Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING ALR-0030 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 000 Initial Comments R 000 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 seg) 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 A pre-move-in ISP will be developed in 9/22/22 findings of the survey were based on observations the community's electronic medical throughout the facility, clinical and administrative records and will be conducted on all record review, and resident, family, and staff new admissions not more than 30 days prior interviews to include review of incidents. to admission. 9/22/22 The Resident Care Director (RCD) will R 471 Sec. 604a1 Individualized Service Plans R 471 train the Wellness Nurses, Assisted Living Coordinator(ALC) and Reminiscence (a)(1) An ISP shall be developed for each resident Coordinator (RC) on developing a Preprior to admission. Admission ISP for all new residents. Based on interview and record review, the Assisted Living Residence (ALR) failed to ensure an that The RCD, Executive Director (ALA), ALC, 9/22/22 Individualized Service Plan (ISP) was developed and RC will meet weekly to ensure all new prior to admission, for six of 21 residents in the move-ins have a Pre-admission ISP sample (Residents #2, 6, 8, 11, 19, and 20). completed not more than 30 days prior to admission. Findings included: 10/5/22 The ALA is responsible for reviewing, 1. On 09/02/2022 beginning at 2:20 PM, a review of tracking and trending the results of any &ongoing Resident #2's records showed that the resident was audits. The results and trends are admitted to the ALR on 05/02/2022. Continued reviewed during the monthly Quality review of the records failed to show evidence that Assurance Performance Improvement an ISP had been developed prior to the resident's Meeting (QAPI) that the ALA and QAPI admission. Committee manages. The POC is reviewed during this meeting and modified 2. At 2:24 PM, a review of Resident #6's records based on the data of the audits and monitoring of the plan.

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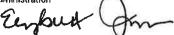
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	present during the re deficient practice and would be trained and be completed.  At the time of the sur	dent Care Director, who was cord reviews confirmed the disaid going forward, the nurses the pre-admission ISP's will vey, the facility failed to provide that all ISP's were reviewed				
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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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R 483	Continued From pag	e 2	R 483				
R 483	(d) The ISP shall be admission and at lea	reviewed 30 days after st every 6 months thereafter.	R 483	Residents #6, #8, and #14 ISPs were updated to include every 6 month or change of condition.		9/16/22	
	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:			The RCD will conduct retraining of the Wellness Nurses on reviewing ISPs 3 after admission, at least every 6 mont with significant changes in resident co	0 days hs and	9/22/22	
				The RCD and the ALA will meet week ensure resident ISPs are completed 3 after admission, every 6 months and residents with significant changes in a The ALA is responsible for reviewing, and trending the results of any audits results and trends are reviewed during monthly Quality Assurance Performar QAPI Committee manages. The POC	0 days vith any	9/22/22	
					tracking The the ce is	10/5/22 & ongoing	
			reviewed during this meeting and mo- based on the data of the audits and n		ified onitoring		
	#6's record showed the to the ALR on 10/11/2 records showed that a 11/04/21; however, the	::20 PM, a review of Resident nat the resident was admitted ::021. Further review of the an ISP was reviewed on ere was no evidence of the record since then.		of the plan.			
	showed that the reside on 01/15/2021. Furthe showed that an ISP w	of Resident #8's record ent was admitted to the ALR er review of the records as reviewed on 07/14/22; o evidence of any other ISP ate.					
!	showed that the reside	of Resident #14's record ent was admitted to the ALR r review of the records					

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING ALR-0030 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X8) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG R 483 Continued From page 3 R 483 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. 9/23/22 The Intermediate Care Facilities R 705 Sec. 802b Medical, Rehabilitation, Psychosocial R 705 Admission/Annual Medical Certification forms Assess. for residents #1, 2, 4, 5, 7, 8, 9, 13, 15, 16, 17, 18, 19, 20 and 21 will be updated to include all (b) The ALR shall maintain resident information areas. obtained from a standardized physician's statement approved by the Mayor. The Information shall 9/22/22 The RCD will conduct retraining of the include a description of the applicant's current Wellness Nurses and the Director of physical condition and medical status relevant to Sales/Admissions on ensuring the defining care needs, and the applicant's MD completes all areas of the DC Mayor's psychological and cognitive status, if so indicated during the medical assessment. Form/Intermediate Care Facilities Admission/Annual Based on interviews and record reviews the Medical Certification Form for pre-admission assisted Living Residence (ALR) failed to ensure and annually. each resident's Intermediate Care Facilities Admission/Annual Medical Certification form was The RCD and the ALA will meet weekly to 9/22/22 completed with all areas addressed for 15 of the 21 ensure resident's Intermediate Care Facilities residents in the sample (residents #1, 2, 4, 5, 7, 8, Admission/Annual Medical Certification form is 9, 13, 15, 16, 17, 18, 19, 20, and 21). completed with all areas addressed Data of the audits and monitoring of the plan. 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

