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 _____	06/12/2018

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 000	INITIAL COMMENTS	F 000		

An unannounced Long Term Care Survey was conducted at Lisner-Louise-Dickson-Hurt Home from June 6, through June 12, 2018. Survey activities consisted of a review of 28 sampled residents. The following deficiencies are based on observation, record review, 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 following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AD- Associate Director
AMS - Altered Mental Status
ARD - Assessment Reference Date
BID - Twice- a-day
BIMS- Brief Interview for Mental Status
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CFU Colony Forming Unit
CRF - Community Residential Facility
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 | TITLE | (X6) DATE

Susan M. Tang | Unit Administrator | 8/1/18

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.

Susan M. Tang

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DMH - Department of Mental Health
DON - Director of Nursing
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
L - Liter
LPN- Licensed Practical Nurse
LTC- Long Term Care
Lbs. - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
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
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
R/P - Responsible party
RN- Registered Nurse

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F 000	Continued From page 2 SCC Special Care Center Sol- Solution SSD- Social Services Director TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483 10(i)(1)-(7) §483.10(i) Safe Environment The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483 10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584	**F584 Dressers and Bedside Chests Marred** **1. Immediate Response:** The identified marred dressers and bedside chests were repaired. **2. Risk Identification:** All resident dressers and bedside chests were inspected for marred surfaces. **3. Systemic Changes:** An in-service was held for staff on checking dressers and chests for marred surfaces and reporting any with marks to Environmental Services for repair or replacement. Monthly checks will be completed by Environmental Services Director or designee. **4. Monitoring:** Findings of the monthly checks will be reported by the Environmental Services Director or designee at the quarterly QA Meetings.	7/27/18

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F 584	Continued From page 3 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure resident room furnishings were maintained in a clean and safe manner as evidenced by dressers and bedside chest marred with gashes and scratch marks in one (1) of 16 resident rooms, and damaged laminate covering on two (2) of 16 resident over-the-bed tables. The failure has the potential to amass dirt and food residue. Findings included... Facility failed to ensure resident room furnishing were maintained in a clean and safe manner. During observations on the Louise Terrace unit on June 11, 2018, at approximately 10:00 AM, the residents' room were observed with the following: 1. In Room #107, two (2) of two (2) dressers and two (2) of two (2) bedside chest were marred with scratch marks and gashes with the potential to collect dirt. 2. In Room #106, the top of one (1) of one (1) over-the-bed table had peeling laminate and the cover to one (1) of two (2) over-the-bed table had	F 584	**F584 Over the Bed Table with Peeling Laminate and hole** **1. Immediate Response:** The identified over the bed table was replaced **2. Risk Identification:** All resident over the bed tables were inspected for damaged surfaces. **3. Systemic Changes:** An in-service was held for staff on checking over the bed tables' surfaces and reporting any with damage to Unit Support Specialist for replacement. Monthly checks will be completed by Director of Environmental Services or her designee. **4. Monitoring:** Findings of the monthly checks will be reported by the Director of Environmental Services or her designee at the quarterly QA Meetings.	7/27/18

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F 584	Continued From page 4 a dime size hole with the potential to amass food residue. During a face-to-face interview on June 11, 2018, Employee #11 acknowledged the findings.	F 584		
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 resident interview, staff interview, and record review for one (1) of 28 sampled residents, the facility staff failed to accurately assess and code the quarterly Minimum Data Set (MDS) under Section Q (Participation in Assessment and Goal Setting) to reflect the resident's preference to discharge from the facility. Resident #37. Findings included... Resident #37 was admitted on November 17, 2017, with diagnoses to include: Acute Cholecystitis Status-post Cholecystectomy, Cerebrovascular Accident with left paresis (weakness), Hypertension, and Atrial Fibrillation. During a resident interview on June 6, 2018, at approximately 10:20 AM, the Resident #37 stated that she has family in Canada and the Philippines and that she wishes to move to Canada to live with family who will then assist her in moving to the Philippines with other family members. When asked if she has discussed this with the facility staff she stated "yes" from the beginning. "I never	F 641	**F641 Accuracy of Assessments** **1. Immediate Response:** An MDS for Resident #37 was completed Section Q was coded to reflect the resident's preference for discharge. **2. Risk Identification:** All residents were interviewed for discharge preference. The last completed MDS for each resident was compared and reviewed for accurate coding of section Q. **3. Systemic Changes:** Staff was in-serviced on the proper coding of MDS section Q. **4. Monitoring:** The Director of Social Services or her designee will conduct random quarterly interviews and audit section Q of the MDS to ensure accuracy of coding the resident's preference for discharge. Audit of findings will be reported at the quarterly QA Meetings	7/27/18

