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-0030	A. BUILDING: _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING ON CONNECTICU	5111 CONNECTICUT AVE NW WASHINGTON, DC 20008

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R 000	Initial Comments An annual survey, in conjunction with an incident investigation, was conducted on 05/28/19 through 06/06/19 to determine 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 110 residents and employed 156 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, family and staff interviews. On 06/06/19 at 10:00 AM, a conference with the State Surveying Agency (DC Health) and the ALR Administrator and management team was held to discuss the systematic failures of the ALR's emergency preparedness plan that posed a risk to residents' health and safety. On 06/17/19, the ALR submitted an emergency preparedness plan to allege a credible allegation of compliance to remove the risk to residents' health and safety. On 6/18/19, surveyors conducted an unannounced revisit and verified the ALR's compliance. Listed below are abbreviations used throughout the body of this report: ALA - Assistant Living Administrator ALR- Assisted Living Residence EPP- Emergency Preparedness Program gm - gram HCA - Home Care Agency IV- intravenous ISP - Individualized Service Plan PICC - Peripherally Inserted Central Catheter OT- Occupational Therapist	R 000	The RCD reviewed Residents #3 and documented blood glucose readings on the ISP. The RCD trained Illness Nurses on documentation of updates regard ges in resident services on the ISP. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving blood glucose services to update ISPs with current services. The RCD/Designee is responsible for reviewing, tracking and trending the results of any audits. yhe results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. The RCD reviewed Residents #6 and documented PT & OT services on the ISP. The RCD trained all Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving PT & OT services to update ISPs with current services. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/19 & ongoing 7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/19 & ongoing

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R 000	Continued From page 1 PT- Physical Therapist RN -Registered Nurse % - percent	R 000		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; Based on record review and interview, the ALR nursing staff failed to follow physician orders timely for one of 11 residents in the sample (Resident #2). Findings included: On 05/29/19 at 11:01 AM, review of Resident #2's medical record showed a physician's order, dated 01/08/19, for the resident to have a psychiatric and neurological consultation. Further review of the record failed to provide documented evidence that the resident had a neurological consultation. At 2:45 PM, the Wellness Nurse also reviewed Resident #2's medical record and produced a psychiatric consultation note, dated 04/05/19, completed three months later. It should be noted that the consult was conducted after the resident eloped from an off-site facility activity. The consultation note was entitled, "Psych consult." The nurse said that the listed consulting physician was a neuro-psychiatrist. When asked why the resident was assessed several months after the order was written, the Wellness Nurse said, "I'm not sure." At the time of survey, the ALR failed to complete	R 292	The Resident Care Director (RCD) and the Executive Director (ALA) audited all resident medical records to ensure that orders for consults were completed. The RCD trained the Wellness Nurses on procedures for transcribing new orders for consultations and setting up appointments. The RCD will conduct a weekly audit for 90 days of resident orders to ensure the orders have been noted and carried out. The RCD or Designee/Wellness Nurse is responsible for reviewing, tracking and trending the results of weekly audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the results of the monitoring of the plan.	7/2/19 7/1/19 & Ongoing 7/2/19 & Ongoing 7/9/19 & Ongoing

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R 292	Continued From page 2 the physician order as prescribed.	R 292		
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on observation, interview and record review, the ALA failed to ensure ISPs included when, how often, and by whom services will be provided for six of 11 residents in the sample (Resident #1, 3, 6, 8, 9 and 11). Findings included: The ALA failed to ensure that all ISPs included services prescribed (PT, OT, skilled nursing), as evidenced below: 1. On 05/29/19 at 1:00 PM, review of Resident #1's clinical record revealed a physician's order dated 01/18/19, for the resident to have PT three times a week for the next four weeks after sustaining a fall without injury. The ISP dated 04/11/19 lacked documented evidence of when, how often and by whom PT services were to be provided to the resident. On 05/29/19 at 2:50 PM, review of Resident #1's "PT Initial Evaluation" dated 01/08/19, showed that PT services started on 01/07/19. During an interview on 05/29/19 at 3:00 PM, the ALA confirmed that the resident was receiving PT services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom PT services would be provided in all residents' ISPs.	R 481	The RCD reviewed Residents #1 and documented PT services on the ISP. The RCD trained the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving PT services to update ISPs with current services. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/19 & ongoing

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R 481	Continued From page 3 2. On 05/29/19 at 10:00 AM, review of Resident #3's clinical record revealed a physician's order, dated 09/03/18, to check the resident's blood glucose level twice a day, on Monday and Thursday. Review of the resident's medical record showed a log of blood glucose levels as ordered. However, the ISPs dated 09/25/18 and 03/12/19, lacked documented evidence of when, how often and by whom the resident's blood sugar would be taken. During an interview on 05/29/19 at 2:10 PM, the Wellness Nurse stated that the ALR's nurses perform the blood glucose tests for Resident #3. She also said that the blood sugar monitoring would be included in the resident's ISP. 3. On 05/29/19 at 10:20 AM, review of Resident #6's clinical record revealed a physician's order dated 02/15/19, for the resident to have PT three times a week for the next four weeks. The ISP dated 03/09/19 lacked documented evidence of when, how often and by whom PT services were to be provided to the resident. During an interview on 05/29/19 at 11:30 AM, the ALA confirmed that the resident was receiving PT services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom PT services would be provided in all residents' ISPs. On 05/29/19 at 12:25 PM, review of Resident #6's "PT Initial Evaluation," dated 02/05/19, showed that PT services started on 02/08/19. 4. On 05/29/19 at 12:05 PM, review of Resident #6's clinical record revealed a physician's order dated 03/08/19, for the resident to have OT three	R 481	The RCD reviewed Residents #3 and documented blood glucose readings on the ISP. The RCD trained the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving blood glucose services to update ISPs with current services. The RCD/Designee is responsible for reviewing, tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. The RCD reviewed Residents #6 and documented PT & OT services on the ISP. The RCD trained the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving PT & OT services to update ISPs with current services The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/19 & ongoing 7/2/2019 7/2/2019 7/9/19 & ongoing

