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 ______	C 04/12/2023

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	F 000		

An unannounced Recertification Survey was conducted at this facility on April 5 - 12, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 52 and the survey sample included 29 residents.

The following Facility Reported Incidents were investigated during this survey: DC00010407, DC00010401, DC00010508, DC00010537, DC00010590, DC00010646, DC00010739, DC00010738, DC00010882, DC00011079, DC00011085, DC00011181, DC000111406, DC00011498, DC00011565, DC00011604,DC00011628, DC00011811, DC00011160, DC00011820.

Federal and Local deficiencies were cited related to the investigation of DC00010646.

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan M. Hargrea (signature) | TITLE: Administrator | (X6) DATE: May 17, 2023

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 _____	C 04/12/2023

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	Continued From page 1	F 000		

CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C - Discontinue
DI - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter

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 _____	C 04/12/2023

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	Continued From page 2 Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		

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 _____	C 04/12/2023

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 607	Continued From page 3 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 29 sampled residents, facility staff failed to implement its policies and procedures for investigating an allegation of abuse. Resident #41. The findings included: Review of the facility policy titled "[Facility Name] Abuse Investigation Protocol", not dated, documented, "...The individual conducting the investigation will, as a minimum... Conduct all interviews in the presence of a witness; Make every effort to interview staff members giving	F 607	**F 607 Abuse Investigation Protocol/Policy** **1. Immediate Response:** Eight staff providing direct care to resident #41 for the two days prior to the reported incident were reinterviewed from 5/12/23 through 5/15/23 and written statements were added to the investigation. The outcome of the investigation did not change and no abuse was found. On 3/23/23 a throat culture was obtained and symptomatic treatment was ordered; vital signs were monitored and resident did not have trouble with swallowing food or liquid. A negative throat culture result was reported on 3/25/23. **2. Risk Identification:** All incident reports with corresponding investigations of alleged abuse were reviewed for the past year. All identified investigations were found to follow facility policy for staff interview timeline and written statement requirements. **3. Systemic Changes:** All licensed staff were in-serviced on the policy for abuse investigations and the taking of witness statements. The facility administration reviewed the policy to assure regulatory compliance and allow for appropriate time to investigate allegations of abuse.	

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 _____	C 04/12/2023

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 607	Continued From page 4 direct care to the resident for two days prior to the incident ... Interview any staff members or others who may have knowledge of the incident ... The following guidelines will be used when conducting interviews...Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports..." Resident #41 was admitted to the facility on 12/29/21 with diagnoses that included: Vascular Dementia, with Anxiety, Chronic Pain and Muscle Weakness. A Quarterly Minimum Data Set (MDS) dated 02/18/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 04, indicating severe cognitive impairment; no indicators of psychosis or behavior issues; required extensive assistance with one-person physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. Resident #41's medical record revealed the following information: 03/21/22 at 2:47 PM [Psychosocial Note Late Entry] "Care conference held on 3/17/2022 for quarterly review. Resident participated in assessment but did not wish to attend meeting. RP (representative) ...notified of meeting but declined to attend. Care plan reviewed. Resident scored 4/15 on BIMS assessment. [Resident] was able to repeat 2/3 test words, could not recall test words with cueing, and was able to accurately state the month, but not day of the week or year. Resident is generally oriented to self, others, and place, although [resident] shows deficits in short-term memory as evidenced by	F 607	**4. Monitoring:** The Director of Nursing will review all incident reports and the corresponding investigation on a quarterly basis to assure compliance with the facility's policy. Findings will be reported at the quarterly QAPI meetings.	5/15/23

