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 ______	08/06/2021

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	R 000		

An annual licensure survey was conducted on 07/28/2021, 07/29/2021, 07/30/2021, 08/02/2021 08/03/2021, 08/04/2021, 08/05/2021 and 08/06/2021 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 78 residents and employed, 80 personnel to include professional and administrative staff. A random sample of 20 resident records and 20 employee records were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, review of the facility's response to complaints and incidents received, and resident, family, and staff interviews.

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

POA- Power of Attorney
ALR - Assisted Living Residence
ALA - Assisted Living Administrator
ISP - Individual Support Plan

In addition to the survey, on 07/21/2021, this office received notification of a complaint voiced by the family of Resident #1. The family's concerns revealed the following:

Allegation #1: The nurse attempted to administer broken medications to Resident #1.

Findings: Substantiated:

On 08/05/2021 at 12:21 PM, the Assistant Wellness Director said during an interview that on

Please begin typing your responses here:

[signature] 9/30/21

Health Regulation & Licensing Administration

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 ______	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A	6420 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	Continued From page 1	R 000		

08/04/2021, when she punched Resident #1's 10:00 AM medications through the bubble one of the pills broke in three places. When the nurse attempted to administer the medication to Resident #1, the resident counted the pills and noted there were more pills than she was accustomed to receiving. The resident refused to take the medication.

Although this incident did happen, the resident was not harmed as she did not take the medication.

Allegation #2: The Pendant is used for emergency and non-emergencies.

Findings: Substantiated.

On 08/09/2021 at 3:00 PM, review of the Assisted Living Residence (ALR's), "Resident Call System" policy, dated 1/2018, revealed that the pendant" ...can be pushed by the resident to notify staff for assistance." The policy also indicated that "If residents choose their own private system, the resident and/or authorized responsible party shall provide the community with information regarding the system."

There was no evidence that Resident #1 and/or the power of attorney (POA) chose an alternate call system.

Allegation #3: Nursing staff talking to private physician without Resident #1 or her family present.

Findings: Not substantiated.

Resident #1's son requests that the nurses not speak with the resident's physicians without him,

R000 The assistant Wellness Director is no longer employed by the community. Nursing staff will be re-educated on medication administration policy. Completion date: October 15, 2021. Resident #1 family will be notified by the Executive Director/designee if medication is wasted.

Michael Costeros [signature]
9/30/21

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 ____	08/06/2021

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	Continued From page 2	R 000		

and his mother being involved in the conversation.

On 08/18/2021 at 3:08 PM, interview with the Wellness Director revealed that she could not recall ever speaking directly with any of Resident #1's physicians without the resident or one of her sons being present. She recalled making a call to the cardiologist regarding a discrepancy in Resident #1's weight. The resident and the son were both on the line to speak to the cardiologist, however he was not available to speak with them. The cardiologist later returned the Wellness Director's call but only left a message.

Allegation #4: Discrepancies in prescribing physician orders and ALR ' s record keeping.

Findings: Substantiated.

Conclusion: On 07/29/2021 at 10:00 AM, Resident #1' s son produced a physician's orders (POS) for Nitroglycerine 0.4 mg one tablet sublingually every five minutes for three doses. If symptoms not resolved after three doses call medical doctor (MD). Resident #1's son was concerned because all other POS' documented "If symptoms not resolved after three doses call 911."

On 07/29/2021 at 2:00 PM, during an interview with the Wellness Director regarding the nitroglycerin order, she acknowledged that the POS that the son presented stated to call the physician. However, since that time the orders all reflect "If symptoms not resolved after three doses call 911."

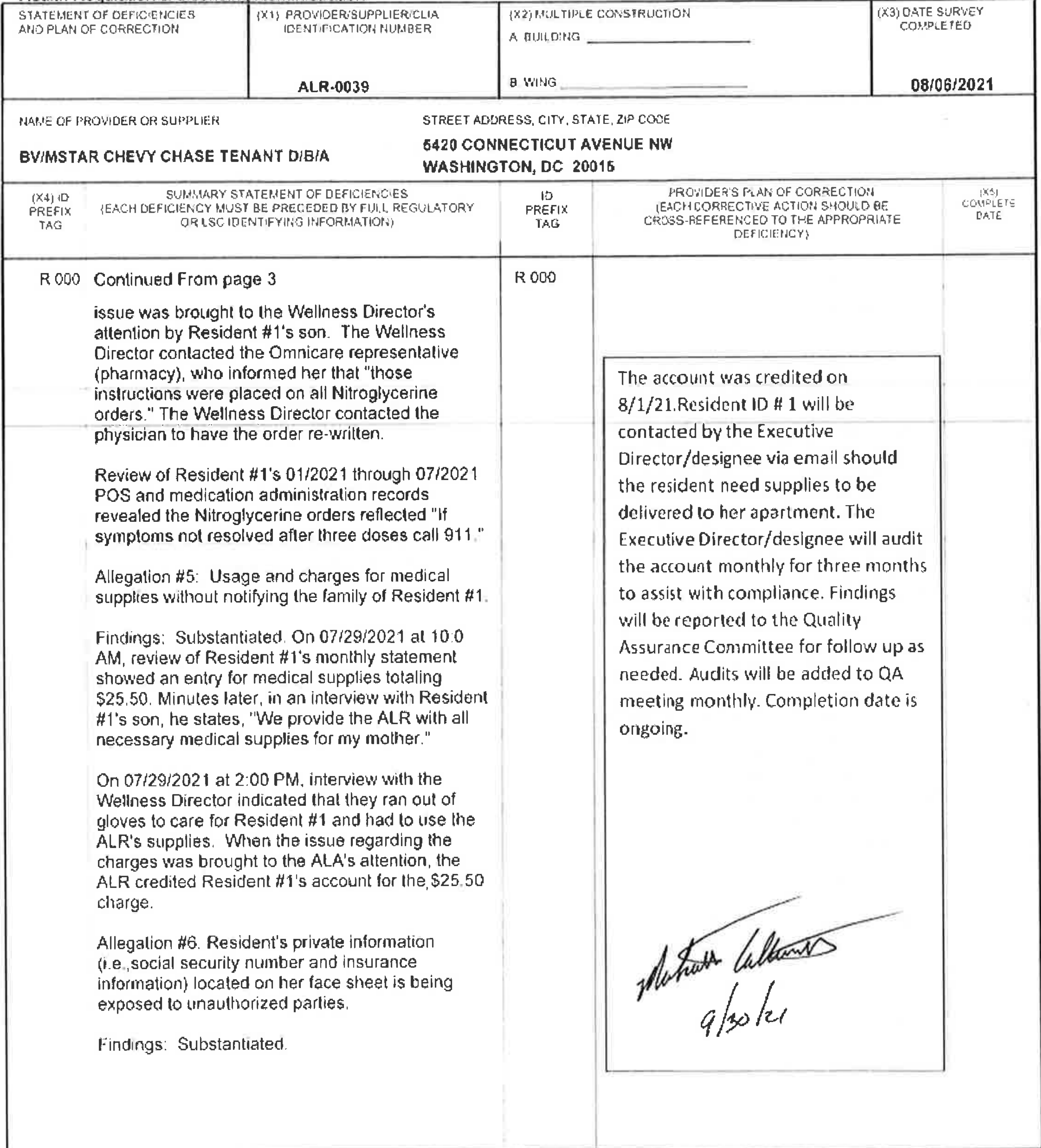
On 07/30/2021, at 12:00 PM, a review of a nursing note dated 01/20/2021, revealed the

Provider's Plan of Correction:

The order for nitroglycerine was corrected on 1/20/21. The order was corrected to reflect the preference of the POA as the resident does not currently have a primary care physician. The monthly physicians' orders sheet will continue to be sent to the POA for his review and follow up.

