Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0031	A. BUILDING: _____ B. WING _____	C 09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARIGOLD AT 11TH STREET	2905 11TH STREET NW WASHINGTON, DC 20001

(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 OOO	Initial Comments	ROOO	The Marigold at 11th Street makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is pre-pared and/or executed solely because it is required by Federal and State Law.	

On 08/13/18, the District of Columbia Adult Protective Services (APS) contacted the Department of Health (DC Health}, via telephone, to inquire about the business operation of the Marigold. APS indicated that they were in the process of triaging an anonymous complaint of a resident abuse (Resident #1) at The Marigold. On 8/16/18, APS provided additional information to DC Health that alleged Resident #1 was injured as a result of staff forcing the resident to take a shower after discovering bed bugs in the resident's apartment on July 25, 2018. The resident was transported to a local hospital's emergency room on 7/26/18 and diagnosed with sprain low back and knee.

Due to the nature of the above incident, DC Health immediately initiated an on-site investigation on 08/16/18. The findings of the investigation were based on observation of the ALR, interviews with residents and employees, and review of administrative and clinical records.

Listed below are abbreviations used throughout the body of this report:

ALA - Assisted Living Administrator
APS -Adult Protective Services
ALR - Assisted Living Residence
CPR- Cardio Pulmonary Resuscitation
ISP - Individualized Service Plan
RN - Registered Nurse
MCI - Mild Cognitive Impairment
PCA - Personal Care Aide
AOL - Activities of Daily Living
POF - Prescription Order Form
PT - Physical Therapy
HCA - Home Care Agency
HHA - Home Health Aide

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R 000	Continued From page 1 WC - Wheelchair LPN - Licensed Practical Nurse NP -Nurse Practitioner TME - Trained Medication Employee ER - Emergency Room	R 000		
R 272'	Sec. 503.1 Dignity. (1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible; Based on observation, interview and record review, the ALR failed to ensure a safe environment for 10 of the 10 residents in the facility. Findings included: 1. A review of administrative records to include an incident report, dated 7/26/2018, and an email to the management company **(MIA),** dated 7/26/2018, revealed that the ALA was aware of the bedbug infestation in Resident #1's apartment (215) on 7/23/18. The incident report also revealed that the ALA inspected the resident's apartment and observed bedbugs on 7/25/18. On 8/16/2018, the ALA was interviewed and confirmed that he was aware of the infestation with bedbugs and that the resident had complained of being bitten by the bedbugs. The ALA was asked to explain the actions that he took to eradicate the infestation. The ALA stated that over-the counter pesticides and protective gear were purchased (receipts confirm purchase date of 7/23/18). The ALA also stated that on 7/26/18, two (2) male staff (a CNA and receptionist) reported to the ALR specifically to exterminate	R272	R 272 Sec. 503.1 Dignity 1.1 Resident #1 was assessed regarding complaint of being bitten by bed bugs. There was no evidence of this following assessment. A new facility manager (Stoddard Baptist Services) is in place as well as a new policy (Bed Bug Policy – see attached) to address this. 1.2 A Bed Bug policy and procedure was developed to address bed bugs as indicated above, and staff was in-serviced. The management company has been changed to Stoddard Baptist Home Services. 1.3 A Quality Assurance/Improvement /committee (QA/QI) has been developed to address 503.1 Dignity. The committee will meet initially monthly, beginning in October 2018 for three consecutive months to ensure deficient practice does not re-occur. Following the initial monthly meeting, the QA/QI committee meeting will be quarterly. **Completion Date – R272: 10/10/18**	