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 _____	C 04/12/2023

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 607	Continued From page 5 repeating conversations and difficulty accurately recalling events ..." 03/23/22 at 4:42 AM [Nurses General Note] "Resident continue c/o (complain of) throat discomfort. Throat culture collected, awaiting technician to pick it up. Resident remain afebrile. No coughing ...Lung sounds clear on auscultation." 03/25/22 at 8:40 AM [Psychosocial Note] "On 3/22/22, at Resident Council, resident reported concerns to include [resident] is treated "roughly" by staff and had a sore throat that was not addressed by staff. Staff investigated reports and RP ... notified about concerns. Resident interviewed. Unable to give details of staff treatment such as which staff, which day or which shift the treatment occurred on ...Staff interviewed. No unusual incidents observed. Staff to monitor resident for additional reports. Investigation closed at this time." A Facility Reported Incident (FRI), DC00010646, received by the State Agency on 03/28/22 documented, "On 3/22/22, at Resident Council, resident reported concerns to include [resident] treated "roughly" by staff and had a sore throat that was not addressed by staff. Staff investigated reports. Resident interviewed. Unable to give details of staff treatment such as which staff, which day or which shift the treatment occurred ..." Review of the facility's investigation documents provided to this surveyor on 04/06/23 showed a typed document dated "March 22, 2022" that documented, "Investigation of Claims of "Rough Handling"- Resident Council. DN (Director of	F 607		

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 _____	C 04/12/2023

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 607	Continued From page 6 Nursing) interviewed [Resident #41] following resident council ... DN verbally interviewed the following staff who are usual caregivers. [Names of four (4) staff members]. No unusual incidents observed ...There is no evidence of abuse. Investigation concluded." The 4 employee names who the Director of Nursing (DON) documented she verbally interviewed were cross-referenced to the facility's assignment sheets for dates 03/20/22 and 03/21/22 (the two days prior to the incident/allegation being reported) and it should be noted that two (2) of those employees did not provide direct care to Resident #41 in that time frame. The assignment sheets also revealed that there were six (6) employees who did provide direct care to Resident #41 during that time frame (03/20/22 to 03/22/22) for which there was no documented evidence of an interview or that they provided a signed and dated witness report/statement regarding Resident #41's allegation of being roughly handled. The evidence showed that the facility staff who conducted the investigation of Resident #41's allegation of abuse failed to follow the facility's policies and procedures as evidenced by failing to: 1. Provide documented evidence that the interviews (Resident #41 and the 4 staff members) were conducted in the presence of a witness; 2. Make every effort to interview all staff members giving direct care to the resident for two days prior to the incident being reported;	F 607		

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 _____	C 04/12/2023

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 607	Continued From page 7 3. Obtain signed and dated written witness reports/statements from the employees. During a face-to-face interview conducted on 04/12/23 at 12:39 PM, Employee #2 (Director of Nursing), who conducted the investigation of this allegation of abuse stated, "I interviewed [Resident #41]. [Resident #41] had a lot of paranoia and documented memory problems." When asked why none of the staff members interviewed provided a signed and dated written report/statement, Employee #2 stated, "There weren't any witnesses; (Resident #41) couldn't tell us who did it or when. I just interviewed the regular staff who took care of [resident]." Employee #2 was then asked if any these interviews (resident and staff) were conducted in the presence of a witness, to which [Resident #41] stated, "No." When asked why all the staff who cared for Resident #41 in the two days prior to the allegation being reported were not interviewed or provided a written report/statement, Employee #2 stated, "[Resident #41] was not able to tell me when this occurred. That would've meant having to interview and get statements from almost all the staff. We didn't have time for that."	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		