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R 481	Continued From page 4	R 481		

times a week for the next four weeks. The ISP dated 03/09/19 lacked documented evidence of when, how often and by whom OT services were to be provided to the resident.

During an interview on 05/29/19 at 12:28 PM, the ALA confirmed that the resident was receiving OT services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom OT services would be provided in all residents' ISPs.

On 05/29/19 at 12:32 PM, review of Resident #6's "OT Initial Evaluation," dated 03/06/19, showed that OT services started on 03/04/19.

5. On 05/30/19 at 9:35 AM, review of Resident #8's clinical record revealed a physician's order, dated 12/11/18, to treat the resident's right foot ulcer with "Ceftriaxone one gm every 24 hours times six weeks via PICC line."

On 05/30/19 at 9:45 AM, review of an ISP dated 04/03/19, lacked documented evidence of when, how often and by whom IV antibiotic therapy services were to be provided to the resident.

During an interview on 05/30/19 at 9:57 AM, the Wellness Nurse confirmed that Resident #8 had received skilled nursing services from a HCA to administer Ceftriaxone one gm via a PICC line for six weeks. On the same day at 10:25 AM, the ALA stated during interview that she would re-train all the nursing staff on documenting when, how often, and by whom IV antibiotic therapy services would be provided in all residents' ISPs.

6. On 05/30/19 at 2:05 PM, review of Resident #9's clinical record revealed a physician's order

The RCD reviewed Residents #8 and documented services provided by outside wound care skilled nurse for wound care services on the ISP.	7/2/2019
The RCD trained the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP.	7/2/2019
The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving wound care services to update ISPs with current services.	7/2/2019 & ongoing
The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	7/9/19 & ongoing

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R 481	Continued From page 5 dated 10/05/18, for the resident to have PT three times a week for the next four weeks after sustaining repeated falls without injuries. The ISP dated 04/27/19 lacked documented evidence of when, how often and by whom PT services were to be provided to the resident. During an interview on 05/30/19 at 2:30 PM, the ALA confirmed that the resident was receiving PT services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom PT services would be provided in all residents' ISPs. On 05/30/19 at 2:40 PM, review of Resident #9's "PT Initial Evaluation," dated 10/04/18, showed that PT services started on 10/01/18. 7. On 05/30/19 at 3:35 PM, review of Resident #11's clinical record revealed a physician's order dated 02/01/19, for the resident to have PT three times a week for the next four weeks. The ISP dated 04/22/19 lacked documented evidence of when, how often and by whom PT services were to be provided to the resident. During an interview on 05/30/19 at 3:55 PM, the ALA confirmed that the resident was receiving PT services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom PT services would be provided in all residents' ISPs. On 05/30/19 at 4:40 PM, review of Resident #11's "PT Initial Evaluation," dated 01/25/19, showed that PT services started on 01/25/19. 8. On 05/30/19 at 1:45 PM, review of Resident #11's clinical record revealed a physician's order dated 03/22/19, for the resident to have OT three	R 481	The RCD reviewed Residents #9 and documented PT services on the ISP. The RCD trained the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving PT services to update ISPs with current services. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. The RCD reviewed Residents #11 and documented PT & OT services on the ISP. The RCD trained the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD will condut a weekly audit for the next 90 days of resident ISPs who are currently receiving PT & OT services to update ISPs with current services. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audit The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/19 & ongoing 7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/19 & ongoing

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R 481	Continued From page 6 times a week for the next four weeks. The ISP dated 04/22/19 lacked documented evidence of when, how often and by whom OT services were to be provided to the resident. During an interview on 05/30/19 at 2:35 PM, the ALA confirmed that the resident was receiving OT services as ordered. Further interview revealed that the ALA would re-train all the nursing staff on documenting when, how often, and by whom OT services would be provided in all residents' ISPs. On 05/30/19 at 2:55 PM, review of Resident #11's "OT Initial Evaluation," dated 03/15/19, showed that OT services started on 03/15/19. At the time of the survey, the ALA failed to provide documented evidence that all ISPs included when, how often, and by whom prescribed services would be provided.	R 481		
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 ALA failed to ensure a resident's ISP was updated with significant changes for three of 11 residents in the sample (Residents #1, 4 and 6).	R 483		

