STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0031	A. BUILDING: _____ B. WING _____	11/12/2019

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 000	Initial Comments An annual survey was conducted on 11/05/19, 11/06/19, 11/07/19, 11/08/19, and 11/12/19 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the Assisted Living Residence (ALR) emergency and proposed regulations. The Assisted Living Residence provided care for eight residents and employed 19 personnel to include professional and administrative staff. The findings of the survey were based on observations throughout the facility, clinical and administrative record reviews, and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALA - Assisted Living Administrator ALR - Assisted Living Residence ISP - Individualized Service Plan LSC - Life Safety Code NFPA - National Fire Protection Association RN - Registered Nurse TME - Trained Medication Employee	R 000	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 prepared and/or executed solely because it is required by Federal and State Law.	
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	R 390		

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R 390	Continued From page 1 failed to report allegations of possible verbal abuse /neglect to the ALA immediately for one of eight residents in the core sample (Resident #2). Findings included: On 11/06/19 beginning at 11:27 AM, review of the ALR's incident report log showed that on 10/03/19, Resident #2 was upset and complained to TME #1 that TME #3 would not heat up the resident's soup in the microwave oven. In addition, the resident stated that the TME #3 demanded that the resident say please. TME #3 stated that Resident #2 was demeaning and disrespectful by not saying please. Further review of the incident report showed that the TME #3 acknowledged that she did not heat up Resident #2's soup but instead, gave the resident the dinner meal that was provided by the ALR for that day. At 2:39 PM, TME #2 said during a telephone interview that on 10/02/19, he heard loud noises while at the front desk coming from the dining room area. TME #2 said that there was arguing between Resident #2 and TME #3 over food. TME #2 stated that he tried to deescalate the situation but Resident #2 was agitated and calling the staff derogatory names. When asked if the incident was reported to the ALA immediately, TME #2 said no because he did not consider the argument an unusual incident. At 2:50 PM, during interview, TME #1 said that on the morning of 10/03/19, she went to administer Resident #2's morning medications. TME #1 said that the resident appeared to be very upset and was talking about TME #3 not warming up her soup on 10/02/19, and trying to make her say please. TME #1 stated that she notified the ALA	R 390	**R390** 1. A meeting was held with the TME's. The responsibilities regarding incidents/accidents particularly incidents that maybe considered neglect and abuse were reviewed. The TME's were also advised of the urgency of reporting events immediately. 2. All staff were re-trained regarding abuse and abuse reporting; as well as unusual incident reporting. This reporting was reported in approximately 12 hours; however, facility staff were advised that the reporting has to be done immediately to the immediate supervisor, who would ensure that the ALA is aware. 3. A review of all incidents is done monthly. This information is reported to the QAPI committee quarterly. **Completion Date: December 22, 2019**	

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R 390	Continued From page 2 and RN about the incident immediately. At 3:30 PM, review of the ALR's internal investigation showed that the allegation of verbal abuse/neglect was substantiated and that the employee resigned. At 3:53 PM, review of the ALR's undated Accidents and Incident Management Policy showed that an employee witnessing an incident involving a resident must report such an occurrence to the immediate supervisor. At approximately 4:00 PM, interview with the ALA confirmed that the incident was not reported to her until the next day. At the time of the survey, the ALR failed to provide immediate notification to the ALA regarding TME #3 verbal abuse/neglect against Resident #2 as required.	R 390		
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 review and interview, the ALR failed to ensure that the ISP was signed by the resident or surrogate, and a representative of the ALR for seven of eight residents in the facility (Resident #2, 3, 4, 5, 6, 7 and 8). Findings included: 1. On 11/8/19 at 10:35 AM, a review of Resident # 2's clinical record showed that the resident's ISPs dated 02/09/19, and 09/06/19, were not signed by the resident or surrogate.	R 475		

