STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0042	A. BUILDING: _____ B. WING _____	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRAM HALL AL OPCO, DBA ABRAM ASSITED	1320 MAIN DRIVE, WASHINGTON, DC20012 WASHINGTON, DC 20012

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R 000	Initial Comments On 10/17/2023 at 5:08 PM, the Department of Health (DOH), Health Regulation and Licensing Administration (HLRA), Intermediate Care Facilities Division (State Survey Agency) Complaint Coordinator, received a telephone call from the Executive Director (ED) of the Assisted Living Residence (ALR) indicated that Resident #1 was missing and was last seen in the facility on 10/12/2023. Based on the nature of the call, the State Survey Agency (SSA) initiated an on-site investigation on 10/18/2023 at 9:30 am, to determine compliance with the ALR Regulatory Act of 2000, "DC Code § 44-101.01" and Title 22-B DCMR (Public Health and Medicine) Chapter 101 attendant regulations. The investigative findings were based on interviews with professional staff and management staff, and a review of administrative records, including facility incidents reports and policies. Based on the information obtained during the investigation, the following was determined: The ALR failed to report the missing person timely to the Administrator and the State Agency (DOH) promptly followed by written notification within 24 hours or the next business day. The ALR staff failed to implement its policies on Unusual Incident Reporting, Missing Resident, and Alcohol Use.	R 000	Please start typing your responses here:	
R 390	Sec. 509b1 Abuse, Neglect, and Exploitation. (b)(1) An ALR, employee of an ALR, or other person who believes that a resident has been subjected to abuse, neglect, or exploitation shall report the alleged abuse, neglect, or exploitation	R 390		

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R 390	Continued From page 1 immediately to the assisted living administrator who shall take appropriate action to protect the resident. The ALR shall report any allegation of abuse, neglect, or exploitation brought to its attention to the Mayor and the Adult Protective Services Program, administered by the Family Services Administration of the Department of Human Development. Based on interview and record reviews, the Assisted Living Residence (ALR) failed to notify the Director of incidents that substantially affects the residents; promptly notifies the Department of Health (DOH) by telephone and follow up by written notification within twenty-four hours or the next business day for all incidents that substantially affects the residents, for 23 of the 22 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22). Findings included: On 10/19/2023 beginning at 11:00 am, the review of the facility's incident reports which included complaints, fall reports, and elopement showed the following: 1. A review of incidents that were self-reported by the facility prior to the complaints/investigative survey showed the following incidents for Resident #1: a). On 10/18/2023 at 10:20 am, an interview was held with the Assisted Living Administrator (ALA), who informed the surveyors that Resident #1 was last seen in the ALR on 10/12/2023. When asked if the incident had been reported to DOH, she replied, "Yes, on 10/16/2023 at approximately 5:00 pm." According to the incident report submitted to DOH on 10/16/2023 at 4:57 pm, the	R 390	R390 1. Corrective Action to be accomplished Examined incident reporting for unusual occurrences, addressed missing resident situations, and discussed the alcohol policy with staff, ensuring updates align with the needs and characteristics of our facility residents. 2. Measures Implemented to ensure it does not recur We have created a checklist for facility staff based on the incident reporting policy and are providing additional training on how, what, and when to make reports. We have implemented a new policy for midnight daily census checks to verify the resident's presence in the facility. This ensures timely notification to the ALA and/or the DON in case of a missing resident or emergency. 3. QA Program Action to Monitor compliance with corrective measures. A review of all incident reports and the status of their required reporting will be included in the monthly reporting which is included in the monthly QA review. 4. Date Completed 12/19/2023	

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R 390	Continued From page 2 resident was last seen in the facility on 10/12/2023. Per the report, the Metropolitan Police was called, and a missing person report was completed. Also, a thorough search of the building was conducted and a few of the local hospitals were called. The DOH was notified of the incident on 10/12/2023 via the DOH on-line incident report form. b). The review of an incident report dated 06/12/2023 at 10:58 pm, showed Resident #1 had a purple area and hematoma on the left side of his face, and on top of his scalp. Per the report, the resident stated he fell on the sidewalk earlier that day. Emergency Medical Services (EMS) was called, but he refused to go to the local emergency room. An ice pack and Tylenol were given. The report showed that DOH was notified of the incident on 06/30/2023 (18 days later) via the DOH on-line incident report form. c). The review of an incident report dated 07/30/2023, showed that the resident reported that he fell while walking outside. The resident sustained a laceration and was sent to the emergency room. The report showed that the DOH was notified of the incident on 08/09/2023 (10 days later) via DOH on-line incident report form. 2. The review of self-reported incidents by the facility prior to the investigation survey showed the following for Resident #2: a). A review of an incident report dated 05/30/2023 at 3:55 pm, showed Resident #2 was found lying on the floor in her closet with two pillows under her head. When asked, the resident said she was looking for something to wear and lost her balance. The staff attempted to lift the	R 390		

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R 390	Continued From page 3 resident but was unable, and so the Emergency Medical Service (EMS) was called, but the resident refused to go the local hospital. The report showed that DOH was notified of the incident on 06/30/2023 (30 days later) via DOH on-line incident report form. b). A review of an incident report dated 06/05/2023 at 6:30 pm, showed Resident #2 was observed lying on the floor in her bathroom on her left shoulder, with vomit like food contents in her mouth. The resident was assessed, EMS was called, and the resident was transferred to a local hospital. The report showed that DOH was notified of the incident on 06/30/2023 (25 days later) via DOH on-line incident report form. c). The review of an incident report dated 06/07/2023 at 5:02 PM, showed Resident #2 was found lying on the floor under the couch, screaming and complaining of pain all over her body. EMS was called and the resident was taken to a local hospital. The report showed that DOH was notified of the incident on 06/30/2023 (23 days later) via DOH on-line incident report form. d). The review of an incident report dated 06/20/2023 at 9:33 pm, showed Resident #2 was noted with discoloration on her left breast and upper inner arm area. The resident reported that she spilled coffee on her body at 3:00 am. EMS was called, and the Resident was transferred to a local emergency room. The report showed that DOH was notified of the incident on 06/30/2023 (10 days later) via DOH on-line incident report form. e). The review of an incident report dated 09/09/2023 at 10:30 am, showed Resident #2 was heard screaming for help, and was found	R 390		

