Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR - 0041	A. BUILDING _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

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R 000	Initial Comments An annual licensure survey in conjunction with complaints and unusual incident investigations were conducted during the period of 01/22/2024, 01/23/2024, 01/24/2024, 01/25/2025, 01/26/2024, 01/29/2024, 01/30/2024 and 01/31/2024, to determine compliance with the Assisted Living Residence (ALR) regulations, Title 22-B DCMR (Public Health and Medicine) Chapter 101, and Assisted Living Law DC ST § 44-101.01. The resident census was 114 and 80 personnel were employed by the ALR, to include professional and administrative staff. The survey sample consisted of 22 resident records to include one death and discharges (three); and 23 employee records. A total of three complaints submitted via the complaint portal/line were investigated during the survey, including one additional complaint and four incidents that occurred while onsite that required investigation due to potential health and safety concerns. See below: Complaints: DC00012534 I. On 01/22/204 at 10:16 am, the Department of Health (DOH) received an anonymous telephone call from an employee of the ALR that alleged the following: a. The residents medical alert buttons (pendants) and emergency alert systems (call bell) had not worked since last Wednesday, (01/19/2024) and the residents were unable to call be help. This allegation was substantiated. [See R tag 0272 (Dignity) in the law]. b. There were three Certified Nursing Assistants (CNA)s on four floors (shift unspecified). Based	R 000	Please start typing your responses here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tatibah Copeland TITLE Executive Director (X6) DATE 5/20/24

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R 000	Continued From page 1 on the observations from 01/22/2024, 01/23/2024, 01/24/2024, 01/25/2024, 01/26/2024, 1/29/2024 and 01/30/2024, interviews and review of the CNAs January 2024 schedule showed that there were six plus CNAs during the morning shift (7:00 am - 3:00 pm) and four CNAs on the 3:00 pm - 11:00 pm shift. There were no observations for the overnight shift (11:00 pm - 7:00 am) from 01/22/2024 through 01/30/2024. However, continued review of the January 2024 scheduled showed that there were at least four CNAs scheduled for the overnight shift. The allegation was unsubstantiated. c. The nurses reported working three to four hours late and the shifts were left uncovered. Based on the observations from 01/22/2024, 01/23/2024, 01/24/2024, 01/25/2024, 01/26/2024, 1/29/2024 and 01/30/2024, interviews and review all nurses time sheets (all shifts) from 01/01/2024 through 01/20/2024 showed no evidence that the nurses reported to work three to four hours late. This allegation was unsubstantiated. d. There was one CNA for the second shift today (01/22/2024). Based on observations on 01/22/2024, interview and review of the CNAs timesheets showed that were at six CNAs the started the evening shift (3:00 pm - 11:00 pm. This allegation is unsubstantiated. DC00012512 II. On 01/3/204 at 10:40 am, the Department of Health (DOH) received a complaint via telephone call from a resident of the ALR that alleged the following: a. All residents of the ALR received the same meals. This allegation was substantiated. [See R tag 0292 (Accommodation of Needs) in the Law]	R 000		

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R 000	Continued From page 2 b. Residents with diagnoses of diabetes and high blood pressure were not receiving meals in accordance with their dietary needs. This allegation was substantiated. [See R tag 0292 (Accommodation of Needs) in the Law] c. Resident feels his free speech constitutional rights are being violated. The residents are unable to voice a complaint and fully explain the rationale/basis of the complaint to staff. This allegation was undetermined. DC00012558 III. While onsite conducting the annual licensure survey, the DOH Complaint Coordinator received an anonymous call from an employee of the ALR that alleged that a resident had head "LICE" and had not received treatment for the LICE. This allegation was substantiated. [See R 282 Sec. 503.11 Dignity in the Law and See R Tag 0380 in the regulations]. Onsite incident investigations: 1. Resident #1 transferred to hospital via 911 on 01/12/204, The resident returned to the facility on 01/18/2024. The resident was observed placed on a gurney and transferred to ER via 911 on 1/25/2024 where he expired on the 01/29/2024 under hospice care. [See R tag 0383 (Reporting) in the regulations] 2. Resident #15 left the facility to go the ER and the facility was not aware (missing). [See R Tag 0383 in the regulations] 3. Resident #19 was observed in front of the facility involved in what appeared to be a drug	R 000		

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R 000	Continued From page 3 transaction. [No deficiencies cited] 4. Resident #22 had fallen and sustained a head injury and was not assessed by the nurse until the next day. [See R Tag 0383(4) in the regulations] The findings of the survey and investigations 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 272	Sec. 503.1 Dignity. (1) A safe, clean, comfortable, stimulating, and homelike environment allowing the resident to use personal belongings to the greatest extent possible. Based on observation, interview, and record review, the Assisted Living Residence (ALR) failed to maintain environmental safeguards to ensure the safety of each resident (i.e. a functioning and reliable emergency alert system), for 114 of the 114 residents residing in the facility. Findings included: On 01/22/2024 at 10:16 am, the Department of Health (DOH) received an anonymous complaint stating that the residents' medical alert buttons had not worked since 1/17/2024. The caller stated that the residents were unable to call for help if they pressed their alert pendants. The caller further stated that residents have been found on the floor and had to go to the hospital. On 01/22/2024 at 3:32 pm during the entrance conference with the administrative staff, the Executive Director/Administrator (ALA) was	R 272	Community submitted Pendant Action Plan during the survey process to immediately rectify the identified deficient practice. The call light system was repaired and fully operable on 1/24/2024. The Pendant Action Plan will be reviewed and converted to policy in the disaster manual by 6/30/2024. Call light monitoring for operability will be monitored on an ongoing basis by the Environmental Service Director. Any issues or concerns will be reported immediately for ALA and notice sent to DOH. If the system is noted to be inoperable the Pendant Action Plan Policy will be implemented. Call Light operability will be included in ESD physical plant rounds and reported to QA Committee monthly for the next 3 months and then quarterly. Compliance Date	6/30/2024

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R 272	Continued From page 4 asked about the emergency alert system (i.e. Residents' pendants and call bell) being inoperable. The ALA confirmed the anonymous caller's complaint that the ALR residents could not use their pendants as well as the call bell system because the system was currently down. When asked how long the system had been inoperable, the ALA stated that she was made aware that the system had been down since Friday, (01/19/2024) by the Health Services Director (HSD). The surveyors asked the ALA if there was a backup system in place to ensure residents were safe due to the call emergency alert system being down. The ALA responded by saying, "No, we have to put a system in place". The ALA did state that the staff were conducting two-hour checks for the residents. On 01/22/2024 at 3:36 pm, the Environmental Services Director (ESD) who was present during the entrance conference, confirmed the ALA's interview. The ESD said that on 01/19/2024, he called the vendor via telephone to troubleshoot the issue regarding the emergency alert system. The ESD stated that they were not able to fix the call bell system on that day. He stated that he called back to the vendor on 01/22/2024 and spoke to another technician and figured out that the "Comtrol" had gone bad and needed to be replaced. The ESD stated that he would call to see if he could have the part expedited to the facility. The ESD explained to the surveyors that if a resident pressed their pendants or pulled the call bell string inside their units or in any location in the ALR, the alert would appear on the computer monitor screen next to the printer located on the first floor out of sight of staff. The ESD stated that if staff were stationed at the computer monitor and the residents needed help, staff would see the location where the help was	R 272		

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R 272	Continued From page 5 needed and alert the staff in that location via walkie talkie to go and check on the resident. On 01/22/2024 at 3:38 pm, observation showed Resident #10 in her wheelchair in the all-purpose room. The ESD verbally instructed the resident to press her pendant located around her neck. No staff was observed to check on the resident. However, the ESD showed the surveyor on the computer monitor the time and location in which Resident #10 pressed her pendant button. The ESD stated that staff would have responded to her if they were positioned in front of the computer monitor due to the system being down. On 01/22/2024 at 3:42 pm, Resident #12 was observed on the second-floor hallway near the elevator and nursing station. The resident was asked if her pendant was working. The replied by saying, "I'm not sure". The surveyor asked her to press the pendant around her neck to see if staff responded to her. Resident #12 pressed the pendant one minute later, and no staff responded to the call. On 01/22/2024 at 4:36 pm, Resident #16 was observed inside his apartment watching television on the third floor. The surveyor asked the resident to pull the call bell in the bathroom. The resident pulled the call bell cord, and no one responded to the call. On 01/22/2024 at 4:50 pm, Resident #9 was observed inside his studio apartment located on the fifth floor. The surveyor asked the resident to press the pendant button around his neck. The resident pressed the button, and no one responded to the call. On 01/22/2024 at 5:32 pm, the ALA submitted	R 272		