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 _____	C 04/12/2023

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 610	Continued From page 8 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 29 sampled residents, facility staff failed to have documented evidence that an allegation of abuse was thoroughly investigated. Resident #41. The findings included: Review of the facility policy titled "[Facility Name] Abuse Investigation Protocol", not dated, documented, "...The individual conducting the investigation will, as a minimum... Conduct all interviews in the presence of a witness; Make every effort to interview staff members giving direct care to the resident for two days prior to the incident ... Interview any staff members or others who may have knowledge of the incident ... The following guidelines will be used when conducting interviews...Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports..." Resident #41 was admitted to the facility on 12/29/21 with diagnoses that included: Vascular Dementia, with Anxiety, Chronic Pain and Muscle Weakness.	F 610	**F 610 Investigate/Prevent/Correct Alleged Violation** **1. Immediate Response:** Eight staff providing direct care to resident #41 for the two days prior to the reported incident were reinterviewed from 5/12/23 through 5/15/23 and written statements were added to the investigation. The outcome of the investigation did not change and no abuse was found. On 3/23/23 a throat culture was obtained and symptomatic treatment was ordered; vital signs were monitored and resident did not have trouble with swallowing food or liquid. A negative throat culture result was reported on 3/25/23. **2. Risk Identification:** All incident reports with corresponding investigations of alleged abuse were reviewed for the past year. All identified investigations were found to follow facility policy for staff interview timeline and written statement requirements. **3. Systemic Changes:** All licensed staff were in-serviced on the policy for abuse investigations and the taking of witness statements. The facility administration reviewed the policy to assure regulatory compliance and allow for appropriate time to investigate allegations of abuse.	

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 _____	C 04/12/2023

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 610	Continued From page 9 Review of Resident #41's medical record revealed: A Quarterly Minimum Data Set (MDS) dated 02/18/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 04, indicating severe cognitive impairment; no indicators of psychosis or behavior issues; required extensive assistance with one person physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. 03/21/22 at 2:47 PM [Psychosocial Note Late Entry] "Care conference held on 3/17/2022 for quarterly review. Resident participated in assessment but did not wish to attend meeting. RP (representative) ...notified of meeting but declined to attend. Care plan reviewed. Resident scored 4/15 on BIMS assessment. [Resident] was able to repeat 2/3 test words, could not recall test words with cueing, and was able to accurately state the month, but not day of the week or year. Resident is generally oriented to self, others, and place, although she shows deficits in short-term memory as evidenced by repeating conversations and difficulty accurately recalling events ..." 03/23/22 at 4:42 AM [Nurses General Note] "Resident continue c/o (complain of) throat discomfort. Throat culture collected, awaiting technician to pick it up. Resident remain afebrile. No coughing ...Lung sounds clear on auscultation." 03/25/22 at 8:40 AM [Psychosocial Note] "On 3/22/22, at Resident Council, resident reported concerns to include [resident] is treated "roughly"	F 610	**4. Monitoring:** The Director of Nursing will review all incident reports and the corresponding investigation on a quarterly basis to assure compliance with the facility's policy. Findings will be reported at the quarterly QAPI meetings.	**5/15/23**

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 _____	C 04/12/2023

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 610	Continued From page 10	F 610		

by staff and had a sore throat that was not addressed by staff. Staff investigated reports and RP ... notified about concerns. Resident interviewed. Unable to give details of staff treatment such as which staff, which day or which shift the treatment occurred on ...Staff interviewed. No unusual incidents observed. Staff to monitor resident for additional reports. Investigation closed at this time."

A Facility Reported Incident (FRI), DC00010646, received by the State Agency on 03/28/22 documented, "On 3/22/22, at Resident Council, resident reported concerns to include [resident] is treated "roughly" by staff and had a sore throat that was not addressed by staff. Staff investigated reports. Resident interviewed. Unable to give details of staff treatment such as which staff, which day or which shift the treatment occurred ..."

Review of the facility's investigation documents provided to this surveyor on 04/06/23 showed a typed document dated "March 22, 2022" that documented, "Investigation of Claims of "Rough Handling"- Resident Council. DN (Director of Nursing) interviewed [Resident #41] following resident council ... DN verbally interviewed the following staff who are usual caregivers. [Names of four (4) staff members]. No unusual incidents observed ...There is no evidence of abuse. Investigation concluded."

The 4 employee names who the DN documented she verbally interviewed were cross-referenced to the facility's assignment sheets for dates 03/20/22 and 03/21/22 (the two days prior to the incident/allegation being reported) and it should be noted that two (2) of those employees did not

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 _____	C 04/12/2023

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 610	Continued From page 11	F 610		

provide direct care to Resident #41 in that time frame. The assignment sheets also revealed that there were six (6) employees who did provide direct care to Resident #41 during that time frame (03/20/22 to 03/22/22) for which there was no documented evidence of an interview or that they provided a signed and dated witness report/statement regarding Resident #41's allegation of being roughly handled.

