| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (7.1.7 | VIDER/SUPPLIER/CLIA INTIFICATION NUMBER: | (X2) MULTIPLE CO | | (X3) DATE SURVEY COMPLETED |
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| | HF | D02-0015 | B WING | | 05/17/2019 |
| IAME OF PROVIDER OR SUPP | LIER | STREET A | DDRESS, CITY, STATE | . ZIP CODE | 00/11/2010 |
| ISNER LOUISE DICKS | ON HURTHOME | 5425 WE | STERN AVE NW | | |
| (X4) ID SUMI | MARY STATEMENT OF | | IGTON, DC 2001 | | |
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| L 000 Initial Comme | ents | | L 000 | | |
| conducted at from May 13, Survey activit | Lisner-Louise-D 2019, through lies consisted of dents. The resid | Care Survey was ickson-Hurt Home May 17, 2019 a review of 26 dent census during th | е | | |
| The following acronyms tha | is a directory of t may be utilized | abbreviations and/or in the report: | | | |
| AMS - Alte ARD - Ass BID - Twi BIMS- Brie B/P - B cm - Ce CMS - Cel Services CNA- Ce CFU C CRF - C DCMR- Dis Regulations D/C Disco DI - DMH - D DMH - D EKG - 12 EMS - C G-tube HSC | ssociate Directo ered Mental Stat sessment Refere ce- a-day ef Interview for N lood Pressure entimeters nters for Medica ertified Nurse Aid colony Forming I community Resid istrict of Columbia entime Deciliter Deciliter Department of Me pirector of Nursin I lead Electrocal Emergency Med Gastrostomy tube Health Service | de Juste de Medicaid de Juste de Juste de Juste de Juste de Juste de Medicaid de Juste de Juste de Medicaid de | | | |
| h Regulation & Licensing A | dministration OVIDER/SUPPLIER RE | PRESENTATIVE'S SIGNATUR | RE | TITLE | (X6) DATE |
| E FORM | W. T. W. | greane- | - HA | Mystrate | If continuation sheet |

| Health R | equiation & Licensing | Administration | | | |
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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| LIGITER | | WASHI | NGTON, DC 20 | 0015 | |
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| L 000 | Continued From pag | ge 1 | L 000 | | |
| | IDT - Interdis L - Liter LPN- License LTC- Long Lbs Pound MAR - Medicat MD- Medicat MD- Minimu Mg - milligr mass) mL - milligr mass) mL - milligra mm/Hg - millimet MN midnig Neuro - Neurolo NP - Neurolo NP - Preadmis Review Peg tube - Percutane PO- by mouth POS - Physici Prn - As nee Pt - Pattial PL- Partial PL- Respo RN- Regis SCC Speci Sol- Solution SSD- Social TAR - Treatm Trach- | aciplinary team and Practical Nurse Form Care s (unit of mass) aion Administration Record aid Doctor am Data Set ams (metric system unit of ars per deciliter ars of mercury and practitioner asion screen and Resident and sorder sheet and contents and sorder sheet and contents a | f | | |
| | | | | | |

| Health Re | qulation & Licensin | Administration | | | FORM APPROVED |
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| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPE | E CONSTRUCTION | (X3) DATE SURVEY |
| | 301112311311 | IDENTIFICATION NOMBER | A BUILDING: | | COMPLETED |
| | | HFD02-0015 | B WING | | 05/17/2019 |
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| L 001 (| Continued From page | ge 2 | L 001 | | |
| L 001 3 | 3200.1 Nursing Fac | ilities | L 001 | L001 Resident Records | |
| | | | 2001 | 1. Immediate Response: The Leve | |
| t 2 5 6 t | these rules and the 483, Subpart B, Sec D, Sections 483.150 section 483.200 to 4 constitute licensing the District of Colum | shall comply with the Act, requirements of 42 CFR Part stions 483.1 to 483.75; Subpart 0 to 483.158; and Subpart E, 83.206, all of which shall standards for nursing facilities in thia. met as evidenced by: | | PASRR for resident #49 was corre include the diagnosis of Schizophi and noted exempting criteria in Sc. The corrected Level I PASRR documentation was forwarded to District of Columbia Department of Behavioral Health for a Level II | renia ection the |
| f. r E | acility's staff failed t referred to the Distri Behavioral Health to | riew and staff interview, the o ensure that Resident #49 was ct of Columbia Department of have a Level II Evaluation I) of 26 sampled residents. | | evaluation. 2. Risk Identification: All resident were reviewed for documentation serious mental illness and correct completed Level I PLASRR forms. | n of ly No |
| F | Findings included | | | additional positive screens for ser mental illness were indicated.3. Systemic Changes: All staff that | |
| 2 | 26, 2018, with diagn | e-admitted to the facility on July oses that included ression, Hypertension and | | completes the Level I PASRR documentation was in-serviced or correct use of the form and the requirements for conducting a Level Evaluation. | n the |
| FS F a 2 S II a H N 2 | Pre-Admission Scre- Serious Mental Illnes Related Conditions, is completed by the 2019. Further revie Section B: Evaluatio Iness, that Residen I known diagnosis of However, according Minimum Data Set fo | ent entitled, Level I ening/Resident Review for es, Intellectual Disabilities, or showed the form. was signed facility's staff on January 24, w of the form, revealed under n Criteria for Serious Mental t #49 was not coded as having f a major mental disorder. to the Significant Change orm completed January 24, I - Active Diagnoses, Resident aving a | | 4. Monitoring: The Director of Soc Services or her designee will do a audit of PASRR documentation for appropriate serious mental illness identification and report findings a quarterly QA meetings. | random 7/1/19 |
| | | 1 | | | 1 |

