident in the sample (Resident #10); and (5) to assess a resident's ability to independently operate DME for one of one resident in the sample (Resident #11).

Findings included:

1. The ALR nursing staff failed to provide wound care per physician orders, as evidenced below:

a. Review of Resident #1's current medical record on 06/27/18 at 11:30 AM showed the following wound care orders:

i. 08/10/17- Cleanse left upper arm skin tear with normal saline, pat dry, apply bacitracin ointment, cover with 4 X 4 gauze, and secure with kerlix daily and PRN.

Further review of the record revealed TARs that lacked documented evidence the wound care mentioned above was provided on the following dates: 08/12/17, 09/07/17, 09/17/17, 09/27/17, 09/30/17,10/23/17, and 12/10/17.

ii. 10/25/17- Cleanse left heel wound with normal saline, pat dry, peri-wound surrounding skin area with skin-prep, apply iodosorb cream to wound bed, cover with 4 X 4 gauze then secure with kerlix wrap and tape daily until healed.

Further review of the record revealed TARs from 10/25/17 through 12/31/17 that showed the above mentioned wound care order was not transcribed completely to the TARs. Continued review of the TARs showed that nursing staff documented that they only applied iodosorb gel to the left heel daily.

b. Review of Resident #2's current medical record

care orders) and record in the MAR/ TAR. DON/Delegate reviewed and verified orders for all residents currently receiving wound/skin care. 8/31/18

b. A binder for copies of physician orders will be kept in DON's office. Each day the DON/Delegate will review any orders for wound care and verify implementation. 8/17/18

All nurses received training on the purpose of the binder to verify that wound/skin care orders are implemented. All nurses received training on how to review, verify and transcribe physician orders (including wound care orders) and to record completion of each application/treatment on the MAR/TAR. Training will be completed and documented upon new hire and annually thereafter. 8/31/18

c. The DON/Delegate will audit the physician's orders for wound care orders for complete transcription to the TAR and report findings to the QA Committee monthly to ensure compliance. The DON/Delegate will print TAR documentation reports from QuickMar (computer software system) and will review the audit monthly with the QA Committee to ensure compliance with documentation of treatment(s) by nurses.

II. The ALR staff failed to follow the wound care policy.

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

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R 292	Continued From page 8 on 06/29/18 at 10:30 AM, showed the following wound care orders: 03/15/18- Cleanse right dorsal ankle with normal saline, apply small amount of saline gel, cover with boarder gauze daily. Continued review of the record lacked documented evidence that the nursing staff provided the wound care. During an interview on 07/03/18 at 2:00 PM, the facility's contract nurse stated that documentation of wound care provided should be in the residents' records. The contract nurse could not verify that wound care services were provided as ordered, due to not working with the facility at that time. At the time of the survey, the ALR nursing staff failed to provide wound care services as ordered. 2. The ALR staff failed to follow the wound care policy, as evidenced below: a. Review of Resident #1's current medical record on 06/27/18 at 11:30 AM showed that the nursing staff provided wound care services from 08/10/17 through 12/31/17. Review of the facility's undated policy titled, "Wound Management," showed the following: - the nursing staff was to institute a weekly wound tracking tool; - the resident's ISP was to be updated immediately with modifications; - the Director of Clinical Services was to review the wound tracking tool weekly; and - the wound care team was to meet weekly to review the resident's wound status.	R 292	b. A binder for copies of physician orders will be kept in DON's office. Each day the DON/Delegate will review any orders for wound care and verify implementation. All nurses received training on purpose of binder to verify that wound/skin care orders are implemented. All nurses received training on how to review, verify and transcribe physician orders (including wound care orders) and to record completion of each application/treatment on the MAR/TAR. Training will be completed and documented upon new hire and annually thereafter. c. The DON/Delegate will audit the physician's orders for wound care orders and report findings to the QA Committee monthly to ensure that nurses are in compliance with the Skin & Wound Care Policy. III. The ALR staff failed to follow the Fall Policy. a. Resident #10 was reassessed by RN and ISP was updated. b. The Chevy Chase Fall Policy was revised. Staff was educated/trained on the revised Fall Policy. Nurses will be educated/trained on how to evaluate a resident at risk for a fall using revised Fall Risk Screening and select a resident-centered intervention if indicated. DON/ Delegate evaluated all current residents using Fall Risk Screening. DON/Delegate updated resident's ISPs that are at risk for a fall. c. The DON/Delegate created a Fall Log. Each new fall will be added to	7/20/18 8/31/18 8/23/18 6/25/18 7/20/18 8/31/18 8/23/18 8/24/18

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Further review of Resident #1's record revealed there was no documented evidence that the ALR's staff followed the wound management policy outlined above.

b. Review of Resident #2's current medical record on 06/29/18 at 10:30 AM showed that the nursing staff was currently providing wound care to the resident's right foot. The wound care services started on 02/27/18.

Review of the facility's policy titled, "Skin & Wound Care," revised in January 2018, showed the Wellness Director was to assure interventions were implemented, documented, and service plans were updated with current interventions.

Further review of Resident #2's record revealed there was no documented evidence the Wellness Director followed the Skin & Wound Care policy outlined above.

During an interview on 07/05/18 starting at 10:30 AM, the ALA stated that the facility's previous DON was to ensure that the wound care policy was followed.

At the time of the survey, the ALR staff failed to follow the wound care policies.

3. The ALR staff failed to follow the fall policy, as evidenced below:

Observation of Resident #10's apartment on 06/26/18 at 12:00 PM showed the resident had a large, purple-colored bruise on the right side of the head that extended down to the neck.

Review of Resident #10's current medical record

the log and reviewed daily in the morning meeting with the IDT. Fall Log will be tracked, trended, and reported to the QA Committee monthly.

I. The ALR failed to ensure that special instructions from hospital discharge were followed.

a. Resident #10's hospital orders were reviewed. RN entered late entry to correct the description of the injury. DON/ Delegate completed a 100% audit of the clinical records for current residents to review special instructions after hospital discharge. — 8/24/18 — 8/24/18

b. A binder for copies of physician orders/ new orders will be kept in DON's office. Each day the DON/Delegate will review all orders, including special instructions from the hospital/ER, along with the discharge summary, and verify implementation and that the resident's MD has been notified of special instructions/discharge orders. — 8/17/18

c. The DON/Delegate will audit daily the physician's orders/new orders for compliance with implementing special instructions from the hospital/ER and notifying the MD & RP, and report findings to the QA Committee monthly to ensure compliance.