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R 272	Continued From page 2 Resident #1's apartment. The resident was moved to a temporary apartment (214) on 7/26/18 while the infested apartment (215) was being treated. The ALA was asked about Resident #1 sleeping arrangement on 7/23/18, 7/24/2018 and 7/25/18. The ALA stated that the resident remained in the infested apartment (215) and continued to sleep in the infested bed. The resident's HHA confirmed that the resident did not move into the temporary apartment until 7/26/2018. The ALR failed to provide the resident with an environment that was free of pests. Additionally, the ALR failed to have the resident assessed after the resident complained of being bitten by bedbugs. 2. On 8/16/18, at approximately 1:45 PM, an inspection of Resident #1's temporary apartment was conducted and revealed that the apartment was sparsely furnished with a twin bed and side table. Observed on the floor next to the bed was a gallon plastic jug that was halfway full of urine. At 1:50 PM, the HHA was questioned about the jug of urine. The HHA stated that the resident asked for the jug and used it to urinate in during the night. The surveyor instructed the ALA to replace the jug with a urinal or a bedside commode. The ALR failed to provide the resident with a clean, stimulating and homelike environment. 3. On 8/18/18, at 10:00 AM a re-inspection of Resident #1's temporary apartment revealed that the urine filled jug remained on the floor next to the resident's bed. The linen on the bed was observed dirty and soiled with urine. The resident	R272	2.1/3.1 Resident #1 initially in a twin bed as this was what he brought into the facility. He has been moved to a different apartment and now has a larger bed. He also indicated he does not like to get up at night and thus he utilized a gallon jug for his convenience. A urinal has been provided for the resident. 2.2/3.2 The staff including the HHA has been re-educated regarding the resident's environment and the importance of cleanliness and emptying the urinal as necessary 2.3/3.3 A Quality Assurance/Improvement program/committee has been developed to address 503.1 Dignity. The committee will meet initially monthly for three consecutive months to ensure deficient practice does not re-occur. Following the initial monthly meetings the committee will meet quarterly.	

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R 272	Continued From page 3 was interviewed to ascertain the use of thejug. The resident stated that a urinal or a bedside commode was never offered. The resident explained a jug was given because of frequent urination at night and inability to make it to the bathroom. The ALA, who was not onsite at the time of the inspection, was called and instructed again to remove the jug and replace the jug with a urinal or a bedside commode. Also the employees (TME and CNA) on duty were also instructed by the surveyor to remove the jug of urine. The ALR failed to provide the resident with a clean, stimulating and homelike environment. 4. On 8/18/18, at 10:10 AM, after the inspection of Resident #1's temporary apartment, the surveyor could not exit the unit. The surveyor attempted to pull the door handle, but the handle came off of the door. After several attempts to remount the handle, Resident #1, who was in neighboring apartment, heard the noise and opened the door from the outside. The resident stated that the handle had been broken since his move to the apartment on 7/26/18. The resident was asked how he managed to open the door with the broken handle. The resident indicated that the door is often kept ajar, and when it closes, it takes time to open it using the broken handle. The ALR failed to provide the resident with a safe environment. 5. Resident #1's apartment was observed during a follow-up monitoring visit on 08/20/18 at 2:40 PM. The apartment, which was initially identified on 07/25/18 with a bed bug infestation, showed that all clothing and personal belongings for	R272	4.1 The door handle to his apartment (he preferred to stay in the temporary apartment and thus is residing in that apartment) has been repaired. 4.2 A new management company is in place and a review of all doors and door handles has been checked and replaced as indicated. 4.3 As a part of the quality program the facility's environment is checked monthly to ensure preventive maintenance as needed has been done. This will be discussed in the monthly then quarterly meeting. 5.1 The mattress in Resident #1's apartment was discarded and a new bed and mattress is in place. All clothing and personal belongings were laundered and/or necessary treatment provided to clothing and belongings prior to going in the room.	