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R 272	Continued From page 6 and implemented the following action plan to address the inoperable emergency alert system: Pendant System Action Plan · The pendant system is displayed on the computer monitor but does not send an emergency alert to the staff to the pagers. · When the residents press their pendants, it signals to the computer monitor that help is needed. The computer monitor is in the room where the copier is behind the wall of the receptionist desk. · An employee will be assigned to sit in front of the computer monitor and will send a message to the nursing staff via walkie talkie to go and check on the residents at their location(s) and clear the system. · Nursing staff will communicate with employees sitting in front of the computer monitor once resident has been attended to. · Staff will be trained by Health Services Director (HSD) on this protocol until the emergency alert system issue is resolved as soon as possible during their shifts. · In addition, two-hours check will be conducted and documented, and notices will be posted on each nursing station door. On 01/23/2024 at 10:28 am, Employee #17 said during an interview that she was assigned to work the 7:00 am - 3:00 pm shift, Monday through Friday. When asked why she was seated in front of the computer monitor, she replied by saying that she was assigned to monitor the computer	R 272		

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R 272	Continued From page 7 screen due to the resident's pendant buttons and call bell systems not working. Employee #17 stated that she did not know how long the call bell system had been down. On 01/23/2024 at 01/23/2024 at 12:31 pm, Employee #12 said during an interview that she was assigned to work the 3:00 pm - 11:00 pm shift, Monday through Friday, and every other weekend. When asked how long the residents pendant buttons and call bell system been down, Employee #12 said she recalled the system being down at least two weeks. On 01/23/2024 at 1:02 pm, Employee #13 said during an interview that she was assigned to work the 7:00 am - 3:00 pm shift, Monday through Friday, and every other weekend. When asked how long the residents pendant buttons and call bell system been down, Employee #13 said she that the system had been down for more than two weeks. On 01/23/2024 at 2:55 pm, the Health Services Director provided the surveyors with documents entitled, "Two Hour Rounding Records" that staff were to complete on all floors effective 01/22/2024. When asked if staff had been documenting two-hour checks prior to 01/22/2024 when the call emergency alert system was down, the Health Services Director said, "No". Note: On 01/24/2024 at 12:19 pm, the ALA said that she found a box inside her cabinet with an order form dated 01/18/2023 with an item labeled Arial Network Manager (Comtrol). She stated that gave the part to the EDS and he replaced the damaged Comtrol with the new Comtrol on the back of the computer. The emergency alert system was operable. The ALA stated that she	R 272		

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R 272	Continued From page 8 was not aware that she had the part (Comtrol) inside her office the entire time.	R 272		
R 282	Sec. 503.11 Dignity. (11) To be free from mental, verbal, emotional, sexual, and physical abuse, neglect, involuntary seclusion, and exploitation; and Based on interview and record review, the ALR failed to ensure that each resident was free from neglect (specifically, receiving timely treatment for head lice) for one of 22 residents in the sample (Resident #21). Findings included: On 01/24/2024 at 12:47 pm, the Department of Health (DOH) received an anonymous complaint regarding Resident #21 having "head lice" and not being treated for it timely. On 01/24/2024 at 1:30 pm, the Health Services Director (HSD) was queried during an interview regarding Resident #21 having head lice. The HSD said that she was informed of the head lice by staff on 1/18/2024. The HSD stated that she informed the Executive Director (ED) of the incident on the same day and was given a directive to get an over-the-counter lice treatment (Nix). The HSD stated that the Assistant Executive Director (AED) ordered the lice treatment on 1/19/2024. When asked if Resident #21 had received the treatment for the head lice, the HSD responded by saying, "No, the treatment is not here yet." It should be noted that the resident had not received treatment for six days at the time of the interview. On 01/29/2026 at 10:53 am, review a nursing	R 282	Resident #21 was treated for head lice and head lice was resolved on 1/25/2024. Nurses (RN and LPNs) will be educated on proper treatment protocol for Head Lice as outlined by the CDC. OTC Treatment for head lice will be purchased locally to prevent delay in initiation of treatment by 7/31/2024. OTC treatment orders such as Head Lice Treatment to be added to EMAR and handled as a missed medication. Timeliness of initiation of treatment orders will be reviewed during 45 Day medication review and results reported to QA Committee quarterly. Compliance Date	7/31/2024

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R 282	Continued From page 9 note dated 01/26/2024 showed that Resident #1 received treatment for head lice (eight days later). This was confirmed through an interview with the HSD at 11:01 am. On 01/30/2024 at 3:10 pm, Resident #1 said during an interview that he received the lice treatment on 1/28/2024 (10 days later). The resident stated no one from the facility had been back to his unit to check if the treatment was effective.	R 282		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents. Based on observation, interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure: (i) each resident was not served the same meals and (II) that meals were prepared in accordance with their dietary needs, for 21 of 21 residents in the core sample (Residents # 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21). Findings included: On 01/09/2024 at 1:13 pm, DC Health received a complaint regarding Resident #7. The complaint alleged that all residents at the facility received the same meals. Residents also alleged that residents with special diets for diabetics, individuals with high blood pressure and other dietary restrictions are not available. I. The ALR failed to ensure Residents # 1, 2, 3, 4,	R 292	Policy and Procedure for Grievances will be reviewed and updated by ALA and consultant to include grievances pertaining to dietary needs by 7/31/2024. Res. #7 will be interviewed by ALA or designee to document and address current grievance related to dietary needs. An Always Available Menu will be created, shared with Residents and posted in the dining area.	

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R 292	Continued From page 10 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21 were served different meal options: On 01/22/2024 at 3:15 pm, the Executive Director (ED) said during an interview that the facility was currently without a Dining Services Director, and that she was responsible for overseeing the dining service needs. The continued interview revealed that the facility used an online company for their nutritional services. Additionally, the ED stated that one menu was used for all residents regardless of their dietary needs. On 01/23/2024 at 11:27 am, observations during the lunch meal showed Dietary Aide Cook (DAC) #1 served lunch to the residents. The lunch meal consisted of two pieces of white bread, ham and cheese, lettuce, tomatoes, and a choice between mayonnaise and mustard. When asked about the lunch menu, DAC #1 said, "This is all that we have for lunch and the fish that is listed on the menu is not available today." On 01/23/2024 at 11:45 am, review of the weekly menu for the week of 01/21/2024 - 01/27/2024 confirmed that all residents received ham and cheese sandwiches on 01/23/2024 during lunch time. Continued review of the lunch menu for 01/23/2024 confirmed DAC #1's interview that baked cod filet with chips and assorted fruit should have been provided as a second option. On 01/23/2024 at 1:03 pm, Resident #4 said during an interview that no other food option was available besides the ham and cheese sandwich during lunch time. Resident #4 stated the residents always receive the same meals. II. The ALR failed to ensure Residents #1, 2, 3, 4,	R 292	Diet boards to be updated by Dining Service Director or Health Service Director at least weekly or with noted changes in diets. Dietary Communication forms will be implemented and utilized by staff for new admissions. Dining Staff to be educated on menu program and following prescribed diets by 7/31/2024.. Dietary staff to be educated on an "Always Available Menu" program by 7/31/2024. Staff to be educated on documenting and handling grievances according to policy to include but not limited to dietary needs. Staff to be educated on utilization of Dietary Communication Form by 7/31/2024. Community will establish monthly "Chef Chat Program" to discuss dining services. Any noted grievances will be handled according to policy. Meal Reviews will be conducted a minimum of three (3) times weekly for a minimum of 1 month (June 1-30) to verify appropriate diets are being served and always available menu is posted and offered to Residents. Frequency of ongoing Meal Reviews to be determined by the QA Committee. Compliance Date	8/30/2024

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R 292	Continued From page 11 5, 6, 7, 9, 10, 11, 12, 13 and 15) meals were prepared in accordance with their dietary needs. On 01/22/2024 at 3:15 pm, the Executive Director (ED) said during an interview that the facility was currently without a Dining Services Director, and that she was responsible for overseeing the dining service needs. The continued interview revealed that the facility used an online company for their nutritional services. Additionally, the ED stated that one menu was used for all residents regardless of their dietary needs. On 01/23/2024 at 11:27 am, observations during the lunch meal showed Dietary Aide Cook (DAC) #1 served lunch to the residents. The lunch meal consisted of two pieces of white bread, ham and cheese, lettuce, tomatoes, and a choice between mayonnaise and mustard. When asked about the lunch menu, DAC #1 said, "This is all that we have for lunch and the fish that is listed on the menu is not available today." DAC #1 showed the surveyor the bulletin board that was used to serve specific food to each resident. DAC #1 said "The bulletin board had not been updated in months and I do not know the specific diets of the residents that I serve, especially new residents." On 01/24/2024 at 2:52 pm, when asked about the discrepancies on the diet communication bulletin board located in the kitchen, the Health Services Director (HSD) confirmed that the bulletin board needed to be updated to reflect residents with a diagnosis of diabetes and high blood pressure received a modified diet in accordance with their physician ' s orders. The HSD stated that she was in the process of updating the diet communication board. On 01/25/2024, review of the residents' records	R 292		