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R 292	Continued From page 10 on 07/05/18 at 1:00 PM revealed the resident fell a total of seven times from December 2017 through June 2018. Review of the facility's policy titled, "Falls," revised in January 2018, showed that after a fall, the Wellness Director was to ensure a fall investigation was completed, the resident's ISP was updated with interventions, a QA of the fall was reviewed, and a fall tracking was completed. Further review of record revealed that there was no documented evidence the Wellness Director followed the fall policy as outlined above. 4. The ALR failed to ensure that special instructions from hospital discharge were followed, as evidenced below: Observation of Resident #10's apartment on 06/26/18 at 12:00 PM showed the resident had a large, purple-colored bruise on the right side of the head that extended down to the neck. Review of Resident #10's current medical record on 07/05/18 at 1:00 PM revealed the resident fell a total of seven times from December 2017 through June 2018. The resident was transferred to a local ER for evaluation of head injury for two of the seven falls. Further review of the record revealed a nursing note dated 06/24/18 that documented, "resident observed on the floor swelling [sic] observed on Lt. front head." The note lacked documented evidence of the resident's orientation status and the exact location of the fall. It should also be noted that resident's injury was on the right side of the head and not on the left side as indicated in the note.	R 292	The ALR failed to assess resident #11's ability to independently operate a CPAP machine. a. The resident was immediately assessed by a registered nurse and educated about the use and operation of the CPAP, and the TED Hose. Resident received size Medium TED Hose on 6/27/18 and demonstrated ability to turn on and off correctly. Obtained order for CPAP on 8/1/18. Order was present for TED hose ordered 5/23/18. b. The resident was assessed by his PCP's Nurse Practitioner. Resident #11 will be assessed for the use and operation of mechanical devices and medical devices during the 6 month ISP, and with any change in condition. All new residents will be assessed for the use and operation of mechanical devices and medical devices prior to admission, at move in, during the 30 day ISP, the 6 month ISP, and with any change in condition. The DON created a Medical Device Log to track residents in the ALR with medical devices. c. The DON/Delegate will audit monthly the Medical Device Log to ensure the equipment is functional and the resident is safely using the equipment.	6/26/18 7/9/18 8/14/18

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Continued review of the record revealed the resident returned from the ER on 06/25/18 with special instructions, which included directions within the first 48 hours to "ask the doctor before using any medicines and don't take sedatives or medicine that make you sleepy". The record lacked documented evidence that Resident #10's physician was made aware of the special instruction. Also, the resident self-administered all medications within the first 48 hours after returning from the ER, including Trazadone 50 mg (a sedative with the side effect of drowsiness).

During an interview on 07/05/18 at 3:30 PM, the resident stated, "Yes, I took my medicines when I came back from the ER."

At the time of the survey, the ALR failed to ensure that Resident #10 followed, and the resident's physician was made aware of, the special instructions from the hospital.

5. The ALR failed to assess Resident #11's ability to independently operate a CPAP machine as evidenced below:

During an interview on 06/26/18 at 12:40 PM, Resident #11 stated that he wanted the nurses to assess him to see if he was using his CPAP machine and [support] stockings correctly. The resident also stated that he used a CPAP machine for sleep apnea, but he did not know how to adjust the settings.

Review of Resident #11's current medical record on 06/26/18 at 2:00 PM showed the resident was admitted on 09/04/17. Further review of the record revealed a H&P dated 09/01/17 that

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R 292	Continued From page 12 indicated the resident had a diagnosis of obstructive sleep apnea. The record lacked documented evidence of a physician order for CPAP therapy or TED support stockings. During an interview on 06/26/18 at 2:30 PM, the ALA stated that she would have the nurse to assess the resident to evaluate his concerns with the CPAP therapy and support stockings. Follow-up review of Resident #11's updated medical record revealed a nursing note written by the Regional Director dated 06/26/18, which indicated the resident was assessed by the contract nurse to evaluate the resident's ability to independently use the CPAP machine and put on TED support stockings. The Regional Director documented that the resident stated, "the current setting at 6 disrupted his sleep, so he would loosen the straps on the mask which decreases the flow." The Regional Director also documented that the nurse would inform the resident's healthcare practitioner and request a respiratory therapy evaluation. Continued review of the nursing note revealed the resident's TED stockings were too big and a smaller size was ordered. At the time of the survey, the ALR failed to ensure Resident #11 was assessed to ensure he could independently use his CPAP machine and TED support stockings.	R 292		
R 390	Sec. 509b1 Abuse, Neglect, and Exploitation. (b)(1) An ALR, employee of an ALR, or other person who believes that a resident has been subjected to abuse, neglect, or exploitation shall report the alleged abuse, neglect, or exploitation	R 390	R 390 Sec. 509b1 Abuse, Neglect, and Exploitation I. The ALR staff failed to immediately report an allegation of sexual abuse to the facility's ALA.	

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R 390	Continued From page 13 immediately to the assisted living administrator who shall take appropriate action to protect the resident. The ALR shall report any allegation of abuse, neglect, or exploitation brought to its attention to the Mayor and the Adult Protective Services Program, administered by the Family Services Administration of the Department of Human Development. Based on interview and record review, employees of the ALR failed to (I) immediately report allegations of sexual abuse to the facility's administrator for Resident #12, and the ALA failed to (II) take appropriate action to protect all residents living in the ALR. Findings included: I. The ALR staff failed to immediately report an allegation of sexual abuse to the facility's ALA, in accordance with the ALR law and implement the facility's internal policy as follows: Record review of the ALR's policy titled, "Abuse - Neglect - Exploitation" revised in January 2018, showed that the staff, "witnessing, suspecting, or having knowledge of abuse, neglect and/or exploitation of a resident have an obligation to report immediately, or as soon as practical." On 04/06/18, one of the ALR's housekeepers observed a construction worker standing in Resident #12's bedroom partially unclothed. During an interview with the housekeeper on 07/03/18 at 11:03 AM, the housekeeper explained that she knocked on Resident #12's door twice. When there was no answer, she proceeded to use a key to access the apartment. The housekeeper further described that upon entry, she observed a construction worker standing at the head of the bed and Resident #12 was laying	R 390	a. The receptionist and activities director were retrained on reporting all allegations, including alleged, to management, regardless of circumstances. Receptionist and activities director received written corrective action regarding abuse of neglect reporting. Housekeeper was trained on the appropriate reporting process after observing a possible abusive situation. The ALR received annual training for the Abuse and Neglect and Reporting policy on 4/26/2018. The ALA was retrained on 7/4/2018 on the Reporting of Abuse, Neglect and Exploitation of a Resident. Staff members that failed to adhere to the policy received disciplinary action, per policy. b. The Abuse, Neglect, and Reporting policy has been revised/updated. The staff will be retrained on the revised/updated policy. The staff will receive annual training and training during new hire orientation on the Abuse, Neglect, and Reporting policy. c. The business office manager will keep an annual education log, listing the annual training. The education log will be monitored monthly by the QA Committee for completion/compliance.	4/12/18 4/12/18 4/26/18 7/4/18 8/22/18 8/31/18