[signature] 9/30/21

Health Regulation & Licensing Administration



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 _______	08/06/2021

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	Continued From page 3	R 000		

issue was brought to the Wellness Director's attention by Resident #1's son. The Wellness Director contacted the Omnicare representative (pharmacy), who informed her that "those instructions were placed on all Nitroglycerine orders." The Wellness Director contacted the physician to have the order re-written.

Review of Resident #1's 01/2021 through 07/2021 POS and medication administration records revealed the Nitroglycerine orders reflected "If symptoms not resolved after three doses call 911."

Allegation #5: Usage and charges for medical supplies without notifying the family of Resident #1.

Findings: Substantiated. On 07/29/2021 at 10:0 AM, review of Resident #1's monthly statement showed an entry for medical supplies totaling $25.50. Minutes later, in an interview with Resident #1's son, he states, "We provide the ALR with all necessary medical supplies for my mother."

On 07/29/2021 at 2:00 PM, interview with the Wellness Director indicated that they ran out of gloves to care for Resident #1 and had to use the ALR's supplies. When the issue regarding the charges was brought to the ALA's attention, the ALR credited Resident #1's account for the $25.50 charge.

Allegation #6. Resident's private information (i.e., social security number and insurance information) located on her face sheet is being exposed to unauthorized parties.

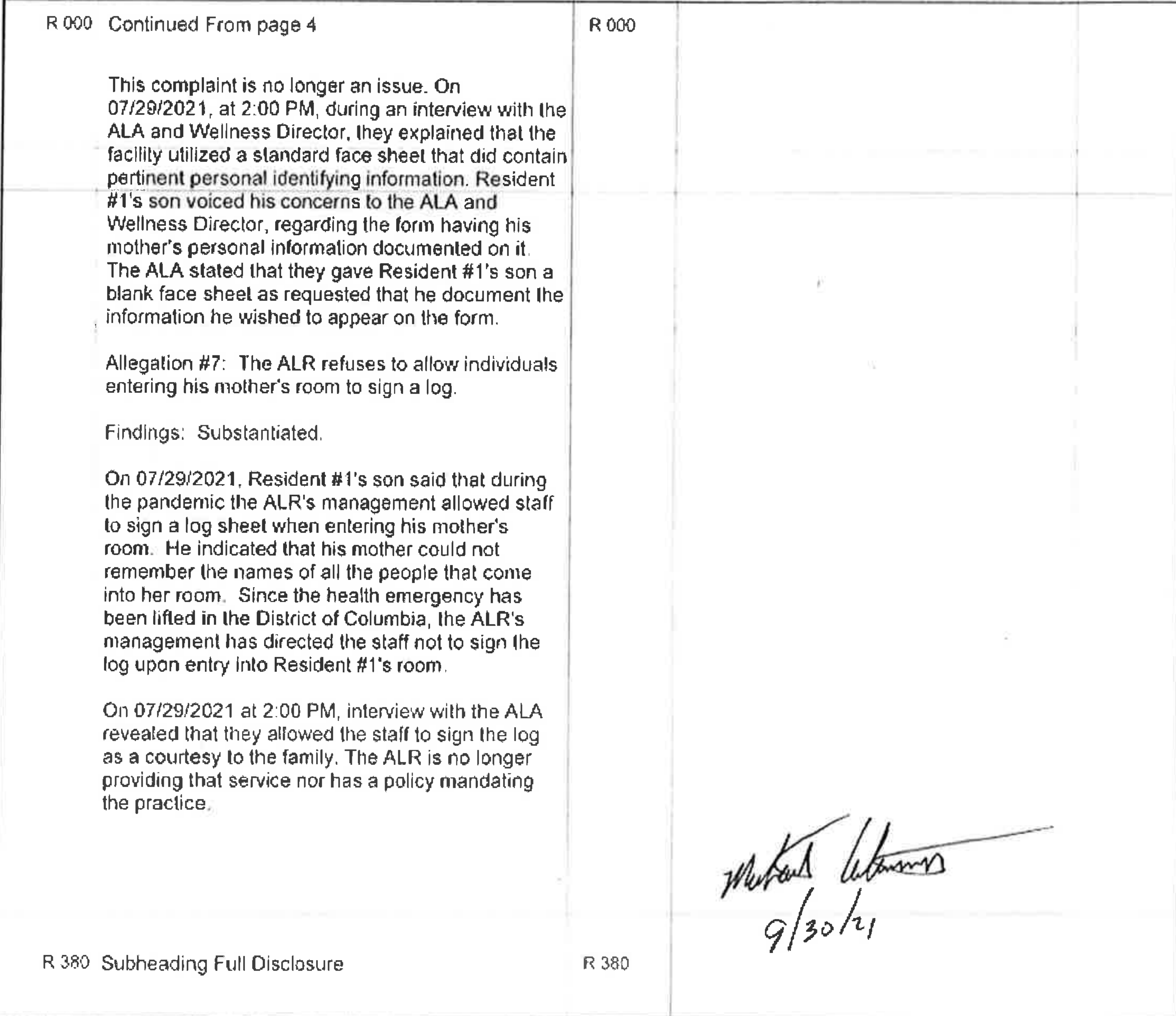
Findings: Substantiated.

Provider's Plan of Correction:

The account was credited on 8/1/21.Resident ID # 1 will be contacted by the Executive Director/designee via email should the resident need supplies to be delivered to her apartment. The Executive Director/designee will audit the account monthly for three months to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed. Audits will be added to QA meeting monthly. Completion date is ongoing.

