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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095025	A. BUILDING _____ B. WING _____	04/26/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted on April 25 through 26, 2007. The following deficiencies were based on record review, observations,and interviews with facility staff. The sample included 15 residents based on a census of 60 residents on the first day of survey.	F 000		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278	**F278 - Plan of Correction** *A review of Resident's #4's record revealed that Section E4 on the quarterly MDS was not coded for wandering behavior within the last 7 days.* **1. Corrective Action for specifically identified Resident #4** Resident #4's record was reviewed and the next MDS will be coded correctly. **2. How to identify other Residents at risk:** Reviewed MDS for accurate coding for all Residents who wander. **3. Corrective Action and Systemic Changes:** All interdisciplinary team members who complete portions of MDS in-serviced on MDS coding and documentation accuracy for wandering. *(continued next page)*	04/27/07 04/27/07 05/08/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan M. Magneau CNHA | Administrator | 5/21/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 by: Based on staff interview and record review of one (1) of 15 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for Resident # 4 ' s behavior of wandering. The findings include: A review of Resident # 4's record revealed a quarterly MDS was completed on March 6, 2007. Section E4 (Behavioral Symptoms) was not coded for wandering behavior within the last seven (7) days. According to the MDS 2.0 User ' s Manual, page 3-29, The Assessment Reference Date (ARD), is the specific end-point of the assessment process. According to a nurse's note of February 25, 2007 at 1:25 PM, " Resident was seen by one of the employees walking outside and sat on the ground near the driveway position on buttocks ... " A face-to-face interview was conducted with the Assistant Director of Nursing on April 26, 2007 at 3:00 PM. He/She acknowledged that Resident # 4's MDS was not coded for wandering. The record was reviewed April 26, 2007.	F 278	(con'd) **4. Monitoring:** Wandering behavior to be reviewed and monitored by the Assessment Care Plan team using weekly compliance tool and cross-checking with MDS codes entered. Any inaccuracies to be corrected and noted for QA report.	05/10/07
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	**F280 - Plan of Correction** *A review of the Falls Care Plan dated 1/25/07 revealed that there were no new goals and approaches initiated to prevent falls for Resident #2.* *(continued next page)*	

Susan M Turgeau CNHA Administrator 8/24/07

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F 280	Continued From page 2 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of fifteen sampled residents, it was determined that facility staff failed to update a care plan for Resident #2 after a fall. The findings include: According to a nurse's noted dated January 11, 2007 at 7:00 AM, Resident #2 sustained a fall that resulted in an abrasion over the right eye. A review of the fall care plan dated January 25, 2007, revealed that there were no new goals and approaches initiated to prevent falls. A face-to-face interview was conducted with the Acting Director of Nursing (ADON) on April 26, 2007 at 10:30 AM. He/she stated that the resident was on the restorative program prior to the fall and continued on the program after the fall. He/she acknowledged that there were no new goals and approaches initiated after the fall. The record was reviewed on April 25, 2007.	F 280	*(con'd)* **1. Corrective Action for specifically identified Resident #2** Resident #2's Care Plan was reviewed and new goals and approaches for fall prevention were added. **2. How to identify other Residents at Risk:** Care Plans for all Residents with incidents of falls were reviewed for goals and approaches to prevent incidents of falls. **3. Corrective Action and Systemic Changes:** Nursing staff in-serviced on updating and setting new goals and approaches in Resident Care Plan for all Residents with incidents of falls. **4. Monitoring:** Random quarterly audit of 10% of Resident Falls Care Plans by DON or designee. Findings incorporated into nursing QA report.	05/08/07 06/10/07 05/08/07 6/10/07
F 363	483.35(c) MENUS AND NUTRITIONAL	F 363		

Sumith. Nair — UMHA Administrator 5/21/07

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F 363 SS=D	Continued From page 3 ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that the diet manual used by the facility lacked nutritional information for food items for renal diets. This finding was based on interviews and record review with the dietitian and food service director. The findings include: The facility's diet manual lacked specific nutritional information on foods for renal diets that were restricted for potassium, protein, phosphorous and sodium. In addition, the manual lacked information on foods that were allowed for renal diets in one (1) of one (1) renal diet manual observation at 2:15 PM on April 25, 2007.	F 363	**F363 - Plan of Correction** *Facility diet manudl found to lack specific nutritional information on foods for renal diets.* **1. Immediate Response** Supplemental diet manual ordered by facility. **2. Corrective Action** Diet manual was amended to include supplemental materials regarding renal diet. **3. Systemic Changes** Registered Dietitian in-serviced Food Service and Nursing Staff on changes to diet manual. **4. Monitoring** Registered Dietitian will evaluate future menu updates to ensure they comply with amendment to diet manual and will report on compliance at Quarterly Meetings.	05/01/07 05/07/07 05/14/07 05/01/07
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364	**F364 - Plan of Correction** *Pureed entrées on tray line lacked sufficient thickener.* *(continued next page)*	