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R 390	Continued From page 14 in bed. The construction worker was partially unclothed from the waist down. When the construction worker noticed the housekeeper, the construction worker was overheard stating "shit." The housekeeper immediately closed the door and left the apartment. a. A review of the ALR's investigative findings on 07/03/18 at 10:00 AM revealed the following timeline and sequence of events surrounding the 04/06/18 incident: Friday, 04/06/18 - The housekeeper, who witnessed an alleged sexual abuse of Resident #12, reported the incident to the receptionist. Sunday, 04/08/18 - The receptionist reported the incident to the Activities Director. Monday, 04/09/18 - The construction worker was observed by the ALR staff working on the ALR premises and on the floor where Resident #12 lived. Wednesday, 04/11/18 - The Activities Director reported the alleged abuse to the ALA. [Note: Interviews conducted with the receptionist and the construction superintendent indicated that both parties had made the ALA aware of the incident on 04/09/18.] b. During an interview on 07/03/18 at 11:03 AM, the housekeeper acknowledged that the incident was not reported to the ALA/supervisor. The housekeeper made a "complaint" to the receptionist who was on duty that day. Review of the housekeeper's written statement on 07/03/18 at 11:30 AM showed that the housekeeper was uncertain whom to report the incident to.	R 390	II. The ALR failed to take appropriate action to protect all residents from potential abuse. 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. b. An investigation will be conducted for all abuse allegations per the revised investigation policy and procedures. Abuse and neglect policy revised 8/22/18. The regional director of operations will be notified immediately of all abuse allegations. The regional director of operations will be actively involved with all ongoing investigations of abuse and neglect allegations to ensure compliance with policy. Residents will be informed about circumstances that require investigation into abuse allegations, if the situation could endanger their safety or well-being. All residents were interviewed by ALR staff to ensure there are no other issues surrounding any contractor. c. Investigations will be reviewed by the QA Committee monthly to ensure compliance for resident protection and safety per Resident Rights and Abuse policy. New contractor policy created to ensure construction workers will not be in residents' rooms.	4/12/18 8/31/18

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c. During an interview on 07/03/18 at 11:45 AM, the receptionist, who was on duty the day of the incident, stated the housekeeper reported the incident to him and not to the ALA/supervisor. The receptionist also stated that when the housekeeper shared the observation of Resident #12 and the construction worker, the receptionist thought they had engaged in a consensual sexual act. The receptionist left the facility that day (04/06/18) at approximately 3:00 PM and informed the facility's Activities Director of the alleged incident on Sunday, 04/08/18.

d. Further review of the ALR's "Abuse - Neglect - Exploitation" policy revealed that the ALA was responsible to:

"- Seek immediate emergency care if needed;
- Notify the Resident's Medical Provider;
- Notify the Residents authorized Responsible Party of the report;
- Notify local law enforcement for any physical injury, sexual abuse, death or other crime related to the alleged abuse;
- Investigate the allegation, enlisting Adult Protective Services, the State Regulatory Agency, and Ombudsmen as needed and required;
- [Ensure] required documentation is completed with the required time frames;
- [Ensure] an insurance report is submitted;
- [Ensure] the identity of the Resident, perpetrator and person making the report remains confidential unless circumstances prevent it;
- [sic] assure no retaliation against the person making the report; and
- If the Incident Report is risk related and/or state reportable, the ALA (or designee) will send a copy of the Regional Director of Operation (RDO), who will forward a copy to the home office legal department." Note: Under risk related incidents,

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Allegations of Resident abuse or neglect was listed.

Interviews with the ALA demonstrated inconsistencies with the investigative findings of the alleged abuse on 04/06/18, as evidenced by the following timeline regarding the administrative response to the incident:

- Thursday, 04/12/18 (6 days post-incident): The ALA reported the incident of alleged sexual abuse to the police, who took a report of the incident. Note: The police report failed to reflect the alleged perpetrator's name.

- Thursday, 04/12/18 (6 days post-incident): The ALA notified Resident #12's son of the alleged abuse.

- Friday, 04/13/18 (7 days post-incident): Resident #12's physician performed a post-incident physical examination. Note: The physician's assessment described Resident #12 as "homebound due to dementia" and having "no recollection" of the incident.

- Friday, 04/13/18 (7 days post-incident): The ALA notified APS and the state licensing agency of the alleged incident.

- Thursday, 04/26/18 (20 days post-incident): The ALR conducted staff in-service training on "Reporting of Abuse, Neglect and Exploitation of a Resident."

It should be noted that there was no documented evidence that the ALA had forwarded notification of the incident to the Long-Term Care Ombudsman's office as required by the ALR's policy.

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e. During an interview on 07/03/18 at 12:52 PM, the ALA stated the incident was reported by the Activities Director on Tuesday, 04/10/18. On 07/05/18 at 12:23 PM during a review of the timeline documented by the ALA, the Activities Director did not inform the ALA of the alleged abuse until Wednesday, 04/11/18.

The findings of the ALA's investigation showed that the ALR's staff failed to immediately notify the ALA of an allegation of sexual abuse involving Resident #12.

II. The ALR failed to take appropriate action to protect all residents from potential abuse as evidenced by:

At the time of the inspection on 06/26/18, a comprehensive review of the ALR's incident management system along with a review of the ALA's investigation was completed to determine if the ALR provided adequate supervision and oversight as required by the ALR law.

a. During an interview on 07/03/18 at 11:03 AM, the ALR's housekeeper, who witnessed the alleged sexual abuse of Resident #12, observed the alleged perpetrator on the ALR premises on Monday, 04/09/18, which was three days after the incident occurred.

b. During an interview on 07/03/18 at 12:52 PM, the ALA stated that written statements were part of the investigative package. Subsequent review of the investigative package, however, failed to evidence that written statements were obtained from the receptionist and the Activities Director.