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R 390	Continued From page 4 sitting on the floor in her room. When asked what happened, the resident stated that her jacket got caught on the wheel of her walker and she fell on her buttocks. The resident denied injury and refused to go to the hospital. On assessment, no injury was noted, and the resident required assistance from the floor to her recliner. The report showed that the DOH was notified of the incident on 09/12/2023 (3 days later) at 11:49 am via DOH on-line incident report form. f). The review of an incident report dated 09/04/2023 at 5:50 am, showed that during medication administration, Resident #2 was found sitting on the floor by her recliner. When asked what happened, the resident said she was trying to get up and slid to the floor. Upon assessment, the resident denied pain or discomfort, and was assisted by three staff to her recliner. The DOH was notified of the incident on 09/06/2023 at 8:41 am (2 days later) via DOH on-line incident report form. g). The review of an incident report dated 06/07/2023 at 10:20 pm, showed Resident #2 was found on the floor lying in a prone position under the couch. The resident was yelling, screaming, and complaining of pain under her neck and entire body. The resident rated the pain level at 10/10. Staff put a pillow under her neck for comfort, and called EMS, and the resident was taken to the local hospital. DOH was notified of the incident on 06/30/2023 at 8:41 am (23 days later) via DOH on-line incident report form. 3. The review of self-reported incidents by the facility prior to the survey revealed the following for Resident #3: a). The review of an incident report dated	R 390		

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R 390	Continued From page 5 06/14/2023 at 7:35 pm, showed Resident #3 fell outside in the courtyard. The Staff went out and found the resident lying on her right should. When asked the resident said she lost her balance. The resident was assessed by staff and a cut was noted on her finger, and a bandage was applied. The report showed that DOH was notified of the incident on 06/30/2023 (16 days later) via DOH on-line incident report form. b). The review of an incident report dated 06/22/2023, showed that Resident #3 reported that she fell and had pain in her lower back, and a head-to-toe assessment was done. The DOH was notified of the incident on 06/30/2023 (8 days later) at 10:56 pm via DOH on-line incident report form. c). The review of an incident report dated 07/10/2023 at 7:00 pm, showed that Resident #3 was inebriated on Georgia Avenue. The residents indicated that she tripped and fell, hurting her knees. The DC Fire Department arrived, and EMS was called, and the resident was transported to the local hospital, and was kept overnight. The resident was discharged around 10:45 am the next morning with a diagnosis of alcohol intoxication with delirium and acute cystitis without hematuria. A further review of the incident report indicated that a care plan meeting was scheduled for 07/12/2023. However, there was no documentation provided. The report showed that the DOH was notified of the incident on 07/12/2023 via DOH on-line incident report form. d). The review of an incident report dated 09/12/2023, showed Resident #3 was found outside the ALR building in a sitting position on the ground and appeared intoxicated. Per the	R 390		

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R 390	Continued From page 6 report, the resident stated that she did not fall. The resident was then assisted back to her room where an assessment was completed. The report showed that DOH was notified of the incident on 10/16/2023 (34 days later) via DOH on-line incident report form. e). The review of an incident report dated 08/17/2023, showed the resident "was falling while walking and holding the rails on the first floor." The resident was intoxicated but said she was ok and was assisted from the floor to her room where an assessment was completed. The report showed that the DOH was notified of the incident on 08/28/2023 (11 days later) via DOH on-line incident report form. f). The review of an incident report dated 07/25/2023, showed the resident was found sitting on the ground outside, next to the bench. Per the report, the resident was intoxicated and smelled of alcohol. The resident was unable to walk and was assisted into a wheelchair and taken to her room. The report showed that the DOH was notified of the incident on 08/09/2023 (15 days later) via DOH on-line incident report form. (4). The review of self-reported incidents by the facility prior to the survey revealed the following incidents for Resident #4: a). The review of an incident report dated 07/06/2023 at 8:15 pm, stated that Resident #4 was sitting on the edge of the bed and slid to the floor. The nurse performed a range of motion exercises on his extremities and the resident was able to move extremities. b). The review of an incident report dated	R 390		

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R 390	Continued From page 7 07/25/2023, showed that the resident was observed on the floor. Per the report the resident fell on the floor and landed on her right side. When asked, the resident stated, "I tried to change my pull-up, felt dizzy and fell." The resident was assisted back in bed and was administered Tylenol for pain. c). The review of an incident report dated 07/25/2023, showed that the resident was observed on the floor. When asked the resident stated that she slid from the chair. The resident was assisted back to the bed where an assessment was completed. (5). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #5. a). An incident report dated 07/11/2023 at 11:16 am, showed that Resident #5 had blood on his right temple due to an unwitnessed fall in his bedroom. When asked the resident said he lost his balance when coming from the bathroom. The resident was assessed by the licensed practical nurse (LPN) and EMS was called; however, he refused to go to the local hospital. The report showed that DOH was notified of the incident on 08/09/2023 (29 days later) via DOH on-line incident report form. b). An incident report dated 06/28/2023 (no time indicated), showed that the LPN received a report that Resident #5 was not feeling well. Per the LPN's report, the resident said, "I am very weak", and had slurred speech. The LPN completed a head-to-toe assessment and noted that the residents blood sugar was low (55). The LPN attempted to give the resident orange juice to boost his sugar levels; however, the resident	R 390		