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R 272	Continued From page 4 Resident #1 had been moved back in from the temporary apartment. On 08/20/18 at 2:56 **PM,** Resident #1's bed was observed. When the sheets were uncovered from the mattress, bed bugs were present in the seam of the mattress. During an interview on 08/20/18 at 3:00 PM, the ALA stated that the ALR's staff performed an immediate treatment of the bed bug infestation on 07/26/18, and a alleged that a professional extermination treatment was performed by Ecolab on 08/02/18. It should be noted that the ALA was unable to produce documented evidence of the professional extermination at the time of inspection. During the interview, the ALA also indicated that the "new" mattress for Resident #1 was a previously used one that was obtained from the ALR's off-site storage unit. The ALR failed to provide the resident with an environment that was free of pests. 6. During an environmental inspection on 8/18/2018, at 9:45 AM, the surveyor pulled the call-bell in the lobby bathroom. Although the alarm sounded at the receptionist desk, the receptionist did not alert the aides to respond to the call. When questioned as to the practice of alerting aides to a call-bell, the receptionist picked up her personal cell phone to call an aide. The receptionist was informed by the surveyor that according to the ALR's policy, carrying cellphones while on duty was prohibited. An aide was later questioned as to how staff were to respond to call bells. The aide showed the surveyor a hand-held radio, and realized that the receptionist did not have a radio. The aide immediately searched the lobby and found the radio. The aide explained that there were three	R272	5.2 Stoddard has provided a new/professional extermination company (Bay City) who has checked the apartment to ensure that it is free of bed bugs. This company will continue to monitor Marigold has it pertains to pest, including Bed bugs. The staff have been re-educated regarding Bed Bugs prevention and management of Infestation. Certification free of Bed bugs was provided on October 3, 2018 and is confirming Marigold is without bed bugs. 5.3 As a part of the quality program the facility's environment is checked monthly by the Pest Control Company (Bayside) to ensure areas of concern are addressed immediately. This will be addressed in the monthly/quarterly QA/QI meetings. 6.1 The Call bell company was contacted and examined the call bell system and repairs we made on 9/17/18. 6.2 The Emergency Call Bell System policy as it pertains to the call bell system, two-way radio and process for communicating with each other (staff) has been reviewed and updated. A beeper system has also been added to ensure successful communication between all staff members. 6.3 As a part of the quality program the facility is monitoring the functionality of the call bell – system and the two-way radio. This information will be presented to the committee monthly/quarterly **Completion Date – R272: 10/10/18**	

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R 272	Continued From page 5 (3) hand-held radios, one which was to be kept near the monitors at the receptionist desk, and the other two (2) were given to the aides. When problems were viewed on the monitor or when call-bells were activated, the receptionist was required to alert the aides using the hand-held radio. The aide confirmed that carrying and using : cellphones were prohibited while on duty. The ALR failed to provide the resident with a safe environment.	R 272		
R 282l	Sec. 503.11 Dignity. (11) To be free from mental, verbal, emotional, sexual and physical abuse, neglect, involuntary seclusion, and exploitation; and Based on observation, interview and record review, the ALR failed (l) to ensure that a resident was free of physical abuse; and (11) to ensure that a resident was free of neglect for one (1) of 10 residents residing in the facility. Findings included: I. On 8/16/18, APS filed a complaint with DC Health that alleged Resident #1 was injured as a result of staff forcing the resident to take a shower after discovering bed bugs in the resident's apartment on July 25, 2018. An onsite investigation was initiated on 8/16/18 at 11:55 **AM. A** review of the incident reports and interviews with the resident and the staff revealed the following: A On 8/16/18, at 12:15 PM, Resident#1 was interviewed concerning the allegation that the resident sustained injuries after being forced in a	R 282	R282 Sec. 503.11 Dignity 1.1 An investigation was done regarding the Abuse allegation. This included interviewing all staff and the Home Health Aide as well as the resident. The resident was sent to the hospital and has returned. The new Administrator has met with Resident #1 on several occasions who indicates that he has no further complaints as it pertains to this incident. 1.2 Following the interviews with staff employees were counseled and/or disciplined as indicated. The Abuse, Neglect and Exploitation policy and procedure has been reviewed and staff have been re-educated regarding abuse on 9/21/18. The management company has been changed to Stoddard Baptist Home Foundation, Inc. who is continuing the facility assessment and making changes to policies and procedures as indicated. All Home Health Agency have been contacted and expectations of HHA particularly as it pertains to abuse was done on 10/12/18.	

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R 282	Continued From page 6	R 282		

bath tub. Resident #1 stated that he was attacked by the ALA and another male employee. The resident explained that the ALA and employee took his clothes off and "threw" him in the tub by lifting his feet and grabbing him under the arms. The resident stated he felt violated, and did not like being touched. He also stated that he was a grown man and capable of taking a bath. When questioned as to why the ALA and the employee put him in the tub, the resident stated that they found "bugs" in his room.