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R 292	Continued From page 12 from 01/22/2024 - 01/31/2024 showed the following: a). A review of Resident #1's Medical Certification form dated 08/30/2022, showed a diagnosis of Congestive heart failure and a diet order for no added salt diet. b). A review of Resident #2's Medical Certification form dated 11/22/2023 showed a diagnosis of Hypertension and a history of Stroke and a diet order for a no added salt. c). A review of Resident #3's Medical Certification form dated 12/13/2023, showed a diagnosis of Diabetes Mellitus and a diet order for no added salt diet. d). A review of Resident #4's Medical Certification form dated 1/4/2024 showed a diagnosis of Diabetes Mellitus with insulin use and a diet order for no concentrated sweets and no added salt. e). A review of Resident #5's Medical Certification form dated 10/31/2023, showed a diagnosis of Hypertension and a diet order for regular diet with mechanical soft texture until dentures are obtained. f). A review of Resident #6's Medical Certification form dated 6/30/2022 showed a diagnosis of Diabetes Mellitus and a diet order for no added salt and no concentrated sweet diet. g). A review of Resident #7's Medical Certification form dated 4/1/2022, showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for a Diabetic and no added salt diet. h). A review of Resident #9's Medical Certification	R 292		

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R 292	Continued From page 13 form dated 2/9/2023 showed a diagnosis of Diabetes Mellitus Type I and Hypertension and a Diabetic and no added salt. i). A review of Resident #10's Medical Certification form dated 10/31/2023, showed a diagnosis of Diabetes Mellitus Type II and a diet order for no added salt and no concentrated sweet diet. j). A review of Resident #11's Medical Certification form dated 6/30/2022 showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for no added salt and no Diabetic diet with mechanical soft texture. k). A review of Resident #12's Medical Certification form dated 7/18/2021, showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for a Diabetic and no added salt diet. l). A review of Resident #13's Medical Certification form dated 11/8/2021 showed a diagnosis of Hypertension and Prediabetes and a diet order for no added salt. m). A review of Resident #15's Medical Certification form dated 11/17/2022 showed a diet order for No concentrated sweet diet. On 01/30/2024 At 9:56 am, the Executive Director (ED) said during an interview that she had not received any complaints regarding the residents' dietary needs, including Resident #7. When asked how the facility tracked or encouraged residents to file grievances complaints regarding food availability or choices, the ED stated that we do not have a system that ensured that meals are	R 292		

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R 292	Continued From page 14 served according to the need of the residents. At 10:34 am, review of the ALR's policy on dietary needs and nutrition dated January 2024 showed that the ALR will serve meals in accordance with the dietary needs of the residents. On 1/31/2024 at 11:10 am, Resident #7 said during an interview that he complained to the ED on several occasions about the food not meeting his dietary needs. Resident #7 stated that there had been no follow-up regarding his complaints. Resident #7 indicated that because of the facility not meeting his dietary needs, he still used a crock pot and skillet in his unit to cook foods that are best for a diabetic. Additionally, the resident stated that all residents continue to receive the same meals. At the time of the survey, the ALR failed to ensure residents were not served the same meals and that meals were in accordance with their dietary needs.	R 292		
R 374	Sec. 506a3 Privacy and Confidentiality. (3) To have their records maintained during their residency. Based on interviews and record reviews, it was determined that the Assisted Living Residence (ALR) failed to maintain each resident's records, for two of 22 residents in the sample (Resident #10 and 11). Findings included: On 1/26/2024 at 12:15 pm, a review of Resident #10's medical records failed to show evidence of the resident's Annual Medical Certification.	R 374	Residents# 10 and 11 will have medical certification completed by July 31, 2024. Resident medical records will be reviewed every 45 days and medical certifications that are due within the next 45 days requested from Resident's healthcare provider. Results of medical record reviews to be reported to QA committee quarterly. Compliance Date	8/30/2024

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R 374	Continued From page 15 At 1:30 pm, a review of Resident #11's medical records failed to show evidence of the resident's Annual Medical Certification. At 2:40 pm, the Assisted Living Administrator (ALA) and the Health Service Director (HSD) both confirmed after looking through Residents #10 and 11 records that they could not locate the Annual Medical Certification documents.	R 374		
R 471	Sec. 604a1 Individualized Service Plans (a)(1) An ISP shall be developed for each resident prior to admission. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that Individualized Support Plans (ISP) were developed prior to admission, for four of 22 residents in the sample (Residents #2, 3, 4 and 5). Findings included: 1. On 1/24/2024 at 10:50 am, a review of Resident #2's medical record showed that the resident was admitted to the ALR on 12/29/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 2. On 1/25/2024 at 10:11 am, a review of Resident #3's medical record showed that the resident was admitted to the ALR on 12/13/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 3. On 1/24/2024 at 1:07 pm, a review of Resident	R 471	Individualized service plan to be completed for Residents #2,3,4 and 5 by June 30, 2024. Audit of service plans to be conducted for all residents. Any Resident without a service plan completed prior to admission will be reviewed and service plan completed by Sept 15, 2024. Admission staff, ALA and HSD to be re-educated on requirements for service plans to be completed no more than 30 days prior to admission. Pre-admission audit to be initiated for all new residents within 72 hours prior admission. Requirement for service plan to be completed with in 30 days prior to be included in the audit. No resident will be admitted without a service plan within 30 days prior to admission. Audit results and corrections to be included in QA Meeting monthly for 3 months and then at least quarterly. Compliance Date	9/30/2024

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R 471	Continued From page 16 #4's medical record showed that the resident was admitted to the ALR on 1/22/2024. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 4. On 1/24/2024 at 11:29 am, a review of Resident #5's medical record showed that the resident was admitted to the ALR on 12/12/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. During an interview on 1/24/2024 at 2:40 pm, the ALR's Assisted Living Administrator and the Director of Nursing both acknowledged the above findings stating they have been looking for the documents and cannot find the ISPs in the records.	R 471		
R 472	Sec. 604a2 Individualized Service Plans (2) An ISP shall be developed following the completion of the "post move-in" assessment. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure that each resident had an Individualized Service Plan (ISP) completed following the completion of the "post move in" assessment, for three of the 22 residents in the sample (Residents #2, 3 and 15). Findings included: 1. On 1/24/2024 at 10:50 am, a review of Resident #2's medical record showed that the resident was admitted to the ALR on 11/24/2023. A further review of the resident ' s record failed to show any documented evidence that an ISP was	R 472		

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R 472	Continued From page 17 developed after a post move in assessment dated 12/20/2023. 2. On 1/25/2024 at 10:11 am, a review of Resident #3's medical record showed that the resident was admitted to the ALR on 12/13/2023. A further review of the resident ' s record failed to show any documented evidence that an ISP was developed after a post move in assessment dated 12/13/2023. 3. On 1/25/2023 at 1:28 pm, a review of Residents #15's medical record showed that the resident was admitted to the ALR on 12/28/2023. A further review of the resident ' s record failed to show any documented evidence that an ISP was developed after the assessment. During an interview on 1/24/2024 at 2:40 pm, the ALR's Assistant Executive Director and the Director of Nursing acknowledged that there were no ISPs in the records.	R 472	Resident's (#2, 3, 4, and 5) identified as not meeting the "post move-in" requirement for individualized service plans will have individualized service completed by June 30, 2024. All other resident medical records will be reviewed and any found to have have required "post move-in " service plans will have services plans completed by Sept 15, 2024. All staff involved in the ISP process will be re-educated on the requirement for post move in assessment to be completed within the initial 72 hours post move-in, and reviewed and updated by day 30 post move-in, with change in condition and every six (6) months during their stay at the ALR. ISP audits will conducted at least monthly on no less than 10 resident records. Findings regarding the timeliness of ISPs "post move-in" will be reported to the QA Committee. Compliance Date	9/30/2024
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on interviews and record reviews, the Assisted Living Residence (ALR) failed to ensure each resident's Individual Service Plan (ISP) were	R 483		

