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	095025	A. BUILDING _____ B. WING _____	09/16/2015

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F 000	INITIAL COMMENTS	F 000		

A recertification Quality Indicator Survey (QIS) was conducted September 9 through September 16, 2015. The deficiencies are based on observation, record review, resident and staff interviews for ----34 sampled residents.

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

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeter
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue/Discharge
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan M. Hargreaves LNHA	Administrator	11/5/15

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 000	Continued From page 1 MD- Medical Doctor MDS - Minimum Data Set Mg - milligram (metric system unit of mass) mL - milliliter (metric system measure of volume) mg/dl - milligram per deciliter mm/Hg - millimeter of mercury Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician's order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party Sol- Solution TAR - Treatment Administration Record	F 000		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 9, 2015 at approximately 3:00 PM and September 16, 2015 at Approximately 11:00 AM it was determined that entrance doors to resident rooms and bathrooms were damaged on the front	F 253	**F253 Marred and Scarred Doors** **1. Immediate Response:** Director of Engineering consulted with outside vendor and placed an order for door protectors. Work to be completed. **2. Risk Identification:** Director of Engineering checked all NF Resident entrance and bathroom doors for any marring and scarring. **3. Systemic Changes:** Maintenance Staff was in-serviced on checking NF Resident entrance and bathroom doors for any marring and scarring and reporting any findings to Director of Engineering. Monthly audits of these doors will be completed by Maintenance staff. **4. Monitoring:** The Director of Engineering or designee will monitor and report findings at quality assurance meetings held quarterly.	11/16/15 9/11/15 11/6/15 11/16/15

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F 253	Continued From page 2 surfaces in 24 of 25 resident rooms observed. The findings include: An environmental tour of the facility was conducted on September 9, 2015 at approximately 3:00 PM and September 16, 2015 at approximately 11:00 AM. It was observed that resident ' s room entrance and bathroom doors were marred and scarred on the frontal areas in 24 of 25 room entrance and bathroom doors observed. The findings were acknowledged by Employee # 1 on September 16, 2015 at approximately 11:30 AM.	F 253	**F309 Provide Care/Services for Highest Well Being: Aspiration Precautions** **1. Immediate Response:** Resident was assessed and there were no signs or symptoms of aspiration.	9/14/15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Facility staff failed to consistently maintain aspiration precautions as directed by the physician and/or failed to implement measures to determine whether or not the positioning method utilized was a safe practice to promote safe swallowing for Resident#1 who was diagnosed with Dysphagia.	F 309	**2. Risk Identification:** Rounds were conducted on all residents who require assistance with feeding to ensure that proper positioning and monitoring was in place. **3. Systemic Changes:** Staff was in-serviced on Aspiration Precautions and proper positioning and monitoring of residents requiring feeding. **4. Monitoring:** The Director of Nursing or her designee will do monthly meal observations to ensure Aspiration Precautions are being followed and report the findings to the QA Committee.	9/14/15 10/8/15 11/6/15

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F 309	Continued From page 3 The findings include: According to Taber ' s Cyclopedic Medical Dictionary Edition 22 Dysphagia = difficulty in swallowing Aspiration Precautions - according to the facility ' s protocol [no date indicated] includes the following: " Universal precautions - feed only when patient is alert/awake; sit patient upright (90 degree angle as tolerated) during all meals and 30 minutes after meals; small bites and sips; if patient is a feeder wait until patient has swallowed food/liquid prior to consecutive bite/sip; alternate liquids and solids; provide proper oral care in between meals ... " Resident #1 was observed on September 9, 2015 at approximately 1:00 PM sitting alone in his/her room in a recliner chair consuming the lunch meal. The resident was observed positioned at a 45 degree angle. He/she used a standard spoon to consume the puree textured meal with spillage of food noted on the clothing protector that was draped around his/her neck. A second observation was conducted on September 14, 2015 at approximately 12:30 PM. Resident #1 was observed sitting alone in his/her room in a recliner chair at a 45 degree angle consuming a puree textured lunch meal. The resident did not speak but grunted/moaned and nodded his/her head in response to a query " how you are ...how is your meal? " According to Section G, Functional status, of the quarterly Minimum Data Set [MDS] dated July 20, 2015 Resident #1 was coded as requiring extensive assistance for eating and totally	F 309		