[signature] 9/30/21

Health Regulation & Licensing Administration



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 ______	08/06/2021

NAME OF PROVIDER OR SUPPLIER: BV/MSTAR CHEVY CHASE TENANT D/B/A

STREET ADDRESS, CITY, STATE, ZIP CODE: 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	Continued From page 4 This complaint is no longer an issue. On 07/29/2021, at 2:00 PM, during an interview with the ALA and Wellness Director, they explained that the facility utilized a standard face sheet that did contain pertinent personal identifying information. Resident #1's son voiced his concerns to the ALA and Wellness Director, regarding the form having his mother's personal information documented on it. The ALA stated that they gave Resident #1's son a blank face sheet as requested that he document the information he wished to appear on the form. Allegation #7: The ALR refuses to allow individuals entering his mother's room to sign a log. Findings: Substantiated. On 07/29/2021, Resident #1's son said that during the pandemic the ALR's management allowed staff to sign a log sheet when entering his mother's room. He indicated that his mother could not remember the names of all the people that come into her room. Since the health emergency has been lifted in the District of Columbia, the ALR's management has directed the staff not to sign the log upon entry into Resident #1's room. On 07/29/2021 at 2:00 PM, interview with the ALA revealed that they allowed the staff to sign the log as a courtesy to the family. The ALR is no longer providing that service nor has a policy mandating the practice.	R 000	9/30/21	
R 380	Subheading Full Disclosure	R 380		

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 ______	08/06/2021

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 380	Continued From page 5	R 380		

Sec. 507. Full disclosure.
Based on observation, staff interview and record review, the Assisted Living Residence (ALR) failed to immediately notify the Department of an alleged incident of abuse, for one of the 20 residents in the sample (Resident #12).

Findings included:

On 07/28/2021, at 10:35 AM, the Assisted Living Administrator (ALA) informed the surveyors that Resident #12 was robbed while out in the community but was not injured. She further indicated that the resident and the Assistant ALA were waiting on the police to arrive at the scene, to file a report.

At 12:30 PM, the surveyors meet Resident #12, while he was going to his apartment. He said to the surveyors that he called his daughter and was not injured. He continued to say, "I'm so blessed that I wasn't hurt."

On 07/29/2021 at 3:00 PM, an inquiry was made to the ALA and Wellness Director if the incident was reported to the Department. They replied, "No, not yet."

On 08/02/2021 at 4:30 PM, review of the Internal Incident Reporting policy dated 01/2018 revealed the following:

The ALA and Wellness Director are responsible to ensure incident reports are completed within 24 hours or as soon as possible after an incident.

The ALA is responsible to [assure] an incident is reported and sent to the State Agency on the appropriate form and within the required time.

R380

The alleged Incident was reported on 8/4/21. The ALA at time of survey is no longer employed by the community. The current ALA and Director of Nursing were re-educated on the reporting requirements by the Regional Director of Clinical Services on 9/16/21. The Regional Director of Clinical Services/designee will audit ten percent of incident reports/ DOH reports monthly for three months, to assist with compliance. Findings will be reported to Quality Assurance Committee for follow up as needed.

Audits will be added to QA meeting monthly. Completion date is ongoing.

