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 _____	03/12/2021

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LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

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F 000	INITIAL COMMENTS	F 000		

An unannounced Long Term Care Recertification Survey was conducted at Lisner-Louise-Dickson-Hurt Home from March 8, 2021 through March 12, 2021. Survey activities consisted of a review of 16 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census on the first day of survey was 50.

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
BPH- Benign Prostatic Hyperplasia
cm - Centimeters
CFR- Code of Federal Regulations
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
Dl- Deciliter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan M. Thorpe — TITLE: Administrator — (X6) DATE: 4/16/21

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	F 000		

DMH - Department of Mental Health
DOH- Department of Health
DON Director of Nursing
DRR Drug Regimen Review
EHR Electronic Health Record
EKG - Electrocardiogram
ER Emergency Room
EMS - Emergency Medical Services (911)
ESRD- End Stage Renal Disease
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
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
mm/Hg - millimeters of mercury
MN- midnight
MRR- Medication Regimen Review
N/C- Nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident

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F 000	Continued From page 2 Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POC- Plan of Correction PCC Point Click Care POS - physician's order sheet Prn - As needed Pt - Patient PTA- Physical Therapy Assistant Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RUE Right Upper Extremities RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		

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F 656	Continued From page 3 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, for one (1) of 16 sampled residents, facility staff failed to implement the interventions specified in the care plan for monitoring a resident on antidepressant and antipsychotic medications. Resident #5.	F 656	**F 656 Develop/Implement Comprehensive Care Plan** **1. Immediate Response:** The interventions on the resident's plan of care were followed including ensuring the resident was free of adverse side effects of antipsychotic and antidepressant medications. **2. Risk Identification:** Care plans of all residents receiving antipsychotic and/or antidepressant medications were reviewed to ensure specific goals and interventions were in place and being followed by staff. **3. Systemic Changes:** Licensed staff were in-serviced on the necessity to follow the interventions documented in the plan of care regarding side effects of antipsychotic and antidepressant medications. Documentation shall occur on the behavior monitoring tool in the medical record. **4. Monitoring:** Random sample of care plans/behavior monitoring tool will be audited by the DON or designee to ensure consistency of planned interventions and the monitoring documentation of these interventions. Findings will be reported at the quarterly QAPI meetings.	4/19/2021

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F 656	Continued From page 4 Findings included ... Resident #5 was admitted to the facility on 10/10/2017, with diagnoses that included Anxiety Disorder, Coronary Artery Disease, Hypertension, and Hyperlipidemia. Review of the medical record showed the following physician's orders: 8/24/2020 at 17:00 (5:00 PM) Seroquel Tablet 25 MG (milligrams) ... Give 0.5 tablet by mouth in the evening for Delusions 0.5tab (tablet) 12.5mg 8/25/2020 at 09:00 (AM) Seroquel Tablet 25 MG ... Give 1 tablet by mouth one time a day for Delusions 8/25/2020 at 09:00 (AM) Zoloft Tablet 25 MG ... Give 1 tablet by mouth one time a day for Anxiety Review of the care plans dated 02/22/2021, showed the following focus area: "[Resident #5] is at risk for adverse reaction related to ... use of antidepressant medication, use of antipsychotic medication" with the following interventions: Administer medications per orders. Monitor/document for effectiveness and any side effects. Administer Psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q (every)-shift. A review of the nursing progress notes, behavior tab, treatment administration record, and the	F 656		