B. On 8/16/18, at 12:30 PM, the resident's private HHAwas interviewed about his whereabouts during the incident. The HHA stated he did not observe the resident's alleged abuse. The HHA stated that the ALA and two (2) employees were observed with Resident #1 in the temporary apartment (214) at approximately 7:00 PM. They were overheard saying that the resident was to be bathed and preceded to undress the resident without resistance. The HHA was asked by the ALA to bag and launder the clothes that he was wearing. After washing the resident's clothes, the HHA returned to the temporary apartment (214). The resident was observed naked on the bed, and the tub was observed filled with dirty water. The resident was upset and complained that they violated his rights by forcing him in the tub. The HHA immediately informed the ALA of the resident's complaint. The ALA explained to the HHA that the resident thought that they were giving "a soft/half bath," but they gave the resident "a full bath." The HHA was asked by the surveyor if it was the responsibility of the HHA to provide personal care to include a bath. The HHA replied , yes. The HHA explained that the resident is often non-compliant with bathing, but will submit, at times, to a sponge bath with the use of the

1.3
A new QA/QI program has been developed. The committee reviews all areas of concern and the POC monthly to ensure compliance. While this committee is scheduled to meet monthly then quarterly, any allegations of abuse are reviewed and investigated as soon as reported.

Completion Date: R 282. 10/10/18

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R 282	Continued From page 7	R 282		

shower chair. The HHA indicated that it would be unlikely that the resident would have consented to a tub bath, where the resident would be submerged in water. It should be noted that the resident had a shower chair, but the shower chair was not observed in the bathroom where he was bathed.

Interview with the ALA confirmed that the resident was bathed in the tub, but denied that he was forced to take a bath. The ALA revealed that the resident was upset after he was submerged in the tub. The ALA also confirmed that on 7/26/2018, shortly after the resident was bathed, the HHA reported the alleged abuse to the ALA.

C. Resident #1 called 911 and reported the incident to the police. The ambulance arrived and the resident was transported to the local hospital emergency room (ER) to assess back pain complaint. Resident #1 provided the hospital discharge papers for the surveyor to review. The review of the hospital discharge summary revealed that Resident #1 arrived to a local emergency room on 7/26/18 at 9:54 PM and was discharged 7/27/18 at 01:10 AM. The resident was diagnosed with "Sprain, low back, knee sprain." The ER physician ordered Tylenol for pain. Further review of the discharge summary did not reflect what caused the visit to the ER.

II. On 7/23/18, the ALA confirmed that he had knowledge that Resident #1's bed and apartment (215) were infested with bedbugs. The ALA neglected to provide the resident with an alternative living unit on 7/23/18, 7/24/18 and 7/25/18, and to ensure that the resident's apartment (215) were free of bedbugs as evidence by the following:

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R 282	Continued From page 8	R 282		

A A review of administrative records to include an incident report, dated 7/26/18, and an email to the management company **(MIA},** dated 7/26/18, revealed that the ALA was aware of the bedbug , infestation in Resident#1's apartment (215) on :7/23/18. The incident report also revealed that the ALA inspected the resident's apartment and observed bedbugs on 7/25/18. On 8/16/2018, the ALA was interviewed and confirmed that he was aware of the infestation and that the resident had complained of being bitten by the bedbugs. The ALA was asked to explain the actions that he took to eradicate the infestation. The ALA stated that over-the counter pesticides and protective gear were purchased (receipts confirm purchase date of 7/23/18). The ALA also stated that on 7/26/18, two (2) male staff (a CNA and receptionist) reported to the ALR specifically to exterminate Resident #1's apartment. The resident was moved to a temporary apartment (214) on 7/26/18 while the infested apartment (215) was being treated. The ALA was asked about Resident #1 sleeping arrangement on 7/23/18, **7/24/18 and 7/25/18 . The ALA stated that the** resident remained in the infested apartment (215) and continued to sleep in the infected bed. The resident's HHA confirmed that the resident did not move into the temporary apartment until 7/26/18.