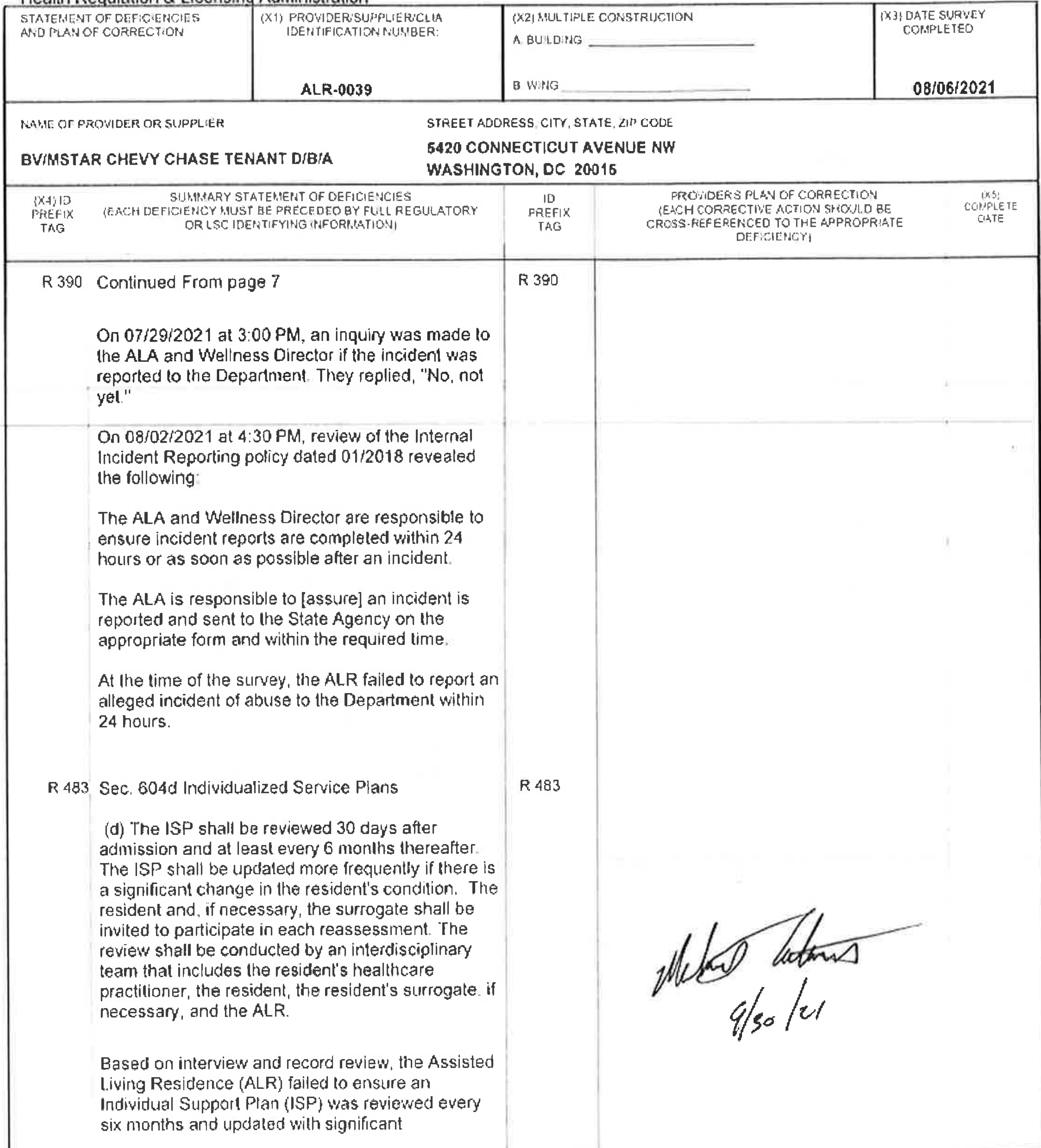
9/30/21

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 ______	08/06/2021

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 380	Continued From page 6 At the time of the survey, the ALR failed to report an alleged incident of abuse to the Department within 24 hours.	R 380		
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 observation, staff interview and record review, the Assisted Living Residence (ALR) failed to immediately notify the Department of an alleged incident of abuse, for one of the 20 residents in the sample (Resident #12). Findings included: On 07/28/2021, at 10:35 AM, the Assisted Living Administrator (ALA) informed the surveyors that Resident #12 was robbed while out in the community but was not injured. She further indicated that the resident and the Assistant ALA were waiting on the police to arrive at the scene, to file a report. At 12:30 PM, the surveyors meet Resident #12, while he was going to his apartment. He said to the surveyors that he called his daughter and was not injured. He continued to say, "I'm so blessed that I wasn't hurt."	R 390	R390 The alleged incident was reported on 8/4/21. The ALA at time of survey is no longer employed b the community. The current ALA and Director of Nursing were re-educated on the abuse, neglect and exploitation policy by the Regional Director of Clinical Services on 9/16/21. The Regional Director of Clinical Services/designee will audit ten percent of incident reports/ DOH reports monthly for three months, to assist with compliance. Findings will be reported to Quality Assurance Committee for follow up as needed. Audits will be added to QA meeting monthly. Completion date is ongoing. 9/30/21	

Health Regulation & Licensing Administration



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 ______	08/06/2021

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 390	Continued From page 7 On 07/29/2021 at 3:00 PM, an inquiry was made to the ALA and Wellness Director if the incident was reported to the Department. They replied, "No, not yet." On 08/02/2021 at 4:30 PM, review of the Internal Incident Reporting policy dated 01/2018 revealed the following: The ALA and Wellness Director are responsible to ensure incident reports are completed within 24 hours or as soon as possible after an incident. The ALA is responsible to [assure] an incident is reported and sent to the State Agency on the appropriate form and within the required time. At the time of the survey, the ALR failed to report an alleged incident of abuse to the Department within 24 hours.	R 390		
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 interview and record review, the Assisted Living Residence (ALR) failed to ensure an Individual Support Plan (ISP) was reviewed every six months and updated with significant	R 483		

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 ______	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT D/B/A	6420 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 483	Continued From page 8	R 483	R483	

changes, for one of 20 residents in the sample (Resident #1).

Findings included:

1. The ALR failed to ensure Resident #1's ISP was reviewed every six months as evidenced below:

Review of Resident #1's record on 07/29/2021, at 2:10 PM, revealed that the resident, her son, the ALR's Registered Nurse (RN), and physician, reviewed the resident's ISP on 06/30/2020. Further review of the resident's record failed to show evidence that the resident's ISP was reviewed in December 2020 or June 2021.

During an interview, on 07/29/2021, at 2:06 PM, the Wellness Director saidshe was awarethat the reviews were not completed, and that the family had not been cooperative with the ISP development and review process.

Review of the ALR's "Assessment & Individualized Service Plan-District of Columbia" policy revealed that an ISP [is] developed within 30 days prior to move in, 30 days post move in updated every six (6) months or upon change in condition."

At the time of the survey, there was no evidence that the ALR reviewed Resident #1's ISP every six months as required.

2. The ALR failed to ensure Resident #1's ISP was updated with significant changes in her health condition i.e., nose bleeding, as evidenced below:

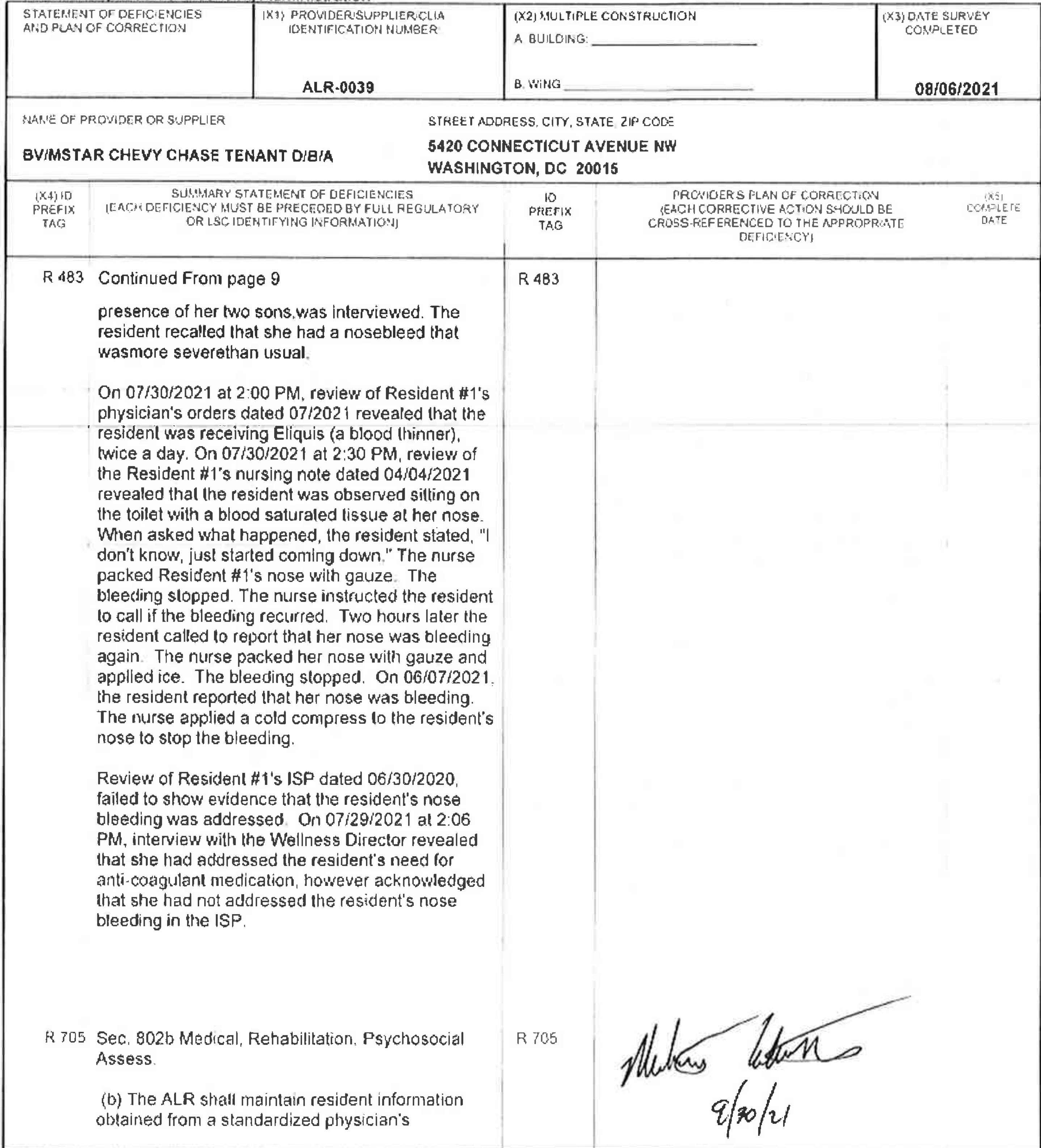
On 07/29/2021 at 10:00AM, Resident #1, in the

R483 (Provider's Plan of Correction):

1. The ISP for Resident #1 will be reviewed by 10/15/21. The Director of Nursing was re-educated on the timeline associated with ISP review on 9/16/21. The Regional Director of Clinical Services/designee will audit ten percent of service plans monthly for three months to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed.
2. The ISP for Resident # 1 was updated to include a history of nose bleeds. The Director of Wellness was re-educated on the significant change policy on 9/16/21. The Regional Director of Clinical Services will conduct a random audit of ten percent of significant changes of condition and corresponding service plans to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed. Audits will be added to QA meeting monthly. Completion date is ongoing.