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F 641	Continued From page 5	F 641		

wanted to stay here permanently." She also stated, "I have friends and family here, who come to see me all the time and we do discuss this".

A face-to-face interview was conducted on June 8, 2018, at approximately 1:00 PM, with Employee #9, Social Work Director, when questioned about discharge plans for Resident #37, she stated, she was aware of her wish to move to Canada. Employee #9 further stated the resident has family visiting her frequently. However, a discharge plan from the facility has never been discussed with the resident or her family. Also, Employee # 9 stated, "It was assumed the resident would remain in the long-term care facility because of her prior residence in the assisted living facility."

On June 8, 2018, at 2:30 PM, a review of Resident #37's Comprehensive Minimum Data Set (MDS) dated April 24, 2018, showed that Section Q "Assessment and Goal Setting" [Q0300] Overall Expectation was coded as" 2" " expects to remain in this facility".

A review of the care plan on June 8, 2018, at 2:30 PM showed the facility documented the approaches and goals for Resident #37 as adjustment to new long-term care home.

The medical record lacked documented evidence of the goals and approaches related to Resident #37's desire to return to the community.

On June 8, 2018, at 3:00 PM, during a

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F 641	Continued From page 6 face-to-face interview, Employee # 9 acknowledged the findings.	F 641		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked	F 660	**F660 Discharge Planning** **1. Immediate Response:** A discharge plan for Resident #37 was developed and a referral was made to the local contact agency. **2. Risk Identification:** All residents were interviewed for discharge preference. All care plans reviewed for active discharging planning and need for referral to local contact agency. **3. Systemic Changes:** Staff was in-serviced on care planning resident's desire to discharge and process of referral to local contact agency. **4. Monitoring:** The Director of Social Services or her designee will conduct random quarterly interviews and audit resident care plans to ensure active discharge planning and referral to the local contact agency is in place per resident preference of this service. Audit of findings will be reported at the quarterly QA Meetings.	7/27/18

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F 660	Continued From page 7 about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.	F 660		

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F 660	Continued From page 8	F 660		

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, and record review for one (1) of 28 sampled residents, the facility staff failed to develop a discharge plan and make a referral to the local contact agency to assist with Resident #37's desire to return to the community upon completion of rehabilitation services. Resident #37.

Findings included...

Resident #37 was admitted on November 17, 2017, with diagnoses to include: Acute Cholecystitis Status-post Cholecystectomy, Cerebrovascular Accident with left paresis (weakness), Hypertension, and Atrial Fibrillation.

During a resident interview on June 6, 2018, at approximately 10:20 AM, the Resident #37 stated that she has family in Canada and the Philippines and that she wishes to move to Canada to live with family who will then assist her in moving to the Philippines with other family members. When asked if she has discussed this with the facility staff she stated "yes" from the beginning. "I never wanted to stay here permanently." She also stated, "I have friends and family here, who come to see me all the time and we do discuss this". Resident further stated "I go for physical therapy two times a day and I'm coming along nicely."