During continued interview, the ALA indicated that

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R 390	Continued From page 18 she also spoke with the superintendent from the construction company, which was verified through email correspondence dated 04/12/18. The email communication indicated that the Activities Director, not the ALA, first contacted the superintendent on Monday, 04/09/18, to alert him to the alleged incident involving one of his employees. Continued review of that email showed that on 04/09/18, the ALR requested the construction company to obtain a written statement from the alleged perpetrator. The alleged perpetrator declined to provide a written statement on 04/10/18 when approached by the superintendent and was subsequently escorted off the ALR premises the same day. An internal memorandum, dated 04/13/18, from the construction company and copied to the ALA, was provided as a part of the investigative package. It should be noted that this memorandum indicated that the supervisors within the construction company, "decided to allow [the accused perpetrator] to return [sic] so [they] could further work with him and the staff to determine what happened." At the time of the survey, there was no evidence that background screening of construction workers had been implemented. During an interview with the ALA on 04/13/18, it was alleged that background checks had been completed by the construction company in accordance with the federal standards, however the clearance criteria was unknown. Additionally, there was no evidence at the time of the survey that the ALR had implemented a system for monitoring or escorting construction workers by facility staff to safeguard all residents when work was required to be performed in residents' apartments. There was also no evidence provided that a system had been established by the ALA to orient or to	R 390		

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communicate the expectations of the ALR with construction workers assigned to the community.

Continued interview with the ALA revealed that she filed a police report on 04/12/18. Review of the police report on 07/05/18 at 1:30 PM showed that it was incomplete, due to missing the perpetrator's name. The ALA stated that the housekeeper told her that the contractor was nicknamed "Big Mike." Further, the ALA indicated that subsequent to the incident, all residents of the ALR were reminded during a community town hall meeting not to allow any construction workers into their apartment and to alert the ALR's maintenance staff.

At the time of the survey, the ALA was not able to provide documented evidence that the town hall meeting had occurred and/or that the ALA had informed the ALR community, including all residents and their responsible parties, of the alleged sexual abuse and the subsequent safety measures to be put in place by the ALR. The ALA also failed to obtain feedback from other residents to identify whether additional incidents of this nature had occurred.

c. During a post-survey telephone interview on 07/23/18 at 1:30 PM, Resident #12's son stated that he was notified of the alleged sexual abuse involving his mother on 04/12/18, which was six days after the incident occurred. As he described the incident, he noted that the construction worker had no reason to be in his mother's residence because renovations had already been completed in her apartment.

Resident #12's son indicated that he was told by the ALA that the housekeeper waited until the end of the shift to report the incident and then

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R 390	Continued From page 20 reported it to the receptionist instead of the administrator/supervisor. The resident's son also was told by the ALA that the receptionist failed to report the incident to the administrator/supervisor and waited two days later before reporting the incident. Resident #12's son mentioned that the police department was notified before he knew about the incident, and his mom was startled when the police showed up at her door, questioning her about an allegation of abuse. At the time of the survey, there was no evidence that the ALA had initiated disciplinary action with the personnel involved in the witnessing and reporting of the alleged sexual abuse of Resident #12. There was also no evidence that the ALA ensured the timely training of the ALR staff on how and when to report unusual incidents. At the time of the survey, the ALR failed to put adequate safeguards in place to prevent potential abuse while the investigation was in progress and also failed to take appropriate corrective action to prevent further incidents.	R 390	
	509b3 Abuse, Neglect, and Exploitation. (3) An ALR shall thoroughly investigate any allegation of abuse, neglect, or exploitation and shall take appropriate action to prevent further incidents. The ALR shall report the results of its investigation and actions taken, if any, to the Mayor. Based on interview and record review, the ALR failed (I) to thoroughly investigate an allegation of abuse involving Resident #12, and (II) to prevent potential abuse while the investigation was in progress for all residents in the facility.	R 392	R 392 Sec. 509b3 Abuse, Neglect, and Exploitation 8/24/18 I. The ALR failed to thoroughly investigate an allegation of abuse. a. Investigation regarding incident immediately conducted. Construction company provided documentation of criminal background checks. Created contractor orientation letter for each contract worker to sign and adhere to. 8/6/18 8/31/18 8/6/18

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R 392	Continued From page 21 Findings included: I. [See also R008 and R390] The ALR failed to thoroughly investigate an allegation of abuse. a. On 4/13/18, the state licensing agency received telephone notification from the ALA regarding the 04/06/18 incident. The ALA stated that the police was investigating this incident, the perpetrator was escorted from the premises, and that the resident had been assessed and determined to have sustained no harm. The ALA also stated that the resident's family had been made aware of the incident and that background checks would be conducted for all construction workers. The licensing agency asked the ALA to forward their internal investigation and supporting documents. On 04/17/18, the occurrence report and a copy of the police report were received. It should be noted that no further documentation was received from the ALA. During the onsite inspection beginning 06/26/18, interviews and record reviews showed that the response actions taken by the ALA were not timely based on when the ALA first became aware of the allegation. b. Additional review of the ALR's investigative report revealed that the response actions taken by the ALA were not complete as evidenced below: A police report was filed on 04/12/18 at 22:21, however failed to reflect the alleged perpetrator's name. The ALA documented that the alleged perpetrator's name was "Big Mike," however there was no further action to obtain the alleged perpetrator's legal name from the construction company. According to record review, the alleged	R 392	Requested/received background screening criteria from the construction company. Created policy on construction worker's interactions in the ALR. Advised all residents that they should not be requesting assistance from outside contractor. Met with residents at town hall on 8/9/18 to discuss this policy. Requested, at town hall, any resident with concerns with construction workers to bring those concerns to the ALA. Met individually with each resident to discuss alleged incident. b. The Investigation Policy & Procedure was revised. All staff was trained on the revised policy on 9/12/18. Staff will be educated annually and during new hire orientation on the Abuse, Neglect, and Exploitation Policy. c. The business office manager will keep an annual education log, listing the annual monthly trainings. The education log will be monitored monthly by the QA Committee for completion/ compliance. Maintenance director will meet with each contractor to go over contractor agreement.	8/9/18 8/31/18 8/22/18

