Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0030	A. BUILDING: _____ B. WING _____	10/26/2023

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 000	Initial Comments 0000 Initial Comments An annual licensure survey was conducted on 10/23/2023, 10/24/2023, 10/25/2023 and 10/26/2023, to determine compliance with the Assisted Living Residence Regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101. The Assisted Living Residence (ALR) provided care for 91 residents and employed 127 personnel, to include professional and administrative staff. The survey sample consisted of 22 resident records (to include one person discharged) and 21 employee records (to include four Private Duty Aids). The findings of the survey were based on observations made throughout the ALR, interviews with staff and residents, and reviews of clinical and administrative records, to include incident reports.	R000		
R383	10125.4a Reporting Complaints to the Director 10125.4a An 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 promptly, and shall be followed up by written notification to the same within twenty-four (24) hours or the next business day: and Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to promptly notify the Department of Health (DOH) by telephone of incidents that involved potential for significant harm to a resident (followed by written notification within 24 hours or next business day), for three of 22 residents in the sample (Residents #2, 3 and 19). Findings included:	R383		

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(X4)1D 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)	(XS) COMPLETE DATE
R 383	Continued From page 1 1.A review of incidents that were self-reported by the facility prior to the survey revealed the following: a) According to an incident report submitted online by the facility on 7/13/2023 at 4:01pm, Resident #2 fell in her unit on the previous day (07/12/2023) at 6:30am. After a nurse assessed her and found a "hematoma noted on the posterior part of her head," the facility telephoned emergency 911. Resident #2 went by ambulance (time not indicated on the incident report) to a local hospital emergency room (ER) for further evaluation. According to the incident report, Resident #2 complained of pain in her left toes; however, the ER reportedly did not assess the toes. After the resident returned from the ER at 4:00pm, she continued complaining of pain in her toes. The facility summoned a mobile x-ray service. Subsequent x-rays (no date or time indicated on the incident report) showed an "acute non-displaced fracture at the base of the 5th proximal phalanx." There was no evidence that the facility reported the fall and called 911 promptly by telephone to the Department of Health (DOH). b). Another incident report submitted online by the facility on 08/07/2023 at 12:22pm showed that Resident #2 was found on the floor in her unit at 4:15am that morning after falli8ng from her bed. A laceration was observed on her head. A facility nurse cleansed the area, "applied a pressure dressing" and telephoned 911. Resident #2 went by ambulance to a local ER (time not indicated on the incident report) where she received four staples for the laceration. There was no evidence that the facility reported the fall and ambulance service promptly by telephone to DOH.	R383	The Resident Care Director (RCD) and the Executive Director (ED) conducted retraining of the wellness nurses on protocols for ensuring all unusual incidents are reported by telephone immediately following an incident and in writing within 24 hours of same incident. The RCD posted the telephone number for the DOH Complaint Coordinator prominently in the Wellness Department. The RCD and ED are responsible. for reviewing, tracking and trending the results of any audits and monitoring. The results and trends are reviewed during the monthly Quality Assurance Performance Improvement meeting that the Executive Director manages. The POC is reviewed during this meeting and modified based on the data of the audits and monitoring of the plan.	11/23/2023 10/27/2023 11/30/2023 & ongoing

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R 383	Continued From page 2	R 383		

c). Another incident report submitted online by the facility on 05/04/2023 at 11:20am showed that on05.02.2023 at 10:25pn, Resident #3 "was yelling out in pain on her left hip." A facility nurse assessed the resident and telephoned emergency 911. Resident #3 went by ambulance to a local hospital ER. Sometime on 05/03/2023 (time not indicated on the incident report), the hospital notified the facility that Resident #3's hip was fractured and had been admitted to the hospital. There was no evidence that the facility reported the fall and ambulance service promptly by telephone to DOH.

On 10/24/2023 at 1:32 pm, when the Resident Care Director (RCD) was asked about Resident #2's 07/12/2023 fall and the delayed reporting, she replied "We did not know that she (Resident #2) had an injury". Tests performed at the ER showed no evidence of serious injury. The RCD then acknowledged that Resident #2 went to the ER with a hematoma on her head. The RCD said she reported the incident online after x-rays showed the fractured toe. When asked for evidence that the facility telephoned DOH on 08/07/2023 after Resident #2 was taken by ambulance to the ER with a laceration to the head, the RCD said the facility did not call but reported it online on the day of the incident.