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F 309	Continued From page 4 dependent for transfer and mobility. Section I, Diagnoses was coded to include Dysphagia, Aphasia, Hemiplegia, Dementia and Psychosis. A review of physician ' s orders signed July 29, 2015 directed: " precautions - aspiration; special orders - provide feeding assistance; diet - pureed, regular, lactose free ... " A review of the most recent care plan dated July 2015 revealed the interdisciplinary team identified the " focus area " of ADL [activities of daily living] self-care performance deficit; interventions included " resident is totally dependent on staff for eating. " A focus area of " nutritional risk related to being on a mechanically altered diet " included the intervention " provide assistance at meals such as cueing or total dependence. " A face-to-face interview was conducted with Employee #7 on September 10, 2015 at approximately 2:30 PM. He/she stated that staff repositioned Resident #1 at a 90 degree angle following the surveyor ' s lunch observation on September 9th but the resident refused to eat. Thereafter, the resident was placed back at a 45 degree angle for meals. A face-to-face interview was conducted with Employee #11 on September 14, 2015 at approximately 1:15 PM. In response to a query regarding the care requirements related to meal intake for Resident #1, he/she stated that set-up assistance is provided then additional assistance is provided as the resident desires ...[Resident #1] " will let you know if [he/she] wants or needs something otherwise we leave [him/her] alone, [he/she] prefers it that way. "	F 309		

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F 309	Continued From page 5 A face-to-face interview was conducted with Employee #2 on September 14, 2015 at approximately 2:00 PM. In response to a query regarding the lack of supervision during meal consumption and the positioning of the resident [45 degree angle vs. 90 degrees that is consistent with aspiration precaution protocol] he/she stated that Resident #1 has " come a long way " and for [him/her] to eat willingly and independently is progress. He/she explained that the resident exhibits challenging behaviors including non-compliance. Staff make efforts to comply with the resident ' s desires. Through observation, it was determined that facility staff failed to consistently maintain aspiration precautions as it relates to positioning and feeding assistance; the resident was observed eating alone in a reclined position. The physician ' s orders directed aspiration precautions and feeding assistance and the interdisciplinary team identified " totally dependent on staff for eating " during care planning. There was no evidence that facility staff initiated measures [e.g. medical team re-evaluation and/or speech re-evaluation of swallowing abilities] to determine whether or not the positioning method and independent meal consumption utilized was a safe practice to promote safe swallowing for Resident #1. The resident did not demonstrate any adverse signs or symptoms related to the eating practices utilized by the facility.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on an isolated observation and through staff interview, it was determined that facility staff failed maintain freedom from potential accident hazards as evidenced by the utilization of standard sharp edged scissors when removing bandages during a wound treatment for Resident #81. The findings include: According to the wound treatment orders initiated by the physician on August 21, 2015, Resident #81 was diagnosed with " skin tears " on bilateral upper extremities and left lower extremity. During a wound treatment observation conducted on September 11, 2015 at approximately 12:45 PM, Employee #10 was observed removing gauze (e.g. Kling or Kerlix) bandages from Resident #81 ' s bilateral upper extremities and left lower extremity with standard sharp edged standard scissors. A face-to-face interview was conducted with Employee #10 following the wound treatment. In response to a query regarding the use of standard sharp edged scissors to remove the	F 323	**F323 Free of Accident Hazards/Supervision/Devices: Use of standard scissors during dressing removal** **1. Immediate Response:** Resident condition reviewed and there were no adverse signs or symptoms related to the use of standard sharp edge scissors. **2. Risk Identification:** All medication and treatment carts were checked to ensure that no sharp edge standard scissors were present. All nursing staff were given blunt edge bandage scissors. **3. Systemic Changes:** Staff was in-serviced as to the importance of utilizing proper bandage scissors for all dressing removals. **4. Monitoring:** The Director of Nursing or her designee will conduct monthly medication and treatment cart audits to ensure that there are no sharp edge scissors present and report the findings to the QAPI Committee.	9/11/15 9/11/15 10/8/15 11/6/15