The evidence showed that the facility staff who conducted the investigation of Resident #41's allegation of abuse failed have documented evidence that an allegation of abuse was thoroughly investigated by failing to:

1. Make every effort to interview all staff members giving direct care to the resident for two days prior to the incident being reported;

2. Obtain signed and dated written witness reports/statements.

During a face-to-face interview conducted on 04/12/23 at 12:39 PM, Employee #2 (Director of Nursing), who conducted the investigation of this allegation of abuse stated, "I interviewed her [Resident #41]. Had a lot of paranoia and documented memory problems." When asked why none of the staff members interviewed provided a signed and dated written report/statement, Employee #2 stated, "There weren't any witnesses; (Resident #41) couldn't tell us who did it or when. I just interviewed the regular staff who took care of [resident] ." Employee #2 was then asked if any these interviews (resident and staff) were conducted in the presence of a witness, to which she stated, "No." When asked why all the staff who cared for

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 _____	C 04/12/2023

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 610	Continued From page 12 Resident #41 in the two days prior to the allegation being reported were not interviewed or provided a written report/statement, Employee #2 stated, "[Resident #41] was not able to tell me when this occurred. That would've meant having to interview and get statements from almost all the staff. We didn't have time for that." Cross Reference: 22B DCMR sec. 3232.2	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 29 sampled residents, facility staff failed to accurately code one resident's dental status in the Significant Change Minimum Data Set (MDS). Resident #21. The findings included: Resident #21 was admitted to the facility on 05/14/21 with diagnoses that included: Mixed Hyperlipidemia, Vesicointestinal Fistula, and Long Term use of Anticoagulants. Review of Resident #21's medical record revealed: 12/31/22 at 11:33 [Nutrition Assessment] "...Oral/Dental Condition: Dentures- full upper; Dentures- full lower." A Significant Change MDS dated 01/09/23	F 641	**F 641 Accuracy of Assessments** **1. Immediate Response:** On 4/12/23, the MDS for resident #21 was corrected and the MDS section L0200 modification was completed and submitted. **2. Risk Identification:** On 4/12/23, the MDS section L was checked for accuracy for all 14 residents who are edentulous and all were correct. **3. Systemic Changes:** MDS Coordinator and their substitutes were in-serviced regarding proper coding of section L0200 of the MDS. **4. Monitoring:** Monthly random sample of MDS assessments section L of residents who are edentulous will be audited by the Director of Nursing or her designee to ensure accurate coding. These findings will be reported at the QAPI quarterly meetings.	5/15/23

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 _____	C 04/12/2023

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 641	Continued From page 13 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 11, indicating moderate impaired cognition. Section L0200 (Dental), directed "check all that apply", which included, "No natural teeth or tooth fragments (edentulous)". The MDS showed facility staff documented an "X" at the line "None of the above were present." During a face-to-face interview conducted on 04/05/23 at 2:59 PM, Resident #21 was noted to have no upper or lower teeth. Resident #21 stated, "I wear dentures." The resident's assigned Certified Nurse Aide (CNA) showed the surveyor a small, white container that contained a set of full upper and lower dentures. During a face-to-face interview conducted on 04/12/23 at 9:55 AM, Employee #6 (MDS Coordinator) reviewed the MDS and stated, "You are correct. I was on vacation and someone else did this MDS." Cross Reference: 22B DCMR sec. 3231.12	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		