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R 390	Continued From page 8 refused. The EMS was called, and the resident was given glycogen, minutes later his blood sugar increased to 98. The resident refused to be transferred to the local emergency room and stated, "I feel better now". The report showed that the DOH was notified of the incident on 06/30/2023 (2 days later) via DOH on-line incident report form. c). An incident report dated 09/12/2023, showed Resident #5 was noted with an open wound on the "left lateral planter foot at the 5th toe pre-existing, odorous, unstageable wound." The LPN cleaned the area with wound cleanser and dried it with gauze, and the resident denied pain when asked. The report showed that the DOH was notified of the incident on 10/16/2023 (34 days later) via DOH on-line incident report form. d). An incident report dated 10/07/2023 at 2:00 pm, showed Resident #5 fell on the first-floor hallway. When asked, the resident said he tripped over his feet, fell, and landed on his buttocks. The resident denied any pain or injury and was able to get up on his own. Upon the LPN assessment, no skin injury, no bleeding, or hematoma were noted. The DOH was notified of the incident on 10/12/2023 (5 days later) via DOH on-line incident report form. (6). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #6. a). An incident report dated 07/14/2023 at 3:58 pm showed Resident #6 is diagnosed with End Stage Renal Disease and required dialysis three times per week. It was further noted that he had not received dialysis services since 06/30/2023 at his regularly scheduled facility. However, he was	R 390		

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R 390	Continued From page 9 seen in the emergency room frequently where he received dialysis. There was no evidence that DOH had been notified. b). An incident report dated 08/22/2023, showed Resident #6 called 911 for shortness of breath, stating he could not breathe. An assessment was completed, and EMS was called, and the resident was transported to the local hospital. The DOH was notified of the incident on 08/28/2023 (6 days later) via DOH on-line incident report form. (7). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #7. a). An incident report dated 02/07/2023 at 9:38 am, showed Resident #7 informed staff that his body was sore from falling twice the previous day. EMS was called, but the resident refused to go to the emergency room. Per the incident report the DOH was notified on 06/30/2023 at 7:48 pm (more than four (4) months after the incident). b). An incident report dated 06/24/2023 at 6:18 pm, stated that the LPN found the Resident #7 in his room sitting in a chair leaning forward. The resident stated he felt weak and wanted to go back to bed. An assessment was completed, and his vital signs were found to be "very low." EMS was called and the resident was taken to a local hospital for evaluation. c). An incident report dated 03/04/2023 at 3:19 pm, showed staff went to Resident #7's room, and he said he felt dizzy and fell in the bathroom. The resident further indicated that he was able to get himself up by holding and leaning on his cane. The DOH was notified of the incidents on 06/30/2023 (more than three months after the	R 390		

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R 390	Continued From page 10 incident) via DOH on-line incident report form. (8). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #8. An incident report dated 06/28/2023 at 11:18 pm, showed the LPN found the resident on the floor lying in a supine position. Per the report, the resident stated, "I tripped on myself and accidentally fell to the floor". A head-to-toe assessment was initiated with no apparent injury noted. The resident was assisted back to her bed by two staff members. The DOH was notified of the incident on 06/30/2023 (2 days later) via DOH on-line incident report form. (9). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #9. a). An incident report dated 06/29/2023 at 8:28 am, showed Resident #9 was found in her room on the floor with blood on her face and on the floor. When asked the resident said she was trying to get out of bed and fell to the floor. The resident was assessed and able to move all extremities without any pain or discomfort. b). An incident report dated 03/28/2023 at 11:00 pm, showed Resident #9 called a staff to her room and the resident was found on the floor. When asked the resident said she rolled over in her bed and fell to the floor. The resident's vital signs were checked, and her oxygen level was low. The EMS was called, and oxygen was administered but the level still remained low, and the resident was taken to a local hospital. The DOH was notified via incident reporting on 06/30/2023 (more than three months after the incident) via DOH on-line incident report form.	R 390		

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R 390	Continued From page 11 (10). A review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #10. An incident report dated 09/21/2023 at 3:15 pm, showed Resident #10 had symptoms of hypoglycemia and was found lying on the bed in a supine position. When asked the resident stated, "I did not eat lunch". Per the report the resident's blood sugar was low when checked and was given orange juice to raise his blood sugar. Thirty minutes later his sugar levels were elevated. DOH was notified of the incident on 09/23/2023 (2 days later) via DOH on-line incident report form. (11). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #11. According to an incident report dated 09/21/2023, Resident #11 was found on the floor, on her knees, in front of the bed. The resident said she was trying to get up to use the bathroom and slid onto the carpet in front of her bed and landed on her buttocks. Per the report, the resident sustained a laceration on her left knee. The DOH was notified of the incident on 09/23/2023 (2 days) via the DOH on-line incident report form. (12). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #12. a). According to an incident report dated 08/25/2023, Resident #12 was heard yelling and screaming. When the staff entered the resident's bedroom, the resident was found on the floor lying on her right side. When asked the resident	R 390		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 390	Continued From page 12 stated that she slid down to the floor while trying to transfer to the wheelchair. The DOH was notified of the incident on 08/28/2023 (3 days) via DOH on-line incident report form. b). An incident report dated 07/18/2023, showed that Resident #12 was observed sitting on the floor upright next to her wheelchair. The resident reported that she slid to floor while trying to self-transfer to her wheelchair. The resident was assisted to the wheelchair and an assessment was completed. The DOH was notified of the incident on 08/21/2023 (over 33 days later) via DOH on-line incident report form. (13). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #13. a). Per an incident report dated 08/27/2023 at 7:30 am, Resident #13 was observed dragging her right foot in a painful manner. When asked, the resident said she was trying to turn her alarm off while still feeling sleepy and that she slid from her bed to the floor and landed on her right knee. The DOH was notified of the incident on 08/28/2023 at 12:18 pm via DOH on-line incident report form. b). An incident report dated 09/25/2023, showed Resident #13 was observed sitting on the floor. When asked the resident said while going to the bathroom, she lost her balance and "landed on her buttocks and hit her right knee." Per the report, the resident's pain level was high. The EMS was called, and the resident was taken to the emergency room. The DOH was notified of the incident on 09/27/2023 (2 days later) via DOH on-line incident report form.	R 390		