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F 323	Continued From page 7 dressings, he/she replied that they were the only scissors that were available for use and they were the only scissors stored in the treatment cart. A follow-up face-to-face interview was conducted with Employee #9 on September 11, 2015 at approximately 1:30 PM. Following an inquiry regarding scissors to be used during wound treatments, Employee #9 retrieved the scissors that Employee #10 utilized during the wound treatment from the treatment cart and stated that bandage scissors [blunt tipped to lessen the potential of accidental injury while cutting] were available for all staff. Employee #9 returned to the nursing station with a box of bandage scissors and distributed them to all licensed nursing staff. Facility staff failed to lessen the potential of accidents by the utilization of sharp edged scissors during the removal of dressings.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	**F329 Drug Regimen is Free from Unnecessary Drugs: Lorazepam given PRN without indication of need** **1. Immediate Response:** Resident # 58's record was reviewed and a behavioral monitoring tool was put into place to indicate the need for administration of lorazepam and to monitor for its effectiveness. **2. Risk Identification:** All records for residents' prescribed PRN lorazepam were reviewed for the use of a behavior monitoring tool including need for administration and effectiveness. **3. Systemic Changes:** Licensed staff was in-serviced on how to complete behavioral monitoring tools when residents are prescribed PRN lorazepam **4. Monitoring:** The Director of Nursing, Pharmacy Consultant or her designee will perform monthly sample audits of records for residents who are prescribed lorazepam for PRN usage to ensure that monitoring tool is being properly used and report the findings to the QAPI Committee.	9/15/15 9/15/15 10/8/15 11/6/15

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F 329	Continued From page 8 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents it was determined that facility staff failed to keep Resident #58 free from unnecessary medications as evidenced by the administration of an " as needed " anxiolytic medication, Lorazepam, in the absence of a reason to warrant its use and/or indication of effectiveness. The findings include: A review of the clinical record for Resident #58 revealed the resident ' s diagnoses included Schizophrenia, Hypertension, Coronary Artery Disease and Hypothyroidism. Physician orders dated September 2, 2015 [initially ordered March 25, 2015] included an " as needed " [prn] order for the administration of an anxiolytic medication, Lorazepam 0.5mg 1 tablet by mouth every 6 hours as need for " behavior; anxiety; insomnia. " A review of Resident #58 ' s Medication Administration record [MAR] for September 2015 revealed the nurse administered " as needed "	F 329	**F 371 Steamer and Fryer** **1. Immediate Response:** Steamer and fryer were cleaned and grease buildup was removed. **2. Risk Identification:** Checked all other surfaces for cleanliness. **3. Systemic Changes:** In-serviced staff on proper equipment cleanliness and was added to Wednesday and Sunday cleaning schedule. It was also added to cooks daily opening and closing checklist. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held quarterly. **F 371 Gas Stove Burner** **1. Immediate Response:** Onsite maintenance fixed the burner so that it would light. **2. Risk Identification:** All other burners were checked to ensure they would light. **3. Systemic Changes:** In-serviced cooks on equipment maintenance and reporting. Added to cooks daily opening and closing checklist. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held quarterly.	9/11/15 9/11/15 10/2/15 11/9/15 9/9/15 9/9/15 10/2/15 11/9/15

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F 329	Continued From page 9 Lorazepam on three (3) occasions in the absence of a reason to warrant its administration and/or evidence of it ' s effectiveness or lack thereof as follows: Lorazepam 0.5mg 1 tablet by mouth 1. September 5th at 1:55 AM 2. September 11th at 11:49 PM 3. September 13th at 9:31 PM A review of the MAR, behavior monitoring records and nursing progress notes lacked evidence of a reason to warrant the administration of Lorezepam on the three (3) dates delineated above. A face-to-face interview was conducted Employees #2 and 5 on September 15, 2015 at 2:00 PM. Each reviewed the MAR, nursing notes and behavior monitoring records and acknowledged that the record lacked an indication for administration of Lorazepam and/or evidence of it's effectiveness. The record was reviewed September 15, 2015.	F 329	**F 371 Drain Pipe** **1. Immediate Response:** Drain pipe was cut to ensure adequate air gap. **2. Risk Identification:** All other drain pipes were checked for adequate air gap. **3. Systemic Changes:** Cooks in-serviced on proper equipment maintenance and reporting. Also added to cooks opening and closing checklist. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held quarterly. **F 371 Cutting Board with Deep Grooves** **1. Immediate Response:** Identified cutting board was disposed of immediately. **2. Risk Identification:** Checked condition of all other cutting boards.	9/9/15 9/9/15 10/2/15 11/9/15 9/9/15 9/9/15
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**3. Systemic Changes:** In-serviced Dietary Staff to not use damaged cutting boards. Added to cooks opening and closing checklist to check all cutting boards. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held	10/2/15 11/9/15