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ ALR-0030 B. WING 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 705 Continued From page 4 R 705 The ALA is responsible for reviewing, tracking 10/5/22 & and trending the results of any audits. The Medical Certification form showed the physician did ongoing results and trends are reviewed during the not document the resident's primary or secondary monthly Quality Assurance diagnosis, vital signs; failed to indicate if the Performance Improvement (QAPI) meeting resident had or needed a prostate specific antigen that the ALA and QAPI Committee manages. (PSA), or Colonoscopy, if the resident used The POC is reviewed during this meeting and tobacco, if the resident used non-prescription drugs, modified based on the data of the audits and and the resident's immunization status. monitoring of the plan. 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

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: \_ B. WING **ALR-0030** 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X6) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LSC IDENTIFYING INFORMATION) DAT DEFICIENCY) R 705 Continued From page 5 R 705 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 dld 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

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: B. WING ALR-0030 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) R 705 Continued From page 6 R 705 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 falled 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

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ ALR-0030 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5111 CONNECTICUT AVE NW SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R1003 Continued From page 10 R1003 -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

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Health Regulation & Licensing Administra, STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ ALR-0030 B. WING 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5111 CONNECTICUT AVE NW SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (X6) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R1003 Continued From page 11 R1003 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

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- 4	Coordinator. However for other team memb weekends. Water ten within the temperatur Department of Health fall within the accepted test is not acceptable type of domestic water Document all results logbook.  At the time of the surv	s a year by the Maintenance er, arrangements must be made ers to perform testing on the inperatures results must fall the range specified by the local in. If water temperatures do not ed range, re-test. If the second in, adjust as appropriate for the er system at your community, in the water temperature	R1003			

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING ALR-0030 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 000 Initial Comments R 000 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. 9/22/22 R 146 10113.1 Individualized Service Plans (ISPs) A pre-move-in ISP will be developed in R 146 the community's electronic medical records and will be conducted on all 10113.1 An ISP shall be developed for each resident not more than thirty (30) days prior to new admissions not more than 30 days prior admission. to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure The Resident Care Director (RCD) will that Individualized Service Plan (ISP) was 9/22/22 train the Wellness Nurses, Assisted developed within 30 days prior to admission, for six Living Coordinator(ALC) and Reminiscence of the 21 residents in the sample (Residents #2, 6, Coordinator (RC) on developing a Pre-8, 11, 19, and 20). Admission ISP for all new residents. The RCD, Executive Director (ALA), ALC, Findings included: and RC will meet weekly to ensure all new move-ins have a Pre-admission ISP 1. On 09/02/2022 beginning at 2:20 PM, a review of completed not more than 30 days Resident #2's records showed that the resident was prior to admission. 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.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING ALR-0030 09/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6111 CONNECTICUT AVE NW** SUNRISE ASSISTED LIVING ON CONNECTICUT WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) (X5) COMPLETE DATE R 330 10122.1 On Site Medication Review R 330 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 45 -day medication reviews were updated for 9/22/22 documentation of any changes to the resident's residents #1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, medication profile, including changes in dosing and 15, 16, 17, 18, 19, and 20 to reflect resident any medications that have been added or response to their medication. 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 medications will 9/22/22 resident's response to their medication every 45 be added to the Sunrise DC 45-day assessment 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). The RCD will conduct retraining of the Findings included: Registered Nurses on including resident's response to their medications every 45 days. On 09/02/2022 starting at approximately 2:18 PM 9/22/22 review of the medical records for Residents #1, 2, 5, The RCD and the ALA will meet weekly to 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and ensure resident's 45-day Assessment includes 20 failed to show evidence that the facility's RN had resident's response to their medications 9/22/22 assessed the residents' response to their medications every 45 days as required. The Resident Care Director, who was present at the The ALA is responsible for reviewing, tracking time of the review confirmed the findings that and trending the results of any audits. The medication reviews did not indicate the residents' results and trends are reviewed during the 10/5/22 responses their prescribed medication. The monthly Quality Assurance Performance &ongoing Resident Care Director said that going forward, all Improvement (QAPI) meeting that the ALA and reviews would contain all the required information QAPI Committee manages. The POC is (i.e. resident response to their medication). reviewed during this meeting and modified based on the data of the audits and monitoring At the time of survey, the facility failed to document of the plan. an assessment of each resident's response to their medication at least every 45 days.

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