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R 392	Continued From page 22 perpetrator was escorted off of the ALR premises after refusing to provide a written statement of the incident as requested. It should be noted that the alleged perpetrator was allowed by the construction company to return to the ALR to work and was seen working on the floor where Resident #12 lived. The ALR's investigation failed to evidence that the ALA had coordinated with the alleged perpetrator's employer to make a work status determination based on the safety of the ALR community. At the time of the survey, the review of the ALA's internal investigation failed to demonstrate complete and timely action by the ALA in accordance with the ALA's initial occurrence report to the state licensing agency. II. The ALR failed to take appropriate action to protect all residents from potential abuse while the investigation was being conducted as evidenced by: At the time of the inspection on 06/26/18, a comprehensive review of the ALR's incident management system along with a review of the ALR's investigation was completed to determine if the ALR provided adequate supervision and oversight as required by the ALR law. a. There was no evidence that the ALA had informed the ALR community, including residents and their family members, of the alleged sexual abuse. During interview with the ALA, it was stated that a town hall meeting was held with residents, however, there was no documented evidence this occurred. No additional memorandum was distributed to the community and family members.	R 392	II. The ALR failed to prevent potential abuse while the investigation was in 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. b. An investigation will be conducted for all abuse allegations per the revised investigation P&P. The regional director of operations will be notified immediately of all abuse allegations. The regional director of operations will be actively involved with all ongoing investigations of abuse and neglect to ensure compliance with policy. Residents will be informed about circumstances that require investigation into abuse allegations, if the situation could endanger their safety or well-being. Contractor orientation letter created to present to each visiting 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 policy.	4/12/18

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R 392	Continued From page 23 b. During interview and record review, the ALA failed to obtain feedback from other residents to identify whether additional incidents of this nature had occurred. c. There was no evidence that a system had been established by the ALA to orient or to communicate the expectations of the ALR community with construction workers assigned to the community. d. There was no evidence that background screening of construction workers had been implemented. During an interview with the ALA on 04/13/18, it was alleged that background checks had been completed by the construction company in accordance with federal standards, however the clearance criteria was unknown. e. There was no evidence that a system for monitoring or escorting construction workers by facility staff had been implemented to safeguard all residents when performing work in residents' apartments. f. There was no evidence that the ALA ensured the timely training of the ALR staff on how and when to report unusual incidents. g. There was no evidence that the ALA initiated disciplinary actions with the personnel involved in the witnessing and reporting of the alleged sexual abuse of Resident #12. At the time of the survey, the ALR failed to put adequate safeguards in place to prevent potential abuse while the investigation was in progress, and the ALR also failed to take appropriate corrective action to prevent further incidents.	R 392		

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R 471	Continued From page 24	R 471		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on record review and interview, the ALR failed to develop an ISP before admission for four of five newly admitted residents in the sample (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. 4. Review of Resident #12's current clinical record on 07/13/18 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 12/27/17. During an interview on 07/06/18 at 10:40 AM , the ALA stated that the facility's previous nurse developed ISPs as required. However, the ALA was unable to locate the pre-admission ISPs at	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. a. ISP's for resident #2, #4, #11 completed. Resident #12 moved out of ALR. 7/31/18 4/21/18 b. An ISP will be developed prior to admission and 30 days post move-in for all new residents. ISP's will be 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 ISP requirement. ISP's will be tracked on spreadsheet and reviewed daily to ensure they are completed timely.	

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R 471	Continued From page 25 the time of the survey. At the time of the survey, the ALR failed to provide documented evidence that pre-admission ISPs were developed for Residents #2, #4, #11, and #12.	R 471		
R 472	Sec. 604a2 Individualized Service Plans (2) An ISP shall be developed following the completion of the "post move-in" assessment. Based on record review and interview, the ALR failed to ensure an ISP had been developed after the post move-in assessment for three of five newly admitted residents in the sample (Residents #2, #4, and #11). Findings included: 1. Review of Resident #2's clinical record on 06/29/18 at 10:30 AM showed that the resident was admitted on 1/22/18, at which time a post move-in assessment was conducted by the facility's nurse. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post move-in assessment. 2. Review of Resident #4's clinical record on 07/02/18 at 10:15 AM showed that the resident was admitted on 06/06/18, at which time a post move-in assessment was conducted by the facility's nurse. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post move-in assessment. 3. Review of Resident #11's clinical record on 07/05/18 at 3:00 PM showed that the resident	R 472	R 472 Sec 604a2 I. The ALR failed to ensure an ISP had been developed after post move-in. a. ISP's for #2, #4, and #11 haven been completed and reviewed by the IDT Team. 7/31/18 b. All new residents will receive a post move-in assessment within 30 days of admission. An ISP Log has been created to track and schedule all ISP assessment due dates. 7/1/18 c. The DON/Delegate will monitor the ISP Log due dates daily to ensure compliance of ISP's to be completed and post move-in assessment within 30 days of move in.	

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R 472	Continued From page 26 was admitted on 09/04/17, at which time a post move-in assessment was conducted by the facility's nurse. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post move-in assessment. During an interview on 07/06/18 starting at 10:40 AM, the ALA stated that the facility's previous nurse developed ISPs as required. However, the ALA was unable to locate the post move-in ISPs at the time of the survey. At the time of the follow-up visit, the ALR failed to ensure ISPs had been developed following the completion of post move-in assessments.	R 472		
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on observation, interview and record review, the facility failed to document in an ISP when, how often, and by whom services would be provided to address the resident's recent fall (a significant change in condition) for one of one resident in the sample who fell (Resident #10). Findings included: Observation on 06/29/18 at 11:30 AM showed Resident #10 with a large purplish bruise on the right side of the face that extended down to the neck. The observation also revealed that the resident was receiving oxygen from a compressor which had long oxygen tubing.	R 481	R 481 Sec. 604b Individualized Service Plans I. The ALR failed to document in an ISP when, how often, and by whom services would be provided to address the resident's recent fall. a. Late entry was added for resident #10 to include details of incident and the ISP was updated with fall. b. Appropriate members of the IDT will review all incident reports during the daily clinical meeting. Any incidents will be updated on corresponding ISP. ISP updates will include details of incident and any appropriate resident centered interventions. ISP will include the	8/24/18

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R 481	Continued From page 27 During an interview on the same day at 11:31 AM, Resident #10 stated that she fell a few days prior and was sent to the ER for evaluation. The resident also explained that she falls a lot. Review of the resident's record revealed a significant change ISP dated 06/25/18 that lacked documented evidence of the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided to address the resident's significant change in condition as evidenced by the increased frequency of falls. During an interview on 07/05/18 starting at 10:30 AM, the ALA stated that she would ensure that all services to be provided for residents experiencing a significant change in condition are included in their ISPs going forward. At the time of the survey, the ALR failed to update Resident #10's ISP with services to address the resident's frequent falls.	R 481	responsible individuals(s) to complete the service. DON will keep an updated incident tracking log. DON/ RN will keep an ISP log including documentation of change in condition. c. The DON will audit the Incident Tracking Log and ISP Tracking Log, track and trend the data outcomes, and report to QA Committee monthly. The QA Committee will determine if additional audits or actions are required.	
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on record review and interview, the ALR failed to ensure residents ISPs were reviewed 30	R 483	R 483 Sec. 604d Individualized Service Plans I. The ALR failed to ensure resident ISPs were reviewed 30 days after admission, every six months, and updated with a change in condition with the resident/surrogate participation and IDT review.	