B. Resident #1's apartment (215) was observed during a follow-up monitoring visit on 08/20/18 at 2:40 PM. The apartment, which was initially identified on 07/25/18 with a bed bug infestation, showed that all clothing and personal belongings for Resident #1 had been moved back in from the temporary apartment (214). On 08/20/18 at 2:56 PM, Resident #1's bed was observed. When the sheets were uncovered from the mattress, bed bugs were present in the seam of the mattress.

2.1
Resident #1 was assessed regarding complaint of being bitten by bed bugs. There is no evidence of itching, burning, rash or bumps on resident's skin. The Resident was sent to the hospital and the report from the hospital confirmed the same. Resident verbalized no further c/o regarding bed bugs.

2.2
The bed bug policy and procedure was developed to address bed bugs and staff was in-serviced on 9/21/18. A meeting was held with all employees involved and disciplinary action was taken as indicated. The management company has been changed to Stoddard Baptist.

2.3
A Quality Assurance/Improvement /committee (QA/QI) has been developed to address 503.1 Dignity. The committee will meet initially monthly for three consecutive months to ensure deficient practice does not re-occur. Following the initial monthly meetings the committee will meet quarterly.

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R 282	Continued From page 9	R 282		

During an interview on 08/20/18 at 3:00 PM, the ALA stated that the ALR's staff performed an immediate treatment of the bed bug infestation on 07/26/18 and alleged that a professional extermination treatment was performed by Ecolab on 08/02/18. It should be noted that the ALA was unable to produce documented evidence of the professional extermination at the time of investigation. During the interview, the ALA also indicated that the "new" mattress for Resident #1 was a previously used one that was obtained from the ALR's off-site storage unit.

R 292 Sec. 504.1 Accommodation Of Needs. R 292

(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 interview and record review, the ALR failed to ensure the provision of adequate and appropriate services consistent with residents' physical and mental capabilities for one of ten residents in the facility (Resident #2).

Findings included:

According to an entrance interview conducted on 08/16/18 at 11:55 AM, the ALA stated that there were two incidents at the facility since the last inspection by DC Health on 06/14/18. One of these incidents included a resident (Resident #2) with frequent falls beginning in July 2018.

I. Record review of the ALR's incident reports was conducted on 08/16/18 at 12:40 PM. The incident reports recorded six unwitnessed falls for

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R 292	Continued From page 10 Resident #2 within a time span of 13 days, which included the following dates and times: -07/23/18 at 7:30 PM -07/24/18 at 6:37 PM **-07/30/18 at 3:00 AM** -07/31/18 at 4:31 PM -08/03/18 at 2:45 PM -08/04/18 at 1:45 PM According to the incident reports, Resident #2 pulled the call bell for assistance on only one of the six occasions that an unwitnessed fall had occurred. Resident #2 was sent to a local emergency room subsequent to the falls on 07/24/18 and 07/31/18. It should be noted that as a result of the 07/31/18 fall, Resident #2 sustained wounds to the left ankle and left toe which required subsequent daily skilled nursing treatment. Record review of the ALR's medical records, **RN** assessments and ISPs for Resident #2 was conducted on 08/16/18 at 12:15 PM. Resident #2's significant medical history included **MCI,** schizophrenia, incontinence, and bilateral foot deformities. Resident #2 received PCA services for one-on-one care eight hours per day on Mondays through Fridays and seven hours per day on weekends to provide assistance with ADLs and safety monitoring. An ISP dated 03/14/18 revealed the following mobility and safety interventions for Resident #2: monitor for falls daily, encourage use of assistive devices, answer call light promptly, ensure adequate lighting, reduce clutter in living areas, maintain mobility/ability to transfer independently with device (walker). Resident #2's ISP was revised and updated by the RN on 08/13/18 in response to the resident's	R 292	R 292 1.1/2.1 Resident # 2 has been assessed and injuries noted have resolved. Resident was also seen by her Doctor who indicated and was further confirmed by her son that she had a pre-existing condition contributing to the frequent falls. She is scheduled for surgery on October 10th to address this condition. The physician and family are aware of resident's condition. 1.2/2.2 Resident #2 has a home health aide for 16 hours a day and a 1-1 on the night shift. Because of her pre-existing condition it was suggested and she is complying with assistance of a wheel-chair for ambulation when indicated. Her ISP has been updated to reflect the changes. Staff were re-educated regarding the importance of ensuring residents receive timely services and documentation of any changes in condition. The residents are assessed prior to each ISP update and after a fall. Pending the risk for falls, if it is determined they are at risk for falls they are checked every 2 hours and their ISP is updated to reflect this. They will also be re-assessed pending change in status. 1.3/2.3 A review of any falls that occurs in the AL is conducted by the clinical staff and addressed in the QA/QI meeting. **Completion Date: R 292: October 10, 2018**	