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R 483	Continued From page 18 reviewed 30 days after admission, at least every six months, updated with significant changes, and that the ISPs had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate, for 12 of 22 residents sampled (Residents #1, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 14). Findings included: I. The ALR failed to review each resident's ISP 30 days after admission, as follows: a. On 1/25/2024 at 10:11 am, a review of Resident #3's medical record showed that the resident was admitted to the ALR on 12/13/2023. However, there was no evidence that an ISP was reviewed 30 days after the resident's admission date. b. On 1/24/2024 at 10:29 am, a review of Resident #5's medical record showed that the resident was admitted to the ALR on 12/12/2023. However, there was no evidence that an ISP was reviewed 30 days after the resident's admission date. II. The ALR failed to update each resident's ISP every six months, as follows: a. On 01/25/2023 at 12:08 pm, a review of Resident #1's medical record showed that the resident was admitted on 09/24/2022. There was no evidence that the ISP was reviewed since 03/28/2023. b. On 01/25/2023 at 12:48 pm, a review of Resident #6's medical record showed that the resident was admitted on 06/30/2022. There was no evidence that an ISP was reviewed since the	R 483	Residents #1,3,5,6,7,8,9,10,11,12,13,and 14. Individualized Service Plans will be reviewed and updated by no later than June 30 ,2024. Admission staff, ALA and HSD to be re-educated on requirements for service plans to be completed no more than 30 days prior to admission, within 72 hours post move-in, within 30 days post admission, every 6 months and with change in resident condition by 7/31/2024. Admission staff and Registered Nurses will be re-educated on the requirement for frequency of Individualized service plans by 7/31/2024.. Individualized Service Plan Audits will be conducted at least every 45 days Audit results and corrections to be included in QA Meeting Quarterly. Compliance Date	9/30/2024

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R 483	Continued From page 19 resident was admitted. c. On 01/25/2023 at 2:00 pm, a review of Resident #7's medical record showed that the resident was admitted on 04/01/2022. There was no evidence that the ISP was reviewed since the resident was admitted. d. On 01/24/2024 at 10:30 am, a review of Resident #8's medical record showed that the resident was admitted on 10/13/2021. There was no evidence that the ISP was reviewed since the resident was admitted. e. On 01/24/2024 at 3:25 pm, a review of Resident #9's medical record showed that the resident was admitted on 2/9/2023. There was no evidence that the ISP was reviewed since the resident was admitted. f. On 01/26/2024 at 12:15 pm, a review of Resident 10's medical record showed that the resident was admitted on 6/29/2021. There was no evidence that the ISP was reviewed since the resident was admitted. g. On 01/26/2024 at 1:30 pm, a review of Resident 11's medical record showed that the resident was admitted on 8/26/2021. There was no evidence that the ISP was reviewed since the resident was admitted. h. On 01/24/2024 at 1:30 pm, a review of Resident 12's medical record showed that the resident was admitted on 7/08/2021. There was no evidence that the ISP was reviewed since the resident was admitted. i. On 01/25/2024 at 1:15 pm, a review of Resident 13's medical record showed that the resident was	R 483		

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R 483	Continued From page 20 admitted on 12/26/2022. There was no evidence that the ISP was reviewed since the resident was admitted. j. On 01/26/2024 at 11:00 am, a review of Resident 14's medical record showed that the resident was admitted on 12/29/2022. There was no evidence that the ISP was reviewed since the resident was admitted. k. On 01/26/2024 at 12:05 pm, a review of Resident 17's medical record showed that the resident was admitted on 10/16/2021. There was no evidence that the ISP was reviewed since the resident was admitted. l. On 01/25/2024 at 1:33 pm, a review of Resident 18's medical record showed that the resident was admitted on 3/10/2023. There was no evidence that the ISP was reviewed since the resident was admitted. m. On 01/25/2024 at 2:15 pm, a review of Resident 19's medical record showed that the resident was admitted on 5/4/2023. There was no evidence that the ISP was reviewed since the resident was admitted. n. On 01/26/2024 at 12:45 pm, a review of Resident 20's medical record showed that the resident was admitted on 8/23/2022. There was no evidence that the ISP was reviewed since the resident was admitted. On 01/24/2024 at 2:52 pm, an interview with the AED and Health Service Director (HSD) showed that there were no ISPs in the record. On 01/30/2024 at 2:51 pm, an interview with the Executive Director (ED) and the HSD confirmed that there were no ISPs in the resident ' s	R 483		

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R 483	Continued From page 21 records.	R 483		
R 523	Sec. 607a2 Services To Be Provided (2) Three nutritious and attractive meals and additional snacks, modified to individual dietary needs as necessary, on a daily basis. Based on observations, interview and record reviews, the Assisted Living Residence (ALR) failed to provide meals that were modified to the resident's dietary needs for 13 of the 22 residents in the sample. (Resident # 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13 and 15). Findings included: On 01/09/2024 at 1:13 pm, DC Health received a complaint indicating Resident #7 alleged that all residents at the facility received the same meals. Residents also alleged that residents with special diets for diabetics, individuals with high blood pressure and other dietary restrictions are not available. On 01/22/2024 at 3:15 pm, the Executive Director (ED) said during an interview that the facility was currently without a Dining Services Director, and that she was responsible for overseeing the dining service needs. The continued interview revealed that the facility used an online company for their nutritional services. Additionally, the ED stated that one menu was used for all residents regardless of their dietary needs. On 01/23/2024 at 11:27 am, observations during the lunch meal showed Dietary Aide Cook (DAC) #1 served lunch to the residents. The lunch meal consisted of two pieces of white bread, ham and cheese, lettuce, tomatoes, and a choice between	R 523	Resident # 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, and 15 will have diet boards and will be offered diets based on their individualized dietary needs. Dining Staff to be educated on menu program and following prescribed diets. Staff to be educated on documenting and handling grievances according to policy to include but not limited to dietary needs. Staff to be educated on utilization of Dietary Communication Form by 7/31/2024. Utilization of form will be added to new resident audit with any discrepancies report to Quality Assurance Committee. Community will establish monthly "Chef Chat Program" to discuss dining services. Any noted grievances will be handled according to policy. Meal Reviews will be conducted a minimum of three (3) times weekly for a minimum of 1 month (June 1-30) to verify appropriate diets are being served. Frequency of ongoing Meal Reviews to be determined by the QA Committee. Compliance Date	8/30/2024

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R 523	Continued From page 22	R 523		

mayonnaise and mustard. When asked about the lunch menu, DAC #1 said, "This is all that we have for lunch and the fish that is listed on the menu is not available today." DAC #1 showed the surveyor the bulletin board that was used to serve specific food to each resident. DAC #1 said "The bulletin board had not been updated in months and I do not know the specific diets of the residents that I serve, especially new residents."

On 01/23/2024 at 11:45 am, review of the weekly menu for the week of 01/21/2024 - 01/27/2024 confirmed that all residents received ham and cheese sandwiches on 01/23/2024 during lunch time. Continued review of the lunch menu for 01/23/2024 confirmed DAC #1's interview that baked cod filet with chips and assorted fruit should have been provided as a second option.

On 01/23/2024 at 1:03 pm, Resident #4 said during an interview that no other food option was available besides the ham and cheese sandwich during lunch time. Resident #4 stated the residents always receive the same meals.

On 01/23/2024 at 3:15 pm, the Executive Director (ED) said during an interview that the facility was currently without a Dining Services Director, and that she was responsible for overseeing the dining service needs. The continued interview revealed that the facility used an online company for their nutritional services. Additionally, the ED stated that one menu was used for all residents regardless of their dietary needs.

On 01/24/2024 at 2:52 pm, when asked about the discrepancies on the diet communication bulletin board located in the kitchen, the Health Services Director (HSD) confirmed that the bulletin board needed to be updated to reflect residents with a

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R 523	Continued From page 23 diagnosis of diabetes and high blood pressure received a modified diet in accordance with their physician's orders. The HSD stated that she was in the process of updating the diet communication board. On 01/25/2024, review of the residents' records from 01/22/2024 - 01/31/2024 showed the following: a). A review of Resident #1's Medical Certification form dated 08/30/2022, showed a diagnosis of Congestive heart failure and a diet order for no added salt diet. b). A review of Resident #2's Medical Certification form dated 11/22/2023 showed a diagnosis of Hypertension and a history of Stroke and a diet order for a no added salt. c). A review of Resident #3's Medical Certification form dated 12/13/2023, showed a diagnosis of Diabetes Mellitus and a diet order for no added salt diet. d). A review of Resident #4's Medical Certification form dated 1/4/2024 showed a diagnosis of Diabetes Mellitus with insulin use and a diet order for no concentrated sweets and no added salt. e). A review of Resident #5's Medical Certification form dated 10/31/2023, showed a diagnosis of Hypertension and a diet order for regular diet with mechanical soft texture until dentures are obtained. f). A review of Resident #6's Medical Certification form dated 6/30/2022 showed a diagnosis of Diabetes Mellitus and a diet order for no added	R 523		