9/30/21

Health Regulation & Licensing Administration



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 ______	08/06/2021

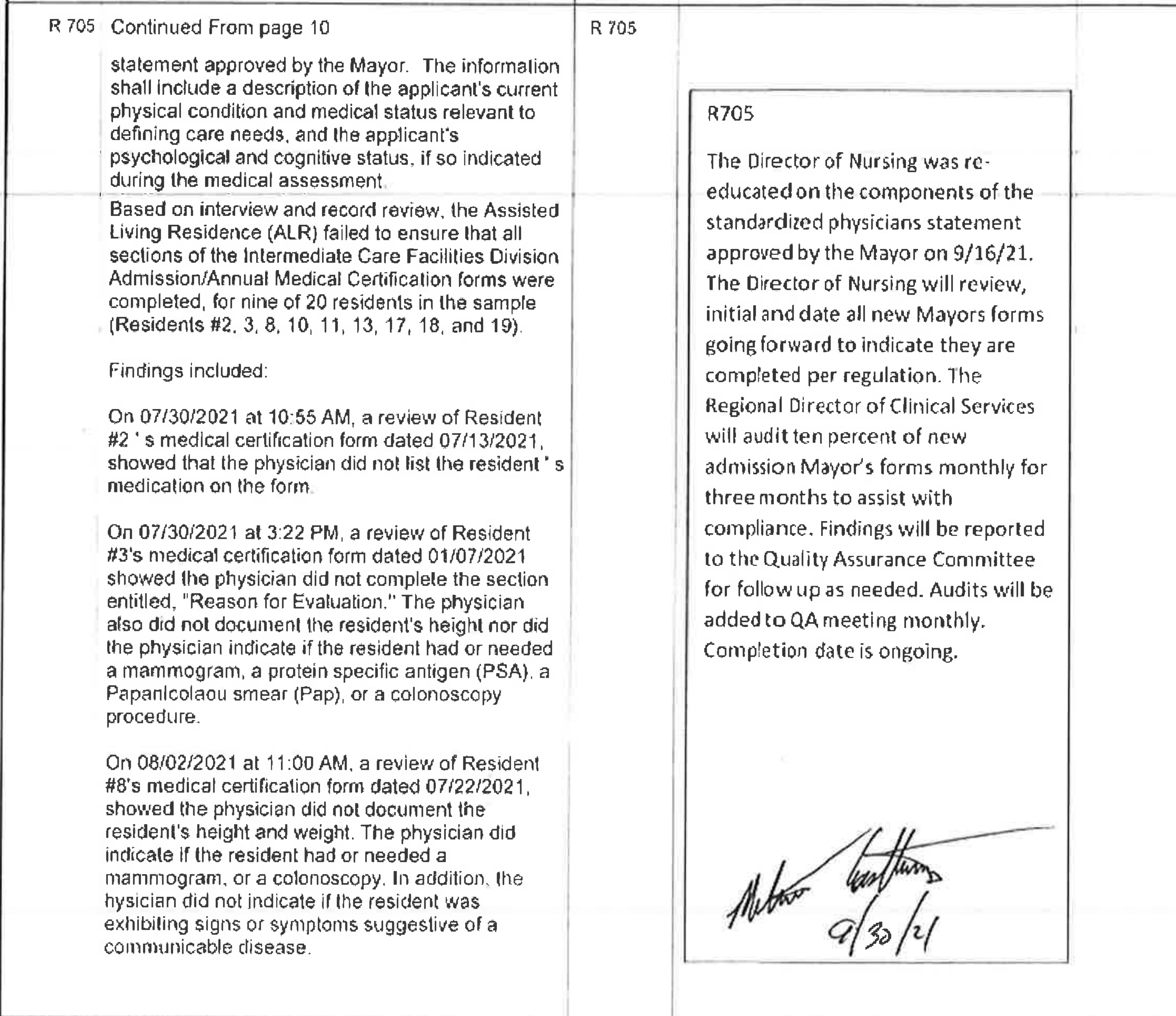
NAME OF PROVIDER OR SUPPLIER: BV/MSTAR CHEVY CHASE TENANT D/B/A

STREET ADDRESS, CITY, STATE, ZIP CODE: 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 483	Continued From page 9 presence of her two sons,was interviewed. The resident recalled that she had a nosebleed that wasmore severethan usual. On 07/30/2021 at 2:00 PM, review of Resident #1's physician's orders dated 07/2021 revealed that the resident was receiving Eliquis (a blood thinner), twice a day. On 07/30/2021 at 2:30 PM, review of the Resident #1's nursing note dated 04/04/2021 revealed that the resident was observed sitting on the toilet with a blood saturated tissue at her nose. When asked what happened, the resident stated, "I don't know, just started coming down." The nurse packed Resident #1's nose with gauze. The bleeding stopped. The nurse instructed the resident to call if the bleeding recurred. Two hours later the resident called to report that her nose was bleeding again. The nurse packed her nose with gauze and applied ice. The bleeding stopped. On 06/07/2021, the resident reported that her nose was bleeding. The nurse applied a cold compress to the resident's nose to stop the bleeding. Review of Resident #1's ISP dated 06/30/2020, failed to show evidence that the resident's nose bleeding was addressed. On 07/29/2021 at 2:06 PM, interview with the Wellness Director revealed that she had addressed the resident's need for anti-coagulant medication, however acknowledged that she had not addressed the resident's nose bleeding in the ISP.	R 483		
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's	R 705	[signature] 9/30/21	