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	ALR-0031	A. BUILDING: _____ 8 WING _____	C 09/10/2018

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significant change in condition related to recurrent falls. Record review of the 08/13/18 ISP showed that it included the following safety interventions: monitor for falls daily, encourage use of assistive devices, answer call light promptly, prompt call bell response, nonskid mat at bedside, check vital signs. The RN indicated the following action plan in the narrative note of the 08/13/18 ISP to address mobility safety and falls prevention, "order hospital bed with floor mat, POF signed, PT from [HHA] ... resident now uses WC to prevent further falls."

The revised ISP dated 08/13/18 failed to account for Resident #2's impaired cognition, which made it difficult for the resident to follow and/or recall directions and prompts for use of the call bell system. The revised ISP also failed to include a provision for increased one-on-one safety monitoring of Resident #2 by the ALR's staff for hours outside of those provided by the PCA service agency.

During an interview on 08/16/18 at 2:40 PM, the ALR's LPN indicated that a request for additional PCA service hours would have to be processed through Resident #2's Case Manager and could take several weeks to receive approval. The LPN denied that the ALR's staff provided any additional one-on-one care following Resident's episode of frequent falls.

II. On 08/23/18 at 2:00 PM, the surveyors were informed that Resident #2 was found by her HHA at approximately 7:30 AM on the floor near her bed. The HHA reported the fall to a TME, who took the resident's vital signs; however, there was no vital signs documented in the resident's
[1] records. The records, however, documented that

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the Acting ALA/LPN was informed of the incident at 8:40 AM, and that the Acting ALA/LPN would alert the resident's physician and family.

The Acting ALA/LPN arrived to the facility at approximately 3:15 PM. She stated that she could not come any sooner because she was in training, unrelated to the ALR. The Acting ALA/LPN was questioned concerning the fall incident. She stated that at approximately 7:30 AM a missed call from the ALR was noted on her cellphone; however, the ALR did not leave a message . At approximately 10:16 AM, she contacted the ALR and spoke with the TME, who informed her of Resident #2's fall. The Acting ALA/LPN was asked if the resident had a fall protocol, she stated that for any fall, the practice was to send residents to the ER, and to notify their PCP or NP. The surveyor asked if the facility followed the protocol. The Acting ALA/LPN stated that the resident refused to go to the ER and the resident's PCP was not notified of the fall. She stated that on her way to the ALR, the RN was notified of the resident's fall. She confirmed that the resident had not been assessed by a health professional (MD, LPN or RN) since the resident was found on the floor at 7:30 AM. Her plan was to access the resident upon arrival later that day and send the resident out to the emergency room.