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R 483	Continued From page 7 Findings included: 1. On 05/29/19 at 12:20 PM, observations showed that the Wellness Nurse cleansed Resident #1's Stage II sacral wound with normal saline, patted the area dry, applied Hydrogel and covered the wound with a 4 x 4 gauze. At 12:22 PM, during an interview with the Wellness Nurse it was stated that Resident #1's alteration in skin integrity was first noted on 05/06/19. On 05/29/19 at 1:20 PM, review of Resident #1's current medical record showed the following physician's wound care order: - 05/06/19 - Cleanse Stage II sacral wound with normal saline, pat dry, apply Hydrogel, cover with 4 X 4 gauze, topically twice a day. On 05/29/19 at 1:05 PM, review of the medical record showed an ISP dated 04/11/19, which lacked documented evidence that staff had updated the ISP to include the residents' new wound care interventions. 2. On 05/29/19 at 1:55 PM, review of Resident #1's nursing progress note dated 05/02/19, showed that the resident sustained a head injury as the result of a fall on 04/30/19. At 2:10 PM, review of an ISP dated 04/11/19 lacked documented evidence of interventions for the above mentioned fall. During an interview on 05/29/19 at 2:30 PM, the ALA stated that the facility would re-train all of the nursing staff on documenting as required on the resident's ISP when there are any significant changes. 3. On 05/29/19 at 12:29 PM, review of Resident	R 483	The RCD conducted retraining of the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD conducted an audit of resident ISPs who are currently receiving wound care services to update ISPs with current wound services. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving wound care services to update ISPs with current wound services. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the Monthly Quality Assurance Performance Improvement Review meeting that the ALA manages. The POC is reviewed during this meeting and modified Based on the data of the audits and monitoring of the plan. The RCD documentedthe fall and interventionson Resident #1's ISP. The RCD conducted retraining of the Wellness Nurses on documentation of updates regarding falls in resident services on the ISP. The RCD conducted an audit of resident ISPs who have falls indcidents and will update ISPs to reflect falls. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who have falls and will update ISPs with falls. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the Monthly Quality Assurance Performance Improvement Review meeting that the ALA manages. The POC is reviewed during this meeting and modified Based on the data of the audits and monitoring of the plan.	7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/2019 & ongoing 7/2/2019 7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/2019 & ongoing

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R 483	Continued From page 8 #4's current medical record showed that the resident received wound care for a right ankle vascular wound, and a left great toe wound. The record also showed a physician assessment note, which documented that Resident #4 had a new wound on the right foot. Continued review of the record showed an ISP dated 01/28/19 which lacked documented evidence that staff had updated the ISP with the significant change of the resident's new wound and wound care services, which started 05/09/19. During an interview on 05/29/19 at 2:10 PM, the Wellness Nurse confirmed that the ISP was not updated with the new wound and wound care orders, but she would ensure residents' ISPs are updated with significant changes going forward. 4. On 05/29/19, at 10:10 AM, review of Resident #6's ISP dated 03/09/19, failed to document interventions for the resident's frequent falls dated 07/13/18 (head injury), 12/21/18, 12/23/18, 12/26/18, 03/23/19 and 04/08/19. During an interview on 05/29/19 at 2:48 PM, the ALA stated that the facility would re-train all of the nursing staff on documenting as required on the resident's ISP when there are any significant changes. At the time of the survey, the ALA failed to provide documented evidence that all ISPs were updated when there were significant changes in the residents' health care status.	R 483	The RCD conducted retraining of the Wellness Nurses on documentation of updates regarding changes in resident services on the ISP. The RCD conducted an audit of resident ISPs who are currently receiving wound care services to update ISPs with current wound services. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who are currently receiving wound care services to update ISPs with current wound services. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the Monthly Quality Assurance Performance Improvement Review meeting that the ALA manages. The POC is reviewed during this meeting and modified Based on the data of the audits and monitoring of the plan. The RCD reviewed Resident #6's falls incidents and investigation documentation, and documented the falls on the resident's ISP. The RCD conducted retraining of the Wellness Nurses on documentation of updates regarding falls in resident services on the ISP. The RCD conducted an audit of resident ISPs who have falls indcidents and will update ISPs to reflect falls. The RCD will conduct a weekly audit for the next 90 days of resident ISPs who have falls and will update ISPs with falls. The RCD/Designee is responsible for reviewing, Tracking and trending the results of any audits. The results and trends are reviewed during the Monthly Quality Assurance Performance Improvement Review meeting that the ALA manages. The POC is reviewed during this meeting and modified Based on the data of the audits and monitoring of the plan.	7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/2019 & ongoing 7/2/2019 7/2/2019 7/2/2019 7/2/2019 & ongoing 7/9/2019 & ongoing
R 589	Sec. 701d2 Staffing Standards. (2) Assure that sufficient staff who know how to	R 589		