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F 656	Continued From page 5 paper chart dated from 08/24/2020, to 03/10/2021, showed that there was no documented evidence that the facility staff monitored Resident # 5 for effectiveness or side effects of the antidepressant and antipsychotic medication as outlined in the care plan. During a face-to-face interview conducted with Employee #5 on 03/10/2021, at approximately 2:20 PM, she stated, "I have not been documenting any behavior assessments on Resident #5." Employee #5 then proceeded to show the surveyor the blank "Behavior" section in the electronic health record. Continued interview revealed that the facility also uses a paper copy of the checklist for monitoring behaviors and side effects however, Employee #5 stated, "Resident #5 has not had one." During a face-to-face interview on 03/10/2021, at approximately 2:30 PM with Employee #6 (Unit Manager), acknowledged the finding and stated, "I am not sure why she [Resident #5] hasn't been getting monitored but she needs to be and needs a behavior sheet." Facility staff failed to implement the interventions (monitor/document for effectiveness and any side effects) specified in the care plan for monitoring Resident #5 who receives antidepressant and antipsychotic medications.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 6 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 16 sampled residents, facility staff failed to follow the professional standards of practice for completing the assessment on Resident #24 prior to leaving the facility for dialysis treatment. Findings included ... Resident #24 was admitted to the facility on 07/16/2020, with diagnoses that include: End Stage Renal Disease, Diabetes Mellitus 2, Peripheral Vascular Disease, Hypertensive Heart Disease, Anxiety and Major Depressive Disorder. A review of the physician's order dated 07/16/2020, showed, "Appointment: Hemodialysis three times a week ...every day shift every Tue [Tuesday], Thu [Thursday] and Sat [Saturday]". A review of Resident #24's Dialysis Communication Record [A form used to facilitate communication between the nursing facility and the dialysis center] showed the following: On 01/30/2021, facility staff failed to complete the resident assessment (resident status, intake by mouth, graft site function, vital signs, mobility, and	F 684	**F 684 Quality of Care** **1. Immediate Response:** Current Dialysis Communication Sheets were complete including an assessment and vital signs. **2. Risk Identification:** All Dialysis Communication Sheets for residents who utilize out-patient dialysis centers were reviewed for completeness and accuracy. **3. Systemic Changes:** Licensed staff were in-serviced to ensure they are accurately communicating the resident condition to the dialysis center via the Dialysis Communication Sheet prior to leaving the facility. A new system has been put in place to track dialysis communication. **4. Monitoring:** Random samples of medical records will be audited by the Director of Nursing or her designee to ensure consistency and accuracy. Audit findings will be reported at the quarterly QAPI meetings.	4/19/2021

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F 684	Continued From page 7 dialysis transportation) on the form prior to the resident leaving the facility for dialysis treatment. On 02/27/2021, facility staff failed to record the vital signs obtained from the resident on the dialysis communication form prior to leaving the facility for dialysis treatment. During a face-to-face interview on 03/11/2021, at 12:30 PM with Employee # 9, she stated, "The information from the facility to the dialysis center is from the Resident's morning assessment that includes resident status, intake by mouth, graft site function, vital signs, mobility and dialysis transportation to dialysis." At the time of the interview, Employee #9 acknowledged the findings. Facility staff failed to follow the professional standards of practice for completing the assessment on a resident going out for dialysis treatment.	F 684		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		

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F 757	Continued From page 8 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, for one (1) of 16 sampled residents, facility staff failed to adequate monitoring a resident who is on antipsychotic medication. Resident #5. Findings included ... Resident #5 was admitted to the facility on 10/10/20217, with diagnoses that included Anxiety Disorder, Coronary Artery Disease, Hypertension, and Hyperlipidemia. Review of the medical record showed the following orders: 8/24/2020 17:00 (5:00 PM) Seroquel Tablet 25 MG (milligrams) ... Give 0.5 tablet by mouth in the evening for Delusions 0.5tab (tablet) 12.5mg 8/25/2020 09:00 (AM) Seroquel Tablet 25 MG ... Give 1 tablet by mouth one time a day for delusions Review of the care plan dated 02/22/2021, showed the following focus area: [Resident #5] is	F 757	**F 757 Drug Regiment is Free from Unnecessary Drugs** **1. Immediate Response:** The resident was assessed for any adverse side effects of antipsychotic medication. **2. Risk Identification:** All residents who are taking antipsychotic medications were assessed for any adverse side effects from the drugs. **3. Systemic Changes:** Licensed staff were in-serviced as to the importance of monitoring residents for side effects from antipsychotic medications. Documentation of this monitoring shall be done on the behavior monitoring tool in the medical record. **4. Monitoring:** Random sample of medical records of residents who take antipsychotic medication shall be audited by the Director of Nursing or her designee. Audit findings will be reported at the quarterly QAPI meeting.	4/19/2021

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F 757	Continued From page 9 at risk for adverse reaction related to ... use of antipsychotic medication with the following interventions: Administer medications per orders. Monitor/document for effectiveness and any side effects. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q (every)-shift. A review of the nursing progress notes, behavior tab, treatment administration record, and the paper chart dated 08/24/2020 to 03/10/2021, showed that there was no documented evidence that the facility staff monitored Resident #5 for effectiveness or side effects of the antidepressant and antipsychotic medication as outlined in the care plan. During a face-to-face interview conducted with Employee #5 on 03/10/2021, at approximately 2:20 PM, she stated, "I have not been documenting any behavior assessments on Resident #5." Employee #5 then proceeded to show the surveyor the blank "Behavior" section in the electronic health record. Continued interview revealed that the facility also uses a paper copy of the checklist for monitoring behaviors and side effects however, Employee #5 stated, "Resident #5 has not had one." During a face-to-face interview on 03/10/2021, at approximately 2:30 PM with Employee #6 (Unit Manager), acknowledged the finding.	F 757		