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 _____	C 04/12/2023

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 657	Continued From page 14 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 29 sampled residents, the facility staff failed to update a resident's care plan to include goals and approaches to address one resident's Sacral pressure ulcer. Residents' #50. Findings included: Resident #50 was admitted to the facility on 2/22/2023 with diagnoses that included: Hypertension, Hyperlipidemia, Osteoarthritis, Chronic Obstructive Pulmonary Disease, Anemia, Hypertensive Heart Disease, and Major Depressive Disease. A review of the medical record revealed the following: A review of care plans showed a focus area, "[Resident Name] has potential for impairment to skin integrity related to frail/fragile skin, memory	F 657	**F 657 Develop/Implement Comprehensive Plan of Care-Failure to update care plan for pressure ulcer** **1. Immediate Response:** The care plan for admission pressure ulcer was updated on 5/16/23 for resident #50. **2. Risk Identification:** Care plans of all residents who were admitted with pressure ulcers were reviewed to ensure specific goals and interventions to be in place and be followed by staff. All were up to date. **3. Systemic Changes:** Licensed staff were in-serviced on the necessity to update care plans for residents who were admitted with pressure ulcers. **4. Monitoring:** Monthly random sample of care plans of residents admitted with pressure ulcers will be audited by the Director of Nursing or her designee to ensure consistency of planned interventions and the monitoring documentation of these interventions. These findings will be reported at the QAPI quarterly meetings.	5/15/23

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 _____	C 04/12/2023

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 657	Continued From page 15 impairment, impaired mobility, use of hypertensive medications", initiated on 2/23/2023. The Admission Minimum Data Set (MDS) dated 3/1/2023 showed in Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "15", indicating an intact cognitive response. Under Section G (Functional Status) - Bed Mobility and Personal Hygiene the resident was coded as requiring extensive assistance with one person's physical assistance from facility staff. In Section M (Skin Condition), M0210 indicated "Does this resident have one or more unhealed pressure ulcers/injuries, the facility staff coded, yes." M0300 indicated, "Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar coded as 1. The number of these unstageable pressure ulcers that were present upon admission/entry or reentry coded as 1." 2/22/2023 18:15 [6:15 PM] Medication Reconciliation Note: "Resident admitted to this nursing facility this afternoon. Reviewed discharged orders with MD. New orders received ... Use Dakin's solution to clean coccyx wound daily and PRN....." 2/22/2023 20:45 [8:45 PM] (Physician's Order) "Dakin's (1/4 strength) external solution (sodium hypochlorite) Apply to coccyx topically as needed for dressing soiling /lifting. After cleansing with ¼ strength Dakin's solution follow with gauze and cover with foam dressing." 4/5/2023 10:55 Skin/wound notes " ... 87-year-old	F 657		

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 _____	C 04/12/2023

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 657	Continued From page 16 A [patient] pt seen at bedside earlier today. ... sacral pressure injury ... The sacrum is an unstageable pressure injury that is covered with 40% thin slough and 60% pale granulation around the wound edges. It is surrounded with intact tissue with scant s/s drainage continue the current treatment." 4/10/2023 16:31 Nurses Skilled Notes: " ... Wound still present and with scant slough in bed, no mal odor to the wound while observing for infection ... wound care done and no bleeding observed ..." There was no documented evidence that facility staff updated Resident #50's care plan to reflect the open area found on 2/22/2023. During a face-to-face interview conducted on 4/12/2023, at approximately 9:00 AM with Employee #3 (ADON/Educator), she acknowledged the finding.	F 657		
F 755 SS=D	Cross Refrence: 22B DCMR sec.3210.4 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		

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 _____	C 04/12/2023

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 755	Continued From page 17 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for two (2) of 29 sampled residents, facility staff failed to account for the dispensing of a controlled medications. Residents' #6 and #23. The findings included: 1. Facility staff failed to account for the dispensing of Resident #6's ordered Tramadol (narcotic pain reliever). Resident #6 was admitted to the facility on 07/18/20 with diagnoses that included: Polyosteoarthritis, Idiopathic Peripheral Autonomic Neuropathy and Dementia. Review of Resident #6's medical record revealed:	F 755	**F 755 Pharmacy Services-Procedures for records/documentation of disposition of controlled substances** **1. Immediate Response:** The pharmacy record for accounting of controlled substances were corrected to be accurate on 4/6/23 for resident #6 and on 4/11/23 for resident #23. **2. Risk Identification:** On 4/13/23 Pharmacy controlled substance records on all medication carts were checked for correct documentation and all were found accurate. **3. Systemic Changes:** All licensed staff were in-serviced regarding proper documentation procedures for dispensing controlled substances. **4. Monitoring:** The Director of Nursing or designee will conduct monthly random audits of medication carts for controlled substances count and corresponding documentation on the pharmacy dispensing sheet. Any inconsistencies found will be corrected at the time of audit. Findings will be reported at the quarterly QAPI meetings.	5/15/23