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R 589	Continued From page 9 implement the ALR's evacuation plan and emergency management plan are on the premises at all times to implement emergency procedures; Based on interview and review of the ALR's emergency preparedness policies and training records, the ALA failed to ensure that sufficient staff who know how to implement the ALR's evacuation plan and emergency management plan are on premises at all time to implement emergency procedures. Findings included: a. On 05/28/19 during the entrance conference, the ALA was requested to provide documentation of the facility's emergency management plan. When asked to identify the ALR's emergency preparedness lead, the ALA identified the Maintenance Coordinator. On 05/30/19 at 12:20 PM, the surveyors asked the Maintenance Coordinator to review the ALR's emergency preparedness policies and procedures. The Maintenance Coordinator provided the surveyors with two binders. One binder contained maintenance guidelines and outdated (1998) emergency policies and procedures. For example, the 1998 policy addressing evacuation required residents to shelter in cars during a hurricane. Currently, residents do not maintain cars on the ALR's premises. The other binder included the facility's fire drills. At 12:40 PM, when asked if he had been trained on fire emergencies, the Maintenance Coordinator replied that all staff was trained for fires drills, however, he was unaware of a written policy for staff response during a fire emergency. Review of the ALR's "Emergency Guidelines," dated 1998, failed to show an emergency	R 589	The ALA completed an Emergency Preparedness Plan according to the standards set for long term care facilities by the Centers for Medicare and Medicaid Services. Team Members were trained on all areas of risk identified by the community ALA and Management Team. The ALA will train residents, and guests as applicable on all areas of risk identified by the community ALA and Management Team. The ALA will audit monthly trainings for team members and residents on all areas of risk identified The ALA is responsible for reviewing, tracking and trending the results of the audit. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting that The ALA manages. The POC is reviewed during this meeting and modified based on the results of the monitoring of the plan.	6/17/2019 6/30/2019 & ngoing 6/25/2019 & ongoing 7/1/2019 & ongoing 7/9/2019 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0030	A. BUILDING: _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING ON CONNECTICU	5111 CONNECTICUT AVE NW WASHINGTON, DC 20008

(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 589	Continued From page 10	R 589		

management plan that described the facility's comprehensive approach to meet the health, safety and security needs of their staff and resident population during an emergency or disaster situation, including evacuation and shelter in place responses.

b. On 05/30/19 at 4:00 PM, the ALA submitted the ALR's risk assessment to the surveyor. Review of the risk assessment showed that the facility was at greatest risk for the following emergency hazards:

Information systems failure (56%)
Water Failure (50%)
Missing Resident (44%)
Hurricanes (41%)
Thunderstorm (39%)

The ALA was asked if the staff had been trained on emergency preparedness. The ALA responded that the staff had recently been trained with how to respond during a hurricane, and in the case of an active shooter. At the time of the survey, however, the ALA failed to provide documented evidence that the staff had been trained on the aforementioned emergency situations or the highest probability hazards per the ALR's risk assessment. [cross refer 107.02(a)]

Revisit Conduct on 06/18/2019:
On 06/17/19, the ALR submitted new EPP policies and procedures. Review of the EPP showed that the facility had developed a training schedule for the emergency events that were identified as the highest on the facility ' s risk assessment. Additionally, on 06/18/19 at 4:45 PM an on-site visit was conducted to verify implementation of the training schedule. Review of training records and interviews with staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0030	A. BUILDING: _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 589	Continued From page 11 confirmed that the facility started to implement the training schedule as documented on the schedule. However, the facility had not yet started to provide training to the residents. At 5:10 PM, the ALA said that the residents will participate in trainings, including active shooter, fire and evacuation starting 06/25/19.	R 589		
R 651	Sec. 702a Staff Training. (a) All staff shall be properly trained and be able to demonstrate proficiency in the skills required to effectively meet the requirements of this act. Prior to the date of hire, an employee must meet or possess one of the following criteria: Based on interview and record review, the ALA failed to properly train all staff to effectively implement emergency procedures and disaster drills. Findings included: a. On 05/28/19 during the entrance conference, the ALA was requested to provide documentation of the facility's emergency management plan. When asked to identify the ALR's emergency preparedness lead, the ALA identified the Maintenance Coordinator. On 05/30/19 at 12:20 PM, the surveyors asked the Maintenance Coordinator to review the ALR's emergency preparedness policies and procedures. The Maintenance Coordinator provided the surveyors with two binders. One binder contained maintenance guidelines and outdated (1998) emergency policies and procedures. For example, the 1998 policy addressing evacuation required residents to shelter in cars during a hurricane. Currently, residents do not maintain cars on the ALR's premises. The other binder	R 651	Team Members were trained on all areas of risk identified by the community ALA and Management Team. The ALA will train residents, and guests as applicable on all areas of risk identified by the community ALA and Management Team. The ALA will audit monthly trainings for team members and residents on all areas of risk identified The ALA is responsible for reviewing, tracking and trending the results of the audit. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting that The ALA manages. The POC is reviewed during this meeting and modified based on the results of the monitoring of the plan.	6/30/2019 & ongoing 6/25/2019 & ongoing 7/1/2019 & ongoing 7/9/2019 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0030	A. BUILDING: _____ B. WING _____	06/06/2019