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R 523	Continued From page 24 salt and no concentrated sweet diet. g). A review of Resident #7's Medical Certification form dated 4/1/2022, showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for a Diabetic and no added salt diet. h). A review of Resident #9's Medical Certification form dated 2/9/2023 showed a diagnosis of Diabetes Mellitus Type I and Hypertension and a Diabetic and no added salt. i). A review of Resident #10's Medical Certification form dated 10/31/2023, showed a diagnosis of Diabetes Mellitus Type II and a diet order for no added salt and no concentrated sweet diet. j). A review of Resident #11's Medical Certification form dated 6/30/2022 showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for no added salt and no Diabetic diet with mechanical soft texture. k). A review of Resident #12's Medical Certification form dated 7/18/2021, showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for a Diabetic and no added salt diet. l). A review of Resident #13's Medical Certification form dated 11/8/2021 showed a diagnosis of Hypertension and Prediabetes and a diet order for no added salt. m). A review of Resident #15's Medical Certification form dated 11/17/2022 showed a diet order for No concentrated sweet diet. On 01/30/2024 at 9:56 am, the Executive Director	R 523		

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R 523	Continued From page 25 (ED) said during an interview that she had not received any complaints regarding the residents' dietary needs, including Resident #7. When asked how the facility tracked or encouraged residents to file grievances complaints regarding food availability or choices, the ED stated that we do not have a system that ensured that meals are served according to the need of the residents. On 01/30/2024 at 10:34 am, review of the ALR's policy on dietary needs and nutrition dated January 2024 showed that the ALR will serve meals in accordance with the dietary needs of the residents. On 1/31/2024 at 11:10 am, Resident #7 said during an interview that he complained to the ED on several occasions about the food not meeting his dietary needs. Resident #7 stated that there had been no follow-up regarding his complaints. Resident #7 indicated that because of the facility not meeting his dietary needs, he still used a crock pot and skillet in his unit to cook foods that are best for a diabetic. Additionally, the resident stated that all residents continue to receive the same meals.	R 523		
R 562	Sec. 701a Staffing Standards. (a) An ALR shall be supervised by an ALA who shall be responsible for all personnel and services within the ALR. Based on observations, record reviews, and interviews, the Assisted Living Administrator failed to establish an effective monitoring mechanism, develop and/or implement written policies and procedures to ensure adequate oversight of the Assisted Living Residence, as evidenced by the ALA's failure to:	R 562		

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R 562	Continued From page 26 A. Establish a mechanism to ensure that the Department of Health (DOH) received prompt notifications of unusual incidents, including an allegation of neglect (Reg-10125.2 R0380 and 10125.4a R0383). B. Establish a mechanism to ensure that healthcare workers are properly credentialed and trained (Reg. 10116.15f, 10116.17) (§ 44-701d9 - R0596). C. Establish a mechanism to ensure deficient practices made known to the facility via compliance surveys were abated, and systems implemented to maintain compliance with applicable District of Columbia laws and regulations. Findings included: 1. [Cross reference Reg-10125.4a - Law R 0380 and R 0383] On 01/23/2024 beginning at 10:22 am, review of the ALR's incidents showed the following: a. On 01/12/2024 at 11:00 am, Resident #1 was sitting on his bed and stated that he was feeling like he was going to black out and that he could not see. The resident stated that his pendant was not working. The nurse checked his vital signs and called 911. The resident was transported to the emergency room for further evaluation. On 01/23/2024 at 11:04 am, the Assistant Executive Director (AED) said during an interview that she was responsible for completing and sending out incident reports. When asked about notifying DOH about Resident #1's emergency room visit, the AED stated that she did not notify	R 562	All incidents identified have been report to state authorities as required at the time of the plan of correction.Incident reports to reviewed during daily stand-up. ALA and Designee to be reeducated on requirement for reporting to DOH and other state entities by 7/31/2024. Non-functional Call Light resolved on 1/24/2024. DOH notified of all areas identified as reportable events. Resident #21 treated for head lice and head lice resolved on 1/25/2024. Employees #3, 4, 5, 6, 7, 12, 17, 18 will have documentation by healthcare practitioner as being free of communicable diseases by no later than June 30. All employee files will be audited to ensure all required licensing, credentialing and education are present in file. Any missing documentation will be obtained by with in 45 days of audit. Audit will verify the following information: 1. Job Description 2. Date of Hire 3. Proof of Valid License 4. Criminal Background Check 5. Fingerprints for all unlicensed employees 6. Employee training 7. CPR Certifications 8. Statement of being free of communicable disease including TB by a healthcare practitioner prior to hire and annually. 9. Three (3) Professional References Staff education on missing resident and requirements for reporting to be completed by July 30, 2024.	

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R 562	Continued From page 27 DOH via telephone promptly. She indicated that she submitted the incident report to DOH just over 24 hours later. b. On 01/22/2024 at 10:16 am, the Department of Health (DOH) received an anonymous complaint stating that the residents' medical alert buttons had not worked since last Wednesday, (1/17/2024). The caller stated that the residents were unable to call for help if they pressed their pendants. The caller further stated that residents have been found on the floor and had to go to the hospital. On 01/22/2024 at 3:32 pm the Executive Director/Administrator (ALA), Assistant Executive Director (AED), Health Service Director (HSD) and Maintenance Director were interviewed regarding the emergency alert system (i.e. Residents' pendants and call bell) not being inoperable. The administrative team all confirmed the anonymous caller's complaint that the ALR residents could not use their pendants because the call bell system was inoperable. When asked how long the system had been inoperable, the ALA stated that she was made aware that the system had been down since Friday, (01/19/2024) by the HSD. The surveyors asked the ALA if there was a backup system in place to ensure residents were safe due to the call emergency alert system being down. The ALA responded by saying, "No, we have to put a system in place". The ALA did state that the staff were conducting two-hour checks for the residents. When asked if an incident was generated and sent to the DOH once the emergency alert system was malfunctioning, the ED said "No". c. On 01/24/2024 at 12:47 pm, the Department of	R 562	Licensed nurses re-educated on importance of timely communication of incidents, accidents, changes in condition to including communicable diseases to ALA and HSD by 7/31/2024. Tracking of unusual incidents and timeliness of notification of DOH to be reported to QA Committee monthly. Verification of QA by manager or consultant quarterly. Compliance Date	8/30/2024

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R 562	Continued From page 28 Health (DOH) received an anonymous complaint regarding Resident #21 having "head lice" and not being treated for it timely. On 01/24/2024 at 1:30 pm, HSD was queried during an interview regarding Resident #21 having head lice. The HSD said that she was informed of the head lice by staff on 1/18/2024. The HSD stated that she informed the Executive Director (ED) of the incident on the same day and was given a directive to get an over-the-counter lice treatment (Nix). The HSD stated that the Assistant Executive Director (AED) ordered the lice treatment on 1/19/2024. When asked if Resident #21 had received the treatment for the head lice, the HSD responded by saying, "No, the treatment is not here yet." It should be noted that the resident had not received treatment for six days at the time of the interview. On 01/25/2024 at 12:44 pm, the AED and HSD both stated during an interview that DOH was not notified of the incident regarding the resident's head lice when first discovered on 01/18/2024. On 01/29/2026 at 10:53 am, review a nursing note dated 01/26/2024 showed that Resident #1 received treatment for head lice (eight days later). This was confirmed through an interview with the HSD at 11:01 am. On 01/30/2024 at 3:10 pm, Resident #1 said during an interview that he received the lice treatment on 1/28/2024 (10 days later). The resident stated no one from the facility had been back to his unit to check if the treatment was effective. d. On 01/26/2024 at 4:40 pm, while making rounds, the nurse noticed that Resident #15 was	R 562		

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R 562	Continued From page 29	R 562		

not inside her unit. The nurses continued to make their rounds in the resident's unit during the second and overnight shifts. Resident #15 was not inside her unit. Continued review of the incident report showed that nursing staff called the son on 01/27/2024 at 8:57 am and left a voicemail. The daughter was called, and she made a three-way phone call to her mother (Resident #15). The resident answered the call and stated that she went to United Medical Hospital about 11:00 am yesterday, [01/26/2024]. She stated that she was discharged at 8:30 am and was on her way to get her medications filled.

On 01/27/2024 at 1:23 pm, when asked about notifying DOH about Resident #15 missing from the facility, the AED stated that the incident was not sent to DOH in a timely manner. She stated that she did not call DOH promptly to report the incident. On 01/27/2024 at 1:44 pm, the HSD said during an interview that she did not contact DOH to report that Resident #15 was missing from the facility once she found out on 01/26/2024 at 11:00 pm.

e. On 01/25/2024 at 11:55 am, observations showed a resident on a gurney being placed inside the ambulance. At 12:02 pm, when asked about the resident on the gurney, the HSD stated Resident #1 was being transported to the hospital emergency room due to complaints of abdominal paln and constipation. Resident #1 was transported to the hospital for abdominal pain and constipation.

On 01/26/2024 at 10:04 am, the HSD and AED both were asked if an incident report had been generated for Resident #1's 911 emergency hospital visit, they responded by saying, "No".