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R 475	Continued From page 3 2. On 11/8/19 at 10:55 AM, a review of Resident # 3's clinical record showed that the resident's ISPs dated 03/15/19, and 09/17/19, were not signed by the resident or surrogate, and a representative of the ALR. 3. On 11/8/19 at 11:25 AM, a review of Resident # 4's clinical record showed that the resident's ISPs dated 03/15/19, 04/29/19, and 07/13/19, were not signed by the resident or surrogate. 4. On 11/8/19 at 12:05 PM, a review of Resident # 5's clinical record showed that the resident's ISPs dated 09/15/19 was not signed by the resident or surrogate. 5. On 11/8/19 at 12:45 PM, a review of Resident # 6's clinical record showed that the resident's ISP dated 10/25/19 was not signed by the resident or surrogate, and a representative of the ALR. 6. On 11/8/19 at 2:15 PM, a review of Resident # 7's clinical record showed that the resident's ISP dated 03/15/19 was not signed by the resident or surrogate. The ISP dated 09/18/19, was not signed by a representative of the ALR. 7. On 11/8/19 at 2:55 PM, a review of Resident # 8's clinical record showed that the resident's ISP dated 08/15/19 was not signed by the resident or surrogate, and a representative of the ALR. During an interview on 11/8/19 at 3:12 PM, the ALA stated that going forward that Residents #2, 3, 4, 5, 6 and 7 ISPs would be signed by either the resident or surrogate, and a representative of the ALR. At the time of survey, the facility failed to ensure that each resident's ISP was signed by the	R 475	R475 1. The Individualized Service Plans (ISPs) were reviewed for residents #2, 3, 4,5,6,7, and 8. ISPs were signed by the resident or surrogate and a representative of the ALR. 2. The Clinical team were re-educated regarding the ISP and the ISP form that should be used and the need for signatures by the resident or surrogate and a representative of the ALR. 3. A resident list including the due dates of ISP and signatures from Resident or surrogate and representative of the ALR is done monthly to ensure accuracy is maintained. *This will be* reported to the QAPI Committee quarterly. **Completion Date: December 22, 2019**	

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R 475	Continued From page 4 resident or surrogate, and a representative of the 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 record review and interview, the ALR failed to ensure all ISP's were updated with each significant change in the residents' condition, for two of eight residents in the sample (Residents #2 and 8). Findings included: 1. On 11/07/19 at 12:08 PM, review an incident report dated 09/06/19, showed that Resident #2 sustained a fall without injury. However, there was no documented evidence that the ISP dated 09/16/19, had been updated to reflect the fall and the interventions needed to prevent further falls. 2. On 11/07/19 at 1:10 PM, review of Resident #8's medical record showed the following: -A discharge summary dated 07/12/19 showed an emergency room visit where Resident #8 sustained a fall without injury. However, there was no documented evidence the ISP dated 08/15/19, had been updated to reflect the fall and	R 483	**R483** **1.** The medical records for residents #2 and #8 were reviewed. A detailed progress note was in place for both residents. The ISP for residents #2 and #8 were updated. **2.** The Clinical team was re-educated regarding the ISP and the importance of updating the ISP after any significant change. **3.** A resident list including the due dates of ISP and signatures from Resident or surrogate and representative of the ALR is done monthly to ensure accuracy is maintained. This will be reported to the QAPI Committee. **Completion Date: December 22, 2019**	

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R 483	Continued From page 5 the interventions needed to prevent further falls. - A discharge summary dated 07/29/19 showed that Resident #8 was treated in the emergency room visit for chest pains. However, there was no documented evidence that the ISP's dated 08/15/19, had been updated to reflect the significant changes in the resident's condition. - A discharge summary dated 09/02/19 showed that Resident #8 was treated in the emergency room visit for chest pains and leg pains. However, there was no documented evidence that the ISP's dated 08/15/19 and 10/29/19, had been updated to reflect the significant changes in the resident's condition. During an interview on 11/08/19 at 3:15 PM, the ALA and RN stated that Residents #2 and 8 ISPs would be updated immediately to reflect the aforementioned significant changes along with interventions. At the time of survey, the ALR failed to ensure all ISPs were updated when there were significant changes in the residents' condition.	R 483		
R 960	Subheading Fire Safety. Sec. 1002. Fire safety. An ALR shall comply with the Life Safety Code of the National Fire Protection Association, NFPA 101, 1997 edition as follows: Based on interview and record review, the ALR failed to follow the LSC of the NFPA that specifically addressed conducting quarterly fire drills on each shift, for two of three assigned shifts (Evening and Overnight).	R 960		