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:00 AM and on September 11, 2015 at approximately 10:00 AM, it was determined that the facility failed to store, prepare and serve foods under sanitary conditions as evidenced by: one (1) of one (1) soiled steamer, one (1) of six (6) broken burner from one (1) of one (1) gas stove, a drain pipe from one (1) of one (1) garbage disposal that lacked the proper air gap from the drain, one (1) of four (4) damaged cutting board, four (4) of four (4) soiled storage bin ins lid, one (1) of one (1) oven with no draining tube, four (4) of four (4) storage bins with expired foods such as sugar, pasta, flour and bread crumbs and a soiled kitchen floor. The findings include: 1. One (1) of one (1) steamer and one (1) of one (1) fryer were soiled with grease buildup. 2. One (1) of six (6) burners from the gas stove did not light when tested. 3. The drain pipe from the garbage disposal extended too far into the drain and needed to be shortened. 4. The blue cutting board, one (1) of four (4) cutting boards, was marred with deep grooves and needed to be replaced.	F 371	**F 371 Storage Bin Lids Soiled** **1. Immediate Response:** All lids were washed and sanitized immediately. **2. Risk Identification:** Checked all other food storage lids for cleanliness. **3. Systemic Changes:** In-serviced Dietary staff on importance of cleaning food storage bin lids. Added to Wednesday and Sunday cleaning schedule. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held quarterly. **F 371 Oven Drain Tube Missing** **1. Immediate Response:** Onsite maintenance replaced missing drain tube on oven. **2. Risk Identification:** Check to make sure all drain tubes in kitchen are in place. **3. Systemic Changes:** In-serviced cooks on equipment maintenance and reporting. Added to cooks opening and closing checklist. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held	9/9/15 9/9/15 10/2/15 11/9/15 9/9/15 9/9/15 10/2/15 11/9/15

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F 371	Continued From page 11 5. The lids to four (4) of four (4) food storage bins were soiled with scattered food debris. 6. The draining tube from one (1) of one (1) oven was missing and fluid was leaking from the oven onto the kitchen floor and into a hotel pan. 7. Four (4) of four (4) storage bins with foods such as sugar, pasta, flour and bread crumbs were stored beyond their labeled expiration dates of August 2015. The sugar filled bin was expired as of August 10, 2015 The pasta filled bin was expired as of August 15, 2015 The flour filled bin was expired as of August 22, 2015 The bread crumbs filled bin was expired as of August 22, 2015. 8. The kitchen floor was soiled, specifically at the entrance to the freezer and behind the ice machine. These observations were made in the presence of Employee #5 who acknowledged the findings.	F 371	**F 371 Stored Food beyond expiration date** **1. Immediate Response:** The identified sugar, pasta, flour and breadcrumbs were disposed of immediately. **2. Risk Identification:** Checked all food items to ensure they have not expired. **3. Systemic Changes:** In-serviced dietary staff on proper food labeling and that expired foods must be thrown out. Added to cooks opening and closing schedule. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held quarterly. **F 371 Soiled Kitchen Floor** **1. Immediate Response:** Soiled kitchen floor in front of freezer and behind ice machine were cleaned immediately. **2. Risk Identification:** All other kitchen floor areas were checked for cleanliness. **3. Systemic Changes:** In-serviced dietary staff that floors must be kept clean and soil free. Added to daily cleaning schedule. **4. Monitoring:** Director of Food Service or designee will monitor weekly and report findings at quality assurance meetings held quarterly.	9/9/15 9/9/15 10/2/15 11/9/15 9/9/15 9/9/15 10/2/15 11/9/15
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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 _____	09/16/2015

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

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F 441	Continued From page 12 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based an observation of the facility's Environmental Services room, it was determined that facility staff failed to ensure that personnel stored linens so as to prevent the spread of infection. The findings include: A tour of the Environmental Services room was	F 441	**F441 Infection Control, Prevent Spreads, Linens; Soiled linens in Utility Room uncovered** **1. Immediate Response:** Environmental Services immediately covered soiled linen bins in utility room. **2. Risk Identification:** Checked all soiled linen bins to assure that they had covers in place. **3. Systemic Changes:** Staff was in-serviced as to the necessity of keeping all soiled linen bins covered for infection control purposes. **4. Monitoring:** The Director of Environmental Services will conduct monthly audits to ensure that all soiled linen bins are covered and report the findings at the quarterly QA meetings.	9/14/15 9/14/15 11/3/15 11/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 13 conducted on September 14, 2015 at approximately 1:45 PM. At this time five (5) of six (6) linen storage bins containing items such as: gowns, bed spreads, bed pads for resident use were observed uncovered. A face-to-face interview was conducted with Employee #6 a the time of the observation. He/she acknowledged the findings. There was no evidence that facility staff stored linens so as to prevent the spread of infection.	F 441		