2. On 10/25/2023 beginning at 11:19 am, a review of Resident #19's record showed that she was admitted to the facility on 06/06/2023 and her Individualized Service Plan was updated on 07/24/2023. According to two nurse progress notes, Resident #19 fell when she got out of bed to use the bathroom on 08/06/2023. At 1:50 am, a facility nurse assessed the resident and "noted a bump on the back of resident head. Resident also verbalized pain on her shoulder...ice pack applied on back of resident head. 911 called. Resident was transferred to a local hospital ER. There was no evidence that the fall and ambulance service was reported to DOH, either promptly by telephone or in writing within 24 hours.

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R 383	Continued From page 3 When asked if there was documentation showing that Resident #19's fall and ambulance service were reported to DOH, the RCD (who was present for the record review) explained that the facility always sent residents to the ER for further evaluation whenever they hit their head during a fall. She said the 08/06/2023 fall and ambulance service to the ER was not reported to DOH because "there was no injury." When the topic was discussed during the Exit Conference on 10/26/2023 at approximately 3:30 pm, the Executive Director (ED) and the RCD said they did not have a telephone number for reporting incidents to DOH. Surveyors reviewed the administrator's definition of "unusual incident" that is provided in Regulation 10125.5. It should be noted that the facility's incident and Event Reporting policy and procedures, dated 06/13/2022, applied to all facilities operated by the corporation in multiple states. The procedures included the following: "The RCD/ED/Designee will...notify appropriate parties in accordance with state/federal/provincial law or regulation. Regulatory Agency, Law Enforcement, Protective Service Agency and other parties...". At the time of the survey, the ALR failed to establish and implement a system to ensure that DOH received prompt notification by telephone, followed by written notification within 24 hours.	R383		

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	Initial Comments			
R 000	An annual licensure survey was conducted on 10/23/2023, 10/24/2023, 10/25/2023 and 10/26/2023, to determine compliance with the Assisted Living Law (DC Official Code s44-101.01 et seq). The Assisted Living Residence (ALR) provided care for 91 residents and employed 127 personnel, to include professional and administrative staff. The survey sample consisted of 22 resident records (to include one person discharged) and 21 employee records (to include four Private Duty Aids). The findings of the survey were based on observations made throughout the ALR, interviews with staff and residents, and reviews of clinical and administrative records, to include incident reports.	R 000		
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 Intermediat4e Care Facilities Admission/Annual Medical Certification form was completed with all areas addressed for 13 of the 22 residents in the sample (Residents #1, 2, 5, 6, 10, 11, 14, 15, 16, 17, 19, 20, and 22). Findings included:	R 705	The Resident Care Director and the Executive Director retrained the Wellness Nurses and Admissions Staff (Director of Sales & Associate Director of Sales), and the Medical Director on protocol for full completion of pre-admission and annual Intermediate Care Facilities Admission/Annual Medical Certification forms (the "form"). The Resident Care Director reviewed the Intermediate Care Facilities Admission/Medical Certification forms for Residents #1, 2, 5, 6, 10, 11, 14, 15, 16, 17, 19, 20, and 22 with the facility medical director to complete forms in their entirety. The Executive Director will create a cover letter, signed by the Medical Director informing all physicians and nurse practitioners of the requirement that the form be completed in its entirety. The Resident Care Director will conduct an audit of all residents Intermediate Care Facilities Admission/Annual Medical Certification forms to ensure completion of forms in their entirety. The Resident Care Director and the Executive Director are responsible for tracking and trending the results of any audits and monitoring. The results and trends are reviewed with the management team during the monthly Quality Assurance Performance Improvement meeting that the Executive Director manages. The POC is reviewed during this meeting and modified based on plan.	10/30/23 11/30/2023 12/15/2023 11/30/2023 12/15/2023 & ongoing