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R 390	Continued From page 13 (14). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #14. An incident report dated 03/05/2023 at 11:57 am, showed Resident #14 fell in the bathroom and hit his head. When asked, the resident said that after taking a shower he slipped and fell, hitting his head on the wall. the resident was assessed from head to toe; there were no bumps or injury found to his head, range of motion was performed to all extremities and were within normal limits. Resident denied any pain or discomfort. EMS was called and the resident was taken to the hospital for a scan of the head. The DOH was notified of the incident on 06/30/2023 (over 3 months later) via DOH on-line incident report form. (15). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #15. a). An incident report dated 02/24/2023 at 4:02 pm, showed Resident #15 had her morning breakfast in the dining room at 8:00 am and returned to her room at 8:45 am. The resident was noted with bruises and swelling on her face but denied any pain or discomfort at that time. An ice pack was applied for swelling and bruising. b). An incident report dated 05/15/2023 at 7:50 pm, showed Resident #15 was found in her room sitting in an upright position on the floor near the bathroom door. The resident was unresponsive but was breathing and a pulse was present. The LPN did a head-to-toe assessment and no apparent injury noted, skin intact, no bruises, no redness, and no hematoma. Two staff members assisted the resident in a chair. EMS was called	R 390		

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R 390	Continued From page 14 and the resident was taken to a local hospital. The DOH was notified of the incident on 06/30/2023 (46 days later) via DOH on-line incident report form. (16). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #16. a). An incident report dated 01/19/2023 at 6:49 pm, revealed that Resident #17 left (eloped) from the facility and was returned (no date of the incident was indicated on the incident report). b). An incident report dated 01/29/2023 at 4:43 pm states Staff observed Resident #16 fall to the floor, landed on his left side and rolled over to his back. The Staff assisted the resident into a sitting position. The LPN completed a head-to-toe assessment. The resident complained of pain in his left arm. The EMS was called, and the resident was transported to a local hospital. The DOH was notified of the incident on 06/30/2023 (6 months later) via DOH on-line incident report form. 17. The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #17. a). An incident report dated 08/07/2023 at 9:30 am, showed Resident #17 was observed in her bathroom sitting on the floor with feces "everywhere". When asked what happened, the resident said she slid from the toilet to the floor. Upon assessment, no fall related injury was noted. The residents was cleaned and made comfortable. The DOH was notified on 08/09/2023.	R 390		

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R 390	Continued From page 15 b). An incident report dated 09/06/2023 at 5:03 pm, showed Resident #17 was found on the floor in her room, lying in a supine position. When asked the Resident said she slid from the wheelchair to the floor. A head-to-toe assessment was completed with no noted injury, no bruises, no complaint of pain, no bleeding and she denied hitting her head. Two staff members assisted in transferring the resident to her wheelchair. DOH was notified on 09/12/2023 via the on-line incident reporting system. c). An incident report dated 09/30/2023 at 9:05 PM, showed Resident #17 was found sitting upright on the floor near her bed. A head-to-toe assessment was completed by the LPN, and swelling was noted on the back of her neck. She complained of pain. There was no bleeding or bruises noted. EMS was called and the resident was taken to the local emergency room. DOH was notified on 10/03/2023 via the on-line incident reporting system. d). An incident report dated 10/15/2023 at 3:15 pm, showed the LPN received a report that Resident #17 had generalized weakness, confusion and refused to eat or drink. The LPN found the resident in her room lying in her bed. The resident informed the LPN that she felt weak. An order was given to send the resident to the emergency room due to a change in mental status and weakness. EMS was called and the resident was transferred to a local hospital. The DOH was notified of the incident on 10/16/2023 via the DOH on-line incident report form. (18). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #18.	R 390		

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R 390	Continued From page 16 An incident report dated 08/19/2023, showed that the resident reported that she lost her balance and fell while trying to open the door. The resident was assisted to bed and a complete assessment was done. The DOH was notified of the incident on 08/28/2023 (9 days later) via DOH on-line incident report form. (19). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #19. An incident report dated 07/28/2023, showed the resident reported that he was feeling dizzy. After an assessment was completed, EMS was called, and the resident was transported to the hospital. The DOH was notified of the incident on 08/09/2023 (12 days later) via DOH on-line incident report form. (20). The review of an incident report dated 10/13/2023, showed that Resident #20 was taken to the emergency room and admitted for suicidal thoughts. The DOH was notified of the incident on 10/16/2023 (3 days later) via the DOH on-line incident report form. 21. The review of an incident report dated 10/13/2023, showed that Resident #21 complained of "cramping pain all over his body, headache and polyuria." An assessment was completed and showed elevated blood sugars, thirty minutes later the levels remained elevated. EMS was called and the resident was taken to the emergency room for high blood sugar and keystones. DOH was notified of the incident on 10/16/2023 via DOH on-line incident report form. 22. The review of an incident report dated 07/10/2023 at 9:00 am, showed the Trained	R 390		

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R 390	Continued From page 17 Medication Employee (TME) observed that Resident #22 had shortness of breath while taking his vitals. The resident initially refused to go to the emergency room, but later agreed to go when the shortness of breath persisted the resident walked outside to the patio. The EMS was called, and the resident was taken to the emergency room. The DOH was notified of the incident on 07/11/2023 at 10:57 am, via DOH on-line incident report form. On 10/18/2023 at 10:20 am, the Executive Director was interviewed regarding their process, and procedure for reporting incidents to the DOH. The administrator said incidents that interfere with the clients' health and safety should be reported to the DOH. On 10/18/2023 at 10:50 am, a review of the ALR's "Incident Reporting" policy, dated 07/10/2023 showed the following instruction: - The ALR will notify the DOH of any unusual incidents that substantially affect a resident. -The Administrator or their designee will contact the DOH by phone promptly and shall follow-up with a written notification via email within 24 hours or the next business day. At the time of the survey, the ALR failed to promptly notify the DOH by telephone of all incidents that substantially affected a resident, followed by written notification within 24 hours.	R 390		