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R 562	Continued From page 30 f. An incident report received by DOH on 1/25/2024 indicated Resident #22 had fallen inside his apartment and sustained a laceration to the mid forehead measuring 2.2 cm in width x 2.0 cm long with bleeding. There was light redness to the left side of his face. 911 emergency services were called and assessed the resident. Resident refused to go to the hospital for further evaluation, so the EMT cleansed the forehead laceration and applied a bandage to the wound. On 1/25/2024 at 11:55 am, the HSD said during an interview that she did not contact DOH to report that Resident #22 had sustained an injury to the forehead via telephone promptly when she first found out about the incident on 01/24/2024. g. On 1/29/2024 at 10:17 am, the HSD reported to the surveyors that Resident #1 had passed away while under hospice care in the hospital. The HSD stated that when Resident #1 went to the hospital via 911 on 1/25/2024, he never returned to the facility. On 01/31/2024 at 9:55 am, the HSD and AED both were asked if an incident report had been generated for Resident #1's death while in the hospital, they responded by saying, "No". When asked if DOH was notified of the death, the HSD and AED said no. At 10:33 am, the ALA said during a follow-up interview that serious incidents should be reported to DC health immediately, followed by a written notification within 24 hours. When they surveyor with the ALA that the above-mentioned incidents were not reported to DOH timely, the ALA looked at the incidents and confirmed that the incidents should have been reported immediately.	R 562		

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R 562	Continued From page 31 On 01/31/2024 at 11:01 am, a review of the ALR's "Incident Reporting" policy, dated 06/04/2021, showed the following instruction: "Serious reportable incidents involving death or other unusual incidents that substantially affect a resident shall be reported to DC Health by phone promptly and shall be followed up by written notification to the Director within 24 hours of (sic) the next business day." 2. [Cross reference [Reg. 10116.15f, 10116.17) (§ 44-701d9 - R0596] On 01/26/2024 beginning at 10:47 am, a review of the personnel records showed there was no documented evidence that Employees #3, 4, 5, 6, 7, 12, 17, 18, the Assistant Executive Director and Sales Director had been screened by a healthcare practitioner for communicable diseases on an annual basis.	R 562		
R 570	Sec. 701c3d Staffing Standards. (D) The development and use of ISPs. Based on record review and interview, the Assisted Living Residence (ALR) failed to ensure each resident had an Individualized Support Plans (ISP) developed and used to manage the resident's care at the ALR, for 17 of 22 residents in the sample (Resident #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19 and 20). Findings included: 1. On 1/24/2024 at 10:50 am, a review of Resident #2's medical record showed that the resident was admitted to the ALR on 12/29/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission.	R 570	Resident # 2,3,4,5,6,7,8,9,10,11,12,13,14, 15, 18, 19 and 20 will have Individualized Service Plans reviewed and updated by June 30, 2024. Resident Records will be reviewed within 72 hours prior to admission, within 7 days post admission, and every 45 days to ensure ISPs are completed as outlined by the Department of Health. Admission Staff, HSD and RNs to be educated on required frequency for ISPs. No Resident to be admitted without ISP within 30 days of admission by 7/31/2024. Audit findings reported to QA Committee monthly for the next 3 months and then quarterly. Compliance date	9/30/2024

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R 570	Continued From page 32 2. On 1/25/2024 at 10:11 am, a review of Resident #3's medical record showed that the resident was admitted to the ALR on 12/13/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 3. On 1/24/2024 at 1:07 pm, a review of Resident #4's medical record showed that the resident was admitted to the ALR on 1/22/2024. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 4. On 1/24/2024 at 11:29 am, a review of Resident #5's medical record showed that the resident was admitted to the ALR on 12/12/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 5. At 12:48 pm, a review of Resident #6's medical record showed that the resident was admitted on 06/30/2022. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 6. At 2:00 pm, a review of Resident #7's medical record showed that the resident was admitted on 04/01/2022. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 7. On 01/24/2024 at 10:30 am, a review of Resident #8's medical record showed that the resident was admitted on 10/13/2021. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission.	R 570		

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R 570	Continued From page 33 8. At 3:25 pm, a review of Resident #9's medical record showed that the resident was admitted on 2/9/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 9. On 01/26/2024 at 12:15 pm, a review of Resident #10's medical record showed that the resident was admitted on 6/29/2021. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 10. At 1:30 pm, a review of Resident #11's medical record showed that the resident was admitted on 8/26/2021. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 11. On 01/24/2024 at 1:30 pm, a review of Resident #12's medical record showed that the resident was admitted on 7/08/2021. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 12. On 01/25/2024 at 1:15 pm, a review of Resident #13's medical record showed that the resident was admitted on 12/26/2022. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 13. On 01/26/2024 at 11:00 am, a review of Resident #14's medical record showed that the resident was admitted on 12/29/2022. Further review of the record failed to show any documented evidence that an ISP was developed	R 570		

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R 570	Continued From page 34 prior to the resident's admission. 14. At 12:05 pm, a review of Resident #17's medical record showed that the resident was admitted on 10/16/2021. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 15. On 01/25/2024 at 1:33 pm, a review of Resident #18's medical record showed that the resident was admitted on 3/10/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 16. At 2:15 pm, a review of Resident #19's medical record showed that the resident was admitted on 5/4/2023. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. 17. On 01/26/2024 at 12:45 pm, a review of Resident #20's medical record showed that the resident was admitted on 8/23/2022. Further review of the record failed to show any documented evidence that an ISP was developed prior to the resident's admission. On 01/30/2024 at 2:52 pm, interviews with the Executive Director/Assistant Living Administrator (ALA)/ED) and the Health Service Director (HSD) both confirmed after looking through the medical records that there were no ISPs in the record.	R 570		
R 571	Sec. 701c3e Staffing Standards.	R 571		

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R 571	Continued From page 35 (E) Medication administration, including cuing, coaching, and monitoring residents who self-administer medications, with or without assistance. Based on observation, interview and record review, the Assisted Living Residence (ALR) Register Nurse failed to complete on-site medication reviews to assess the residents' capability to self-administer their medications, for seven of 22 residents in the sample (Resident #1, 8, 12, 17, 18, 19 and 21). Findings included: On 01/22/2024 at 3:13 pm, the surveyor requested from the Health Service Director (HSD) a list of all residents who administered their own medications. The HSD provided the following: 1. On 01/25/2024 at 12:08 pm, a review of Resident #1 medical record showed an Intermediate Care facilities Division Admission/ Annual Medical Certification form dated 08/30/2022 stating the resident can self-medicate with supervision. Further review of the record showed 45 days medication reviews dated 08/22/2023 and 12/27/2023. However, the resident was not assessed for their capability to self-administer their own medications. 2. On 01/24/2024 at 10:00 am, a review of Resident #8 medical record showed an Intermediate Care facilities Division Admission/ Annual Medical Certification form dated 10/13/2021 stating the resident cannot self-medicate. Further review of the record showed 45 days medication reviews dated 12/27/2023. However, the resident was not assessed for their capability to self-administer their own medications.	R 571	Resident #1, 8, 12, 17, 18, 19 and 21 will have on-site medication review completed by July 30, 2024. Registered nurses to be educated on completion of on-site medication reviews. Reviews need to reflect the resident's abilities to continue to self-administer medications, any changes in medication profile, to include changes in dosing, addition or discontinuation of medications. Calendar for assessment schedule to be created by July 15, 2024 and all in-house residents to have Medication Management Review completed by July 30, 2024. On-site Medication Review audits to conducted quarterly with results and corrections reported to QA committee quarterly. Compliance Date	8/30/2024

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R 571	Continued From page 36 3. On 01/24/2024 at 11:00 am, a review of Resident #12 medical record showed an Intermediate Care facilities Division Admission/ Annual Medical Certification form dated 07/02/2021 stating the resident can self-medicate. Further review of the record showed 45 days medication reviews dated 08/09/2023 and 12/27/202., However, the resident was not assessed for their capability to self-administer their own medications. 4. On 01/26/2024 at 12:05 pm, a review of Resident #17 medical record showed 45 days medication reviews dated 08/09/2023 and 12/27/2023. However, the resident was not assessed for their capability to self-administer their own medications. 5. On 01/25/2024 at 1:33 pm, a review of Resident #18 medical record showed 45 days medication reviews dated 08/30/2023. However, the resident was not assessed for their capability to self-administer their own medications. 6. On 01/25/2024 at 2:15 pm, a review of Resident #19 medical record showed 45 days medication reviews dated 08/30/2023. However, the resident was not assessed for their capability to self-administer their own medications. On 01/23/2024 at 1:12 pm, an interview with Resident #17 confirmed that he had been self-administering his medication and he gets his medications from his private pharmacy. When surveyor asked if a nurse follows up on him regarding his medications, she stated that a nurse had not checked on his medication regimen.	R 571		