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R 651	Continued From page 12 included the facility's fire drills. At 12:40 PM, when asked if he had been trained on fire emergencies, the Maintenance Coordinator replied that all staff was trained for fires drills, however, he was unaware of a written policy for staff response during a fire. Review of the ALR's "Emergency Guidelines," dated 1998, failed to show a program that described the facility's comprehensive approach to meet the health, safety and security needs of their staff and resident population during an emergency or disaster situation, including evacuation and shelter in place responses. b. On 05/30/19 at 4:00 PM, the ALA submitted the ALR's risk assessment to the surveyor. Review of the risk assessment showed that the facility was at greatest risk for the following emergency hazards: Information systems failure (56%) Water Failure (50%) Missing Resident (44%) Hurricanes (41%) Thunderstorm (39%) The ALA was asked if the staff had been trained on emergency preparedness. The ALA responded that the staff had recently been trained with how to respond during a hurricane, and in the case of an active shooter. At the time of the survey, however, the ALA failed to provide documented evidence that the staff had been trained on the aforementioned emergency situations or the highest probability hazards per the ALR's risk assessment. [cross refer 107.01(d)(2)] Revisit Conduct on 06/18/2019: On 06/17/19, the ALR submitted new EPP	R 651		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 651	Continued From page 13 policies and procedures. Review of the EPP showed that the facility had developed a training schedule for the emergency events that were identified as the highest on the facility ' s risk assessment. Additionally, on 06/18/19 at 4:45 PM an on-site visit was conducted to verify implementation of the training schedule. Review of training records and interviews with staff confirmed that the facility started to implement the training schedule as documented on the schedule. However, the facility had not yet started to provide training to the residents. At 5:10 PM, the ALA said that the residents will participate in trainings, including active shooter, fire and evacuation starting 06/25/19.	R 651		

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:
HCRI Connecticut Avenue Subtenant, LLC d/b/a Sunrise on Connecticut Avenue ALR -0030	5111 Connecticut Ave, NW Washington, DC 20008	05/28/19 -06/06/19 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	An annual survey, in conjunction with an incident investigation, was conducted on 05/28/19 through 06/06/19 to determine 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 110 residents and employed 156 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, family and staff interviews. On 06/06/19 at 10:00 AM, a conference with the State Surveying Agency (DC Health) and the ALR Administrator and management team was held to discuss the systematic failures of the ALR's emergency preparedness plan that posed a risk to residents' health and safety. On 06/17/19, the ALR submitted an emergency preparedness plan to allege a credible allegation of compliance to remove the risk to residents' health and safety. On 6/18/19, surveyors conducted an unannounced revisit and verified the ALR's compliance.			

C. McPee for Caryn Stringfield — Name of Inspector
06/19/19 — Date Issued

Facility Director/Designee
7/10/19 — Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	Listed below are abbreviations used throughout the body of this report: ALA – Assisted Living Administrator ALR - Assisted Living Residence EPP – Emergency Preparedness Program HCA –Home Care Agency NSA – Nurse Staffing Agency PDA – Private Duty Aide RSA – Residential Services		
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 observation, record review and interview, the ALR failed to develop emergency preparedness policies and procedures to protect resident safety. Findings included: 1. The ALR failed to establish a working plan to address emergency preparedness, as evidenced by: On 05/28/19 during the entrance conference, the ALA was	TypeThe ALA completed an Emergency Preparedness Plan according to the standards set for long term care facilities by the Centers for Medicare and Medicaid Services. All Team Members were trained on all areas of risk identified by the community ALA and Management Team. The ALA will train all residents, and guests as applicable on all areas of risk identified by the community ALA and Management Team. The ALA will audit monthly trainings for team members and residents on all areas of risk identified The ALA is responsible for reviewing, tracking and trending the results of the audit. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting that The ALA manages. The POC is reviewed during this meeting and modified based on the results of the monitoring of the plan. text here	6/17/2019 6/30/2019 & ongoing 6/25/2019 & ongoing 7/1/2019 & ongoing 7/9/2019 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

requested to provide documentation of the facility's EPP. When asked to identify the ALR's EPP lead, the ALA identified the Maintenance Coordinator.

a. On 05/30/19 at 12:20 PM, the Maintenance Coordinator provided the surveyors with two binders and indicated that the binders contained emergency preparedness procedures.

b. Review of the first binder showed maintenance guidelines and outdated (1998) emergency policies and procedures. For example, the 1998 policy addressing evacuation required residents to shelter in cars during a hurricane. Further review of the first binder disclosed the ALR's "Emergency Guidelines," dated 1998, which failed to show a program that described the facility's comprehensive approach to meet the health, safety and security needs of their staff and resident population during an emergency or disaster situation.

c. At 12:40 PM, after a review of the documents contained in the binder, the surveyors interviewed the Maintenance Coordinator to obtain additional information and to verify if there were any additional policies. The surveyors asked the Maintenance Coordinator how the facility handled issues with sewage disposal during an emergency. The Maintenance Coordinator stated that the facility would use "a big plunger" to get rid of the waste in

the commodes. When the surveyors attempted to clarify the question by asking how he would dispose of sewage if there was interruption to the water supply, the Maintenance Coordinator stated, "we will use a very big plunger." The Maintenance Coordinator was asked to describe the ALR policy and procedures on waste and trash disposal during an emergency. The Maintenance Coordinator informed the surveyors that the ALR had a contract with a waste management company. The company comes daily to remove the ALR's trash. The surveyor clarified the question by asking how the ALR would manage the collection of trash if the waste management company could not come to the facility during a weather emergency. The Director of Maintenance stated that the company would be scheduled to come every other day and that the ALR had a big fan to keep down odors. The Maintenance Coordinator indicated that the ALR had a contract with the waste removal company, but did not provide a copy of the contract prior to the survey exit.

d. Review of the second binder showed that it contained logs of fire drills that had been conducted by the ALR. The logs showed the names of ALR staff who participated in the drill. Although there were dates of the drills, the majority of the documents failed to include times (or shifts) of when the drills were conducted, and did not show evidence of resident involvement in the drills. The Maintenance Coordinator was interviewed to

ascertain the reasons for not including the residents in the fire drills. The Maintenance Coordinator stated that when residents were engaged in group activities during the time of a fire drill, the ALR staff would not disturb the residents.