Susan M. Haugen CNHA Administrator 5/24/07

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F 364	Continued From page 4 by: Based on observations during the survey period, it was determined that two (2) pureed entrees on the tray line lacked sufficient thickener. These observations were made in the presence of the dietician and the Food Service Director. The findings include: Pureed tuna and potato salad on the tray line during the lunch meal were observed to have a thin, watery consistency. At the time of this observation, the dietician acknowledged that the pureed tuna and potato salad lacked sufficient thickener and was not the proper consistency for residents requiring a pureed diet in two (2) of three (3) puree entree observations at 11:45 AM on April 25, 2007.	F 364	*(con'd)* **1. Immediate Response** Consistency for entrees identified was corrected. **2. Corrective Action** Mixture was corrected on all puree entrees. **3. Systemic Changes** All Cooks and Management Staff were in-serviced on correct consistency for puree diets. **4. Monitoring** Registered Dietitian will observe puree diets during weekly meal rounds and will report at Quarterly QA	04/25/07 04/25/07 05/24/07 05/14/07
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a sanitary manner as evidenced by: soiled cooking hood and deep fryer, and clean cooking vessels stored on a soiled and rusty metal shelf. These findings were observed in the presence of the Food Service Director. The findings include:	F 371	**F371 - Plan of Correction** *Hoods soiled with grease and dust; deep fryer soiled with food/grease; shelf over wash sink soiled and rusty.* **1. Immediate Response** Cooking hood and deep fryer cleaned; rusty shelf removed and will be replaced. **2. Corrective Action** Weekly rounds by Supervisors and Director of Food Service to ensure all equipment is clean and free of rust. *(continued next page)*	04/25/07 05/01/07

Susan M. Haigh CNHA Administrator 5/21/07

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F 371	Continued From page 5 1. The interior and filter surfaces of a cooking hood located over food preparation areas were soiled with grease and dust in one (1) of one (1) cooking hood observation at 8:45 AM on April 25, 2007. 2. The interior panels and outer surfaces of a deep fryer were soiled with accumulated food and grease in one (1) of one (1) deep fryer observation at 8:50 AM on April 25, 2007. 3. Clean cooking vessels that were ready for re-use were stored on a soiled and rusty shelf over the wash sink in one (1) of one (1) observation at 9:00 AM on April 25, 2007.	F 371	*(con'd)* **3. Systemic Changes** In-service all Dietary Staff on how to properly clean hoods, fryer and shelf and check for grease, rust and dust in food area. **4. Monitoring** Food Service Director will monitor weekly and report at QA.	05/31/07 05/01/07
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to write a complete description of an attempted elopement incident for Resident #4.	F 514	**F514 - Plan of Correction** *It was determined that facility staff failed to write a complete description of an attempted elopement incident for Resident #4.* **1. Corrective Action for specifically identified Resident #4** Documentation of Resident #4's attempted elopement was clarified with the team and documented accurately in Resident's chart. *(continued next page)*	05/17/07

Susan M Thag UHA Administrator 5/21/07

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F 514	Continued From page 6 The findings include: A review of Resident # 4 ' s record revealed the following nurses ' note: February 25, 2007 at 1:25 PM, " Resident was seen by one of the employees, walking outside and sat on the ground near the drive way position on buttocks alert and verbally responsive, denies pain, able to ambulate to facility with assistance of staff members ...small skin tear to (rt) [right] knee, no other bruises ...Alarm on leg in place ... " A telephone interview was conducted on May 3, 2007 at 12:30 PM with the Assistant Director of Nursing and the charge nurse on duty the afternoon of the elopement. The charge nurse stated, " ...The resident had a functioning Wanderguard on leg. The alarm buzzed when [resident] approached the sensor by the administrator ' s office. Staff member followed after resident insisted on leaving through the front door. The receptionist assisted in calling for more help. The resident exited through the front door and sat on [his/her] buttocks. [Resident] accepted staff assistance to return to the nursing unit. " The Assistant Director of Nursing acknowledged that the nurse ' s note failed to include a complete description of the incident as it occurred. The nurse ' s note was not inclusive of the circumstances leading to the discovery of the resident in the driveway. The record was reviewed April 26, 2007	F 514	*(con'd)* **2. How to identify other Residents at Risk:** All Residents records who have attempted elopement were reviewed for accurate documentation. **3. Corrective Action and Systemic Changes:** Staff in-serviced on documentation in Resident's clinical record, to be all-inclusive with complete description of any incident of attempted elopement. **4. Monitoring:** Random audits of 10% of Residents' records for accurate documentation by DON (or designee) and findings reported at QA meetings.	05/08/07 05/08/07 06/10/07

Susan M. Tarp — Administrator 5/21/07