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R 705	Continued from Page 2 On 10/25/2023 beginning at 4:24 pm, review of the Intermediate Care Facilities Admission/Annual Medical Certification forms (the "form") in the sampled residents' medical records showed the following: 1.At 4:24 pm, the pre-admission form in Resident #22's record, dated 04/21/2023, showed the resident had "constant" pain due to rheumatoid arthritis in her hands. The physician did not document the type or intensity of the pain the resident felt. For self-medicating, the physician circled "yes with assistance" but did not further document the nature or appropriate level of assistance needed by Resident #22.	ROOO		
R383	2.At 4:39 pm, the pre-admission form in Resident #6's record, dated 08/31/2023, showed the physician failed to document the resident's vital signs (blood pressure, temperature, respiration, pulse, height and weight). The physician also failed to indicate if the resident was or was not exhibiting signs or symptoms of communicable disease, whether the resident was incontinent (bladder or bowel), the resident's ability to participate in Activities of Daily Living or was dependent on any medical equipment. 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. The physician did not indicate the resident was not in need of 24-hour skilled nursing care and failed to document Resident #6's recommended level of care. 3.AT 4:51 pm, the 12-month form in Resident #20's record, dated 07/17/2023, showed the physician failed to document the resident's vital signs (blood pressure, temperature, respiration,	R383		

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R 705	Continued from Page 3 pulse, height, and weight). In addition, the physician indicated the resident had a history of mental disability but did not document if Resident #20 had ever been hospitalized for a mental health condition. 4. At 4:56 pm, the pre-admission form in Resident #5's record, dated 08/22/2023, showed the physician failed to indicate if the resident had any podiatric concerns requiring treatment or was exhibiting signs or symptoms of any skin conditions which required treatment. On 10/26/2023 at 9:59 am, continued review of the Intermediate Care Facilities Admission/Annual Medical Certification forms (the "form") in the sampled residents' medical records showed the following: 5. At 9:59 am, the form in Resident #11's record, dated 11/08/2022, showed the physician failed to document the resident's vital signs (blood pressure, temperature, respiration, pulse, height, and weight). The physician also failed to indicate if the resident used non-prescription drugs. 6. At 10:00 am, the form in Resident #14's record, dated 08/11/2023, showed the physician documented that the resident needed long term medical or nursing care in a hospital or nursing home, needed 24-hour skilled nursing care, and needed assisted living level of care (all three categories were checked as "needed"). 7. At 10:15 am, the 12-month form in Resident #15's record, dated 08/24/2023, showed the physician failed to document the resident's vital signs (blood pressure, temperature, respiration, pulse, height, and weight). 8. AT 10:16 am, the form in Resident #16's record, dated 06/14/2023, showed the physician failed to document the resident's height. 9. At 10:25 am, the pre-admission form in Resident #10's record, dated 04/17/2023, showed the physician failed to document the resident's pulse, if the resident used non-prescription drugs, needed a mammogram, or pap test, or colonoscopy, and failed to document Resident #10's immunization status.	R705		

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R 705	Continued from Page 4 10. At 10:27 am, the pre-admission form in Resident #19's record, dated 05/31/2023, showed the physician failed to document the resident's immunization status, including tuberculosis. In addition, the physician indicated the resident was screened for dementia while hospitalized in 11/2022, failed to indicate the results of said screening, and then failed to indicate whether Resident #19 should be screened or tested again for dementia. 11. At 10:39 am, the pre-admission form in Resident #2's record, dated 12/26/2022, showed the physician failed to document whether the resident was incontinent (bladder or bowel) and failed to document Resident #2's immunization status. 12. At 10:43 am, the pre-admission form in Resident #17's record, dated 12/05/2023, showed the physician failed to document the resident's home address, vital signs (blood pressure, temperature, respiration, pulse, height and weight), if the resident needed a mammogram, or pap test, if the resident was exhibiting signs or symptoms of a communicable disease, or whether the physician recommended that Resident #17 be screened or tested for dementia or cognitive impairment. 13. At 12:10pm, the 12-month form in Resident #1's record, date4d 02/23/2023, showed the physician failed to document if the resident needed a pap test or mammogram. On 10/26/2023 beginning at 12:10 pm, when asked about the missing information on the medical certification forms, the Resident Care Director confirmed the deficient practice. She said when the facility "faxes the form to the doctor, we request they complete all of the form." She further stated that the facility's medical director would review the form and sign if the outside doctor did not reply or respond to the medical director's feedback. No additional information was made available for review before the survey ended later that day. At the time of the survey, the ALR failed to ensure the physician completed all sections of the Intermediate Care Facilities Division Admission/Annual Medical Certification forms, as required. This is a repeat deficiency. See Deficiency Report	R705		

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dated 09/02/2022.

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