On 05/30/19 at 1:30 PM, the ALA informed the surveyors that she was unaware that the ALR regulations (emergency and proposed rulemaking), which included the Emergency Preparedness Program, were being enforced. She said that the ALR had some current emergency policies in place, and had begun training on emergency preparedness. At the time of the onsite exit, the current emergency preparedness policies and procedures were not provided to the surveyors.

There was no evidence presented during the survey to support that an EPP plan had been developed by the ALR, or that the facility's staff had been trained in accordance with 42 CFR & 483.73.

On 06/17/19, the ALR submitted new EPP policies and procedures. Review of the EPP showed that the facility had developed policies and procedures based on the risk assessment identified for the facility. The policies and procedures were in substantial compliance.

2. The ALR failed to develop a plan that addressed the resident population, including persons at risk, the types of services the ALR had to provide in an emergency, and continuity of operations, as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

On 05/28/19 through 05/30/19, observations conducted throughout the facility showed there were oxygen tanks, wheelchairs, four-wheeled walkers, two-wheeled walkers, and canes in some of the residents' apartments. Further observations showed care managers and PDAs assisting residents during lunch time and group activities.

On 05/30/19 at 12:20 PM, review of the ALR's maintenance binders failed to address strategies and supports that would be used to assist vulnerable residents in an emergency.

On 05/30/19 at 1:30 PM, the ALA informed the surveyors that the ALR had plans in place that addressed the resident population. Review of the submitted maintenance binders, however, failed to document such plans.

On 06/17/19, the ALR submitted new EPP policies and procedures. Review of the EPP showed that the facility had developed policies and procedures that addressed the vulnerable residents, including a list of each resident with the specialized services and adaptive equipment they utilize. The policies and procedures for this requirement were in substantial compliance.

3. The facility failed to develop a policy that included a process for cooperation and collaboration with local, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency, as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

On 05/30/19 at 12:20 PM, review of the ALR's maintenance binders failed to address how the facility would collaborate and communicate with officials in an emergency situation.

On 05/30/19 at 1:30 PM, the ALA said that she would review all of the ALR's policies for how the facility would comply with the requirement.

Post on-site survey on 05/31/19 at 10:48 AM, the ALA submitted emergency preparedness policies via email. The submission failed to include policies and procedures for collaboration and communication with emergency preparedness officials.

4. The facility failed to develop a policy that addressed the provisions of subsistence needs for staff and residents, as evidenced by:

During an interview with the Maintenance Coordinator on 05/30/19 at 2:45 PM, he said that the ALR was equipped with a generator for supplemental energy in case of a power outage. The Maintenance Coordinator however was not aware if the ALR had a policy which addressed the generator, food, medical and pharmaceutical supplies, or sewage and waste disposal.

Post on-site survey on 05/31/19 at 10:48 AM, the ALA submitted emergency preparedness policies via email. The submission failed to include policies and procedures for subsistence needs during an emergency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

On 06/17/19, the ALR submitted new EPP policies and procedures. Review of the EPP showed that the facility had developed policies and procedures to address subsistence in the event of an emergency. Additionally, on 06/18/19 at 6:00 PM, during an on-site visit, paper goods, potable and non-potable water, labelled "for emergencies only", was observed in a storage area in the facility's garage. Also, a three day supply of non-perishable foods, labelled "for emergencies only" was observed in the facility's pantry. The policies and procedures were in substantial compliance.

5. The facility failed to develop a system to track the location of on-duty staff and sheltered residents in the ALR's care during an emergency, as evidenced by:

On 05/30/19 at 12:20 PM, review of the ALR's maintenance binders failed to address how the facility would track staff and residents.

On 05/30/19 at 1:30 PM, the ALA said that she would review all of the ALR's policies to ensure that the facility complied with the tracking requirement.

Post on-site survey on 05/31/19 at 10:48 AM, the ALA submitted emergency preparedness policies via email. The submission failed to include policies and procedures to track staff and residents during an emergency.

On 06/17/19, the ALR submitted new EPP policies and procedures. Review of the EPP showed that the facility had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

developed policies and procedures to address how staff and residents would be located during an emergency with the use of employee "scout phones", the facility's public announcement system, and lists that identify each resident. The policies and procedures were in substantial compliance.

6. The facility failed to devclop arrangements with other facilities or providers to receive patients in an emergency cessation of operations, as evidenced by:

On 05/30/19 at 12:20 PM, review of the ALR's maintenance binders showed a document titled, "Resident Evacuations," dated 11/02/98, revised 08/01/18. The document said that residents could be transported to the ALR's other communities, local shelters, or a local hotel. However, there was no documented agreement between the ALR and the other facilities.