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R 571	Continued From page 37 On 01/23/2024 at 1:20 pm, surveyor visited Resident #22 who stood at the door and did not welcome surveyor in his unit. Brown bottles of medications were observed on top of the resident's table. In an interview with the resident on 1/23/2024 at 1:22 pm, he stated that he administered his own medications and that he usually gets his medications from a local pharmacy. Continued interview with Resident #22 revealed that the pharmacy recently moved and had caused him to have barriers to receiving his medications timely. When asked if a nurse had checked on him regarding his medications, he stated that a nurse had not checked on his medication regimen. The HSD was present for this interview. On 1/23/2024 at 1:40 pm, the HSD said during an interview that residents who could self-administer their medications were also responsible for ordering their own medications. When asked if the residents had been assessed for their ability to continue to self-medicate, the HSD stated that the residents have not been assessed nor were they provided oversight by the nursing staff.	R 571		
R 596	Sec. 701d9 Staffing Standards. (9) Assure that members of the staff appear to be free from apparent signs and symptoms of communicable disease, as documented by a written statement from a healthcare practitioner. Based on observation, interview and record review, the Assisted Living Residence (ALR) failed to ensure that all staff had obtained a written statement from a healthcare practitioner stating that they were free from communicable disease, for 10 of the 22 employees (Employees #3, 4, 5, 6, 7, 12, 17, 18, the Assistant Executive	R 596		

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R 596	Continued From page 38 Director and Sales Director) employed by the facility. Findings included: Observations conducted from 01/22/2024 through 01/31/2024 showed Employees #3, 4, 5, 6, 7, 12, 17 and 18), the Assistant Executive Director and Sales Director providing care services, talking with the residents, and assisting the surveyors with obtaining information throughout the survey process. On 01/22/2024 at beginning at 3:13 pm, the surveyor requested documentation showing that each observed employee, the Assistant Executive Director, and Sales Director had obtained a statement from a healthcare practitioner declaring that he or she were free from communicable disease. On 01/26/2024 beginning at 10:47 am, a review of the personnel records showed there was no documented evidence that Employees #3, 4, 5, 6, 7, 12, 17, 18, the Assistant Executive Director and Sales Director had been screened by a healthcare practitioner for communicable diseases. On 01/31/2024 at 10:06 am, the Assistant Executive Director said during an interview that she thought the employees' files were up to date regarding their healthcare statements. The Assistant Executive Director confirmed after looking through the personnel files that the employees did not have current written statements regarding communicable disease, including tuberculosis (TB) health screenings completed by a Healthcare Practitioner.	R 596	Employees #3, 4, 5, 6, 7, 12, 17, 18 AED and Sales Director to have healthcare practitioner written statement as to whether the employees bears any communicable diseases, including communicable TB in employee file by June 30, 2024. All employee files will be audited to ensure all employees with a tenure of greater than one year have a written statement acknowledging they are free of communicable disease including TB. Any missing documentation will be obtained within 45 days of audit. Post initial audit ALA or Designee will conduct ongoing employee file audits to include any new hire employees in the last 30 days and at least 10% of the employees to ensure ongoing compliance with requirement. Initial and ongoing audit findings will be reported to QA Committee monthly for the first 3 months and then quarterly thereafter. Compliance Date	8/30/2024

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R 602	Continued From page 39	R 602		
R 602	Sec. 701f Staffing Standards. (f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Based on observation, interview and record review, the Assisted Living Residence (ALR) failed to ensure all staff had a written statement annually from a healthcare practitioner confirming they were free from tuberculosis in a communicable form, for 10 of the 23 employees (Employees #3, 4, 5, 6, 7, 12, 17, 18, the Assistant Executive Director and Sales Director). Findings included: Observations conducted from 01/22/2024 through 01/31/2024 showed Employees #3, 4, 5, 6, 7, 12, 17, 18, the Assistant Executive Director and Sales Director providing care services, talking with the residents, and assisting the surveyors with obtaining information throughout the survey process. On 01/22/2024 at beginning at 3:13 pm, the surveyor requested documentation showing that each observed employee, the Assistant Executive Director, and Sales Director had obtained an annual statement from a healthcare practitioner declaring that he or she were free from tuberculosis in a communicable form. On 01/26/2024 beginning at 10:47 am, a review of the personnel records showed there was no documented evidence that Employees #3, 4, 5, 6, 7, 12, 17, 18, the Assistant Executive Director and Sales Director had been screened by a healthcare practitioner for tuberculosis in a communicable form on an annual basis.	R 602	Employees #3, 4, 5, 6, 7, 12, 17, 18 AED and Sales Director to have healthcare practitioner written statement as to whether the employees bears any communicable diseases, including communicable TB in employee file by June 30, 2024. All employee files will be audited to ensure all employees with a tenure of greater than one year have a written statement acknowledging they are free of communicable disease including TB. Any missing documentation will be obtained within 45 days of audit. Post initial audit ALA or Designee will conduct ongoing employee file audits to include any new hire employees in the last 30 days and at least 10% of the employees to ensure ongoing compliance with requirement. Initial and ongoing audit findings will be reported to QA Committee monthly for the first 3 months and then quarterly thereafter. Compliance Date	8/30/2024

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R 602	Continued From page 40 On 01/31/2024 at 10:06 am, the Assistant Executive Director said during an interview that she thought the employees' files were up to date regarding their healthcare statements. The Assistant Executive Director confirmed after looking through the personnel files that the employees did not have current written statements regarding updated tuberculosis health screenings completed by a Healthcare Practitioner.	R 602		
R 667	Sec. 702a4l Staff Training. (L) Basic competence in housekeeping, laundry, food handling, and meal preparation; and Based on observation, interview and recorded review, the Assisted Living Residence (ALR) failed to ensure each dietary staff was trained on meal plans in accordance with residents' dietary needs, for 13 of 22 residents in the sample (Residents #1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13 and 15). Findings included: On 01/22/2024 at 3:15 pm, the Executive Director (ED) said during an interview that the facility was currently without a Dining Services Director, and that she was responsible for overseeing the dining service needs. Continued interview with the ED revealed that the facility used an online company for their nutritional services. Additionally, the ED stated that one menu was used for all residents regardless of their dietary needs. On 01/23/2024 at 11:27 am, observations during	R 667	Residents # 1,2,3,4,5,6,7,9,10,11,12,13, and 15 will be served meals based on their dietary needs. Menu program to following and Always available menus established. Always available menu to be posted in the dining area and given to residents. Dietary communication form and diet boards to be utilized to communicate dietary needs. Staff to be educated on importance of following prescribed diet, always available menu and use of diet board and dietary communication forms by 7/31/2024. Meal reviews to be completed at least 3 time per week in June an results presented to QA Committee. QA Committee to designate ongoing frequency of Meal Reviews. Compliance Date	7/31/2024

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R 667	Continued From page 41 the lunch meal showed Dietary Aide Cook (DAC) #1 served lunch to the residents. The lunch meal consisted of two pieces of white bread, ham and cheese, lettuce, tomatoes, onions, and a choice between mayonnaise and mustard. When asked about the lunch menu, DAC #1 said, "This is all that we have for lunch and the fish that is listed on the menu is not available today." DAC #1 showed the surveyor the bulletin board that was used to serve specific food to each resident. DAC #1 said "The bulletin board had not been updated in months and I do not know the specific diets of the residents that I serve, especially new residents." On 01/24/2024 at 2:52 pm, when asked about the discrepancies on the diet communication bulletin board located in the kitchen, the Health Services Director (HSD) confirmed that the bulletin board needed to be updated to reflect residents with a diagnosis of diabetes and high blood pressure received a modified diet in accordance with their physician's orders. The HSD stated that she was in the process of updating the diet communication board. At 2:58 pm, when asked if dietary staff had been trained on the specific dietary needs of the residents, the ED responded by saying, "No, just the menu." However, the ED did state that Employee #4 would be the acting Kitchen Director until one is hired. On 01/25/2024, review of the residents' records from 01/22/2024 - 01/31/2024 showed the following: a). A review of Resident #1's Medical Certification form dated 08/30/2022, showed a diagnosis of Congestive heart failure and a diet order for no added salt diet.	R 667		