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R 960	Continued From page 6 Findings included: On 11/05/19 at 4:07 PM, the ALA said during an interview that the ALR had designated shifts (7:00 PM - 3:00 PM; 3:00 PM - 11:00 PM and 11:00 PM -7:00 AM), Monday through Friday. The ALA stated that weekend shifts were the same as the weekday shifts. At 4:09 PM, review of the ALR's fire drill records showed the following: - There was only one fire drill held during the weekday evening shift (3:00 PM - 11:00 PM) from October 2018 to October 2019. - There were no fire drills held during the overnight shift (11:00 PM - 7:00 AM) from October 2018 to October 2019. At 4:41 PM, the maintenance staff was interviewed regarding fire drills. The maintenance staff said that he was responsible for ensuring fire drills were conducted for the ALR. When asked why fire drills were only conducted during the 7:00 AM - 3:00 PM shift and once on the 3:00 PM-11:00 PM shift, the maintenance staff stated that the majority of the drills were conducted at that time because that was the shift that he worked. The maintenance staff said that he was not sure why drills were not conducted on the other two shifts because he did not work during those shifts. The maintenance staff then stated that going forward; he would ensure drills were conducted on the other two shifts. At the time of the survey, the ALR failed to ensure that fire drills were conducted quarterly on each shift in accordance with the LSC of the NFPA.	R 960	**R960** **1.** The Engineering Director updated the fire drill schedule to ensure fire drills are conducted on the evening and night shifts. A fire drill has already been conducted on the evening and night shift. **2.** The Maintenance staff was re-educated regarding the LSC of the NFPA as it pertains to the quarterly fire drills for all shifts (Days, Evenings and Nights) as well as re-educated regarding the fire drill schedule developed by the Engineering Director. **3.** The monthly schedule and fire drill schedule and implementation of the fire drills is audited monthly and presented to the QAPI committee quarterly. **Completion date: December 22, 2019**	

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R 971	Sec. 1003a General Building Exterior (a) An ALR shall ensure that the exterior of its facility, including walkways, yards, porches, chimney, gutters, downspouts, paintable surfaces, and accessory buildings are maintained structurally sound, sanitary, and in good repair. Based on observation and interview, the ALR failed to ensure that the facility was free of old items that were no longer in use, for eight of eight residents in the facility (Residents #1, 2, 3, 4, 5, 6, 7 and 8). Finding included: On 11/05/19 at 2:02 PM, observations during an environmental walk-through showed that there was a broken refrigerator, chair, lawn mower, and dresser stored at the back of the facility. The maintenance staff who accompanied the surveyor during the walk-thru stated that the aforementioned items were not being used and needed to be removed. The maintenance staff stated that he would make the ALA aware of the findings. During an interview on 11/06/19 at 9:12 AM, the ALA stated that the bulk trash company would be called to remove the broken items from the back of the facility. At the time of the survey, the ALR failed to ensure the facility was free of all broken items that needed to be removed from the facility.	R 971	**R971** **1.** DC Bulk trash was contacted to pick up the items that were securely stored; however, were old and no longer in use. Established arrangement with outside vendor to pick up trash. **2.** The Maintenance staff was re-educated regarding the General Building Exterior ensuring that bulk trash is picked up timely. In the event that DC Bulk Trash does not respond timely, an outside vendor will be contacted. **3.** The Engineering Director conducts monthly audits, which includes the interior and exterior of the building. Areas of concern are reported to the QAPI Committee quarterly. **Completion date: December 20, 2019**	
R 981	Sec. 1004a General Building Interior (a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained	R 981		

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R 981	Continued From page 8 structurally sound, sanitary, and in good repair. Based on observation and interview, the ALR failed to ensure each resident's ceiling was maintained and in good repair, for one of six residents' bedrooms in the facility (Resident #6). Findings included: On 11/05/19 at 2:02 PM, observations during an environmental walk-through showed that there were water stains on the ceiling just above Resident #6's bed. The maintenance staff who accompanied the surveyors during the walk-thru stated that contractors was on-site within the last couple months (unable to recall the date) to assess the ceiling. The maintenance staff stated that the contractors had fixed the leak coming from the roof. The maintenance staff then stated that he would paint the ceiling. At the time of the survey, the ALR failed to ensure Resident #6's ceiling was maintained in good repair.	R 981	**R981** **1.** The ceiling tile in Resident #6's room was repaired immediately. **2.** The Maintenance staff was re-educated regarding the requirements of the Interior and exterior of the facility. The Ceiling Tile will be monitored on the Preventative Maintenance Program. **3.** The Engineering Director conducts monthly audits. Areas of concern in the interior and exterior are reported to the QAPI Committee quarterly. **Completion date: December 22, 2019**	
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation, interview and record review, the ALR failed to ensure water temperatures did not exceed 110 degrees Fahrenheit in one of three bathrooms tested and five of eight residents' apartment sinks and bathrooms tested (Residents #1, 3, 4, 6 and 7).	R1003		

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R1003	Continued From page 9	R1003		

Findings included:

On 11/05/19 beginning at 1:50 PM, a walk-thru of the facility with maintenance staff showed the following:

- At 2:11 PM, the water temperature in Resident #6's kitchenette sink measured at 120 degrees Fahrenheit while the bathroom temperature measured at 121 degress Fahrenheit. Interview with Resident #6 who was present during the testing, said that she regulates her own hot water temperatures.

