STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0039	A. BUILDING: ______ B. WING ______	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A	5420 CONNECTICUT AVENUE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments 0000 Initial Comments An annual survey, in conjunction with a complaint investigation was conducted on 08/16/2022, 08/17/2022, 08/18/2022, 08/19/2022, 08/22/2022, 08/23/2022 and 08/24/2022, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 96 residents and employed 87 personnel, to include professional and administrative staff. A random sample of 20 resident records, 13 employee records, four Private Duty Aide/Certified Nurse Assistant records, one Regional Director of Clinical Services record, one Hospice Nurse record and one Agency nurse record were selected for review. The findings of the survey/complaint investigation were based on observation, clinical and administrative record review, and resident and staff interviews. On 08/3/2022 at 8:48 AM, the Department of Health, Health Regulations and Licensing Administration, Intermediate Care Facilities (DOH/HRLA/ICFD), received an email notification from a complainant. The complainant alleged the following: 1. The facility deliberately opened a package that was addressed to my mother (Resident #1) and placed the items from the package inside her apartment on 08/01/2022. Conclusion: Not substantiated (See Tag 9999, Final Observations) 2. The items from the package were not all there	R 000	Please start typing your responses here: Chevy Chase House is filing this Plan of Correction for the purpose of regulatory compliance. This ALR is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all state regulations, the ALR has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the community's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Castleberry | TITLE: ED | (X6) DATE: 9/19/22

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R 000	Continued From page 1 and three tubes of the arthritis gel was not delivered at all. Conclusion: Not substantiated (See Tag 9999, Final Observations) 3. Resident #1 went to the hospital because the newly hired Certified Nursing Assistant (CNA) did not know how to transfer Resident #1 from the shower to her walker. Resident #1 ended up partially falling and twisting her ankle and foot which she is still laboring from today. According to the caregiver's written statement, on 07/14/2022, after receiving a shower, Resident #1 asked the caregiver to support her by holding her arms as she turned to grab her walker. In the course of turning for the walker, the caregiver stated that Resident #1 twisted her ankle and started screaming. After assessment by the facility's nurse, Resident #1 stated that she was ok, but the son insisted that the resident be taken to the hospital. On 08/18/2022 at 1:38 PM, the Executive Director (ED) said during an interview that Resident #1's son stated that the caregiver did not transfer her properly and asked the son if his mother's foot can be x-rayed onsite. The son said no, I will take her to the hospital. The ED said that Resident #1 returned to the facility without any ankle brace and walked around with her walker without any problems. The ED said that he asked Resident #1's son for the discharge papers and was not given any documents, but that he called the hospital where Resident #1 was taken, spoke to the attending nurse and received the discharge papers. According to the ED, Resident #1's foot was perfectly normal.	R 000		

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R 000	Continued From page 2 At 2:20 PM review of the hospital discharge papers dated 07/15/2022 showed the left foot was x-rayed. The left ankle was negative for acute fracture or other abnormality. Conclusion: Not substantiated 4. Resident #1 was assigned a newly hired Licensed Practical Nurse (LPN), less than a week on the job. The new LPN did not dispense the correct number of medications. Five days later, the same LPN had an extra foreign pill for 10:00 AM consumption. On 08/19/2022, at 10:00 AM, the nurse was observed pushing the medication through the bubble into a medicine cup. One of the pills was crushed. The nurse and the surveyor entered the residents' apartment. The resident's son observed the surveyor enter his mother's apartment through the camera mounted on the wall. Although the surveyor identified herself and gave the reason for her presence, Resident #1's son became irate and informed the surveyor that she needed to make an appointment to enter his mother's apartment. At that time, Resident #1 became agitated stating, "somebody needs to make an appointment!" The surveyor apologized and exited the apartment. It should be noted that the pills in the cup were the pills from the bubble pack provided by the pharmacy. No other pills were added to the cup prior to leaving the medication room. At the time of the observation, there was no evidence that the wrong medications were dispensed to Resident #1. Conclusion: Not substantiated based on Resident #1's son interfering with the survey process.	R 000		

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R 146	Continued From page 3	R 146		
R 146	10113.1 Individualized Service Plans (ISPs) 10113.1 An ISP shall be developed for each resident not more than thirty (30) days prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that Individualized Support Plans (ISP) was developed within 30 days prior to admission, for 11 of the 21 residents in the sample (Residents #2, 5, 6, 8, 10, 11, 12, 16, 18, 19 and 20). Findings included: The ALR failed to ensure that an Individualized Support Plan (ISP) was developed within 30 days prior to admission of the residents, as evidenced below: 1. On 08/17/2022 at 2:55 PM, a review of Resident #6's medical record showed that the resident was admitted to the ALR on 06/18/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 2. On 08/19/2022 at 1:05 PM, a review of Resident #5's medical record showed that the resident was admitted to the ALR on 01/05/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 3. On 08/22/2022 at 3:13 PM, a review of Resident #10's medical record showed that the resident was admitted to the ALR on 04/20/22. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission.	R 146	Resident's ISPs are developed within 30 days of admission to establish appropriateness for Assisted Living Residence, within 72 hours of admission, 30 days post admission, every six months and when there is a change in physical and mental condition. ISPs of all sampled residents have been updated as of 9/16/2022. To minimize recurrence of this deficient practice the ALR has revised established move-in guidelines and reviewed updated standards with clinicians on 9/9/22 (in-service attached) A. Move-in process will be continuously reviewed prior to each admission to ensure an ISP has been developed within the required timeline	