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 _____	C 04/12/2023

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 755	Continued From page 18	F 755		

A physician's order dated 08/25/22 that directed, "Tramadol HCl (hydrochloride) Tablet 50 MG Give 0.5 tablet by mouth everyday shift for pain control..."

During a narcotic count conducted on 04/06/23 at 10:16 AM of the Team A medication cart with Employee #7 (Licensed Practical Nurse), it was noted that Resident #6's inventory sheet for Tramadol (narcotic pain reliever) 50 mg (milligrams) ½ (half) tablets documented "21" remaining, however, the blister packet was observed to have 20 half tablets remaining.

Review of the Medication Administration Record (MAR) for April 2023 showed that Employee #7 initialed to indicate that Resident #6 was administered Tramadol 25 MG on 04/06/23 for "day" shift.

During a face-to-face interview conducted at the time of the observation, Employee #7 acknowledged the findings and stated, "I gave it to [resident] this morning and forgot to sign it out."

2. Facility staff failed to account for the dispensing of Resident #23's ordered Lorazepam (anti-anxiety medication).

Resident #23 was admitted to the facility on 09/21/16 with multiple diagnoses that included: Dementia with Anxiety, Hallucinations and Hypertensive Heart Disease.

A physician's order dated 07/20/21 that directed, "Ativan tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 6 hours for anxiety."

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 _____	C 04/12/2023

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 755	Continued From page 19 Review of the Medication Administration Record (MAR) for April 2023 showed that Employee #8 initialed to indicate that Resident #23 was administered Lorazepam 0.5 mg tablet at 1:00 PM. During a narcotic count on 04/11/23 at 1:08 PM of the Team A medication cart with Employee #8 (Licensed Practical Nurse), it was noted that Resident #23's inventory sheet for Lorazepam 0.5 mg tablets documented "6" remaining, however, the blister packet was observed with 5 tablets remaining. During a face-to-face interview conducted at the time of the observation, Employee #8 acknowledged the findings and stated, "I know to sign out the narcotic medications when I give it. I don't know what happened." Cross Reference: 22B DCMR sec 3224.3	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

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 _____	C 04/12/2023

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 812	Continued From page 20 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by final rinse temperatures from one (1) of two (2) dishwashers that were consistently below 180 degrees Fahrenheit (F) in high heat disinfect mode. The findings included: During observations in dietary services on April 5, 2023, at approximately 12: 45 PM, one (1) of one (1) dishwasher in the main kitchen failed to reach a minimum of 180 degrees Fahrenheit on numerous consecutive occasions. Two (2) of two (2) trays of dishes and utensils that had been washed were rewashed in the chemical disinfect dishwasher located in the resident's small kitchen, on the Long-Term Care unit. When tested, the chemical disinfect solution from that dish machine was at 200 PPM. Employee #10 confirmed the findings on April 10, 2023, at approximately 11:00 AM. Cross Refrence: 22 DCMR sec.3219.1	F 812	**F 812 Food Safety Requirements** **1. Immediate Response:** On 4/5/23, the noted dishwasher was shut down and the dishes were washed in the NF kitchen dishwasher. Dietary Director contacted the vender to repair the dishwasher on 4/5/23. The dishwasher repair was completed on 4/6/23. There was no harm to any resident. **2. Risk Identification:** The other dishwasher onsite was checked to ensure that it was working properly and it was. While checking daily, if dishwasher is found to be not working properly, the dishes will be moved to the other dishwasher and a work order will be placed with the vender. **3. Systemic Changes:** On 4/6/23, the Dietary Director in-serviced the dishwashers and dietary managers on correctly operating the dishwashers and properly checking them to ensure correct temperature is reached. **4. Monitoring:** Dietary Director or designee will check the dishwasher daily for proper operating and temperature. Findings will be reported at the quarterly QAPI meetings.	5/15/23
F 842 SS=D	Resident Records - Identifiable Information	F 842		