- At 2:26 PM, the water temperature located beside the LPN's office on the first floor measured 116 degrees Fahrenheit. When asked, maintenance staff stated that the resident's used this bathroom regularly.

- At 2:36 PM, the water temperature in Resident #7's kitchenette sink measured at 118 degrees Fahrenheit while the bathroom temperature measured at 124 degrees Fahrenheit.

- At 2:41 PM, the water temperature in Resident #1's kitchenette sink measured at 124 degrees Fahrenheit while the bathroom temperature measured at 116 degrees Fahrenheit.

- At 2:43 PM, the water temperature in Resident #4's kitchenette sink measured at 118 degrees Fahrenheit while the bathroom temperature measured at 123 degrees Fahrenheit.

- At 2:48 PM, the water temperature in Resident #3's kitchenette sink measured at 123 degrees Fahrenheit while the bathroom temperature measured at 124 degrees Fahrenheit.

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R1003	Continued From page 10 At 3:05 PM, the temperature findings were brought to the attention of the ALA. The ALA said that she would contact someone from housing to come and adjust the water temperatures. The ALA then stated that the water temperatures usually ranged between 107 to 108 degrees Fahrenheit. When asked, the ALA stated that residents' were able to adjust the water temperatures. At 3:11 PM, review of the ALR's water temperature log from June 2019 to present showed that the ALR's water temperatures remained below 110 degrees Fahrenheit. At 3:40 PM, the technician that was responsible for the overall maintenance of the building arrived to the ALR to adjust the hot water temperature. At 4:50 PM, follow-up observations showed that the technician adjusted the hot water temperatures in the aforementioned locations that measured between 101 to 108 degrees Fahrenheit. At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110 degrees Fahrenheit.	R1003	**R1003** 1. Repairs were done on the mixing valves. All water temperatures were decreased to <110. 2. Water temperatures are reviewed daily to ensure the temperature is <110. This will be maintained on a Preventative Maintenance Program (PM). The Maintenance staff was re-educated regarding this requirement. 3. The Engineering Director conducts monthly audits which includes the water temperatures and monitoring the PM Program. Areas of concern are reported to the QAPI Committee quarterly. **Completion date: December 18, 2019**	

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
The Marigold at 11th Street ALR -0031	2905 11th Street, N.W. Washington, DC 20001	11/05/19 – 11/12/19 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An annual survey was conducted on 11/05/19 to 11/12/19 compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and the ALR emergency and proposed regulations. The Assisted Living Residence (ALR) provided care for eight residents and employed 19 personnel to include professional and administrative staff. The findings of the survey were based on observation throughout the facility, clinical and administrative record review, and resident and staff interviews. Listed below are abbreviations used throughout the body of this report: ALA – Assisted Living Administrator ALR - Assisted Living Residence EP – Emergency Plan EPP – Emergency Preparedness Program TME – Trained Medication Employee		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 prepared and/or executed solely because it is required by Federal and State Law.	

C. Milam for [signature]
Name of Inspector

12/13/19
Date Issued

[signature], Exe. Dir / Adm.
Facility Director/Designee

12/20/19
Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

10125.2	**In addition to the requirement to report abuse, neglect and exploitation of a resident provided in Section 509 of the Act (D.C. Official Code & 44-105.09), each ALR shall notify the Director of any unusual incidents that substantially affects a resident. Notifications of unusual incidents shall be made by contacting the Department of Health by phone immediately, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day.** This regulation is not met as evidenced by: Based on interview and record review, the ALR failed to report allegations of possible verbal abuse/neglect to the ALA and DC Health immediately for one of eight residents in the core sample (Resident #1). Findings included: On 11/05/19 at 10:48 AM, the ALA said during an interview that on 11/05/19, the receptionist, the Cook and TME #1 entered her office and reported that on 11/04/19, Resident #1 was observed sitting at the dining table preparing to go smoke a cigarette. Resident #1 stuck his left pinky finger inside his left ear while at the same time, flickering a cigarette lighter that was observed in the same hand. The resident's left sideburn caught on fire and Resident #1 immediately patted				

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his left sideburn and put the fire out. When asked, the ALA stated that DC Health was not notified immediately of Resident #1's unusual incident involving the cigarette lighter.