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R 146	Continued From page 4 4. On 08/23/2022 at 10:21 AM, a review of Resident #11's medical record showed that the resident was admitted to the ALR on 07/30/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 5. On 08/23/2022 at 10:21 AM, a review of Resident #12's medical record showed that the resident was admitted to the ALR on 05/08/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 6. On 08/23/2022 at 10:21 AM, a review of Resident #18's medical record showed that the resident was admitted to the ALR on 03/03/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 7. On 08/23/2022 at 10:55 AM, a review of Resident #2's medical record showed that the resident was admitted to the ALR on 01/27/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 8. On 08/23/2022 at 11:38 AM, a review of Resident #8's medical record showed that the resident was admitted to the ALR on 09/30/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 9. On 08/23/2022 at 12:47 PM, a review of Resident #19's medical record showed that the resident was admitted to the ALR on 02/03/2022. Further review of the record failed to show documented evidence that an ISP was developed	R 146		

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R 146	Continued From page 5 prior to the resident's admission. 10. On 08/23/2022 at 12:53 PM, a review of Resident #16's medical record showed that the resident was admitted to the ALR on 07/04/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 11. On 08/23/2022 at 1:44 PM, a review of Resident #20's medical record showed that the resident was admitted to the ALR on 02/16/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. During interview with the ALR's acting Director of Nursing (DON) on 08/17/2022 at 2:00 PM, she indicated that she started working for the ALR in May 2022 and could not provide information regarding the admissions prior to her employment. At the time of the survey, the ALR failed to ensure all residents had an ISP developed prior to admission. This is a repeat deficiency. See deficiency report dated 03/03/2021, Citation 44-106.04 (a)(1)	R 146		
R 330	10122.1 On Site Medication Review 10122.1 The on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or	R 330	A registered nurse will assess and review the resident's medication regimen every 45 days. The ALR reviewed the requirements with the ADON and established a medication review that aligns with resident's cycle fill every 30 days.	

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R 330	Continued From page 6 discontinued. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure Registered Nurses (RN) assessed each resident's medication regimen and their response to the medications every 45 days, for 14 of the 21 residents in the sample (Residents #1, 2, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19 and 20). Findings included: 1. On 08/16/2022 at 1:00 PM, review of Resident #1's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days. 2. On 08/18/2022 at 9:25 AM, review of Resident #13's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days. 3. On 08/19/2022 at 1:05 PM, review of Resident #5's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days. 4. On 08/22/2022 at 1:33 PM, review of Resident #15's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days. 5. On 08/22/2022 at 3:13 PM, review of Resident #10's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to his medications every 45 days.	R 330	The more frequent reviews exceed the current standard and will minimize the risk of this deficient practice recurring. All residents in the sample have updated medication reviews on file. To minimize the risk of recurrence a random sample of resident records will be reviewed during monthly QA.	

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R 330	Continued From page 7	R 330		

6. On 08/23/2022 at 9:35 AM, review of Resident #14's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days.

7. On 08/23/2022 at 10:15 AM, review of Resident #2's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days.

8. On 08/23/2022 At 10:21 AM, Review of Resident #11's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to his medications every 45 days.

9. On 08/23/2022 at 11:02 AM, review of Resident #12's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days.

10. On 08/23/2022 at 11:38 AM, review of Resident #8's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days.

11. On 08/23/2022 at 11:47 AM, review of Resident #9's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to his medications every 45 days.

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R 330	Continued From page 8 12. On 08/23/2022 at 12:47 PM, review of Resident #19's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days. 13. On 08/23/2022 at 12:53 PM, review of Resident #16's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to his medications every 45 days. 14. On 08/23/2022 at 1:44 PM, review of Resident #19's medical record failed to show documented evidence that the assisted living residence's registered nurse assessed the resident's response to her medications every 45 days. On 08/23/2022 at 3:18 PM, the Assisted Living's Acting Director of Nursing acknowledged that the residents' medications were not reviewed every 45 days as required. At the time of the survey, the assisted living residence's registered nurses failed to consistently review the residents' medication regimen and the response to their medications every 45 days.	R 330		
R 383	10125.4a Reporting Complaints To The Director 10125.4a An ALR shall notify the Director of any unusual incident that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health	R 383		