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R 483	Continued From page 28 days after admission, every six months thereafter, or updated with significant changes for ten of 12 residents in the sample (Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, and #12). Findings included: 1. Review of Resident #1's current clinical record on 06/27/18 at 11:30 AM showed that the resident was admitted on 02/25/15. Further review of the record revealed an ISP dated 06/27/18 which lacked documented evidence that the resident's health care practitioner or surrogate reviewed it. The record also lacked documented evidence that an ISP review was conducted six months prior to 06/27/18. Continued review of the resident's clinical record revealed that the resident started hospice services on 03/21/18. The record, however, showed that the ALR staff did not update the ISP of the significant change until three months later on 06/27/18. 2. Review of Resident #2's current clinical record on 06/29/18 at 10:30 AM showed that the resident was admitted on 01/22/18. Further review of the record revealed an ISP dated 06/29/18 which lacked documented evidence that the resident's health care practitioner or surrogate reviewed it. 3. Review of Resident #3's current clinical record on 06/29/18 at 1:18 PM showed that the resident was admitted on 03/12/15. Further review of the record revealed an ISP dated 07/02/18 which lacked documented evidence that the resident's health care practitioner or surrogate reviewed it. The record also lacked documented evidence that an ISP review was conducted six months prior to 07/02/18.	R 483	a. ISP's for Residents #1, #2, #3, #5, #6, #7, #8, #9, #10 and all current residents were reviewed and updated as of 7/20/18. Resident #12 moved out of ALR. All ISP's have been discussed with resident and IDT with appropriate signatures. b. An ISP Log was created in order to schedule and track revised due dates to spread them out over the next 6 months. Each week four ISP's will be reviewed by Medical Director and IDT to ensure all change of conditions and updates to ensure resident needs are being met. c. DON/Delegate will audit weekly meetings and discuss any issues with the QA committee monthly.	7/25/18 4/21/18 8/24/18 7/1/18

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4. Review of Resident #5's current clinical record on 07/02/18 at 11:30 AM showed that the resident was admitted on 08/01/16. Further review of the record revealed a significant change ISP dated 05/17/18 which lacked documented evidence that the resident's health care practitioner or surrogate reviewed it. The record also lacked documented evidence that an ISP review was conducted six months prior to 05/17/18.

5. Review of Resident #6's current clinical record on 07/02/18 at 11:45 AM showed an ISP dated 02/12/18 which lacked documented evidence that it was reviewed by the resident's health care practitioner.

6. Review of Resident #7's current clinical record on 07/02/18 at 2:00 PM showed there was no documented evidence of an ISP review by the interdisciplinary team since 07/19/16.

7. Review of Resident #8's current clinical record on 07/05/18 at 1:55 PM showed that the resident was admitted on 12/07/15. Further review of the record revealed an ISP dated 02/10/18 which lacked documented evidence that it had been reviewed by the resident's health care practitioner, the resident, or the resident's surrogate. Also, the record showed there was no documented evidence that an ISP review was conducted six months prior to 02/10/18.

8. Review of Resident #9's current clinical record on 07/05/18 at 10:00 AM showed that the resident was admitted on 03/30/15. Further review of the record revealed an ISP dated 07/05/18 which lacked documented evidence that it had been reviewed by the resident's health care practitioner. Also, the record showed there was

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no documented evidence that an ISP review was conducted six months prior to 07/05/18.

9. Review of Resident #10's current clinical record on 07/05/18 at 1:00 PM showed that the resident was admitted on 09/25/13. Further review of the record revealed an ISP dated 10/19/17 which lacked documented evidence that it was reviewed by the resident's health care practitioner, the resident, or the resident's surrogate. Also, the record showed there was no documented evidence that an ISP review was conducted six months after 10/19/17.

Continued review of the record revealed a significant change ISP dated 06/25/18. The ISP lacked documented evidence that it was reviewed by the health care practitioner or resident's surrogate.

10. Review of Resident #12's current clinical record on 07/13/18 at 2:00 PM showed that the resident was admitted on 12/27/17. Further review of the record revealed a post move-in ISP dated 12/27/18. The ISP lacked documented evidence that it was reviewed by the resident's health care practitioner, the resident, or the resident's surrogate 30 days after admission.

Continued review of the record revealed a nursing note dated 01/21/18, which documented that the resident was found at a library (2 miles away from the ALR) asking the staff how to get back to the facility. The note also indicated that after leaving church, Resident #12 followed a "man with a dog" because she thought the man knew how to get to Connecticut Avenue. The resident, however, stopped following the man when she realized he was not going the right way. Further review of the record revealed that the

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R 483	Continued From page 31 ALR staff made Resident #12's physician aware of the incident, at which time he instructed facility staff not to allow the resident to leave the ALR without supervision. The record, however, lacked documented evidence that the ALR staff had updated the ISP, dated 12/27/18, to address the change in supervision. During an interview on 07/06/18 at 10:40 AM , the ALA stated that the facility's previous nurse reviewed and updated ISPs as required. However, the ALA was unable to locate the ISPs at the time of the survey. During a post-survey interview on 07/23/18 starting at 1:00 PM, Resident #12's son stated he was not aware that the ALR had ISP meetings. He also stated that after the incident on 01/21/18, his mother continued to leave the facility without supervision. When asked if the ALR made him aware of the physician's instructions for his mother to have supervision when leaving the facility, the son stated, "No, I thought it was a recommendation from the nurse." At the time of the survey, the ALR failed to ensure the ISPs for Residents #1, #2, #3, #5, #6, #7, #8, #9, #10, and #12 were updated as required.	R 483		
R 605	Sec. 701g2 Staffing Standards. (2) Possess current and appropriate licensure and certifications as required by law; Based on observation, interview, and record review, the ALA failed to ensure that the PDAs working with ALR residents possessed a current license or certification to provide ADL assistance for one of six PDAs in the sample (PDA #2).	R 605	R605 Sec.701g2 Staffing Standards I. The ALR failed to ensure that the PDAs working with ALR residents possessed a current license or certification to provide ADL assistance.	

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R 605	Continued From page 32 Findings included: Observation on 06/26/18 at 11:36 AM showed Resident #1 in her apartment accompanied by an aide (PDA #6). During an interview on 06/26/18 at 11:39 AM, PDA #6 stated that she was hired by the resident's family and assisted the resident with feeding. 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. The ALA maintained a list entitled, "Residents Who Have Private Duty Aides," which indicated the residents in the ALR who received PDA care and the respective names of the PDAs. The ALA provided a current copy this list on 07/13/18 at 3:41 PM. Review of the listing showed that PDA #6, who was previously observed in Resident #1's apartment, was not included on the list. Continued record review of the listing showed a different PDA (PDA #2) was indicated for Resident #1. Review of PDA #2's personnel record on 07/05/18 at 2:30 PM lacked documented evidence of the required CNA certification. It should be noted that on 07/13/18, a certification search conducted on the DC Health professional license database verified that PDA #2's CNA certification status was "expired" as of 10/31/07. At the time of survey, the ALA failed to ensure PDA #2 possessed a valid certification to provide ADL assistance for Resident #1.	R 605	a. ALR revised Caregiver (Sitter) policy. ALR updated PDA list to include PDA #6. Resident #1 has expired. PDA #2 no longer provides assistance in ALR; unable to obtain copy of valid license. b. ALA/Designee will obtain copy of valid license for all PDA's prior to providing assistance to residents. Responsible party will sign PDA policy upon admission into ALR. ALA/Designee will review revised Caregiver (Sitter) Policy with Resident/Responsible Party for residents that currently have PDA's and will obtain the Private Caregiver Agreement. c. QA Committee will review PDA List monthly during QA meetings.	8/7/18 8/31/18 8/31/18

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R 782	Continued From page 33	R 782		
R 782	Sec. 901 1 Responsibilities Of The ALR Personnel	R 782	R782 Sec. 901 Responsibilities of the ALR Personnel	8/24/18

(1) Is capable of self-administering his or her own medications;
Based on record review and interview, the ALA failed to ensure an initial assessment had been conducted to determine if a resident was capable of self-medicating for two of two newly admitted residents who self-medicate (Residents #4 and #11).

Findings included:

1. Review of Resident #4's current clinical record on 07/02/18 at 10:15 AM showed that the resident was admitted on 06/06/18. Further review of the record revealed an H&P dated 05/14/18 which indicated the resident could independently self-medicate. The record, however, lacked documented evidence that an initial assessment was conducted to assess the resident's ability to self-medicate.

During an interview on 07/02/18 at 11:25 AM, Resident #4 reported that no medication assistance was needed from the ALR staff.

2. Review of Resident #11's current clinical record on 07/02/18 at 3:00 PM showed that the resident was admitted on 09/04/17. The record also revealed a nursing note dated 09/04/17 which indicated the resident self-medicates. The record, however, lacked documented evidence an initial assessment was conducted to assess the resident's ability to self-medicate. It should also be noted that the facility did not have a physician order for the Resident #11 to self-medicate until 06/29/18, which was approximately eight months

I. The ALR failed to ensure an initial assessment had been conducted to determine if a resident was capable of self-medicating.

a. ALR arranged for RN Consultant from Allied Pharmacy to review #4, #11, and all residents that self-administer medications. Obtained orders for residents to self-administer medications from Medical Provider/ Medical Director. — 6/28/18, 8/30/18

b. DON/Delegate will complete the Initial Assessment of each resident that self-administers prior to/at time of admission and obtain Physician's order to self-administer. Medical director to be consulted about self-medicating resident concerns during Monthly QA meeting. DON/Delegate created a Medication Review Log to include schedules for review.

c. DON/Delegate will report status of medication review during Monthly Quality Assurance Meeting.

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R 782	Continued From page 34 after the resident's admission to the ALR. During an interview on 07/03/18 at 11:00 AM, the contract nurse could not validate that an initial assessment had been conducted to determine the resident's ability to self-medicate. The contract nurse was not working for the facility when the resident was admitted. At the time of the survey, the ALA failed to ensure an initial assessment was conducted to determine the ability of Resident #4 and #11 to self-administer medications.	R 782		
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record review and interview, the RN failed to assess each resident's response to medications every 45 days for six of 12 residents in the sample (Residents #1, #2, #5, #6, #7, and #12). Findings included: 1. Review of Resident #1's clinical record on 06/27/18 at 11:00 AM showed that the resident was admitted on 02/25/15, and the nursing staff was responsible for administering Resident #1's medications. Further review of the clinical record revealed that there was no documented evidence the RN reviewed the resident's response to medications. 2. Review of Resident #2's clinical record on 06/29/18 at 10:30 AM showed that the resident was admitted on 01/22/18, and the nursing staff was responsible for administering Resident #2's	R 802	R802 Sec. 903 On-Site Review I. RN failed to assess each resident's response to meds every 45 days. a. ALR arranged for RN Consultants to complete the 45-day medication reviews for Resident #1, #2, #5, #6, and #7. Resident #12 moved out of ALR. Medications were reviewed and verified by resident Primary Care Provider/Medical Director. ALR arranged for RN's to complete 45 Med Reviews for all current residents. b. DON/Delegate will be responsible for ensuring resident 45-day medication reviews are completed. DON/Delegate will keep a Medication Review Log.	7/31/18 4/21/18 8/31/18

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R 802	Continued From page 35 medications. Further review of the record lacked documented evidence the RN reviewed the resident's response to medications. 3. Review of Resident #5's clinical record on 07/02/18 at 11:30 AM showed that the resident was admitted on 08/01/16, and the nursing staff was responsible for administering Resident #5's medications. Further review of the record lacked documented evidence the RN reviewed the resident's response to medications. 4. Review of Resident #6's clinical record on 07/02/18 at 11:30 AM showed that the resident was admitted on 02/12/18, and the nursing staff was responsible for administering Resident #6's medications. Further review of the record lacked documented evidence the RN reviewed the resident's response to medications. 5. Review of Resident #7's clinical record on 07/02/18 at 2:00 PM showed that the resident was admitted on 02/04/14, and the nursing staff was responsible for administering Resident #7's medications. Further review of the record lacked documented evidence the RN reviewed the resident's response to medications. 6. Review of Resident #12's clinical record on 07/13/18 at 2:00 PM showed that the resident was admitted on 12/27/17, and the nursing staff was responsible for administering Resident #12's medications. Further review of the record lacked documented evidence the RN reviewed the resident's response to medications. During an interview on 07/05/18 starting at 10:30 AM, the ALA stated that going forward she would ensure that the nurse assesses residents' response to medication every 45 days.	R 802	c. DON/Delegate will report status of medication review schedule monthly to the QA Committee.	

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R 802	Continued From page 36 At the time of the survey, the RN failed to assess each resident's response to medications for the aforementioned residents in the sample.	R 802		
R 803	Sec. 903 3 On-Site Review. (3) Assess the resident's ability to continue to self-administer his or her medications. Based on record review and interview, the RN failed to assess the resident's ability to safely continue to self-administer medications every 45 days for five of five residents in the sample who self-medicate (Residents #3, #8, #9, #10, and #11). Findings included: 1. Review of Resident #3's clinical record on 06/29/18 at 1:18 PM showed that the resident was admitted on 03/12/15. Further review of the record revealed a H&P dated 03/11/15 that documented the resident could independently administer medication. The record, however, lacked documented evidence the RN assessed the resident's ability to continue to self-medicate. 2. Review of Resident #8's clinical record on 07/05/18 at 2:00 PM showed that the resident was admitted on 12/07/15. Further review of the record revealed a H&P dated 11/14/15 that documented the resident could independently administer medication. The record, however, lacked documented evidence the RN assessed the resident's ability to continue to self-medicate. 3. Review of Resident #9's clinical record on 07/05/18 at 10:00 AM showed that the resident	R 803	R803 Sec. 903 On-Site Review I. The RN failed to assess the resident's ability to self-administer medications every 45 days. a. ALR arranged for RN Consultants to complete the 45-day medication reviews for resident's who self-administer medications. Resident's ability to self-administer medications was observed RN Consultants. DON/ RN notified Physician/Medical Director for clarification of orders for self-medicators. DON/Delegate obtained Physician order for resident to continue to self-administer medication. b. DON/Delegate will be responsible for ensuring resident reviews for self-administration are completed every 45 days. DON/Delegate will keep a Medication Review Log that includes residents that self-administer medications.	6/28/18 8/31/18

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R 803	Continued From page 37 was admitted on 03/30/15. Further review of the record revealed a H&P dated 04/11/17 that documented the resident could self-administer medications independently. The record, however, lacked documented evidence the RN assessed the resident's ability to continue to self-medicate. 4. Review of Resident #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 documented the resident 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 was admitted on 09/04/17. Further review of the record revealed that there was no documented evidence the RN assessed the resident's ability to continue to self-medicate from 09/12/17 through 06/28/18. It should also be noted that the facility did not have a physician order for the resident to self-medicate until 06/29/18, which was approximately eight months after the resident's admission to the facility. During an interview on 07/05/18 starting at 10:30 AM, the ALA stated that going forward she would ensure that the nurse assesses the residents' ability to continue to self-medicate every 45 days. At the time of the survey, the RN failed to assess the residents' ability to continue to self-medicate. This is a repeat deficiency.	R 803	c. DON/Delegate will report status of medication review schedule monthly to the QA Committee.	

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R 953	Continued From page 38	R 953		
R 953	Sec. 1001b General Conditions. (b) An ALR shall maintain all structures, installed equipment, grounds, and individual living units in good repair and operable. Based on observation and interview, the ALR failed to ensure the facility's grounds were safe, installed equipment was operable, and individual living units were in good repair for 73 of 73 residents (Residents #1-73). Finding included: An environmental inspection of the ALR on 06/26/18 at 11:13 AM showed that the utility closet on the fourth floor, which contained electrical wiring, did not contain a lock to ensure the safety of all the residents living in the ALR.	R 953	R 953 Sec. 1001b General Conditions I. Utility closet on fourth floor did not contain a lock to ensure the safety of all residents living in the ALR. a. ALR staff installed lock on electrical closet. 8/1/18 b. All doors have been assessed for need for lock. All needed locks have been attained and installed. c. Maintenance team will continue to monitor door locks for safety during their weekly walk-through.	
R 971	Sec. 1003a General Building Exterior (a) An ALR shall ensure that the exterior of its facility, including walkways, yards, porches, chimney, gutters, downspouts, paintable surfaces, and accessory buildings are maintained structurally sound, sanitary, and in good repair. Based on observation and interview, it was determined that the facility failed to ensure that the exterior of its building was maintained structurally sound and in good repair. Findings included: Observation on 06/26/18 at 10:26 AM showed that the ALR's walkway had several cracked areas and missing pieces of flagstone noted from the front sidewalk to the facility's front door entrance. The surveyors noted eight to ten separate areas of broken or missing pieces of	R 971	R 971 Sec. 1003a General Building Exterior I. ALR's walkway had several cracked areas and missing pieces of flagstone. a. Flagstone walkway project completed as of 8/1/18. 8/1/18 b. Exterior has been reviewed by ALR for any safety concerns on 8/1/18. No additional safety concerns were found. c. Maintenance team will review safety of exterior building monthly.	

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R 971	Continued From page 39 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 trip hazards remained.	R 971		
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means,	R1003	R 1003 Sec. 1006c Bathrooms I. ALR failed to ensure that the hot water temperature did not exceed 110 degrees.	

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R1003	Continued From page 40 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 did not exceed 110 degrees Fahrenheit in six of the six bathrooms inspected (Apartments #718, #616, #617, #404A, #412, and #214). Findings included: 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: -Apartment #617 = 115.3 degrees Fahrenheit -Apartment #616 = 115.7 degrees Fahrenheit -Apartment #404A = 111.9 degrees Fahrenheit -Apartment #412 = 113.7 degrees Fahrenheit -Apartment #214 = 112.5 degrees Fahrenheit Follow-up observations on 06/28/18 and 06/29/18 at 2:20 PM and 2:40 PM, respectively, showed the hot water temperatures at the hand sinks in the aforementioned apartments were between 109.5 and 110 degrees Fahrenheit. At the time of the survey, the ALR failed to ensure the water temperatures did not exceed 110 degrees Fahrenheit in six of the apartment bathrooms inspected.	R1003	a. Hot water heater temperature set to below 110 degrees. b. Facility Maintenance Director to maintain daily log of temperature checks. c. Maintenance team will do weekly temperature checks. Any room found with excessive heat, hot water heater will immediately be reset to appropriate temperature while staff and resident are informed not to utilize until temperature is within approved range.	8/1/18