Health Regulation & Licensing Administration

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R 000	Initial Comments 0000 Initial Comments On 10/17/2023 at 5:08 PM, the Department of Health (DOH), Health Regulation and Licensing Administration (HLRA), Intermediate Care Facilities Division (State Survey Agency) Complaint Coordinator, received a telephone call from the Executive Director (ED) of the Assisted Living Residence (ALR) indicating that Resident #1 was missing, and was last seen in the facility on 10/12/2023. Based on the nature of the call, the State Survey Agency (SSA) initiated an on-site investigation on 10/18/2023 at 9:30 am, to determine compliance with the ALR Regulatory Act of 2000, "DC Code § 44-101.01" and Title 22-B DCMR (Public Health and Medicine) Chapter 101 attendant regulations. The investigative findings were based on interviews with professional staff and management staff, and a review of administrative records, including facility incidents reports and policies. Based on the information obtained during the investigation, the following was determined: The ALR failed to report the missing person timely to the Administrator and the State Agency (DOH) promptly followed by written notification within 24 hours or the next business day. The ALR staff failed to implement its policies on Unusual Incident Reporting, Missing Resident, and Alcohol Use.	R 000	Please start typing your responses here:	
R 383	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	R 383		

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R 383	Continued From page 1 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 notify the Director of incidents that substantially affects the residents; promptly notifies the Department of Health (DOH) by telephone and follow up by written notification within twenty-four hours or the next business day for all incidents that substantially affects the residents, for 23 of the 22 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22). Findings included: On 10/19/2023 beginning at 11:00 am, the review of the facility's incident reports which included complaints, fall reports, and elopement showed the following: 1. A review of incidents that were self-reported by the facility prior to the complaints/investigative survey showed the following incidents for Resident #1: a). On 10/18/2023 at 10:20 am, an interview was held with the Assisted Living Administrator (ALA), who informed the surveyors that Resident #1 was last seen in the ALR on 10/12/2023. When asked if the incident had been reported to DOH, she replied, "Yes, on 10/16/2023 at approximately 5:00 pm." According to the incident report submitted to DOH on 10/16/2023 at 4:57 pm, the resident was last seen in the facility on 10/12/2023. Per the report, the Metropolitan Police was called, and a missing person report was completed. Also, a thorough search of the	R 383	R383 1. Corrective Action to be accomplished Examined incident reporting for unusual occurrences, addressed missing resident situations, and discussed the alcohol policy with staff, ensuring updates align with the needs and characteristics of our facility residents. 2. Measures Implemented to ensure it does not recur We have created a checklist for facility staff based on the incident reporting policy and are providing additional training on how, what, and when to make reports. We've implemented a new policy for midnight daily census checks to verify the resident's presence in the facility. This ensures timely notifications to the ALA and/or DON in the case of a missing resident or emergency. 3. QA Program Action to Monitor compliance with corrective measures. A review of all incident reports and the status of their required reporting will be included in the monthly reporting which is included in the monthly QA review. 4. Date to be completed 12/19/2023	

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R 383	Continued From page 2 building was conducted and a few of the local hospitals were called. The DOH was notified of the incident on 10/12/2023 via the DOH on-line incident report form. b). The review of an incident report dated 06/12/2023 at 10:58 pm, showed Resident #1 had a purple area and hematoma on the left side of his face, and on top of his scalp. Per the report, the resident stated he fell on the sidewalk earlier that day. Emergency Medical Services (EMS) was called, but he refused to go to the local emergency room. An ice pack and Tylenol were given. The report showed that DOH was notified of the incident on 06/30/2023 (18 days later) via the DOH on-line incident report form. c). The review of an incident report dated 07/30/2023, showed that the resident reported that he fell while walking outside. The resident sustained a laceration and was sent to the emergency room. The report showed that the DOH was notified of the incident on 08/09/2023 (10 days later) via DOH on-line incident report form. 2. The review of self-reported incidents by the facility prior to the investigation survey showed the following for Resident #2: a). A review of an incident report dated 05/30/2023 at 3:55 pm, showed Resident #2 was found lying on the floor in her closet with two pillows under her head. When asked, the resident said she was looking for something to wear and lost her balance. The staff attempted to lift the resident but was unable, and so the Emergency Medical Service (EMS) was called, but the resident refused to go the local hospital. The report showed that DOH was notified of the	R 383		

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R 383	Continued From page 3 incident on 06/30/2023 (30 days later) via DOH on-line incident report form. b). A review of an incident report dated 06/05/2023 at 6:30 pm, showed Resident #2 was observed lying on the floor in her bathroom on her left shoulder, with vomit like food contents in her mouth. The resident was assessed, EMS was called, and the resident was transferred to a local hospital. The report showed that DOH was notified of the incident on 06/30/2023 (25 days later) via DOH on-line incident report form. c). The review of an incident report dated 06/07/2023 at 5:02 PM, showed Resident #2 was found lying on the floor under the couch, screaming and complaining of pain all over her body. EMS was called and the resident was taken to a local hospital. The report showed that DOH was notified of the incident on 06/30/2023 (23 days later) via DOH on-line incident report form. d). The review of an incident report dated 06/20/2023 at 9:33 pm, showed Resident #2 was noted with discoloration on her left breast and upper inner arm area. The resident reported that she spilled coffee on her body at 3:00 am. EMS was called, and the Resident was transferred to a local emergency room. The report showed that DOH was notified of the incident on 06/30/2023 (10 days later) via DOH on-line incident report form. e). The review of an incident report dated 09/09/2023 at 10:30 am, showed Resident #2 was heard screaming for help, and was found sitting on the floor in her room. When asked what happened, the resident stated that her jacket got caught on the wheel of her walker and she fell on her buttocks. The resident denied injury and	R 383		