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 ______	08/06/2021

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 705	Continued From page 10 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 interview and record review, 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 nine of 20 residents in the sample (Residents #2, 3, 8, 10, 11, 13, 17, 18, and 19). Findings included: On 07/30/2021 at 10:55 AM, a review of Resident #2 ' s medical certification form dated 07/13/2021, showed that the physician did not list the resident ' s medication on the form. On 07/30/2021 at 3:22 PM, a review of Resident #3's medical certification form dated 01/07/2021 showed the physician did not complete the section entitled, "Reason for Evaluation." The physician also did not document the resident's height nor did the physician indicate if the resident had or needed a mammogram, a protein specific antigen (PSA), a Papanicolaou smear (Pap), or a colonoscopy procedure. On 08/02/2021 at 11:00 AM, a review of Resident #8's medical certification form dated 07/22/2021, showed the physician did not document the resident's height and weight. The physician did indicate if the resident had or needed a mammogram, or a colonoscopy. In addition, the hysician did not indicate if the resident was exhibiting signs or symptoms suggestive of a communicable disease.	R 705	R705 The Director of Nursing was re-educated on the components of the standardized physicians statement approved by the Mayor on 9/16/21. The Director of Nursing will review, initial and date all new Mayors forms going forward to indicate they are completed per regulation. The Regional Director of Clinical Services will audit ten percent of new admission Mayor's forms monthly for three months to assist with compliance. Findings will be reported to the Quality Assurance Committee for follow up as needed. Audits will be added to QA meeting monthly. Completion date is ongoing. 9/30/21	

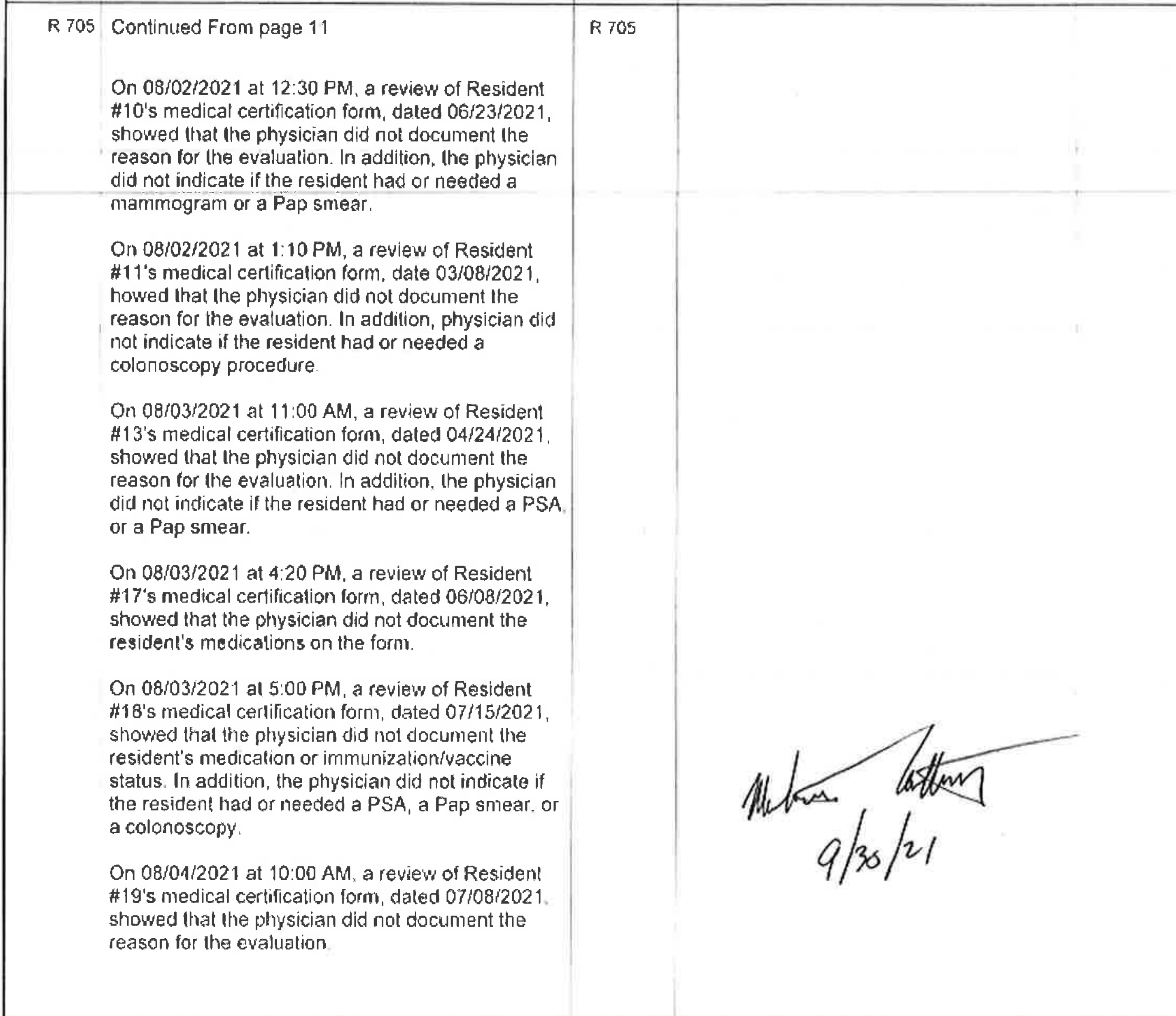
PRINTED: 09/13/2021
FORM APPROVED

Health Regulation & Licensing Administration

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 ______	08/06/2021

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 705 Continued From page 11

R 705

On 08/02/2021 at 12:30 PM, a review of Resident #10's medical certification form, dated 06/23/2021, showed that the physician did not document the reason for the evaluation. In addition, the physician did not indicate if the resident had or needed a mammogram or a Pap smear.

On 08/02/2021 at 1:10 PM, a review of Resident #11's medical certification form, date 03/08/2021, howed that the physician did not document the reason for the evaluation. In addition, physician did not indicate if the resident had or needed a colonoscopy procedure.

On 08/03/2021 at 11:00 AM, a review of Resident #13's medical certification form, dated 04/24/2021, showed that the physician did not document the reason for the evaluation. In addition, the physician did not indicate if the resident had or needed a PSA, or a Pap smear.

On 08/03/2021 at 4:20 PM, a review of Resident #17's medical certification form, dated 06/08/2021, showed that the physician did not document the resident's medications on the form.

On 08/03/2021 at 5:00 PM, a review of Resident #18's medical certification form, dated 07/15/2021, showed that the physician did not document the resident's medication or immunization/vaccine status. In addition, the physician did not indicate if the resident had or needed a PSA, a Pap smear, or a colonoscopy.

On 08/04/2021 at 10:00 AM, a review of Resident #19's medical certification form, dated 07/08/2021, showed that the physician did not document the reason for the evaluation.

9/30/21

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 ______	08/06/2021

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 705 Continued From page 12 R 705

On 08/04/2021 beginning at 4:00 PM, the findings of the records reviewed were and discussed with the Assisted Living Administrator (ALA) the Wellness Director and the Assistant Wellness Director. They acknowledged that the physician had no 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 Immediate Care Facilities Division Admission/Annual Medical Certification forms.