A face-to-face interview was conducted on June 8, 2018, at approximately 1:00 PM, with Employee #9, Social Work Director, when questioned about discharge plans for Resident

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F 660	Continued From page 9 #37, she stated, she was aware of her wish to move to Canada. Employee #9 further stated the resident has family visiting her frequently. However, a discharge plan from the facility has never been discussed with the resident or her family. Also, Employee # 9 stated it was assumed the resident would remain in the long-term care facility because of her prior residence in the assisted living facility On June 8, 2018, at 2:30 PM, a review of Resident #37's Comprehensive Minimum Data Set (MDS) dated April 24, 2018, showed that Section Q "Assessment and Goal Setting" [Q0300] Overall Expectation was coded as" 2" " expects to remain in this facility". A review of the care plan on June 8, 2018, at 2:30 PM showed the facility documented the approaches and goals for Resident #37 as adjustment to new long-term care home The medical record lacked documented evidence the facility referred Resident #37 to the Local Contact Agency to address her desire to be discharged from the facility upon completion of physical therapy On June 8, 2018, at 3:00 PM, during a face-to-face interview, Employee # 9 acknowledged the findings.	F 660	**F684 Hearing Aids** **1. Immediate Response:** Resident's hearing aids were checked and placed in resident's ears. **2. Risk Identification:** All residents who have a physician's order to wear hearing aids were checked to ensure they were working properly and were in the resident's ears per MD order. **3. Systemic Changes:** All nursing staff were in-serviced as to the importance of checking function and encourage resident use of their hearing aids. **4. Monitoring:** The Director of Nursing or her designee will conduct monthly audits of all residents with physician orders for the use of hearing aids to ensure proper functioning and usage. Audit of findings will be tracked and reported at the quarterly QA Meetings.	7/27/18
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 10	F 684		

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 observation, interview and record review for one (1) of 28 sampled residents, facility staff failed to ensure resident received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being as evidenced by the failure of staff to provide care in accordance with a physician's order to apply hearing aids in the daytime. Resident #7.

Findings included...

Review of the medical record showed Resident #7 was admitted to the facility on 1/25/11, with diagnoses which include Heart Failure, Chronic Obstruction Pulmonary Disease, and Type II Diabetes Mellitus.

During an observation on 6/6/18, at 10:30 AM, Resident #7 was lying in bed watching television without wearing hearing aids.

During a resident interview on 6/6/18, at 10:30 AM, Resident #7 was asked if he wears glasses or uses hearing aids? The resident states they [staff] don't put them in because they [hearing aids] don't fit right they cost too much money to get the ones I really need.

Additional observations on 6/6/18, at 3:30 PM

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F 684	Continued From page 11 Resident #7 was not wearing his hearing aid; and on 6/11/18 at 3.10 PM, the Resident was observed lying in bed not wearing his hearing aid as per the physician's order. Review of the physician's order dated 1/15/18, directed, "Hearing aid every day and evening shift, apply in AM and remove at bedtime." Review of the Quarterly Minimum Data Set [MDS] dated 3/12/18, showed section [B0300 Hearing Aid] or other appliances used in completing Hearing, the code was entered as "1" to indicate "yes." On 6/11/18, at 3:15 PM a face-to-face interview was conducted with Employee #17, Registered Nurse, states I usually put them in when he goes to dialysis. Employee#17 was unable to provide evidence as to why the Resident was not wearing his hearing aid in accordance with the doctor's order. During a staff interview on 6/11/18 at 3:30 PM, with Employee #4, Clinical Nurse Manager, she was informed of the observations and states I did not know he had a hearing aid, let me look into this. During a face-to-face interview with Employees #4 and #17 acknowledged the finding (resident was not wearing hearing aid as per the physician's order).	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 12 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by a frayed call bell cord and a damaged telephone cord in two (2) of 16 observations and missing door closure covers in two (2) of 16 observations. Findings included: 1. On June 11, 2018, at approximately 10:00 AM, during observations on the Louise Terrace Unit, the call bell and telephone cords for Resident Room #110-B was noted to have uncovered electrical wires creating a potential electrical safety hazard in two (2) of 16 observations. 2. On June 11, 2018, approximately 10:30 AM, during observations on the Dickerson Drive Unit, the door closure housings located above the entrance door of resident room #117 lacked a cover with electrical wires and connectors visible and accessible creating a potential safety hazard in one (1) of 16 resident rooms. 3. On June 11, 2018, approximately 11:00 AM, during observations on the Special Care Unit, the door closure housings located above the entrance door of resident room #132 lacked a	F 689	**F689 Electrical Wires Uncovered** **1. Immediate Response:** The identified call bell and phone cords were replaced. **2. Risk Identification:** All resident call bell and phone cords were checked to make sure no electrical wires were uncovered. **3. Systemic Changes:** Staff was in-serviced on the importance of checking and reporting any uncovered phone cords and call bell cords to the Facility Manager. The Facility Manager or his designee will do monthly checks of the cords to ensure that they are covered. **4. Monitoring:** The Facility Manager or his designee will report audit findings at the quarterly QA Meetings. **F689 Door Closure Housings** **1. Immediate Response:** Covers were installed on the two identified door closure housings above the entrance doors that lacked covers and had visible wires. **2. Risk Identification:** All door closure housings were checked for covers and that no wires were visible. **3. Systemic Changes:** Staff was in-serviced on the importance of checking and reporting any missing covers on the door closure housings to the Facility Manager. The Facility Manager or his designee will do monthly checks of the door closure housings to ensure that they are covered and no wires are visible. **4. Monitoring:** The Facility Manager or his designee will report audit findings at the quarterly QA Meetings.	7/27/18 7/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
his designee will report audit findings at the quarterly QA Meetings.	095026	A. BUILDING _____ B. WING _____	06/12/2018