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R 383	Continued From page 4	R 383		

refused to go to the hospital. On assessment, no injury was noted, and the resident required assistance from the floor to her recliner. The report showed that the DOH was notified of the incident on 09/12/2023 (3 days later) at 11:49 am via DOH on-line incident report form.

f). The review of an incident report dated 09/04/2023 at 5:50 am, showed that during medication administration, Resident #2 was found sitting on the floor by her recliner. When asked what happened, the resident said she was trying to get up and slid to the floor. Upon assessment, the resident denied pain or discomfort, and was assisted by three staff to her recliner. The DOH was notified of the incident on 09/06/2023 at 8:41 am (2 days later) via DOH on-line incident report form.

g). The review of an incident report dated 06/07/2023 at 10:20 pm, showed Resident #2 was found on the floor lying in a prone position under the couch. The resident was yelling, screaming, and complaining of pain under her neck and entire body. The resident rated the pain level at 10/10. Staff put a pillow under her neck for comfort, and called EMS, and the resident was taken to the local hospital. DOH was notified of the incident on 06/30/2023 at 8:41 am (23 days later) via DOH on-line incident report form.

3. The review of self-reported incidents by the facility prior to the survey revealed the following for Resident #3:

a). The review of an incident report dated 06/14/2023 at 7:35 pm, showed Resident #3 fell outside in the courtyard. The Staff went out and found the resident lying on her right should. When asked the resident said she lost her balance. The

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R 383	Continued From page 5 resident was assessed by staff and a cut was noted on her finger, and a bandage was applied. The report showed that DOH was notified of the incident on 06/30/2023 (16 days later) via DOH on-line incident report form. b). The review of an incident report dated 06/22/2023, showed that Resident #3 reported that she fell and had pain in her lower back, and a head-to-toe assessment was done. The DOH was notified of the incident on 06/30/2023 (8 days later) at 10:56 pm via DOH on-line incident report form. c). The review of an incident report dated 07/10/2023 at 7:00 pm, showed that Resident #3 was inebriated on Georgia Avenue. The residents indicated that she tripped and fell, hurting her knees. The DC Fire Department arrived, and EMS was called, and the resident was transported to the local hospital, and was kept overnight. The resident was discharged around 10:45 am the next morning with a diagnosis of alcohol intoxication with delirium and acute cystitis without hematuria. A further review of the incident report indicated that a care plan meeting was scheduled for 07/12/2023. However, there was no documentation provided. The report showed that the DOH was notified of the incident on 07/12/2023 via DOH on-line incident report form. d). The review of an incident report dated 09/12/2023, showed Resident #3 was found outside the ALR building in a sitting position on the ground and appeared intoxicated. Per the report, the resident stated that she did not fall. The resident was then assisted back to her room where an assessment was completed. The report showed that DOH was notified of the incident on	R 383		

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R 383	Continued From page 6 10/16/2023 (34 days later) via DOH on-line incident report form. e). The review of an incident report dated 08/17/2023, showed the resident "was falling while walking and holding the rails on the first floor." The resident was intoxicated but said she was ok and was assisted from the floor to her room where an assessment was completed. The report showed that the DOH was notified of the incident on 08/28/2023 (11 days later) via DOH on-line incident report form. f). The review of an incident report dated 07/25/2023, showed the resident was found sitting on the ground outside, next to the bench. Per the report, the resident was intoxicated and smelled of alcohol. The resident was unable to walk and was assisted into a wheelchair and taken to her room. The report showed that the DOH was notified of the incident on 08/09/2023 (15 days later) via DOH on-line incident report form. (4). The review of self-reported incidents by the facility prior to the survey revealed the following incidents for Resident #4: a). The review of an incident report dated 07/06/2023 at 8:15 pm, stated that Resident #4 was sitting on the edge of the bed and slid to the floor. The nurse performed a range of motion exercises on his extremities and the resident was able to move extremities. b). The review of an incident report dated 07/25/2023, showed that the resident was observed on the floor. Per the report the resident fell on the floor and landed on her right side. When asked, the resident stated, "I tried to	R 383		

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R 383	Continued From page 7 change my pull-up, felt dizzy and fell." The resident was assisted back in bed and was administered Tylenol for pain. c). The review of an incident report dated 07/25/2023, showed that the resident was observed on the floor. When asked the resident stated that she slid from the chair. The resident was assisted back to the bed where an assessment was completed. (5). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #5. a). An incident report dated 07/11/2023 at 11:16 am, showed that Resident #5 had blood on his right temple due to an unwitnessed fall in his bedroom. When asked the resident said he lost his balance when coming from the bathroom. The resident was assessed by the licensed practical nurse (LPN) and EMS was called; however, he refused to go to the local hospital. The report showed that DOH was notified of the incident on 08/09/2023 (29 days later) via DOH on-line incident report form. b). An incident report dated 06/28/2023 (no time indicated), showed that the LPN received a report that Resident #5 was not feeling well. Per the LPN's report, the resident said, "I am very weak", and had slurred speech. The LPN completed a head-to-toe assessment and noted that the residents blood sugar was low (55). The LPN attempted to give the resident orange juice to boost his sugar levels; however, the resident refused. The EMS was called, and the resident was given glycogen, minutes later his blood sugar increased to 98. The resident refused to be transferred to the local emergency room and	R 383		

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stated, "I feel better now". The report showed that the DOH was notified of the incident on 06/30/2023 (2 days later) via DOH on-line incident report form.

c). An incident report dated 09/12/2023, showed Resident #5 was noted with an open wound on the "left lateral planter foot at the 5th toe pre-existing, odorous, unstageable wound." The LPN cleaned the area with wound cleanser and dried it with gauze, and the resident denied pain when asked. The report showed that the DOH was notified of the incident on 10/16/2023 (34 days later) via DOH on-line incident report form.

d). An incident report dated 10/07/2023 at 2:00 pm, showed Resident #5 fell on the first-floor hallway. When asked, the resident said he tripped over his feet, fell, and landed on his buttocks. The resident denied any pain or injury and was able to get up on his own. Upon the LPN assessment, no skin injury, no bleeding, or hematoma were noted. The DOH was notified of the incident on 10/12/2023 (5 days later) via DOH on-line incident report form.