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R 667	Continued From page 42 b). A review of Resident #2's Medical Certification form dated 11/22/2023 showed a diagnosis of Hypertension and a history of Stroke and a diet order for a no added salt. c). A review of Resident #3's Medical Certification form dated 12/13/2023, showed a diagnosis of Diabetes Mellitus and a diet order for no added salt diet. d). A review of Resident #4's Medical Certification form dated 1/4/2024 showed a diagnosis of Diabetes Mellitus with insulin use and a diet order for no concentrated sweets and no added salt. e). A review of Resident #5's Medical Certification form dated 10/31/2023, showed a diagnosis of Hypertension and a diet order for regular diet with mechanical soft texture until dentures are obtained. f). A review of Resident #6's Medical Certification form dated 6/30/2022 showed a diagnosis of Diabetes Mellitus and a diet order for no added salt and no concentrated sweet diet. g). A review of Resident #7's Medical Certification form dated 4/1/2022, showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for a Diabetic and no added salt diet. h). A review of Resident #9's Medical Certification form dated 2/9/2023 showed a diagnosis of Diabetes Mellitus Type I and Hypertension and a Diabetic and no added salt. i). A review of Resident #10's Medical Certification form dated 10/31/2023, showed a diagnosis of Diabetes Mellitus Type II and a diet order for no added salt and no concentrated	R 667		

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R 667	Continued From page 43 sweet diet. j). A review of Resident #11's Medical Certification form dated 6/30/2022 showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for no added salt and no Diabetic diet with mechanical soft texture. k). A review of Resident #12's Medical Certification form dated 7/18/2021, showed a diagnosis of Diabetes Mellitus and Hypertension and a diet order for a Diabetic and no added salt diet. l). A review of Resident #13's Medical Certification form dated 11/8/2021 showed a diagnosis of Hypertension and Prediabetes and a diet order for no added salt. m). A review of Resident #15's Medical Certification form dated 11/17/2022 showed a diet order for No concentrated sweet diet. On 01/26/2024 at 1:17 pm, Employee #4 (the acting Kitchen Director) said during an interview that he was just given the title of acting Kitchen Director by the ED. When asked if the ED provided training on the residents' dietary needs, he said "No". The Acting Kitchen Director stated that his food handler's certification was the only formal training he had related to food preparation. Additionally, the Acting Kitchen Director stated that he had no training in preparing foods that met the specific dietary needs for residents diagnosed with diabetes and high blood pressure, when asked.	R 667		
R 704	Sec. 802a Medical, Rehabilitation, Psychosocial Assess.	R 704		

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R 704	Continued From page 44 (a) A medical, rehabilitation, and psychosocial assessment of the resident shall be completed within 30 days prior to admission. Based on record reviews and interviews, it was determined the Assistant Living Residence (ALR) failed to ensure that a medical, rehabilitation, and psychosocial assessment had been completed within 30 days prior to admission, for six of 22 residents in the sample (Residents #11, 14, 17, 18, 19 and 20). Findings included: 1. On 01/26/2024 at 1:30 pm, a review of Resident #11's medical record showed the resident was admitted on 8/26/2021. Continued review of the resident's medical record revealed there was no documented evidence of a medical, rehabilitation or psychosocial assessment. 2. On 01/26/2024 at 11:00 am, a review of Resident #14's medical record showed the resident was admitted on 12/29/2022. Continued review of the resident's medical record revealed there was no documented evidence of a medical, rehabilitation or psychosocial assessment. 3. On 01/26/2024 at 12:05 pm, a review of Resident #17's medical record showed the resident was admitted on 10/16/2021. Continued review of the resident's medical record revealed there was no documented evidence of a medical, rehabilitation or psychosocial assessment. 4. On 01/25/2024 at 1:33 pm, a review of Resident #18's medical record showed the resident was admitted on 03/10/2023. Continued review of the resident's medical record revealed there was no documented evidence of a medical,	R 704	Resident # 11, 14, 17, 18, 19 and 20 will have missing medical, rehabilitation, and psychosocial assessments completed by 6/30/2024. Admission staff, ALA, and HSD to be re-educated on the requirements for these assessments within 30 day s of admission by 6/30/2024. Pre-admission audit to be conducted within 72 hours of admission and any missing assessments obtained prior to resident admission. Results of Pre-admission audits to be presented to the QA committee monthly for the next 3 months and then quarterly. Compliance date	7/31/2024

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R 704	Continued From page 45 rehabilitation or psychosocial assessment. 5. On 01/25/2024 at 2:15 pm, a review of Resident #19's medical record showed the resident was admitted on 05/04/2023. Continued review of the resident's medical record revealed there was no documented evidence of a medical, rehabilitation or psychosocial assessment. 6. On 01/26/2024 at 12:45 pm, a review of Resident #20's medical record showed the resident was admitted on 8/23/2022. Continued review of the resident's medical record revealed there was no documented evidence of a medical, rehabilitation or psychosocial assessment. On 01/25/2024 at 3:15 pm, during a face-to-face interview with Assistant Executive Director (AED) and Health Services Director (HSD) indicated they were unable to find the assessments. During the exit interview on 01/31/24, no documents were presented to the surveyors.	R 704		
R 803	Sec. 903 3 On-Site Review. (3) Assess the resident's ability to continue to self-administer his or her medications. Based on interview and record review, the Assisted Living Residences (ALR) Registered Nurse (RN) failed to assess the resident's ability to safely continue to self-administer medications for seven of 22 residents in the sample who self-medicated (Resident #1, 8, 12, 17, 18, 19 and 22). Findings included: On 01/22/2024 beginning at 3:13 pm, the Registered Nurse (RN) identified Resident #1, 8,	R 803	Resident # 1,8,12,17,18,19, 21 and 22 will have on-site medication review to include the ability for ongoing self-medication administration completed by July 30, 2024. Registered nurses to be educated on completion of on-site medication reviews. Reviews need to reflect the resident's abilities to continue to self-administer medications, any changes in medication profile, to include changes in dosing, addition or discontinuation of medications. Calendar for assessment schedule to be created by July 15, 2024 and all in-house residents to have Medication Management Review completed by July 30, 2024.	

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	ALR - 0041	A. BUILDING _____ B. WING _____	01/31/2024

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SOUTHERN AVE SP LLC DBA LIVINGSTON AT	4656 LIVINGSTON ROAD, SE WASHINGTON, DC 20032

(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 803	Continued From page 46 12, 17, 18, 19 and 21 as being able to self-medicate. 1. On 01/25/2024 at 12:08 pm, a review of Resident #1 medical record showed an Intermediate Care facilities Division Admission/ Annual Medical Certification form dated 08/30/2022 stating the resident can self-medicate with supervision. Further review of the record showed 45 days medication reviews dated 08/22/2023 and 12/27/2023, however the records failed to show evidence that the nurse documented the resident's ability to continue to self-administer their medications. 2. On 01/24/2024 at 10:00 am, a review of Resident #8 medical record showed an Intermediate Care facilities Division Admission/ Annual Medical Certification form dated 10/13/2021 stating the resident cannot self-medicate. Further review of the record showed 45 days medication reviews dated 12/27/2023, however the records failed to show evidence that the nurse documented the resident's ability to continue to self-administer their medications. 3. On 01/24/2024 at 11:00 am, a review of Resident #12 medical record showed an Intermediate Care facilities Division Admission/ Annual Medical Certification form dated 07/02/2021 stating the resident can self-medicate. Further review of the record showed 45 days medication reviews dated 08/09/2023 and 12/27/2023, however the records failed to show evidence that the nurse documented the resident's ability to continue to self-administer their medications. 4. On 01/26/2024 at 12:05 pm, a review of	R 803	On-site Medication Review audits to conducted every 45 days with results and corrections reported to QA committee quarterly. Compliance Date	8/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR - 0041	A. BUILDING: _____ B. WING _____	01/31/2024

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R 803	Continued From page 47 Resident #17 medical record showed 45 days medication reviews dated 08/09/2023 and 12/27/2023, however the records failed to show evidence that the nurse documented the resident's ability to continue to self-administer their medications. 5. On 01/25/2024 at 1:33 pm, a review of Resident #18 medical record showed 45 days medication reviews dated 08/30/2023, however the records failed to show evidence that the nurse documented the resident's ability to continue to self-administer their medications. 6. On 01/25/2024 at 2:15 pm, a review of Resident #19 medical record showed 45 days medication reviews dated 08/30/2023, however the records failed to show evidence that the nurse documented the resident's ability to continue to self-administer their medications. 7. On 01/23/2024 at 1:12 pm, an interview with Resident #22 confirmed that he had been self-administering his medication and he gets his medications from his private pharmacy. When surveyor asked if a nurse checks on him regarding his medications, he stated that a nurse has not checked on his medication regimen. At 1:20 pm, in another interview with Resident #22, the resident confirmed that he was administering his own medication and that he usually gets his medication from a local pharmacy which recently moved and have caused him to have barriers to receiving timely. When asked if a nurse checks on him regarding his medications, he stated that a nurse has not checked on his medication regimen. On 01/23/2024 at 1:40 pm, an interview with the Health Service Director (HSD) confirmed that the above residents identified as being responsible for ordering their medications and self-administering the	R 803		

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R 803	Continued From page 48 medication have not been assessed for their ability to continue the self-medication program or was provided oversight by the nursing staff.	R 803		