R 811 Sec. 904b Medication Storage R 811

(b) The storage area shall be kept locked when not in use.
Based on observation, interview and record review,the Assisted Living Residence (ALR) failed to ensure medications were locked when not in use.

Findings included:

The ALR failed to keep the medication storage area locked when not in use as evidenced below:

On 07/28/2021 at 12:50 PM, during the environmental inspection with the Assisted Living Administer (ALA) and the Facilities Director (both are unlicensed nursing personnel), the first-floor medication room was observed unlocked as well as the medication cabinet inside the medication room. At the time of the observation, residents were observed walking in the hallway going to and from their apartments. When the ALA was informed that the medication room was unlocked,

Provider's Plan of Correction:

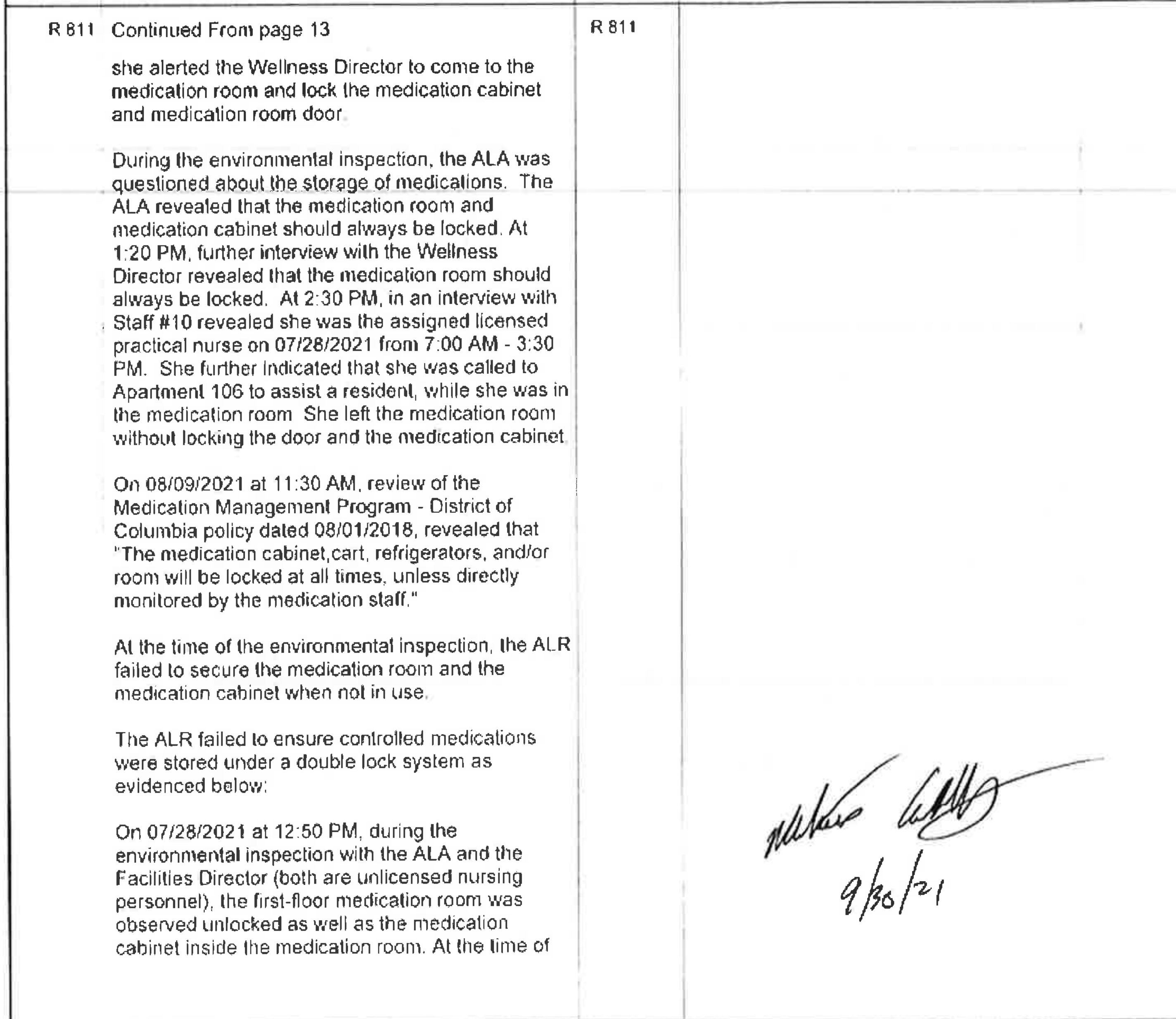
R811

The door to the medication room and med cart were locked at time of survey. The locks on all the medication room doors will be changed to self- lock upon closure by October 15, 2021. Nursing staff will be re-educated on locking of the doors and controlled substance policy by October 15, 2021. The maintenance director/designee will conduct a random audit of the doors weekly for four weeks and report findings to the Quality Assurance Committee for follow up as needed. The Director of Nursing/designee will conduct a random audit of controlled substance storage weekly for four weeks to assist with compliance and report findings to the Quality Assurance Committee for follow up as needed. Audits will be added to QA meeting monthly. Completion date is ongoing.