(6). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #6.

a). An incident report dated 07/14/2023 at 3:58 pm showed Resident #6 is diagnosed with End Stage Renal Disease and required dialysis three times per week. It was further noted that he had not received dialysis services since 06/30/2023 at his regularly scheduled facility. However, he was seen in the emergency room frequently where he received dialysis. There was no evidence that DOH had been notified.

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R 383	Continued From page 9 b). An incident report dated 08/22/2023, showed Resident #6 called 911 for shortness of breath, stating he could not breathe. An assessment was completed, and EMS was called, and the resident was transported to the local hospital. The DOH was notified of the incident on 08/28/2023 (6 days later) via DOH on-line incident report form. (7). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #7. a). An incident report dated 02/07/2023 at 9:38 am, showed Resident #7 informed staff that his body was sore from falling twice the previous day. EMS was called, but the resident refused to go to the emergency room. Per the incident report the DOH was notified on 06/30/2023 at 7:48 pm (more than four (4) months after the incident). b). An incident report dated 06/24/2023 at 6:18 pm, stated that the LPN found the Resident #7 in his room sitting in a chair leaning forward. The resident stated he felt weak and wanted to go back to bed. An assessment was completed, and his vital signs were found to be "very low." EMS was called and the resident was taken to a local hospital for evaluation. c). An incident report dated 03/04/2023 at 3:19 pm, showed staff went to Resident #7's room, and he said he felt dizzy and fell in the bathroom. The resident further indicated that he was able to get himself up by holding and leaning on his cane. The DOH was notified of the incidents on 06/30/2023 (more than three months after the incident) via DOH on-line incident report form. (8). The review of incidents self-reported by the facility prior to the survey revealed the following	R 383		

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R 383	Continued From page 10 incidents for Resident #8. An incident report dated 06/28/2023 at 11:18 pm, showed the LPN found the resident on the floor lying in a supine position. Per the report, the resident stated, "I tripped on myself and accidentally fell to the floor". A head-to-toe assessment was initiated with no apparent injury noted. The resident was assisted back to her bed by two staff members. The DOH was notified of the incident on 06/30/2023 (2 days later) via DOH on-line incident report form. (9). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #9. a). An incident report dated 06/29/2023 at 8:28 am, showed Resident #9 was found in her room on the floor with blood on her face and on the floor. When asked the resident said she was trying to get out of bed and fell to the floor. The resident was assessed and able to move all extremities without any pain or discomfort. b). An incident report dated 03/28/2023 at 11:00 pm, showed Resident #9 called a staff to her room and the resident was found on the floor. When asked the resident said she rolled over in her bed and fell to the floor. The resident's vital signs were checked, and her oxygen level was low. The EMS was called, and oxygen was administered but the level still remained low, and the resident was taken to a local hospital. The DOH was notified via incident reporting on 06/30/2023 (more than three months after the incident) via DOH on-line incident report form. (10). A review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #10.	R 383		

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R 383	Continued From page 11 An incident report dated 09/21/2023 at 3:15 pm, showed Resident #10 had symptoms of hypoglycemia and was found lying on the bed in a supine position. When asked the resident stated, "I did not eat lunch". Per the report the resident's blood sugar was low when checked and was given orange juice to raise his blood sugar. Thirty minutes later his sugar levels were elevated. DOH was notified of the incident on 09/23/2023 (2 days later) via DOH on-line incident report form. (11). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #11. According to an incident report dated 09/21/2023, Resident #11 was found on the floor, on her knees, in front of the bed. The resident said she was trying to get up to use the bathroom and slid onto the carpet in front of her bed and landed on her buttocks. Per the report, the resident sustained a laceration on her left knee. The DOH was notified of the incident on 09/23/2023 (2 days) via the DOH on-line incident report form. (12). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #12. a). According to an incident report dated 08/25/2023, Resident #12 was heard yelling and screaming. When the staff entered the resident's bedroom, the resident was found on the floor lying on her right side. When asked the resident stated that she slid down to the floor while trying to transfer to the wheelchair. The DOH was notified of the incident on 08/28/2023 (3 days) via DOH on-line incident report form.	R 383		

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R 383	Continued From page 12 b). An incident report dated 07/18/2023, showed that Resident #12 was observed sitting on the floor upright next to her wheelchair. The resident reported that she slid to floor while trying to self-transfer to her wheelchair. The resident was assisted by the wheelchair and an assessment was completed. The DOH was notified of the incident on 08/21/2023 (over 33 days later) via DOH on-line incident report form. (13). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #13. a). Per an incident report dated 08/27/2023 at 7:30 am, Resident #13 was observed dragging her right foot in a painful manner. When asked, the resident said she was trying to turn her alarm off while still feeling sleepy and that she slid from her bed to the floor and landed on her right knee. The DOH was notified of the incident on 08/28/2023 at 12:18 pm via DOH on-line incident report form. b). An incident report dated 09/25/2023, showed Resident #13 was observed sitting on the floor. When asked the resident said while going to the bathroom, she lost her balance and "landed on her buttocks and hit her right knee." Per the report, the resident's pain level was high. The EMS was called, and the resident was taken to the emergency room. The DOH was notified of the incident on 09/27/2023 (2 days later) via DOH on-line incident report form. (14). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #14.	R 383		