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

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F 689	Continued From page 13 cover with electrical wires and connectors visible and accessible creating a potential safety hazard in one (1) of 16 resident rooms During a face-to-face interview on June 11, 2018, approximately 12:00 PM, the findings were discussed with Employee #11 and acknowledged.	F 689	**F812 Food Held Past Expiration Date** **1. Immediate Response:** The identified expired food was discarded. **2. Risk Identification:** All food was checked and ensured that it was not stored past its expiration date. **3. Systemic Changes:** An in-service was held for dietary staff on expiration date labeling of food items and how to ensure items are not stored past expiration dates. Dietary Managers will conduct daily cooler checks to ensure no food is stored past its expiration date. **4. Monitoring:** Findings of the cooler checks will be reported by the Dietary managers at the quarterly QA Meetings.	7/27/18
F 812 SS=F	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: Based on observations, record review and staff interview, the facility failed to store food in accordance with professional food safety standards as evidenced by foods held beyond expiration date in four (4) of four (4) observations. Also, the facility failed to periodically test the	F 812	**F812 Testing of Low Temperature Dishwasher Chemical Solution** **1. Immediate Response:** The identified low temperature dishwasher was taken out of service while the low temperature dishwasher chemical solution was tested and the machine was then put back in service. **2. Risk Identification:** No other low temperature dishwashers are in the facility. **3. Systemic Changes:** An in-service was held for dietary staff on proper testing and logging of the low temperature dishwasher chemical solution. Dietary Managers will conduct daily audits to ensure accuracy of testing and logging the information. **4. Monitoring:** Findings of the low temperature dishwasher chemical solution checks will be reported by the Dietary managers at the quarterly QA Meetings.	7/27/18

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	095025	A. BUILDING _____ B. WING _____	06/12/2018

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

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F 812	Continued From page 14 chemical solution for the low temperature dishwasher and ensure the high temperature dishwasher consistently reached 180 degrees Fahrenheit for sanitization of dishes and utensils. Finding included 1. Facility failed to ensure food was not held beyond the expiration date. During observations on June 6, 2018, at approximately 8:00 AM, the following expired food items were observed in the reach-in refrigerator: one(1) of one (1) half pan of puree fruit, one (1) of one (1) container of salad dressing, one (1) of one (1) block of hard cheese, and one (1) of one (1) jar of Maraschino cherries. During a face-to-face interview conduct with Employee #13 on June 6, 2018, the employee acknowledged the findings. 2. Facility failed to periodically test the chemical solution for the low temperature dishwasher in accordance with manufacturer's recommendations. During observations on June 11, 2018, at approximately 2:00 PM, in the small kitchen, the staff was observed placing utensils into the low temperature dishwasher. At the time of the observation, Employee #12 was asked about the use of the low temperature dishwasher, temperature logs and testing of the sanitizing solution. Review of the "Dish Machine Temperatures" log dated January 2018 through July 2018 showed	F 812	**F812 Testing of High Temperature Dishwasher and Maintaining 180 F** **1. Immediate Response:** The identified high temperature dishwasher was tested and ensured to be consistently reaching 180 F. **2. Risk Identification:** No other high temperature dishwashers are in the facility. **3. Systemic Changes:** An in-service was held for dietary staff on proper testing and logging of the high temperature dishwasher. Dietary Managers will conduct daily audits to ensure accuracy of testing and logging the temperatures. **4. Monitoring:** Findings of the high temperature dishwasher checks will be reported by the Dietary managers at the quarterly QA Meetings.	7/27/18