The surveyor interviewed the RN via telephone at 3:57 PM. The RN stated that she was aware of Resident #2's fall and the resident's refusal to go to the ER. The RN stated that she instructed the Acting ALA/LPN to do vital signs and to call back with the results. The RN stated that the Acting ALA/LPN had not reported the results of the resident's vital signs. The RN was unaware that the Acting ALA/LPN was not onsite when she

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R 292	Continued From page 13 provided the instructions. The RN was asked how was she ensuring the resident's care. When questioned what further actions would be taken to ensure that the resident, the **RN** stated that the plan was to assess the resident the next morning. At 3:15 PM, the Acting ALA/LPN arrived to the facility and stated she was going to Resident #2's apartment. The Acting ALA /LPN was observed to complete an assessment, to include vital signs. Resident #2's was encouraged at that time to go to the ER for further evaluation. Shortly thereafter, Resident #2 was observed leaving the facility with EMS. At the time of the investigation, the ALR failed to ensure the provision of adequate and appropriate services to address the individual needs of Resident #2 and in a manner consistent with the resident's physical and mental capabilities to ensure her health and safety.	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 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, the ALR failed to report an allegation of physical abuse,	R 390	Sec. 509b1 Abuse, Neglect and Exploitation 1.1 An investigation was done regarding the Abuse allegation. This included interviewing all staff and the Home Health Aide as well as the resident. The resident was sent to the hospital and has returned. The new Administrator has met with Resident #1 on several occasions who indicates that he has no further complaints as it pertains to this incident. 1.2 Following the interviews with staff employees were counseled and/or disciplined as indicated. The Abuse, Neglect and Exploitation policy and procedure has been reviewed and staff have been re-educated regarding abuse. The management company has been changed to Stoddard Baptist Services who is continuing the facility assessment and making changes to policies and procedures as indicated. All Home Health Agencies providing services at Marigold has been contacted and expectations of HHA particularly as it pertains to abuse	

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R 390	Continued From page 14 and the ALA failed to take appropriate action to protect the resident. Findings included: Cross Reference R282: On 8/16/18, APS filed a complaint with DC Health that alleged Resident #1 was injured as a result of staff forcing the resident to take a shower after discovering bed bugs in the resident's apartment on July 25, 2018. An onsite investigation was initiated on 8/16/2018 at 11:55. A review of the incident reports and interviews with the ALA, resident, and the resident's HHA revealed that the ALA was made aware of Resident #1's complaint of abuse on 7/26/2018, but failed to report the incident to the DC Health and APS as required.	R 390	1.2 continued Staff have also been trained regarding the reporting of incidents/allegations on 9/21/18. 1.3 A new QA/QI program has been developed. The committee reviews all areas of concern and the POC monthly to ensure compliance. While this committee is scheduled to meet monthly then quarterly, any allegations of abuse are reviewed and investigated as soon as reported. **Completion Date: R 390 Sec. 509b 1: October 10, 2018**	
R 392	Sec. 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 to investigate an allegation of physical abuse for one of one resident. Findings included: Cross Reference R282: On 8/16/18, APS filed a complaint with DC Health that alleged Resident #1 was injured as a result of staff forcing the resident to take a shower after discovering bed bugs in the resident's apartment on July 25, 2018. An onsite investigation was initiated on 8/16/2018 at 11:55. A review of the incident reports and	R 392	R 392 Sec. 509b3 Abuse, Neglect and Exploitation 1.1 An investigation was done regarding the Abuse allegation. This included interviewing all staff and the Home Health Aide as well as the resident. The resident was sent to the hospital and has returned. The new Administrator has met with Resident #1 on several occasions who indicates that he has no further complaints as it pertains to this incident. 1.2 Following the interviews with staff employees were counseled and/or disciplined as indicated. The policies and procedures have been reviewed and staff have been re-educated regarding abuse and investigation of abuse. The management company has been changed to Stoddard Baptist who is continuing the facility assessment and making changes to policies and procedures as indicated. The Home Health Agency has been contacted and expectations of HHA particularly as it pertains to abuse. Staff have also been trained regarding the importance of conducting an investigation when allegations of abuse.	

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R 392	Continued From page 15 interviews with the ALA, resident, and the resident's HHA revealed that the ALA was made aware of Resident #1's complaint of abuse on 7/26/2018, but failed to report and investigate the allegation of abuse.	R 392	1.3 A new QA/QI program has been developed. The committee reviews all areas of concern and the POC monthly to ensure compliance. While this committee is scheduled to meet monthly then quarterly, any allegations of abuse are reviewed and investigated as soon as reported. **Completion Date: R390 Sec. 509b3: October 10, 2018**	