During a post-survey meeting on 06/06/19 at 10:00 AM, the ALA stated that, in case of an evacuation, the ALR's residents could be transported to another community or hotel. She also said that the written agreements would be added to the ALR's emergency preparedness plan.

7. The facility failed to develop policies and procedures that described its role in providing care during an emergency waiver declaration by the Secretary, in accordance with section 1135 of the Act, as evidenced by:

On 05/30/19 at 12:20 PM, review of the ALR's maintenance binders showed no evidence that the ALR developed policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

and procedures to address the role of the ALR under a waiver declaration, or the provision of care and treatment at an alternate care site in the event of an emergency.

On 05/30/19 at 1:30 PM, the ALA said that she would review all of the ALR's policies for how the facility would comply with the requirement.

Post on-site survey on 05/31/19 at 10:48 AM, the ALA submitted emergency preparedness policies via email. The submission failed to include policies and procedures on the 1135 waiver.

8. The facility failed to develop an emergency preparedness communication plan, as evidenced by:

On 05/30/19 at 12:20 PM, review of the ALR's maintenance binders showed an undated document titled, "Emergency Contact Telephones for Our Communication System". The document listed phone numbers for four utility companies. However, the document did not address how the facility coordinated patient care within the facility, across healthcare providers, and with the state and local public health departments.

On 05/30/19 at 1:30 PM, the ALA said that the facility had a communication plan. She also said the communication plans would be added to the ALR's emergency preparedness plan.

On 06/17/19, the ALR submitted new EPP policies and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

procedures. Review of the EPP showed that the facility had developed a communication plan, policies and procedure during an emergency with the use of employee "scout phones" and the facility's public announcement system.

9. The ALR failed to develop an emergency preparedness training and testing program that is based on the facility's risk assessment, as evidenced by:

On 05/30/19 at 4:00 PM, the ALA submitted the ALR's risk assessment to the surveyor. Review of the risk assessment showed that the facility was at greatest risk for the following:

Information systems failure (56%)
Water Failure (50%)
Missing Resident (44%)
Hurricanes (41%)
Thunderstorm (39%)

The ALA was asked if the staff had been trained on the emergency preparedness. The ALA responded that the staff had recently been trained with how to respond during a hurricane, and in the case of an active shooter. At the time of this survey, the emergency policies and procedures, however, failed to provide documented evidence that the staff had been trained on the aforementioned emergency situations.

On 06/17/19, the ALR submitted new EPP policies and procedures. Review of the EPP showed that the facility had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	developed a training schedule for the emergency events that were identified as the highest on the facility's risk assessment. Additionally, on 06/18/19 at 4:45 PM an on-site visit was conducted to verify implementation of the training schedule. Review of training records and interviews with staff confirmed that the facility started to implement the training schedule as documented on the schedule. However, the facility had not yet started to provide training to the residents. At 5:10 PM, the ALA said that the residents will participate in trainings, including active shooter, fire and evacuation starting 06/25/19.			
10119 Companions	**10119.04 A companion shall be subject to immediate removal from the ALR premises upon determination by the ALA or designee that he or she has, or is suspected to have, a communicable disease, is mentally or physically incapable of performing his or her duties, or otherwise presents a risk to the health and safety of the residents.** Based on interview and record review, the ALA failed to ensure evidence to show if companions were free from any communicable diseases for one of six Companion files (Companion #5). Findings included: Review of the personnel records on 05/30/19 at 11:34 AM showed that Companion #5 had a health examination dated	The Human Resources Manager (HRM) updated Companion #5's record to include health examination and date & results of PPD. The ALA retrained the HRM, the Assited Living Coordinator (ALC) and Reminiscence Coordinator (RC) on documentation required for Companions. The ALA will conduct a monthly audit on all Companion records to ensure health examination and PPD results are current. The HRM and ALA are responsible for tracking and	7/2/2019 7/2/2019 7/2/2019 & ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	06/21/18 that included a PPD dated 09/28/17 with no results. During an interview on 05/30/19 at 4:01 PM, the Human Resources Director verified that the result of the PPD was not disclosed to the ALR. Further review of Companion #5 personnel record showed no evidence of a Tuberculosis Symptom Screening. At the time of the survey, there was no documented evidence that Companion #5 was free from a communicable disease including communicable tuberculosis. **10119.05 Pursuant to Section 701(a) of the Act (D.C. Official Code § 44-107.01(a)), the ALA shall be responsible for all personnel within the ALR, including companions providing companion services on the ALR's premises.** Based on interview and record review, the ALA failed to assume responsibility for all personnel within the ALR, including companions providing services to the facility's residents, for six of six companions (Companion #1, #2, #3, #4, #5, and #6). Findings included:	trending the results of any audits related to team member and companion files. The results and trends are reviewed during the monthly Quality Assurance Performance Review meeting that the ALA manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan. The facility allows for Companion services for residents for socialization, companionship, and life enrichment activities. All Companions complete a criminal background and a health pracitioner's statement. A copy is kept in a record at the facility Effective immediately Sunrise no longer uses a "Private Duty Aide Acknowledgement & Indemnification" form. This form has been retired and does not apply to "Companion" assistance. The HRM and ALA reviewed the Companion policy with all current companions and updated the Companion record to reflect. The ALA will conduct an audit monthly to ensure all Companion records include acknowledment of Companion policy. The ALA and HRM are responsible for reviewing tracking and trending the results of Companion audits. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement Review meeting that the ALA manages. The POC is reviewed during this meetings and modified based on the data of the audits and monitoring of the plan.	7/9/2019 & ongoing 7/1/2019 7/1/2019 6/6/2019 7/1/2019 7/9/2019 7/9/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

During an interview on 05/30/19 at 1:00 PM, the Human Resources Director stated that the Private Duty Aides and Companions were each required to sign a form titled, "Private Duty Aide Acknowledgement & Indemnification."