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R 383	Continued From page 13 An incident report dated 03/05/2023 at 11:57 am, showed Resident #14 fell in the bathroom and hit his head. When asked, the resident said that after taking a shower he slipped and fell, hitting his head on the wall. the resident was assessed from head to toe; there were no bumps or injury found to his head, range of motion was performed to all extremities and were within normal limits. Resident denied any pain or discomfort. EMS was called and the resident was taken to the hospital for a scan of the head. The DOH was notified of the incident on 06/30/2023 (over 3 months later) via DOH on-line incident report form. (15). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #15. a). An incident report dated 02/24/2023 at 4:02 pm, showed Resident #15 had her morning breakfast in the dining room at 8:00 am and returned to her room at 8:45 am. The resident was noted with bruises and swelling on her face but denied any pain or discomfort at that time. An ice pack was applied for swelling and bruising. b). An incident report dated 05/15/2023 at 7:50 pm, showed Resident #15 was found in her room sitting in an upright position on the floor near the bathroom door. The resident was unresponsive but was breathing and a pulse was present. The LPN did a head-to-toe assessment and no apparent injury noted, skin intact, no bruises, no redness, and no hematoma. Two staff members assisted the resident in a chair. EMS was called and the resident was taken to a local hospital. The DOH was notified of the incident on 06/30/2023 (46 days later) via DOH on-line incident report form.	R 383		

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R 383	Continued From page 14 (16). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #16. a). An incident report dated 01/19/2023 at 6:49 pm, revealed that Resident #17 left (eloped) from the facility and was returned (no date of the incident was indicated on the incident report). b). An incident report dated 01/29/2023 at 4:43 pm states Staff observed Resident #16 fall to the floor, landed on his left side and rolled over to his back. The Staff assisted the resident into a sitting position. The LPN completed a head-to-toe assessment. The resident complained of pain in his left arm. The EMS was called, and the resident was transported to a local hospital. The DOH was notified of the incident on 06/30/2023 (6 months later) via DOH on-line incident report form. 17. The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #17. a). An incident report dated 08/07/2023 at 9:30 am, showed Resident #17 was observed in her bathroom sitting on the floor with feces "everywhere". When asked what happened, the resident said she slid from the toilet to the floor. Upon assessment, no fall related injury was noted. The residents was cleaned and made comfortable. The DOH was notified on 08/09/2023. b). An incident report dated 09/06/2023 at 5:03 pm, showed Resident #17 was found on the floor in her room, lying in a supine position. When asked the Resident said she slid from the	R 383		

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R 383	Continued From page 15 wheelchair to the floor. A head-to-toe assessment was completed with no noted injury, no bruises, no complaint of pain, no bleeding and she denied hitting her head. Two staff members assisted in transferring the resident to her wheelchair. DOH was notified on 09/12/2023 via the on-line incident reporting system. c). An incident report dated 09/30/2023 at 9:05 PM, showed Resident #17 was found sitting upright on the floor near her bed. A head-to-toe assessment was completed by the LPN, and swelling was noted on the back of her neck. She complained of pain. There was no bleeding or bruises noted. EMS was called and the resident was taken to the local emergency room. DOH was notified on 10/03/2023 via the on-line incident reporting system. d). An incident report dated 10/15/2023 at 3:15 pm, showed the LPN received a report that Resident #17 had generalized weakness, confusion and refused to eat or drink. The LPN found the resident in her room lying in her bed. The resident informed the LPN that she felt weak. An order was given to send the resident to the emergency room due to a change in mental status and weakness. EMS was called and the resident was transferred to a local hospital. The DOH was notified of the incident on 10/16/2023 via the DOH on-line incident report form. (18). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #18. An incident report dated 08/19/2023, showed that the resident reported that she lost her balance and fell while trying to open the door. The resident was assisted to bed and a complete	R 383		

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R 383	Continued From page 16 assessment was done. The DOH was notified of the incident on 08/28/2023 (9 days later) via DOH on-line incident report form. (19). The review of incidents self-reported by the facility prior to the survey revealed the following incidents for Resident #19. An incident report dated 07/28/2023, showed the resident reported that he was feeling dizzy. After an assessment was completed, EMS was called, and the resident was transported to the hospital. The DOH was notified of the incident on 08/09/2023 (12 days later) via DOH on-line incident report form. (20). The review of an incident report dated 10/13/2023, showed that Resident #20 was taken to the emergency room and admitted for suicidal thoughts. The DOH was notified of the incident on 10/16/2023 (3 days later) via the DOH on-line incident report form. 21. The review of an incident report dated 10/13/2023, showed that Resident #21 complained of "cramping pain all over his body, headache and polyuria." An assessment was completed and showed elevated blood sugars, thirty minutes later the levels remained elevated. EMS was called and the resident was taken to the emergency room for high blood sugar and keystones. DOH was notified of the incident on 10/16/2023 via DOH on-line incident report form. 22. The review of an incident report dated 07/10/2023 at 9:00 am, showed the Trained Medication Employee (TME) observed that Resident #22 had shortness of breath while taking his vitals. The resident initially refused to go to the emergency room, but later agreed to go	R 383		

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R 383	Continued From page 17 when the shortness of breath persisted the resident walked outside to the patio. The EMS was called, and the resident was taken to the emergency room. The DOH was notified of the incident on 07/11/2023 at 10:57 am, via DOH on-line incident report form. On 10/18/2023 at 10:20 am, the Executive Director was interviewed regarding their process, and procedure for reporting incidents to the DOH. The administrator said incidents that interfere with the clients' health and safety should be reported to the DOH. On 10/18/2023 at 10:50 am, a review of the ALR's "Incident Reporting" policy, dated 07/10/2023 showed the following instruction: - The ALR will notify the DOH of any unusual incidents that substantially affect a resident. -The Administrator or their designee will contact the DOH by phone promptly and shall follow-up with a written notification via email within 24 hours or the next business day. At the time of the survey, the ALR failed to promptly notify the DOH by telephone of all incidents that substantially affected a resident, followed by written notification within 24 hours.	R 383		