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 _____	C 04/12/2023

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 842	Continued From page 21 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	**F 842 Progress Note** **1. Immediate Response:** On 4/11/23, a progress note was entered for resident #105 to reflect the resident allegations of 1/28/23 and the corresponding investigation outcome that no abuse was found. **2. Risk Identification:** All incident reports for the past twelve months were reviewed for proper documentation in the medical record progress note section. No additional records were identified as lacking documentation. **3. Systemic Changes:** Licensed staff were in-serviced on the need to document resident reported incidents in the progress notes section of the medical record. **4. Monitoring:** The Director of Social Services or designee will review incident reports and corresponding progress note documentation quarterly and report findings to the QAPI committee.	5/15/23

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 _____	C 04/12/2023

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 842	Continued From page 22 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 29 sampled residents, facility staff failed to maintain medical records on each resident that were complete. Residents' #105. The findings included: Resident #105 was admitted to the facility on 12/28/2018, with diagnoses that included Peripheral vascular Disease, Gastroesophageal	F 842		

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 _____	C 04/12/2023

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 842	Continued From page 23 Reflux Disease, Chronic Kidney Disease, and Major Depression. The facility submitted a facility reported incident (FRI) on 2/1/2023 to the State Agency, that documented, "Resident reported to Guardian during routine monthly visit that he had been slapped by a staff member at 3 AM [morning] on the day of the visit. Guardian reported to social worker staff. Investigation initiated. Resident interviewed by [registered nurse] RN on day of report. Resident interviewed by Dir of SW [Director of Social Work] on day after report and two days after report. Resident did not repeat report in theses interviews. No bruising, or abraisions noted. Alert and oriented to person only, Hx of Vascular dementia, with paranoid ideation. Hx of recent GDR [gradual drug reduction] of antipsychotic and tx [treatment]of UTI [urinary tract infection]. Staff interviewed by DN [director of nursing] with written statement taken. No unusual incident reported, Investigation concluded as not substantiated for abuse. Resident to be tx [treated] by behavioral health and followed by SW services for possible f/u report." Review of the medical record showed progress notes dated 1/27- 2/2023 documentation was not complete as there was no mention in the progress note of resident #105's reported allegation of abuse information ..." The evidence showed that facility staff failed to maintain resident #105's medical records which were not complete with the resident's allegation of abuse information in the progress note when it was reported on 1/28/2023.	F 842		

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 _____	C 04/12/2023

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 842	Continued From page 24 During a face-to-face interview conducted on 4/11/2023 at 11:00 AM, Employee #4 (Director of Social Service) acknowledged the findings and stated, "I made a mistake of not documenting it in the resident record."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880	**F 880 Infection Prevention and control would dressing disposal** **1. Immediate Response:** On 4/6/23 staff properly disposed of soiled gauze dressing. Resident #50 was assessed and there was no harm. **2. Risk Identification:** Dressing change observations were done on all licensed staff to ensure proper disposal of soiled dressings. **3. Systemic Changes:** Licensed staff were in-serviced regarding the correct method of disposing of soiled dressings. **4. Monitoring:** Monthly random audits of dressing change observations will be done and reviewed by the Director of Nursing or their designee. These findings will be reported at the QAPI quarterly meetings.	**5/15/23**

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 _____	C 04/12/2023

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 880	Continued From page 25 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, facility staff failed to maintain infection prevention and control practices during a wound care dressing change observation for one	F 880		