At 1:09 PM, record review of the form showed ten terms of agreement between the ALR and each PDA or companion. Two of the ten terms contradicted the requirements of 10119.05 by stating the following:

- "I understand and agree that (the ALR) has no control over the care that I provide to residents or the way that I provide care."
- "I understand that I am responsible for my actions and that the Community is not responsible, and will not pay for any injuries or damages that I cause."

At the time of the survey, the ALA failed to assume responsibility for all personnel within the ALR, including companions, as evidenced by the terms of the "Private Duty Aide Acknowledgement & Indemnification" form that Companions #1, #2, #3, #4, #5, and #6 were required by the ALA to sign. **[See also 10119.06]**

10119.06 Pursuant to Section 607(a)(1) of the Act (D.C. Official Code § 44-106.07(a)(1)), the ALR shall be responsible for the safety and well-being of its residents, including residents receiving companion services from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

companions on the ALR's premises.

Based on interview and record review, the ALR failed to assume responsibility for the safety and well-being of its residents for three of three residents receiving companion services (Resident #2, #4, and #6).

Findings included:

During an interview on 05/30/19 at 1:00 PM, the Human Resources Director stated that the Private Duty Aides and Companions were each required to sign a form titled, "Private Duty Aide Acknowledgement & Indemnification."

Record review of the form showed ten terms of agreement between the ALR and each PDA or Companion. Two of the ten terms contradicted the requirements of 10119.06 by stating the following:

- "I understand and agree that (the ALR) has no control over the care that I provide to residents or the way that I provide care."
- "I understand that I am responsible for my actions and that the Community is not responsible, and will not pay for any injuries or damages that I cause."

At the time of the survey, the ALR failed to assume

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

10125 Reporting Abuse, Neglect, Exploitation, and Unusual Incidents	responsibility for the safety and well-being of its residents receiving companion services, as evidenced by the terms of the "Private Duty Aide Acknowledgement & Indemnification" form that Companions #1, #2, #3, #4, #5, and #6 were required by the ALA to sign. **[See also 10119.05]** **10125.02 In addition to the requirements 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 incident 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) or the next business day.** Based on interview and the review of incident reports, the ALR failed to ensure that all incidents that presented a risk to residents' health and safety were reported to the Department of Health for Residents #1, #2, and #3. Findings included:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

During the entrance conference interview on 05/28/19 at 10:15 AM, the Administrator stated that the ALR maintained an unusual incident report log.

A review of unusual incident reports on 05/28/19 through 5/30/19 showed the following incident reports that were not reported to the Department of Health.

1. On 01/28/19 at 11:15 AM, Resident #1 was sitting in her wheelchair. It was reported that she slid from her wheelchair and was observed on the floor. The resident sustained an abrasion on the right side of her forehead and was transported to the ER for further evaluation.

2. On 04/30/19 at 2:45 PM, Resident #1 was found on the floor faced down with her wheelchair flipped over. The wheelchair was moved and the resident was rolled over to a supine position. The resident sustained an abrasion on the right side of her forehead and was transported to the ER for further evaluation.

3. On 07/13/18 at 5:40 PM, Resident #6 was found on the floor. The resident stated that she hit her head and complained of neck pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Review of the ALR's "Internal Incident Reporting Policy" revised 09/16/13, showed that the Executive Director was responsible for notifying the resident's health care practitioner and the resident's representative as soon as possible following each resident-specific incident during daytime hours. There was no documented evidence included in the internal incident policy to notify the Department of Health.

4. On 05/28/19 at 11:30 AM, the ALA provided the surveyors with a list of discharges since the last survey date (06/20/18). The list contained a total of 50 discharges, including 18 deaths since the implementation of the proposed and emergency rulemaking (08/16/18).

During an interview with the ALA on 05/30/18 at 1:30 PM, she was asked if the resident deaths were reported to the Department of Health. The ALA responded that the deaths were not reported.

The ALA will begin immediately to report all unusual incidents including deaths to DC Health.	6/1/2019 & ongoing
The ALA conducted training to the RCD, Wellness Nurse and Associate Executive Director on required reporting of all unusual incidents to DC Health.	6/1/2019
The ALA will conduct a monthly audit of the Incident Reporting and Investigation sheets to ensure all unusual incidents are reported to DC Health.	7/1/2019 & ongoing
The ALA is responsible for reviewing, tracking and trending the results of any audits. The results and trends are revewed during the monthly Quality Assurance Performance Review meeting that the ALA manages. The POC is reveiwed during this meeting and modified based on the data of the audits and monitoring of the plan.	7/9/2019 &

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION