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 _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING ON CONNECTICUT	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 000	Initial Comments An annual licensure survey was conducted on 08/31/2022, 09/01/2022, and 09/02/2022 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 80 residents and employed 129 personnel, to include professional and administrative staff. A random sample of 21 resident records, 13 employee records, one companion record and six Private Duty Aides (PDAs) records were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, and resident, family, and staff interviews to include review of incidents.	R 000		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure an that Individualized Service Plan (ISP) was developed prior to admission, for six of 21 residents in the sample (Residents #2, 6, 8, 11, 19, and 20). Findings included: 1. On 09/02/2022 beginning at 2:20 PM, a review of Resident #2's records showed that the resident was admitted to the ALR on 05/02/2022. Continued review of the records failed to show evidence that an ISP had been developed prior to the resident's admission. 2. At 2:24 PM, a review of Resident #6's records	R 471	A pre-move-in ISP will be developed in the community's electronic medical records and will be conducted on all new admissions not more than 30 days prior to admission. The Resident Care Director (RCD) will train the Wellness Nurses, Assisted Living Coordinator(ALC) and Reminiscence Coordinator (RC) on developing a Pre-Admission ISP for all new residents. The RCD, Executive Director (ALA), ALC, and RC will meet weekly to ensure all new move-ins have a Pre-admission ISP completed not more than 30 days prior to admission. The ALA 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 (QAPI) that the ALA and QAPI Committee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	9/22/22 9/22/22 9/22/22 10/5/22 &ongoing

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R 471	Continued From page 1 showed that the resident was admitted to the ALR on 10/11/2021. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 3. At 2:33 PM, review of Resident #8's records showed that the resident was admitted to the ALR on 01/15/2021. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 4. At 2:38 PM, review of Resident #11's records showed that the resident was admitted to the ALR on 02/05/2022. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 5. At 2:45 PM, review of Resident #19's records showed that the resident was admitted to the ALR on 05/26/2022. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 6. At 4:50 PM, review of Resident #20's records showed that the resident was admitted to the ALR on 06/10/2021. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. At 4:51 PM, the Resident Care Director, who was present during the record reviews confirmed the deficient practice and said going forward, the nurses would be trained and the pre-admission ISP's will be completed. At the time of the survey, the facility failed to provide documented evidence that all ISP's were reviewed prior to admission, as required.	R 471		

Elizabeth Jones Director 9/19/22

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R 483	Continued From page 2	R 483		
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 residents Individualized Service Plans (ISP's) were reviewed every six months or updated with significant changes, for three of the 21 residents in the sample (Residents #6, 8, and 14). Findings included: 1. On 09/02/2022 at 2:20 PM, a review of Resident #6's record showed that the resident was admitted to the ALR on 10/11/2021. Further review of the records showed that an ISP was reviewed on 11/04/21; however, there was no evidence of another ISP review in the record since then. 2. At 2:23 PM, review of Resident #8's record showed that the resident was admitted to the ALR on 01/15/2021. Further review of the records showed that an ISP was reviewed on 07/14/22; however, there was no evidence of any other ISP reviews prior to this date. 3. At 2:33 PM, review of Resident #14's record showed that the resident was admitted to the ALR on 11/28/2016. Further review of the records	R 483	Residents #6, #8, and #14 ISPs were updated to include every 6 month or change of condition. The RCD will conduct retraining of the Wellness Nurses on reviewing ISPs 30 days after admission, at least every 6 months and with significant changes in resident conditions. The RCD and the ALA will meet weekly to ensure resident ISPs are completed 30 days after admission, every 6 months and with any residents with significant changes in condition. The ALA is responsible for reviewing, tracking and trending the results of any audits. The results and trends are reviewed during the monthly Quality Assurance Performance QAPI Committee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	9/16/22 9/22/22 9/22/22 10/5/22 & ongoing

Elizabeth Jones Executive Director 9/19/22

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R 483	Continued From page 3 showed that an ISP was reviewed on 07/29/22; however, there was no evidence of any other ISP reviews every six months since admission. During interview on 09/02/2022 at 4:51 PM, the Resident Care Director, who was present during the record review confirmed the deficient practice and said going forward, the nurses would be trained, and the ISP's will be completed every six months, as required. At the time of the survey, the facility failed to provide documented evidence that all ISP's were reviewed every six months thereafter as required.	R 483		
R 705	Sec. 802b Medical, Rehabilitation, Psychosocial Assess. (b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor. The information shall include a description of the applicant's current physical condition and medical status relevant to defining care needs, and the applicant's psychological and cognitive status, if so indicated during the medical assessment. Based on interviews and record reviews the assisted Living Residence (ALR) failed to ensure each resident's Intermediate Care Facilities Admission/Annual Medical Certification form was completed with all areas addressed for 15 of the 21 residents in the sample (residents #1, 2, 4, 5, 7, 8, 9, 13, 15, 16, 17, 18, 19, 20, and 21). Findings included: 1. On 09/01/2022 at 4:00 PM, a review of Resident #1's undated pre-admission Intermediate Care Facilities Admission/Annual	R 705	The Intermediate Care Facilities Admission/Annual Medical Certification forms for residents #1, 2, 4, 5, 7, 8, 9, 13, 15, 16, 17, 18, 19, 20 and 21 will be updated to include all areas. The RCD will conduct retraining of the Wellness Nurses and the Director of Sales/Admissions on ensuring the MD completes all areas of the DC Mayor's Form/Intermediate Care Facilities Admission/Annual Medical Certification Form for pre-admission and annually. The RCD and the ALA will meet weekly to ensure resident's Intermediate Care Facilities Admission/Annual Medical Certification form is completed with all areas addressed Data of the audits and monitoring of the plan.	9/23/22 9/22/22 9/22/22

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R 705	Continued From page 4 Medical Certification form showed the physician did not document the resident's primary or secondary diagnosis, vital signs; failed to indicate if the resident had or needed a prostate specific antigen (PSA), or Colonoscopy, if the resident used tobacco, if the resident used non-prescription drugs, and the resident's immunization status. 2. At 4:30 PM, a review of Resident #2's Intermediate Care Facilities Admission/Annual Medical Certification form showed the physician failed to indicate if the resident had or needed a PSA, or Colonoscopy, screen, or test for dementia. 3. At 4:25 PM, a review of Resident #4's Intermediate Care Facilities Admission/Annual Medical Certification form showed the physician failed to indicate if the resident had or needed a PSA, or mammogram and the resident's ability to participate in Activities of Daily Living. 4. At 4:25 PM, review of Resident #5's Intermediate Care Facilities Admission/Annual Medical Certification form showed the physician failed to indicate if the resident had or needed a PSA, Pap test, colonoscopy, or mammogram. In addition, the physician did not indicate that the resident was not in need of acute or long term medical or nursing care, or supervision which would require placement in a hospital or nursing home. 5. At 4:36 PM, a review of Resident #7's pre-admission Intermediate Care Facilities Admission/Annual Medical Certification form showed the physician failed to indicate if the resident had any podiatry issues. The resident's tuberculosis status was not documented. The	R 705	The ALA 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 (QAPI) meeting that the ALA and QAPI Commiltee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	10/5/22 & ongoing

Executive Director 9/19/22

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R 705	Continued From page 5 physician did not list the resident's medication on the form and failed to indicate if the resident needed a to be screened or tested for dementia or cognitive impairment. 6. At 4:40 PM, a review of Resident #8's pre-admission Intermediate Care Facilities Admission/Annual Medical Certification form showed the physician failed to indicate if the resident had or needed a Pap test, or mammogram. The physician did not indicate if the resident was able to participate in Activities of Daily Living. 7. At 4:53 PM, a review of Resident #9's pre-Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 04/06/2022, showed the physician failed to indicate if the resident had or needed a Pap test, or mammogram. The physician did not indicate if the resident needed a to be screened or tested for dementia or cognitive impairment. 8. At 4:59 PM a review of Resident #13's annual Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 07/21/2021, showed the physician failed to indicate if the resident had or needed a Pap test, PSA, colonoscopy, or mammogram. The resident's medications were not listed on the form nor did the physician indicate if the resident was taking any non-prescription medications. Also, the physician did not indicate if the resident had vision or podiatric issues. 9. At 5:04 PM, a review of Resident #15's undated Intermediate Care Facilities Admission/Annual Medical Certification form showed the physician failed to indicate if the resident had or needed a colonoscopy, PSA, Pap	R 705		

Elizabeth Jones Executive Director 9/19/22

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R 705	Continued From page 6 test, or mammogram. Also, the physician did not indicate if the resident needed a to be screened or tested for dementia or cognitive impairment. In addition, the physician did not indicate if the resident had any dental, vision, or podiatric issues. 10. At 5:08 PM, a review of Resident #16's pre-Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 05/02/2022, showed the physician failed to indicate if the resident had or needed a Pap test, or mammogram. The physician did not indicate if the resident was able to participate in Activities of Daily Living. Also, the physician did not list the resident's current medication on the form. 11. At 2:48 PM, a review of Resident #17's annual Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 07/29/2022, showed the physician failed to indicate the resident's immunization and tuberculosis status. 12. At 5:08 PM, a review of Resident #18's annual Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 08/05/2022, showed the physician failed to indicate if the resident had or needed a colonoscopy, PSA, Pap test, or mammogram. The physician did not indicate if the resident had any skin or podiatric issues. Also, the physician did not indicate if the resident required addition medical or laboratory services. 13. At 5:17 PM, a review of Resident #19's pre-Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 05/18/2022, showed the physician failed to indicate if the resident had or needed a	R 705		

Executive Director 9/19/22

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R 705	Continued From page 7 colonoscopy, or PSA. The physician did not document the resident's height. In addition, the physician did not indicate if the resident had any dental issues and if the resident was able to participate in Activities of Daily Living. Also, the resident's Tuberculosis status was not noted on the form. 14. At 5:21 PM, a review of Resident #20's annual Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 06/28/2022, showed the physician failed to indicate if the resident had or needed a colonoscopy, PSA, Pap test, or mammogram. The physician did not indicate if the resident had any dental or podiatric issues. Also, the physician did not indicate if the resident required addition medical or laboratory services. 15. At 9:43 AM, review of resident #21's pre-Annual Admission Intermediate Care Facilities Admission/Annual Medical Certification form dated 12/01/2021, showed the physician failed to indicate if the resident had or needed a colonoscopy, or PSA. The physician did not indicate if the resident had any dental or podiatric issues. The physician did not indicate if the resident required addition medical or laboratory services. Also, the physician did not list the resident's current medication on the form. During interview on 09/02/2022 at 4:51 PM, the Resident Care Director, was made aware of the findings of the record review. The Resident Care Director confirmed the deficient practice and said going forward, a process would be put in place to ensure the health form will be completed as required. At the time of the survey, the ALR failed to ensure	R 705		

Emphanie Jones Executive Director 9/19/22

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R 705	Continued From page 8 the physician completed all sections of the Intermediate Care Facilities Division Admission/Annual Medical Certification forms, as required.	R 705		
R 802	Sec. 903 2 On-Site Review. (2) Assess the resident's response to medication; and Based on record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure that the Registered Nurse (RN) assessed each resident's response to their medication every 45 days, for 18 of the 21 residents in the sample (Residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20). Findings included: On 09/02/2022 starting at approximately 2:18 PM, review of the medical records for Residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 failed to show evidence that the facility RN had assessed the residents' response to their medications every 45 days. The Resident Care Director, who was present at the time of the review confirmed the findings that medication reviews did not indicate the residents' responses their prescribed medication. The Resident Care Director said that going forward, all reviews would contain all the required information (i.e., resident response to their medication). At the time of survey, the facility failed to document an assessment of each resident's response to their medication at least every 45 days.	R 802	45 -day medication reviews were updated for residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 to reflect resident response to their medication. Resident's response to their medications will be added to the Sunrise DC 45-day assessment. The RCD will conduct retraining of the Registered Nurses on including resident's response to their medications every 45 days. The RCD and the ALA will meet weekly to ensure resident's 45-day Assessment includes resident's response to their medications. The ALA 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 (QAPI) meeting that the ALA and QAPI Committee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	9/22/22 9/22/22 9/22/22 9/22/22 10/5/22 &ongoing

Executive Director 9/19/22

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R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation, interview and record review, the ALR failed to ensure water temperatures did not exceed 110 degrees Fahrenheit (°F), on five of six floors in the common bathrooms and apartments (2nd, 3rd, 4th, 5th and 7th). Findings included: On 08/31/2021 beginning at 11:22 AM, a walk-thru of the facility with the Administrator, Resident Care Director and Maintenance Assistant showed the following: - At 11:26 AM, apartment #203's kitchenette and bathroom sink water temperatures both measured 113.5 degrees Fahrenheit (°F). When asked about the parameters for the hot water temperatures, the Maintenance Assistant stated that the hot water temperatures should not exceed 110 °F. -At 11:34 AM, apartment #309's kitchenette sink water temperature measured 113.9 °F and the bathroom sink water temperature measured 114.6 °F. -At 11:48 AM, apartment #403's kitchenette sink water temperature measured 111.0 °F and the bathroom sink water temperature measured 112.8 °F.	R1003	The Maintenance Coordinator (MC) immediately adjusted the water temperature in the mixing valve to bring water temperatures back into compliance of 110 degrees Fahrenheit and he went back to apartments #203, 309, 403, 508, 709 and to common area bathrooms on each floor to test and verify temperatures did not exceed 110 degrees. The Regional Director of Facilities contacted a Plumber to come on-site to assess and Verify the equipment is working to Specifications and producing consistent Water temperatures per regulations. The MC conducted training on procedures for taking water temperatures The ALA 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 (QAPI) meeting that the ALA and QAPI Committee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	9/2/22 9/5/22 9/5/22 10/5/22 & ongoing

Executive Director 9/19/22

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R1003	Continued From page 10 -At 11:52 AM, apartment #508's kitchenette sink, and bathroom sink water temperatures both measured 111.0 °F. The bathroom sink water temperature located directly beside the rehabilitation center on the fourth floor measured 112.8 °F; and -At 12:08 PM, apartment #709's kitchenette sink water temperature measured 113.4 °F and the bathroom sink water temperature measured 113.9 °F. At 12:17 PM, the Maintenance Assistant said that the facility had some issues with regulating the hot water temperatures. He stated that he would let the Maintenance Coordinator know of the findings and that the hot water heater would be adjusted to meet the Assisted Living Residence (ALR) law regarding hot water temperatures not exceeding 110 °F. The ALR will ensure residents are monitored when turning on the hot water. He said that the residents in the Assisted Living that are independent, are able to adjust their own hot water. On 09/01/2022 at 10:03 AM, the Maintenance Coordinator said during an interview that he and the regional director are in the process of adjusting the hot water heater to meet the ALR regulations. He stated that he would contact the surveyor once he retests the hot water temperatures throughout the building. At 11:20 AM, the Maintenance Coordinator stated that the hot water temperatures had been adjusted to meet the local requirements. Beginning at 11:24 AM, follow-up observations showed that the Maintenance Coordinator adjusted the hot water temperatures throughout	R1003		

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R1003	Continued From page 11 the facility, and that the readjusted water temperatures measured the following: - At 11:26 AM, apartment #203's kitchenette sink was temperature measured 106.9 °F and bathroom sink water temperatures measured 109.4 degrees Fahrenheit (°F). -At 11:34 AM, apartment #309's kitchenette sink water temperature measured 106.2 °F and the bathroom sink water temperature measured 108.1 °F. -At 11:48 AM, apartment #403's kitchenette sink water temperature measured 104.4 °F and the bathroom sink water temperature measured 106.5 °F. -At 11:52 AM, apartment #508's kitchenette sink water temperature measured 104.7 °F and bathroom sink water temperatures both measured 105.6 °F. The bathroom sink water temperature located directly beside the rehabilitation center on the fourth floor measured 104.5 °F; and -At 12:08 PM, apartment #709's kitchenette sink water temperature measured 103.8 °F and the bathroom sink water temperature measured 103.9 °F. On 09/02/2022 beginning at 1:35 PM, review of the water temperature logs from August 2022 through June 2022 showed the temperatures remained within the normal range in accordance with local requirements. At 2:02 PM, review of the Water Temperature Testing Policy last reviewed on 01/01/2006, showed the facility staff was to test the water	R1003		

Executive Director 9/19/22

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	ALR-0030	A. BUILDING: _____ B. WING _____	09/02/2022

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R1003	Continued From page 12 temperature 365 days a year by the Maintenance Coordinator. However, arrangements must be made for other team members to perform testing on the weekends. Water temperatures results must fall within the temperature range specified by the local Department of Health. If water temperatures do not fall within the accepted range, re-test. If the second test is not acceptable, adjust as appropriate for the type of domestic water system at your community. Document all results in the water temperature logbook. At the time of the survey, the ALR failed to ensure that the hot water temperature did not exceed 110 degrees Fahrenheit throughout the facility.	R1003		

