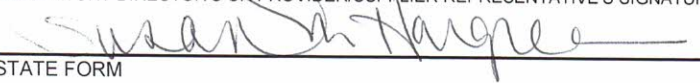


Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2021</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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) COMPLETE DATE
L 000	<p>Initial Comments</p> <p>The Annual Licensure 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 staff interviews.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <ul style="list-style-type: none"> <li>AMS - Altered Mental Status</li> <li>ARD - Assessment Reference Date</li> <li>AV- Arteriovenous</li> <li>BID - Twice- a-day</li> <li>B/P - Blood Pressure</li> <li>BPH- Benign Prostatic Hyperplasia</li> <li>cm - Centimeters</li> <li>CFR- Code of Federal Regulations</li> <li>CMS - Centers for Medicare and Medicaid Services</li> <li>CNA- Certified Nurse Aide</li> <li>CRF - Community Residential Facility</li> <li>CRNP- Certified Registered Nurse Practitioner</li> <li>D.C. - District of Columbia</li> <li>DCMR- District of Columbia Municipal Regulations</li> <li>D/C- Discontinue</li> <li>DI- Deciliter</li> <li>DMH - Department of Mental Health</li> <li>DOH- Department of Health</li> <li>DON Director of Nursing</li> <li>DRR Drug Regimen Review</li> <li>EHR Electronic Health Record</li> <li>EKG - Electrocardiogram</li> <li>ER Emergency Room</li> <li>EMS - Emergency Medical Services (911)</li> <li>ESRD- End Stage Renal Disease</li> </ul>	L 000		

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/16/21
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------	----------------------

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2021</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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) COMPLETE DATE
L 000	Continued From page 1  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 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	L 000		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2021</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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) COMPLETE DATE
L 000	Continued From page 2  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	L 000		
L 051	3210.4 Nursing Facilities  A charge nurse shall be responsible for the following:  (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;  (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;  (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;  (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;  (e) Supervising and evaluating each nursing	L 051	<p><b>L 051 Nursing Facility</b></p> <p><b>1. Immediate Response:</b> 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.</p> <p><b>2. Risk Identification:</b> 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.</p> <p><b>3. Systemic Changes:</b> 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.</p> <p><b>4. Monitoring:</b> 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.</p>	4/19/2021

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2021</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

L 051	<p>Continued From page 3</p> <p>employee on the unit; and</p> <p>(f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:</p> <p>Based on record review, and staff interview, for one (1) of 16 sampled residents, the charge nurse failed to implement the interventions specified in the care plan for monitoring a resident on antidepressant and antipsychotic medications. Resident #5.</p> <p>Findings included ...</p> <p>Resident #5 was admitted to the facility on 10/10/2017, with diagnoses that included Anxiety Disorder, Coronary Artery Disease, Hypertension, and Hyperlipidemia.</p> <p>Review of the medical record showed the following physician's orders:</p> <p>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</p> <p>8/25/2020 at 09:00 (AM) Seroquel Tablet 25 MG ... Give 1 tablet by mouth one time a day for Delusions</p> <p>8/25/2020 at 09:00 (AM) Zoloft Tablet 25 MG ... Give 1 tablet by mouth one time a day for Anxiety</p> <p>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:</p>	L 051		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2021</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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) COMPLETE DATE
L 051	<p>Continued From page 4</p> <p>Administer medications per orders. Monitor/document for effectiveness and any side effects.</p> <p>Administer Psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q (every)-shift.</p> <p>A review of the nursing progress notes, behavior tab, treatment administration record, and the 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.</p> <p>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.</p> <p>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."</p> <p>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."</p> <p>The charge nurse failed to implement the</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2021</b>
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

L 051 Continued From page 5  
interventions (monitor/document for effectiveness and any side effects) specified in the care plan for monitoring Resident #5 who receives antidepressant and antipsychotic medications.

L 051

**L 099 Nursing Facilities**  
**1. Immediate Response:**  
The identified expired cheese and mustard were thrown away.

L 099 3219.1 Nursing Facilities  
Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:  
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.

L 099

**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.

4/19/2021

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.

**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.

**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. 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.

4/19/2021