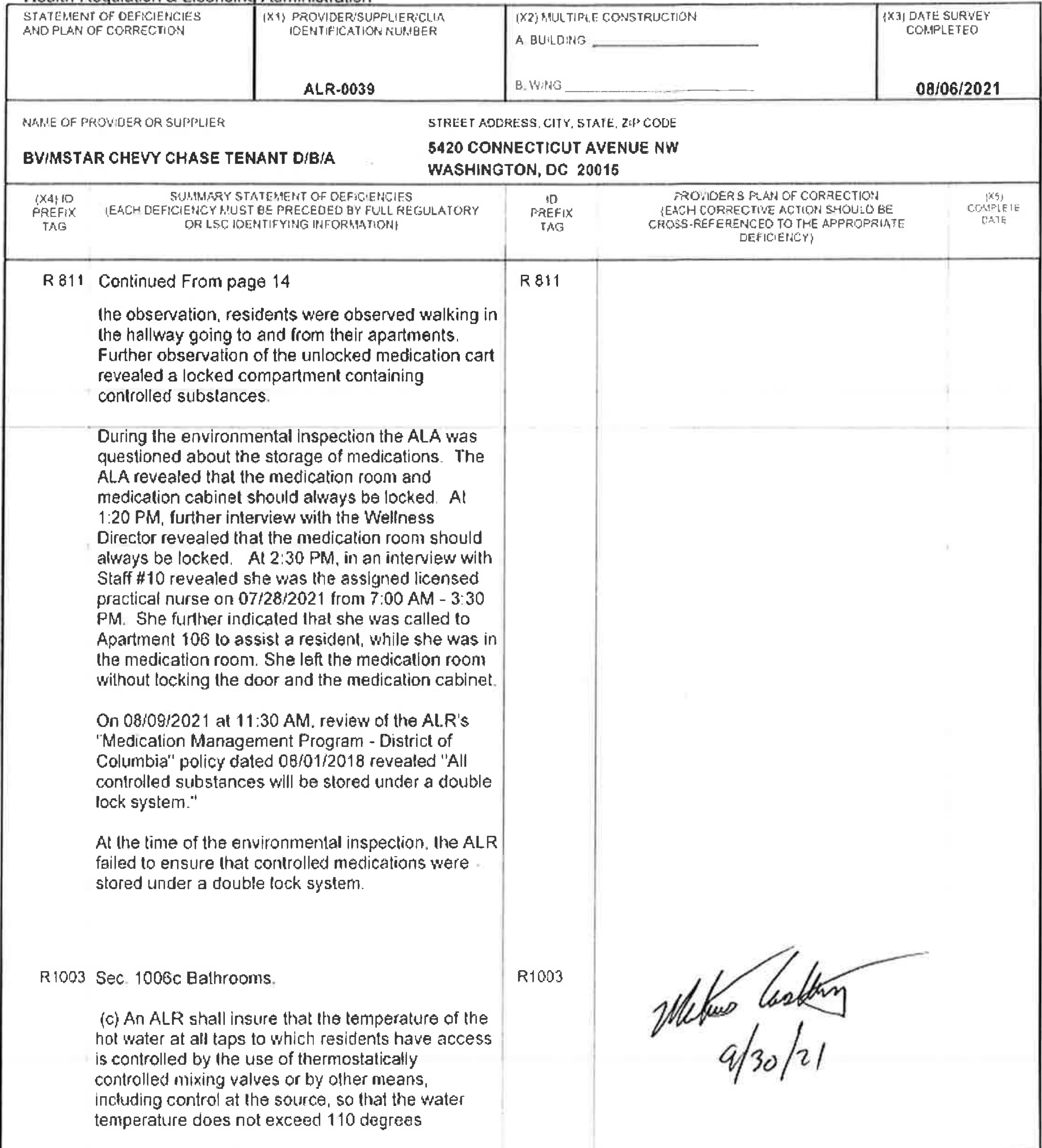
[signature]
9/30/21

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 ______	08/06/2021

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 811	Continued From page 13 she alerted the Wellness Director to come to the medication room and lock the medication cabinet and medication room door. During the environmental inspection, the ALA was questioned about the storage of medications. The ALA revealed that the medication room and medication cabinet should always be locked. At 1:20 PM, further interview with the Wellness Director revealed that the medication room should always be locked. At 2:30 PM, in an interview with Staff #10 revealed she was the assigned licensed practical nurse on 07/28/2021 from 7:00 AM - 3:30 PM. She further indicated that she was called to Apartment 106 to assist a resident, while she was in the medication room She left the medication room without locking the door and the medication cabinet. On 08/09/2021 at 11:30 AM, review of the Medication Management Program - District of Columbia policy dated 08/01/2018, revealed that "The medication cabinet,cart, refrigerators, and/or room will be locked at all times, unless directly monitored by the medication staff." At the time of the environmental inspection, the ALR failed to secure the medication room and the medication cabinet when not in use. The ALR failed to ensure controlled medications were stored under a double lock system as evidenced below: On 07/28/2021 at 12:50 PM, during the environmental inspection with the ALA and the Facilities Director (both are unlicensed nursing personnel), the first-floor medication room was observed unlocked as well as the medication cabinet inside the medication room. At the time of	R 811	9/30/21	



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 _____	08/06/2021

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 811	Continued From page 14 the observation, residents were observed walking in the hallway going to and from their apartments. Further observation of the unlocked medication cart revealed a locked compartment containing controlled substances. During the environmental inspection the ALA was questioned about the storage of medications. The ALA revealed that the medication room and medication cabinet should always be locked. At 1:20 PM, further interview with the Wellness Director revealed that the medication room should always be locked. At 2:30 PM, in an interview with Staff #10 revealed she was the assigned licensed practical nurse on 07/28/2021 from 7:00 AM - 3:30 PM. She further indicated that she was called to Apartment 106 to assist a resident, while she was in the medication room. She left the medication room without locking the door and the medication cabinet. On 08/09/2021 at 11:30 AM, review of the ALR's "Medication Management Program - District of Columbia" policy dated 08/01/2018 revealed "All controlled substances will be stored under a double lock system." At the time of the environmental inspection, the ALR failed to ensure that controlled medications were stored under a double lock system.	R 811		
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	R1003	[signature] 9/30/21	

Health Regulation & Licensing Administration

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 ______	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV/MSTAR CHEVY CHASE TENANT O/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
R1003	Continued From page 15	R1003		

Continued From page 15

Fahrenheit.
Based on observation, interview and record review, the assisted living residence (ALR) failed to ensure water temperatures did not exceed 110° (degrees) F(Fahrenheit), for three of ten apartments (Apartments #523, 421 and 316).

Findings included:

On 07/28/2021 beginning at 11:25 AM, a walk-thru of the facility with the Assisted Living Administer (ALA) and the Facilities Director showed the following:

-The kitchenette sink and bathroom sink located in Apartment #523 showed a water temperature that measured 114.1 °F and 110.8 °F, respectively.

-The kitchenette sink and bathroom sink located in Apartment #421 showed a water temperature that measured 110.7 °F and 111.2 °F, respectively.

- The kitchenette sink and bathroom sink located in Apartment #316 showed a water temperature that measured 114.6 °F and 115.9 °F, respectively.

When asked about the parameters for the hot water temperatures: the Facility Director stated that the hot water temperatures should not exceed 110 °F. Additionally, the Facility Director stated that water temperatures were randomly checked throughout the facility.

On 07/29/2021 at 2:30 PM, follow-up observations showed that the maintenance staff adjusted the hot water temperatures in the locations, and that the readjusted water

R1003

The mixing valves in the affected rooms has been adjusted to ensure the water temperatures do not exceed the required 110 degrees. The Director of Maintenance/designee will conduct a random audit of apartments weekly for four weeks to assist with compliance and document results in the TELS system. Findings will be reported to the Quality Assurance Committee for follow up as needed. Audits will be added to QA meeting monthly. Completion date is ongoing.

9/30/21

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 ________	08/06/2021

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
R1003	Continued From page 16	R1003		

temperatures measured the following:

-Apartment #523 water temperature readings was 103.5 °F.

-Apartment #421 water temperature readings was 108.7 °F and 103.3 °F.

-Apartment #316 water temperature readings was 113.5 °F and 113.9 °F.

On 08/02/2021 at 11:30 AM, review of the Water Temperature Testing Policy dated 01/01/2019, showed that the hot water at fixtures accessible to residents shall not exceed 110 °F at any time.

At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110 °F throughout the facility.

9/30/21