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 _____	C 04/12/2023

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 880	Continued From page 26 resident. Resident #50. The findings included: According to the National Library of Medicine, when performing wound care, staff should, "Wash your hands ..... Clean the trolley using soap and water, or disinfectant, and a cloth. Start at the top of the trolley and work down to the bottom legs of the trolley using single strokes with your damp cloth. Place the sterile dressing/procedure pack on the top of the trolley. Open the sterile dressing pack on top of the trolley. Open the sterile field using the corners of the paper. Open any other sterile items needed onto the sterile field without touching them. Wash your hands and put on non-sterile gloves (to protect yourself) before removing an old dressing. Dispose of this dressing in a separate dirty clinical waste bag. ... Fold up the dressing/procedure pack and place all contaminated material in a bag designated for clinical waste, making sure all sharps are removed and disposed of in a sharp's container. ...Remove gloves and place them in a waste bag. Wash your hands. (www.ncbi.nlm.nih.gov/pmc/articles/PMC4579997/) During wound care observation for Resident #50's pressure ulcer on 04/06/23 at 11:27 AM Employee #7 was observed cleaning the sacral wound with gauze covered with Dakin solution. He then placed the used unclean gauze on the bedside table with the clean gauze and foam dressing he needed to complete the dressing change. Physician orders dated 02/22/23 at 8:45 PM showed, "Dakin's (1/4 strength) external solution	F 880		

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 _____	C 04/12/2023

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 880	Continued From page 27 (sodium hypochlorite) Apply to coccyx topically as needed for dressing soiling /lifting. After cleansing with ¼ strength Dakin's solution follows with gauze and cover with foam dressing". During wound care observation on resident #50 4/6/2023 at 11:27 AM Employee #7 was observed cleaning the sacral wound with gauze covered with Dakin solution. He then placed the used unclean gauze on the bedside table with the clean gauze and foam dressing he needed to complete the dressing change. In a face-to-face interview conducted on 4/6/2023 at approximately 11:28 AM, Employee #7 stated, "I did not have a red bag to put it (used soiled gauzed) in." He was able to verbalize the procedure for completing the dressing change. A face-to-face interview was conducted on 4/12/2023, at approximately 9:00 AM with Employee #5 (Infection Control), she acknowledged the finding and stated, "Staff will be trained."	F 880		
F 908 SS=D	Cross Reference: 22B DCMR sec 3217.6 Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by final rinse	F 908		

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 _____	C 04/12/2023

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 908	Continued From page 28 temperatures that were below 180 degrees Fahrenheit (F) on April 4, 2023, at approximately 12:45 PM. The findings include: During observation in dietary services on April 5, 2023, at approximately 12:45 PM, final rinse temperatures from one (1) of one (1) dishwasher in the main kitchen did not reach a minimum of 180 degrees Fahrenheit as required. Facility staff attempted to use the dishwasher in chemical disinfect mode. However, when tested, the chlorine disinfect solution failed to reach the minimum requirement of 50 Parts per Million (PPM). Employee #10 confirmed the findings on April 10, 2023, at approximately 11:00 AM Cross Refrence: 22B DCMR sec. 3258.13	F 908	**F 908 Essential Equipment, Safe Operating Condition** **1. Immediate Response:** On 4/5/23, the noted dishwasher was shut down and the dishes were washed in the NF kitchen dishwasher. Dietary Director contacted the vender to repair the dishwasher on 4/5/23. The dishwasher repair was completed on 4/6/23. There was no harm to any resident. **2. Risk Identification:** The other dishwasher onsite was checked to ensure that it was working properly and it was. While checking daily, if dishwasher is found to be not working properly, the dishes will be moved to the other dishwasher and a work order will be placed with the vender. **3. Systemic Changes:** On 4/6/23, the Dietary Director in-serviced the dishwashers and dietary managers on correctly operating the dishwashers and properly checking them to ensure correct temperature is reached. **4. Monitoring:** Dietary Director or designee will check the dishwasher daily for proper operating and temperature. Findings will be reported at the quarterly QAPI meetings.	**5/15/23**