Executive Director 9/19/22

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R 000	Initial Comments 0000 Initial Comments An annual licensure survey was conducted on 08/31/2022, 09/01/2022, and 09/02/2022 to determine compliance with the Assisted Living Law (DC Official Code § 44-101.01 et seq) and Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 80 residents and employed 129 personnel, to include professional and administrative staff. A random sample of 21 resident records, 13 employee records, one companion record and six Private Duty Aides (PDAs) records were selected for review. The findings of the survey were based on observations throughout the facility, clinical and administrative record review, and resident, family, and staff interviews to include review of incidents.	R 000		
R 146	10113.1 Individualized Service Plans (ISPs) 10113.1 An ISP shall be developed for each resident not more than thirty (30) days prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that Individualized Service Plan (ISP) was developed within 30 days prior to admission, for six of the 21 residents in the sample (Residents #2, 6, 8, 11, 19, and 20). Findings included: 1. On 09/02/2022 beginning at 2:20 PM, a review of Resident #2's records showed that the resident was admitted to the ALR on 05/02/2022. Continued review of the records failed to show evidence that an ISP had been developed prior to the resident's admission.	R 146	A pre-move-in ISP will be developed in the community's electronic medical records and will be conducted on all new admissions not more than 30 days prior to admission. The Resident Care Director (RCD) will train the Wellness Nurses, Assisted Living Coordinator(ALC) and Reminiscence Coordinator (RC) on developing a Pre-Admission ISP for all new residents. The RCD, Executive Director (ALA), ALC, and RC will meet weekly to ensure all new move-ins have a Pre-admission ISP completed not more than 30 days prior to admission.	9/22/22 9/22/22

Executive Director 9/19/22

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R 146	Continued From page 1 2. At 2:24 PM, a review of Resident #6's records showed that the resident was admitted to the ALR on 10/11/2021. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 3. At 2:33 PM, review of Resident #8's records showed that the resident was admitted to the ALR on 01/15/2021. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 4. At 2:38 PM, review of Resident #11's records showed that the resident was admitted to the ALR on 02/05/2022. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 5. At 2:45 PM, review of Resident #19's records showed that the resident was admitted to the ALR on 05/26/2022. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. 6. At 4:50 PM, review of Resident #20's records showed that the resident was admitted to the ALR on 06/10/2021. Continued review of the records failed to show evidence that an ISP was developed prior to the resident's admission. At 4:51 PM, the Resident Care Director, who was present during the record reviews confirmed the deficient practice and said going forward, the nurses would be trained, and the pre-admission ISP's will be completed. At the time of the survey, the facility failed to provide documented evidence that all ISP's were reviewed prior to admission, as required.	R 146	The ALA 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 (QAPI) that the ALA and QAPI Committee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	10/5/22 & ongoing

Executive Director 9/19/22

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R 330	10122.1 On Site Medication Review 10122.1 The on-site medication review by a registered nurse that is arranged to occur every forty-five (45) days, pursuant to § 903 of the Act (D.C. Official Code § 44-109.03), shall include documentation of any changes to the resident's medication profile, including changes in dosing and any medications that have been added or discontinued. Based on record reviews and interviews, the Assisted Living Residence (ALR) failed to ensure that the Registered Nurse (RN) assessed each resident's response to their medication every 45 days, for 18 of the 21 residents in the sample (Residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20). Findings included: On 09/02/2022 starting at approximately 2:18 PM, review of the medical records for Residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 failed to show evidence that the facility's RN had assessed the residents' response to their medications every 45 days as required. The Resident Care Director, who was present at the time of the review confirmed the findings that medication reviews did not indicate the residents' responses their prescribed medication. The Resident Care Director said that going forward, all reviews would contain all the required information (i.e. resident response to their medication). At the time of survey, the facility failed to document an assessment of each resident's response to their medication at least every 45 days.	R 330	45 -day medication reviews were updated for residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 to reflect resident response to their medication. Resident's response to their medications will be added to the Sunrise DC 45-day assessment. The RCD will conduct retraining of the Registered Nurses on including resident's response to their medications every 45 days. The RCD and the ALA will meet weekly to ensure resident's 45-day Assessment includes resident's response to their medications The ALA 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 (QAPI) meeting that the ALA and QAPI Committee manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	9/22/22 9/22/22 9/22/22 9/22/22 10/5/22 &ongoing

Elizabeth Jones Executive Director 9/19/22

Health Regulation & Licensing Administration

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