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R 383	Continued From page 9 by phone promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day; and Based on interview and record review, the Assisted Living Residence (ALR) failed to report timely, an unusual incident of a missing person to the Department of Health (DOH), for one of the 20 twenty residents in the sample (Resident #2). Findings included: On 08/11/2022, the Department of Health (DOH) received an unusual incident report via an email notification of a missing resident from the Assisted Living Residence (ALR) facility. According to the incident report, on 08/09/2022 at approximately 10:00 AM, Resident #2 left the facility and had not returned to the facility. The resident was found by the nephew the next day on 08/10/2022 at approximately 3:30 PM (over 24-hours later) at Farragut Parkway Metro/Bus station. The incident was reviewed during the annual survey as part of the incident/fall/complaint record review on 08/16/2022 beginning at 10:45 AM. On 08/16/2022 interviews with Executive Director (ED), Assistant Director of Nursing (ADON) and the front desk Concierge staff at 12:22 PM, 12:51 PM and 1:06 PM respectively, all indicated that Resident #2 was independent, comes and goes as she pleases. For example, the ED stated that the resident walked up to CVS all the time. On 08/18/2022 at 11:03 AM, interview with the Regional Director of Clinical Services (RDCS) showed that she was in the District of Columbia conducting training on the day (08/09/2022) Resident #2 went missing. The Regional Director of Clinical Services said she received notification	R 383	The ALR shall notify the Director of any unusual incident that substantially affects a resident. The Department of Health will be contacted via telephone Immediately. A written notification on the appropriate DOH form to follow within 24 hours or next business day of any unusual incident. Community leadership, clinicians, caregivers, et al. actively participated/attended in-service training on reporting unusual incidents to Department of Health on 8/30/22 to reinforce reporting standards. The Executive Director and ADON or designee will review each resident related incident in real time, to determine the need for reporting to the department, ensure prompt notification to the DOH, thereby, minimizing the risk of recurrence of this deficient practice.	

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R 383	Continued From page 10	R 383		

on the morning of 08/10/2022 that the resident was missing and notified the DOH of the incident on 08/11/2022 since the ED was on vacation.

At 2:53 PM, review of the ALR's Internal Incident Reporting policy dated 02/15/2020 showed that all incidents or unusual occurrences will be reported promptly to the Community Management and documented on the Community's Incident Report form within 24-hours of the incident. Further review of the policy showed that ED, Wellness Director, or designee will assure reporting to the Medical Provider and authorized Responsible Party is completed and documented promptly. The policy also showed that the ED is responsible for assuring an incident (i.e., Elopement or missing resident) is reported to and sent to the state Agency on the appropriate form and within the required time required.

At the time of the survey, the ALR failed to notify DOH of an unusual incident (missing resident) that substantially affected residents by phone promptly and follow-up with written notification within 24 hours or the next business day.

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R 000	Initial Comments An annual survey, in conjunction with a complaint investigation was conducted on 08/16/2022, 08/17/2022, 08/18/2022, 08/19/2022, 08/22/2022, 08/23/2022 and 08/24/2022, to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 96 residents and employed 87 personnel, to include professional and administrative staff. A random sample of 20 resident records, 13 employee records, four Private Duty Aide/Certified Nurse Assistant records, one Regional Director of Clinical Services record, one Hospice Nurse record and one Agency nurse record were selected for review. The findings of the survey/complaint investigation were based on observation, clinical and administrative record review, and resident and staff interviews. On 08/3/2022 at 8:48 AM, the Department of Health, Health Regulations and Licensing Administration, Intermediate Care Facilities (DOH/HRLA/ICFD), received an email notification from a complainant. The complainant alleged the following: 1. The facility deliberately opened a package that was addressed to my mother (Resident #1) and placed the items from the package inside her apartment on 08/01/2022. Conclusion: Not substantiated (See Tag 9999, Final Observations) 2. The items from the package were not all there and three tubes of the arthritis gel was not	R 000	Please start typing your responses here: Chevy Chase House is filing this Plan of Correction for the purpose of regulatory compliance. This ALR is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all state regulations, the ALR has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the community's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. [signature] ED	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Castleberry TITLE: ED (X6) DATE: 9/19/22

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R 000	Continued From page 1	R 000		

delivered at all.

Conclusion: Not substantiated (See Tag 9999, Final Observations)

3. Resident #1 went to the hospital because the newly hired Certified Nursing Assistant (CNA) did not know how to transfer Resident #1 from the shower to her walker. Resident #1 ended up partially falling and twisting her ankle and foot which she is still laboring from today.

According to the caregiver's written statement, on 07/14/2022, after receiving a shower, Resident #1 asked the caregiver to support her by holding her arms as she turned to grab her walker. In the course of turning for the walker, the caregiver stated that Resident #1 twisted her ankle and started screaming. After assessment by the facility's nurse, Resident #1 stated that she was ok, but the son insisted that the resident be taken to the hospital.

On 08/18/2022 at 1:38 PM, the Executive Director (ED) said during an interview that Resident #1's son stated that the caregiver did not transfer her properly and asked the son if his mother's foot can be x-rayed onsite. The son said no, I will take her to the hospital. The ED said that Resident #1 returned to the facility without any ankle brace and walked around with her walker without any problems. The ED said that he asked Resident #1's son for the discharge papers and was not given any documents, but that he called the hospital where Resident #1 was taken, spoke to the attending nurse and received the discharge papers. According to the ED, Resident #1's foot was perfectly normal.

At 2:20 PM review of the hospital discharge

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	ALR-0039	A. BUILDING: ______ B. WING ______	08/24/2022

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papers dated 07/15/2022 showed the left foot was x-rayed. The left ankle was negative for acute fracture or other abnormality.

Conclusion: Not substantiated

4. Resident #1 was assigned a newly hired Licensed Practical Nurse (LPN), less than a week on the job. The new LPN did not dispense the correct number of medications. Five days later, the same LPN had an extra foreign pill for 10:00 AM consumption.

On 08/19/2022, at 10:00 AM, the nurse was observed pushing the medication through the bubble into a medicine cup. One of the pills was crushed. The nurse and the surveyor entered the residents' apartment. The resident's son observed the surveyor enter his mother's apartment through the camera mounted on the wall. Although the surveyor identified herself and gave the reason for her presence, Resident #1's son became irate and informed the surveyor that she needed to make an appointment to enter his mother's apartment. At that time, Resident #1 became agitated stating, "somebody needs to make an appointment!" The surveyor apologized and exited the apartment. It should be noted that the pills in the cup were the pills from the bubble pack provided by the pharmacy. No other pills were added to the cup prior to leaving the medication room. At the time of the observation, there was no evidence that the wrong medications were dispensed to Resident #1.

Conclusion: Not substantiated based on Resident #1's son interfering with the survey process.

Michael Lehman ED

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R 471	Continued From page 3	R 471		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that Individualized Support Plans (ISP) were developed within 30 days prior to admission, for 11 of the 21 residents in the sample (Residents #2, 5, 6, 8, 10, 11, 12, 16, 18, 19 and 20). Findings included: The ALR failed to ensure that an Individualized Support Plan (ISP) was developed within 30 days prior to the admission of residents, as evidenced below: 1. On 08/17/2022 at 2:55 PM, a review of Resident #6's medical record showed that the resident was admitted to the ALR on 06/18/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 2. On 08/19/2022 at 1:05 PM, a review of Resident #5's medical record showed that the resident was admitted to the ALR on 01/05/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 3. On 08/22/2022 at 3:13 PM, a review of Resident #10's medical record showed that the resident was admitted to the ALR on 04/20/22. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 4. On 08/23/2022 at 10:21 AM, a review of	R 471	Resident's ISPs are developed 30 days prior to admission to establish appropriateness for Assisted Living Residence, within 72 hours of admission, 30 days post admission, every six months and when there is a change in physical and mental condition. ISPs of all sampled residents have been updated as of 9/16/2022. To minimize recurrence of this deficient practice the ALR has revised established move-in guidelines and reviewed updated standards with clinicians on 9/9/22 (in-service attached). Move-in process will be continuously reviewed prior to each admission to ensure an ISP has been developed within the required timeline.	

Mathew Williams ED

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R 471	Continued From page 4 Resident #11's medical record showed that the resident was admitted to the ALR on 07/30/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 5. On 08/23/2022 at 10:21 AM, a review of Resident #12's medical record showed that the resident was admitted to the ALR on 05/08/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 6. On 08/23/2022 at 10:21 AM, a review of Resident #18's medical record showed that the resident was admitted to the ALR on 03/03/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 7. On 08/23/2022 at 10:55 AM, a review of Resident #2's medical record showed that the resident was admitted to the ALR on 01/27/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 8. On 08/23/2022 at 11:38 AM, a review of Resident #8's medical record showed that the resident was admitted to the ALR on 09/30/2021. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 9. On 08/23/2022 at 12:47 PM, a review of Resident #19's medical record showed that the resident was admitted to the ALR on 02/03/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission.	R 471		

Michael Castleberry OD

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R 471	Continued From page 5 10. On 08/23/2022 at 12:53 PM, a review of Resident #16's medical record showed that the resident was admitted to the ALR on 07/04/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. 11. On 08/23/2022 at 1:44 PM, a review of Resident #20's medical record showed that the resident was admitted to the ALR on 02/16/2022. Further review of the record failed to show documented evidence that an ISP was developed prior to the resident's admission. During an interview with the ALR's acting Director of Nursing (DON) on 08/17/2022 at 2:00 PM, she indicated that she started working for the ALR in May 2022 and could not provide any information related to admissions prior to her employment by the ALR. At the time of the survey, the ALR failed to ensure all residents had an ISP developed prior to admission.	R 471		
R 475	Sec. 604a5 Individualized Service Plans (5) The ISP shall be signed by the resident, or surrogate, and a representative of the ALR. Based on record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure that ISP was signed by the resident or surrogate, and a representative of the ALR for 14 of the 21 residents in the sample (Resident #1, 2, 4, 5, 6, 8, 9, 11, 12, 15, 16, 18, 19 and 20). Findings included:	R 475	All ISPs will be signed by the resident, surrogate, and a representative of the ALR upon completion and review. All ISPs reviewed during survey have been reviewed and signed by the resident or surrogate and ALR representative. The ALR will establish a bi-annual cadence of resident and/or family touchpoints to ensure ISPs are reviewed and signed IAW Sec. 604a5. To minimize the risk of this deficient practice reoccurring the ALR will conduct a monthly QA Audit and review a random sample of resident ISPs for completion, review, and signatures.	9/9/22

Michael Castleberry ED

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R 475	Continued From page 6 1. On 08/16/2022 at 1:00 PM, a review of Resident # 1's clinical record showed that the resident's ISP dated 09/30/2021 was not signed by the resident or surrogate. 2. On 08/17/2022 at 2:55 PM, a review of Resident # 6's clinical record showed that the resident's ISP dated 07/31/2021 was not signed by the resident or surrogate. 3. On 08/17/2022 at 1:05 PM, a review of Resident # 5's clinical record showed that the resident's ISP dated 01/05/2022 was not signed by the resident or surrogate. 4. On 08/22/2022 at 12:44 PM, a review of Resident # 4's clinical record showed that the resident's ISP dated 08/17/2022 was not signed by the resident or surrogate. 5. On 08/23/2022 at 10:15 AM, a review of Resident # 2's clinical record showed that the resident's ISP dated 01/27/2021 was not signed by the resident or surrogate. 6. On 08/23/2022 at 10:21 AM, a review of Resident # 11's clinical record showed that the resident's ISP dated 02/24/2022 was not signed by the resident or surrogate. 7. On 08/23/2022 at 11:38 AM, a review of Resident # 11's clinical record showed that the resident's ISP dated 10/19/2021 was not signed by the resident or surrogate. 8. On 08/23/2022 at 11:02 AM, a review of Resident # 12's clinical record showed that the resident's ISP dated 07/25/2022 was not signed by the resident or surrogate.	R 475		

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9. On 08/23/2022 at 11:47 AM, a review of Resident # 9's clinical record showed that the resident's ISP's dated 02/27/2022 and 07/25/2022 was not signed by the resident or surrogate.

10. On 08/23/2022 12:47 PM, a review of Resident # 19's clinical record showed that the resident's ISP dated 08/02/2022 was not signed by the resident or surrogate.

11. On 08/23/2022 at 12:53 PM, a review of Resident # 16's clinical record showed that the resident's ISP dated 07/04/2022 was not signed by the resident or surrogate.

12. On 08/22/2022 1:33 PM, a review of Resident # 15's clinical record showed that the resident's ISP dated 08/03/2022 was not signed by the resident or surrogate.

13. On 08/23/2022 at 1:44 PM, a review of Resident # 20's clinical record showed that the resident's ISP dated 02/16/2022 was not signed by the resident or surrogate.

14. On 08/23/2022 1:54 PM, a review of Resident # 18's clinical record showed that there was two residents ISP (undated) that were not signed by the resident or surrogate.

During interviews with the Director of Nursing on 08/23/2022 at 2:00 PM, she acknowledged the deficient practices and indicated that she was going to provide the nurses with training on the ISP process.

At the time of survey, the facility failed to ensure that each resident's ISP was signed by the resident or surrogate, and a representative of the

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R 475	Continued From page 8 ALR.	R 475		
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 observations, interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure residents Individualized Support Plans (ISP) were reviewed 30 days after admission, every six months thereafter, and updated with significant changes in a resident's condition for 15 of the 21 residents in the sample (Residents #1, 2, 3, 4, 5, 7, 8, 12, 13, 15, 16, 17, 18, 19, and 20). Findings included: 1. The ALR failed to ensure residents' ISPs were reviewed 30 days after admission, as evidenced below: a. On 8/17/2022 at 1:05 PM, review of Resident #5's clinical record showed that the resident was admitted on 01/05/2022. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR. b. On 8/23/2022 at 11:38 AM, review of Resident	R 483	All ISPs will be reviewed 30 days after admission, every six months and with a change of physical and mental condition. All ISPs reviewed during survey have been reviewed and updated. The ALR will establish a quarterly cadence of resident reviews with Medical Director. To minimize the risk of this deficient practice reoccurring the ALR will conduct a monthly QA Audit and review a random sample of resident ISPs for completion, review, and updates as appropriate.	9/9/22

[signature] ED

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R 483	Continued From page 9 #8's clinical record showed that the resident was admitted on 09/30/2021. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR. c. On 8/23/2022 at 12:47 PM, review of Resident #19's clinical record showed that the resident was admitted on 02/03/2022. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR. d. On 8/23/2022 at 12:53 PM, review of Resident #16's clinical record showed that the resident was admitted on 07/04/2022. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR. e. On 8/23/2022 at 1:54 PM, review of Resident #18's clinical record showed that the resident was admitted on 03/03/2022. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR. f. On 8/23/2022 at 1:44 PM, review of Resident #20's clinical record showed that the resident was admitted on 02/16/2022. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR. g. On 8/23/2022 at 2:21 PM, review of Resident #17's clinical record showed that the resident was admitted on 03/08/2022. Further review of the records showed no documented evidence that the residents ISP was reviewed or updated 30 days after the resident was admitted to the ALR.	R 483		

Michael [illegible] ED

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During an interview on 08/23/2022 at 2:00 PM, the Acting Director of Nursing (ADON) acknowledged the missing documents and added that she was not employed at the time of the admissions.

2. The ALR failed to ensure residents' ISPs were reviewed every six months after admission, as evidenced below:

a. On 8/23/2022 at 1:54 PM, a review of Resident #1's clinical records showed that the resident was admitted on 03/31/2015 to the ALR. Further review of the records showed that the last ISP review was dated 09/30/2021. There was no documented evidence that the resident #1's ISP was reviewed or updated every six months after 09/30/2021 as required.

b. On 8/23/2022 at 10:15 AM, a review of Resident #2's clinical records showed that the resident was admitted on 01/27/2021 to the ALR. Further review of the records showed that the last ISP review was dated 08/17/2022. There was no documented evidence that the resident's ISP was reviewed or updated every six months after 09/30/2021 as required.

c. On 8/22/2022 at 12:11 PM, a review of Resident #3's clinical records showed that the resident was admitted on 12/05/2019 to the ALR. Further review of the records showed that the last ISP review was dated 02/26/2021. There was no documented evidence that the resident's ISP was reviewed or updated every six months after 02/26/2021 as required.

d. On 8/22/2022 at 12:44 PM, a review of

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R 483	Continued From page 11 Resident #4's clinical records showed that the resident was admitted on 12/01/2020 to the ALR. Further review of the records showed that an ISP was reviewed on 06/02/2021 there was no documented evidence that an ISP was reviewed prior to the most current ISP reviewed on 02/26/2021. There was no documented evidence that the resident's ISP was reviewed or updated prior to a current ISP 08/17/2022 as required. e. On 8/18/2022 at 1:21 PM, a review of Resident #7's clinical records showed that the resident was admitted on 01/10/2020 to the ALR. Further review of the records showed that an ISP was reviewed on 08/29/2020 there was no documented evidence that an ISP was reviewed prior to an ISP that was reviewed on 08/21/2021. There was no documented evidence that the resident's ISP was reviewed or updated every six months as required. f. On 8/23/2022 at 11:38 AM, a review of Resident #8's clinical records showed that the resident was admitted on 09/30/2021 to the ALR. Further review of the records showed that the last ISP review was dated 07/25/2022. There was no documented evidence that the resident's ISP was reviewed or updated every six months after 09/30/2021 as required. g. On 8/23/2022 at 11:02 AM, a review of Resident #12's clinical records showed that the resident was admitted on 05/08/2021 to the ALR. Further review of the records showed that an ISP was reviewed on 07/17/2021 there was no documented evidence that an ISP was reviewed prior to an ISP that was reviewed on 07/25/2022. There was no documented evidence that the resident's ISP was reviewed or updated every six months as required.	R 483		

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R 483	Continued From page 12 h. On 8/18/2022 at 09:25 AM, a review of Resident #13's clinical records showed that an ISP was reviewed on 04/02/2021 there was no documented evidence that an ISP was reviewed or updated every six months as required. i. On 8/22/2022 at 01:33 PM, review of Resident #15's clinical records showed that an ISP was reviewed on 04/25/2021 there was no documented evidence that an ISP was reviewed or updated every six months as required. At the time of the survey, the ALR failed to provide documented evidence that all ISP's were updated 30 days after admission, every six months thereafter, and updated when there were significant changes in the resident's health care status.	R 483		
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so, indicated during the medical assessment. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that all sections of the Intermediate Care Facilities Division Admission/Annual Medical Certification forms were completed, for five of the 21 residents in the sample (Residents #2, 6, 7, 12 and 21).	R 705	All sections of the Intermediate Care Facilities Division Admission/Annual Medical Certification will be completed for each resident admitted to the ALR. The DON or ADON will review all forms prior to the day of admission for completion and accuracy. A move-in checklist has been developed to ensure required forms, documents and timelines are met. The five residents reviewed during survey will be updated. To minimize the risk of recurrence of this deficient practice, a record review will be conducted on the day of move-in to ensure certification is completed in its entirety and on file.	10/1/22

Mahvey [signature] ED

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 705	Continued From page 13 Findings included: 1. On 08/23/2022 at 10:15 AM, a review of Resident #2's medical certification form dated 01/27/2021 showed that the physician failed to complete the primary, secondary diagnosis, mental health, and self-medicate sections of the form. 2. On 08/17/2022 at 2:55 PM, a review of Resident #6's medical certification form dated 06/16/2021 showed that the physician failed to indicate if the resident had or needed a mammogram, colonoscopy or a Papanicolaou test. 3. On 08/18/2022 at 1:21 PM, a review of Resident #7's medical certification form dated 01/09/2020 showed that the physician failed to indicate if the resident had or needed a mammogram, colonoscopy, a Papanicolaou (PAP) test, or a Prostate-Specific Antigen (PSA) test. The resident's medications were not listed on the form. In addition, the resident's tuberculin status was not indicated nor if there was evidence if the resident had any signs or symptoms of an infectious disease. 4. On 08/23/2022 at 11:02 AM, review of Resident #12's medical certification form dated 05/04/2022 showed that the physician failed to indicate if the resident had or needed a Prostate-Specific Antigen (PSA) test. In addition, the resident's medications were not listed on the form. 5. On 08/22/2022 at 10:19 AM, a review of Resident #21's medical certification form dated 07/19/2022 showed that the physician failed to address the resident's dental status or indicate if the resident needed to be screened for dementia.	R 705		

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	ALR-0039	A. BUILDING: ______ B. WING ______	08/24/2022

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

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R 705	Continued From page 14 On 08/22/2022 at 2:30 PM, the findings of the records reviewed were discussed with the Acting Director of Nursing (ADON). The Acting DON acknowledged that the physician had not completed all sections of the Intermediate Care Facilities Division Admission/Annual Medical Certification forms. At the time of the survey, the ALR failed to ensure the physician completed all sections of the Intermediate Care Facilities Division Admission/Annual Medical Certification forms.	R 705		
R 800	Subheading On-Site Review Sec. 903. On-site review. The ALR shall arrange for an on-site review by a registered nurse every 45 days to: Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure the Registered Nurses (RN) assessed each resident's medication regimen every 45 days, for 14 of the 21 residents in the sample (Residents #1, 2, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19 and 20). Findings included: 1. On 08/16/2022 at 1:00 PM, review of Resident #1's medical record failed to show documented evidence that the assisted living residence's registered nurse (RN) assessed the resident's medication regimen and response to her medications every 45 days. 2. On 08/18/2022 at 9:25 AM, review of Resident #13's medical record failed to show documented	R 800	A registered nurse will assess and review the resident's medication regimen every 45 days. The ALR reviewed the requirements with the ADON and established a medication review that aligns with resident's cycle fill every 30 days. The more frequent reviews exceed the current standard and will minimize the risk of this deficient practice recurring.	9/8/22

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R 800	Continued From page 15 evidence that the assisted living residence's RN assessed the resident's response to her medications every 45 days. 3. On 08/19/2022 at 1:05 PM, review of Resident #5's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days. 4. On 08/22/2022 at 1:33 PM, review of Resident #15's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to her medications every 45 days. 5. On 08/22/2022 at 3:13 PM, review of Resident #10's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to his medications every 45 days. 6. On 08/23/2022 at 9:35 AM, review of Resident #14's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to her medications every 45 days. 7. On 08/23/2022 at 10:15 AM, review of Resident #2's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days. 8. On 08/23/2022 At 10:21 AM, Review of Resident #11's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to his medications every 45 days.	R 800		

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R 800	Continued From page 16 9. On 08/23/2022 at 11:02 AM, review of Resident #12's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to her medications every 45 days. 10. On 08/23/2022 at 11:38 AM, review of Resident #8's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's medication regimen and response to her medications every 45 days. 11. On 08/23/2022 at 11:47 AM, review of Resident #9's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to his medications every 45 days. 12. On 08/23/2022 at 12:47 PM, review of Resident #19's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to her medications every 45 days. 13. On 08/23/2022 at 12:53 PM, review of Resident #16's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to his medications every 45 days. 14. On 08/23/2022 at 1:44 PM, review of Resident #19's medical record failed to show documented evidence that the assisted living residence's RN assessed the resident's response to her medications every 45 days. On 08/23/2022 at 3:18 PM, the Assisted Living's Residences Acting Director of Nursing	R 800		

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R 800	Continued From page 17 acknowledged that the residents medications were not reviewed every 45 days as required. At the time of the survey, the assisted living residence's registered nurse failed to consistently review the residents' medication regimen and their responses to their medications every 45 days.	R 800		
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record reviews and interviews, the Assisted Living Facility failed to ensure the Registered Nurse (RN) assessed each resident's response to their medication at least every 45 days, for 12 of the 21 residents in the sample (Residents #2, 3, 4, 5, 9, 11, 12, 14, 15, 17, 18 and 19). Findings included: 1. On 08/23/2022 at 1:21 PM, a review of Resident #2's medical record showed that the RN documented medication reviews for the resident on 07/21/2021, 05/20/2021, 04/01/2021 and 03/35/2021. Further review of the records failed to show evidence that the nurse assessed the resident's response to the medication. 2. On 08/22/2022 at 12:11 PM, review of Resident #3's medical record showed that the RN performed a medication review for the resident every 45 days, however the review failed to show evidence that the nurse assessed the resident's response to the medication. 3. On 08/22/2022 at 12:44 PM, review of	R 802	A registered nurse will assess and review the resident's medication regimen every 45 days. The ALR reviewed the requirements with the ADON and established a medication review that aligns with resident's cycle fill every 30 days. The more frequent reviews exceed the current standard and will minimize the risk of this deficient practice recurring.	

Mahaut Lealhung ED

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R 802	Continued From page 18 Resident #4's medical record showed that the RN performed a medication review for the resident every 45 days, however the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 4. On 08/19/2022 at 1:21 PM, review of Resident #5's medical record showed that the RN documented medication reviews for the resident on 02/01/2022, 05/27/2022 and 07/11/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 5. On 08/18/2022 at 1:21 PM, review of Resident #7's medical record showed that the RN documented medication reviews for the resident on 11/06/2021, 03/02/2022, and 08/04/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 6. On 08/23/2022 at 11:47 AM, review of Resident #9's medical record showed that the RN documented a medication review for the resident on 07/25/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 7. On 08/23/2022 at 11:47 AM, review of Resident #11's medical record showed that the RN documented medication reviews for the resident on 08/22/2021, 12/13/2021, 02/16/2022, 03/26/2022, 05/10/2022, 06/20/2022, and 07/15/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 8. On 08/23/2022 at 11:02 AM, review of Resident #12's medical record showed that the RN	R 802		

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R 802	Continued From page 19 documented medication reviews for the resident on 08/21/2021, 02/21/2022, 03/26/2022, 05/06/2022, 06/16/2022, and 07/26/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 9. On 08/23/2022 at 9:35 AM, review of Resident #14's medical record showed that the RN documented medication reviews for the resident on 05/10/2021 and 07/25/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 10. On 08/22/2022 at 1:33 PM, review of Resident #15's medical record showed that the RN documented medication reviews for the resident on 03/25/2022, 04/02/2022, 05/21/2022, and 07/16/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 11. On 08/23/2022 at 2:21 PM, review of Resident #17's medical record showed that the RN documented medication reviews for the resident on 05/23/2022, and 07/16/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 12. On 08/23/2022 at 1:54 PM, review of Resident #18's medical record showed that the RN documented medication reviews for the resident on 04/10/2022, 05/25/2022, 07/08/2022, and 08/09/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. 11. On 08/23/2022 at 12:47 PM, review of	R 802		