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F 812	Continued From page 15	F 812		

the staff documented the wash and final rinse temperatures. However, the log failed to show the facility staff periodically tested the sanitizing chemical solution at least once per shift.

On June 11, 2018, Employee #12 demonstrated testing of the sanitizing solution for the low temperature dishwasher to meet the 50 parts per million (PPM) per the manufacturer's recommendations.

During a face-to-face interview conduct with Employees #12 and 13, the employees acknowledged the findings.

3. Facility failed to ensure the high temperature dish machine consistently reached 180 degree Fahrenheit to sanitize the dishware and utensils.

Review of the "Dish Machine Temperatures" logs dated January 2018 through June 2018, on June 11, 2018, at approximately 2:30 PM, in the main kitchen showed the high temperature dish machine failed to reach the minimum final rinse temperature of 180 degree Fahrenheit in one (1) of 93 opportunities in January 2018; 12 of 84 opportunities in February 2018; 31 of 93 opportunities in March 2018; 27 of 90 opportunities in April 2018; and nine (9) of 93 opportunities in May 2018. The high temperature dish machine final rinse temperatures are documented three (3) times per day at "breakfast, noon, and evening."

During a face-to-face interview with Employees #12 and 13, they acknowledged the findings.

F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908	

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LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20016

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F 908	Continued From page 16 §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 interview, the facility failed to ensure all electrical and patient care equipment is maintained in a safe operating condition evidenced by a frayed call bell cord and a damaged telephone cord in one (1) of 16 resident rooms and missing door closure covers in two (2) of 16 resident rooms. Findings included... 1. On June 11, 2018, at approximately 10:00 AM, during observations on the Louise Terrace Unit, the call bell and telephone cords for Resident Room #110-B was noted to have uncovered electrical wires creating a potential electrical safety hazard in two (2) of 16 observations. 2. On June 11, 2018, approximately 10:30 AM, during observations on the Dickerson Drive Unit, the door closure housings located above the entrance door of resident room #117 lacked a cover with electrical wires and connectors visible and accessible creating a potential safety hazard in one (1) of 16 resident rooms. 3. On June 11, 2018, approximately 11:00 AM, during observations on the Special Care Unit, the door closure housings located above the entrance door of resident room #132 lacked a cover with electrical wires and connectors visible and accessible creating a potential safety hazard in one (1) of 16 resident rooms.	F 908	**F908 Electrical Wires Uncovered** **1. Immediate Response:** The identified call bell and phone cords were replaced. **2. Risk Identification:** All resident call bell and phone cords were checked to make sure no electrical wires were uncovered. **3. Systemic Changes:** Staff was in-serviced on the importance of checking and reporting any uncovered phone cords and call bell cords to the Facility Manager. The Facility Manager or his designee will do monthly checks of the cords to ensure that they are covered. **4. Monitoring:** The Facility Manager or his designee will report audit findings at the quarterly QA Meetings. **F908 Door Closure Housings** **1. Immediate Response:** Covers were installed on the identified two door closure housings above the entrance doors that lacked covers and had visible wires. **2. Risk Identification:** All door closure housings were checked for covers and that no wires were visible. **3. Systemic Changes:** Staff was in-serviced on the importance of checking and reporting any missing covers on the door closure housings to the Facility Manager. The Facility Manager or his designee will do weekly checks of the door closure housings to ensure that they are covered and no wires are visible. **4. Monitoring:** The Facility Manager or his designee will report audit findings at the quarterly QA Meetings.	7/27/18 7/27/18

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F 908	Continued From page 17	F 908		

During a face-to-face interview on June 11, 2018, approximately 12:00 PM, the findings were discussed with Employee #11 and acknowledged.