At 1:01 PM, the Cook said during an interview that on 11/04/19 at 3:20 PM, he was standing near Resident #1 as he sat at the dining table. The Cook stated that Resident #1 stuck his left finger in his ear while holding a cigarette lighter in the same hand and mistakenly flicked the lighter switch on which caused his left sideburn to catch on fire. The Cook stated that Resident #1 patted the fire out immediately. The Cook further stated that he did not see any burns on the resident's scalp but noted some hair was shorter on the left side where his sideburn caught on fire. When asked, the Cook stated that he did not report the incident to anyone. In addition, the Cook stated that he did not think Resident #1 meant to burn himself and that TME #2 was present and walked over immediately to the resident to assess his condition.

At 12:01 PM, TME #2 said during an interview that he did not see Resident #1 light his left side burn on fire because he rushed to use the bathroom when he arrived to the facility. TME #2 stated that after using the bathroom, he walked over to assess Resident #1 for any injuries. When TME #2 was asked if he reported the incident to the ALA, TME #2 said no, because the resident looked fine to me.

At the time of the survey, the ALR failed to provide immediate notification to DC Health regarding Resident #1's incident involving the cigarette lighter.

10125.2

1.
The Staff and Resident were interviewed regarding resident #1. Additionally, Resident was assessed and there was no evidence to indicate burn. In fact, resident laughed stating that I saw smoke and I patted my side burn. Resident willingly gave facility staff his cigarette lighter. The staff were informed that this would be considered unusual incident and as opposed to waiting 12 hours for the ALA it must be reported to Supervisor on duty or the ALA/representative.

2.
All staff were re-trained regarding reporting unusual incidents reports. The facility staff was advised that the reporting has to be done immediately to the immediate supervisor, who would ensure that ALA is aware.

3.
A review of all incidents is done monthly. This information is reported to the QAPI committee quarterly.

Completion Date: December 22, 2019

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10110 Required Policies and Procedures	**10110.01 (k) Emergency preparedness, which shall meet the same standards for emergency preparedness as those set for long term care facilities by the Centers for Medicare and Medicaid Services, at 42 CFR & 483.73;** This regulation is not met as evidenced by: Based on record review and interview, the ALR failed to ensure each client's family member or representative had been given information regarding the facility's EPP, for five of eight clients in the core sample (Residents #1, 2, 3, 5 and 6). Findings included: On 11/08/19 beginning at 9:00 AM, review of the facility's EPP binder showed EPP information had been disseminated via email, mail and/or face to face meeting to the guardians and/or family members of Client #1, 2, 3, 5 and 6. At 9: 05 AM, Resident #1's sister was interviewed via telephone regarding the facility's EPP. Resident #1's sister said that she had not received any information regarding the facility's EPP. At 9:10 AM, Resident #2's daughter was interviewed via telephone regarding the facility's EPP. Resident #2's daughter said that she had not received any information regarding the facility's EPP.				

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At 9:15AM, Resident #3's daughter was interviewed via telephone regarding the facility's EPP. Resident #3's daughter said that she had not received any information regarding the facility's EPP

At 9:20 AM, Resident #5's responsible party (RP) was interviewed via telephone regarding the facility's EPP. Resident #6's RP said that she had not received any information regarding the facility's EPP.

At 9:30 AM, Resident #6's responsible party was interviewed via telephone regarding the facility's EPP. Resident #6's RP said that she had not received any information regarding the facility's EPP.

At 1:38 PM, the ALA confirmed during an interview that Residents' #1, 2, 3, 5 and 6 responsible party and/or family members had received information regarding the facility's EPP.

At the time of the survey, the ALR failed to ensure residents' #1, 2, 3, 5 and 6's families and or responsible parties were made aware of the facility's EPP once the plan had been developed.

10110 (k)

1.
The Emergency Preparedness Program (EPP) information was sent out to residents and/or RP/POA. Facility will maintain documentation of the dates and times the information has been provided.

2.
Annually the family members, representatives and/or residents will be contacted and review of EPP will take place.

3.
The Engineering Director and ALA and/or designee will review and discuss the EPP annually which will include notification of residents and family of the EPP. This information will be presented to the QAPI committee.

Completion Date: December 31, 2019