Michael Cottery ED

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R 802	Continued From page 20 Resident #19's medical record showed that the RN documented medication reviews for the resident on 02/14/2022 and 08/02/2022. Further review of the reviews failed to show evidence that the nurse assessed the resident's response to the medication. On 08/24/2022 at 02:37 PM, the Acting Director of Nursing acknowledged that the 45-day review forms did not include an assessment of the resident's response to their medications. At the time of survey, the facility failed to document an assessment of each resident's response to their medication at least every 45 days.	R 802		
R9999	Final Observations It is recommended that this area be reviewed, and a determination be made regarding appropriate actions. On 08/03/2022, the Department of Health, Health Regulations and Licensing Administration, Intermediate Care Facilities Division (DOH/HRLA/ICFD), received a complaint from a complainant. The complainant stated that on 07/31/2022, he ordered gloves and Asper creme for his mother (Resident #1) that arrived at [facility name] that night. The complainant verified with the front desk staff around 10:47 PM that the packages were delivered. Based on the nature of this complaint, the State Survey Agency (SSA) initiated an onsite annual survey in conjunction with a complaint investigation survey beginning on 08/16/2022, to determine compliance with the Assisted Living	R9999		

Mitra S. Eating ED

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R9999	Continued From page 21 Residence Regulatory Act of 2000, "DC Code § 44-101.01" and attendant regulations. 08/18/2022 at 12:40 PM, Employee #12 said during an interview that she remembered a package that arrived from Amazon that was addressed to Resident #1 on Sunday, July 31, 2022. Employee #12 stated that she arrived at work that morning and saw the package sitting on her desk. Employee #12 said that when packages arrive late Sunday nights, they would be delivered to the residents on Monday mornings, after being logged into the sign-in book by Employee #9. Employee #12 further stated that Resident #1's son requested that the Community Relations Director, Maintenance staff and/or the Certified Nursing Assistant working with Resident #1 come down to the front desk, retrieve the package and deliver the package to the resident. At 12:44 PM, Employee #7 said during interview that while providing care to Resident #1, she received a call over the walkie talkie to come down and retrieved a package from the front desk that was addressed to Resident #1. Employee #7 said that she retrieved the package from the front desk, went back upstairs to Resident #1's bedroom and opened the package in front of the resident. She said there were three boxes of gloves inside the package, and she put one box of gloves in Resident #1's room and the other two box of gloves in the resident's closet. Employee #7 stated that Resident #1's son was ok with me opening his mother's packages. He [the son] has cameras inside his mother's apartment. When ask if there were three tubes of arthritis gel inside the package, Employee #7 said, "no." Employee #7 indicated that she had put some type of creme on Resident #1's knees today, which was kept inside the bathroom.	R9999		

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R9999	Continued From page 22 At 2:12 PM, the Executive Director (ED) said during interview that he believed the package/box with the arthritis gel was delivered to Resident #22's apartment (109). At 2:17 PM, interview with Resident #22 in his apartment showed that he received a box a few weeks ago but cannot recall the exact date. The resident said that Employee #9 brought the box up to him. Resident #22 said he asked Employee #9 to open the box, because he did not remember ordering anything. After opening the box, the resident said that Employee #9 tilted the box so he could see inside the box. The resident said that the box contained Asper creme, and he told the employee to place the creme on the counter. The resident said a day or two later, he got a call from the front desk indicating that the box was sent to him in error, and that Employee #8 came and got the box and took it to Resident #1. At 2:50 PM, Employee #9 said during an interview that Resident #22 always asks me to open his packages when I deliver them to his apartment. Employee #9 said that he did not recall delivering a box to Apartment 109 that was addressed to Resident #1. Employee #9 stated that when packages/boxes come in, I sign them in and leave them at the front desk. "I don't deliver packages/boxes to apartment 405 and 302. At 3:11 PM, Employee #8 said during an interview that she was the one who delivered Resident #1's package to Resident #22's apartment 109. She indicated that she was at the front desk and a received a call to attend to a resident upstairs on the same floor near apartment 109. Employee #8 stated that before rushing upstairs, the Front Desk staff gave her a box with Resident #22's mail on top of the box. She said that she	R9999		

Michael Castleberry ED

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R9999	Continued From page 23 assumed the mail and box belong to the same resident, she dropped the mail and box off to Resident #22 quickly and left out of the apartment to attend to resident on the same floor who was having issues with oxygen. The following day, the Front Desk staff stated she gave me the wrong box. Employee #8 said "honestly", I did not check to see who the box belong to. I had a piece of mail with Resident #22's name on the mail which was paced on top of the box, and I assumed it was his mail and box. She stated that Resident #1's son came the next day and asked about the Asper creme. She stated she went back to Resident #22's apartment, retrieved the box with the Asper creme and took the creme to Resident #1's apartment. On 08/19/2022 at 2:52 PM, the surveyor requested a copy of the Assisted Living Residence (ALR) policy on privacy and/or a protocol for receiving and disseminating mail and packages. There was no policy given to the surveyors prior to the exit on 08/23/2022.	R9999		