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F 757	Continued From page 10 Facility staff failed to adequately monitor a resident who is on antipsychotic medication.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to store biologicals in safe condition as evidenced by nine (9) of 54 containers of sterile water, that were stored past their expiration date of November 2019, in the oxygen storage room	F 761	**F 761 Label/Store Drugs and Biologicals** **1. Immediate Response:** The containers of expired water were removed from the storage room and disposed of. **2. Risk Identification:** All storage rooms were checked for expired bottles of sterile water and none were found. **3. Systemic Changes:** Unit Support Specialist was in-serviced as to the importance of rotating stock of sterile water in the storage room. Stock will be audited by nursing staff. **4. Monitoring:** Director of Nursing or designee will audit storage closets to ensure there are no expired containers of sterile water. Findings will be reported at the quarterly QAPI meeting.	4/19/2021

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F 761	Continued From page 11 located on the Dickson Drive unit. Findings included ... During a walkthrough of the facility on March 11, 2021, at approximately 1:10 PM, nine (9) of 54, 3.4 ounces containers of sterile water were stored past their expiration date of November 2019, in the oxygen room located on the Dickson Drive unit. Employee #3 acknowledged the findings during a face-to-face interview on March 11, 2021, at approximately 1:15 PM.	F 761	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary Cheese and mustard expired** **1. Immediate Response:** The identified expired cheese and mustard were thrown away. **2. Risk Identification:** Inventory of all stored cheese and mustard containers were checked to ensure they were not expired. **3. Systemic Changes:** Dietary staff were in-serviced on the necessity to dispose of any expired containers of food. **4. Monitoring:** Audits will be done by the Dietary Manager or her designee to ensure no expired cheese or mustard containers are stored. Findings will be reported at the quarterly QAPI meeting.	
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. (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:	F 812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary Grease Fryer Soiled** **1. Immediate Response:** The identified soiled grease fryer was cleaned. **2. Risk Identification:** No other grease fryers in the building. **3. Systemic Changes:** Dietary staff were in-serviced on the necessity keep the grease fryer clean after use.	4/19/2021

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F 812	Continued From page 12 Based on observations made on March 8, 2021, at approximately 12:30 PM, it was determined that dietary staff failed to store and prepare food in accordance with professional standards for food service safety, as evidenced by one (1) of one (1) open pack of parmesan cheese and one (1) of one (1) open container of mustard that were stored beyond their use-by-date of March 4, 2021, one (1) of one (1) grease fryer that was soiled with cooked food residue, and four (4) of seven (7) sheet pans that were dented throughout. Findings included ... 1. One (1) of one (1) open pack of parmesan cheese and one (1) of one (1) container of mustard were stored in one (1) of one (1) walk-in refrigerator beyond their use-by-date of March 4, 2021. 2. One (1) of one (1) grease fryer was soiled with leftover fried food residue. 3. Four (4) of seven (7) sheet pans, stored in the ready-for-use area, were dented throughout. These observations were acknowledged by Employee #7 during a face-to-face interview on March 12, 2021, at approximately 11:00 AM.	F 812	**4. Monitoring:** Audits will be done by the Dietary Manager or her designee to ensure the grease fryer is not soiled. Findings will be reported at the quarterly QAPI meeting. **F 812 Food Procurement, Store/Prepare/Serve-Sanitary** **Four Sheet Pans dented** **1. Immediate Response:** The four identified dented sheet pans were thrown away. **2. Risk Identification:** All other sheet pans were inspected to ensure that they are free of dents. **3. Systemic Changes:** Dietary staff were in-serviced on the necessity of proper handling of sheet pans to reduce denting and to not use dented sheet pans. **4. Monitoring:** Audits will be done by the Dietary Manager or her designee to ensure the sheet pans in use are not dented. Findings will be reported at the quarterly QAPI meeting.	4/19/2021 4/19/2021
F 908 SS=D	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:	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 _____	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 908	Continued From page 13 Based on observation and interview, facility staff failed to maintain building equipment in good working condition as evidenced by one (1) of one (1) hopper that did not function as intended. Findings included ... One (1) of one (1) hopper, located in the soiled utility room on the Dickson Drive unit failed to flush when tested. During a face-to-face interview on March 11, 2021, at approximately 1:45 PM, Employee #8 acknowledged that the hopper was no longer functioning and needed to be removed from the soiled utility room.	F 908	**F 908 Hopper failed to flush** **1. Immediate Response:** The hopper was covered to ensure it was not used. **2. Risk Identification:** No other hoppers in the building. **3. Systemic Changes:** Facility Manager scheduled the removal of the hopper for May 1, 2021 and instructed staff to keep the out of service hopper covered until removed. **4. Monitoring:** The Facility Manager will report and confirm that the removal of the hopper has taken place at the quarterly QAPI meeting.	5/14/2021