| Health R | equiation & Licensing | Administration | | | | |
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| L 001 | Continued From pag | ge 3 | | L 001 | | |
| | diagnosis of Schizor | ohrenia. | | | | |
| | Continued review of Screening/Resident Illness, Intellectual E Conditions, dated Ja documented eviden | the Level I Pre-A Review for Seriou Disabilities, or Rela anuary 24, 2019, I | us Mental ated acked | | | |
| | Resident #49 as has serious mental illness Subsequently, the R | ving a positive scr | een for | | | |
| | diagnosis of Schizor District of Columbia Health for a Level II form. Which indicate considered to have (SMI) if (1) question answered Yes", "Wi beneficiary must be Columbia Behaviora Evaluation". | ohrenia was not re Department of Be evaluation as stip es if "The beneficia a positive serious s 1 or 2 in section th a positive scree referred to the Dis | eferred to the chavioral ulated by the ary is mental illness B are en for SMI the strict of | | | |
| | During a face-to-fac May 16, 2019 at 2:0 findings, she acknow evaluation screening | 0 PM, after a reviewledged that the L | ew of the evel II | | | |
| L 051 | 3210,4 Nursing Faci | lities | | L 051 | | |
| | A charge nurse shal following: | l be responsible fo | or the | | | |
| | (a)Making daily residuand emotional status | | | | | |

| nealth R | equiation & Licensing | Administration | | | |
|--------------------------|--|---|-----------------------------|---|-------------------------------|
| | T OF DEFICIENCIES DE CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLI A_BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PI | ROVIDER OR SUPPLIER | | DRESS, CITY, ST | ATE 7ID CODE | 05/1//2019 |
| | 1.7 | 5426 WE | STERN AVE | | |
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| L 051 | Continued From pag | ge 4 | L 051 | | |
| | required nursing inte | ervention; | | L051 Care Plan Timing and Revis | |
| | | | | 1. Immediate Response: Residen | t was |
| | | ation records for completeness, scription of physician orders, | | assessed and was cleared of any | Cana |
| | and adherences to s | | | complication due to dysphagia. plan for resident #34 was update | d to |
| | | nts' plans of care for | | reflect intermittent supervision b | У |
| | appropriate goals an them as needed: | nd approaches, and revising | | nursing staff during meals. 2. Risk Identification: Care plans | for all |
| | arom ao nocaca, | | | residents with dysphagia were re | |
| | (d)Delegating respon | nsibility to the nursing staff for | | and updated for appropriate goal | |
| | direct resident nursi | ng care of specific residents: | | approaches. | |
| | (e)Supervising and e employee on the uni | evaluating each nursing it, and | | 3. Systemic Changes: All nursing was in-serviced on appropriate ca | |
| | | | | goals and interventions for reside | |
| | her designee information | tor of Nursing Services or his or ed about the status of residents. | | dysphagia. | |
| | | met as evidenced by: | | 4. Monitoring: The Director of Nu | |
| | | | | her designee will conduct month | |
| | | | | of care plans of residents with dy | , , |
| | Based on observation | on, record review, resident and one (1) of 26 sampled records | | to ensure person-centered goals approaches. Audit findings will be | |
| | the charge nurse fail | led to update/revise the care | | tracked and reported at the quar | |
| | plan to include reside | ent-centered goals and sident with Dysphagia. Resident | | QAPI meetings. | , |
| | Findings included | | | | |
| | 11/13/17, with diagn Hernia without Obstr Dysphagia, Oral Pha Hypertension, Unspe | admitted to the facility on oses, which included Ventral ruction or Gangrene, ase, Essential (Primary) ecified Dementia without nce, and Major Depressive | | | |

| | tegulation & Licensing | Administration | 1 | | | |
|--------------------------|--|--|--|--------------------------------|--|-------------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/S IDENTIFICA | UPPLIER/CLIA ATION NUMBER | (X2) MULTIPLE C A_BUILDING: | | (X3) DATE SURVEY COMPLETED |
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| L 051 | Continued From pag | je 5 | | L 051 | | |
| | On 5/13/19, at approwas observed in her time, no staff were p | room eating bi | reakfast. At this | 1 | | |
| | During a resident int Resident states, "I d the other residents to have to concentrate from the resident's n concentrate." Reside supervise me when and I eat my food." | on't eat in the o because I don't on my chewing hay cause me r ent further state | dining room with want to choke I g and the noise not to es, "They don't | | | |
| | Review of a physicia showed the resident Occupational and Sp | was ordered a | "Physical, | | 2 | |
| | Review of the Minim 04/08/19 showed un and Vision], Reside indicated the resider to make self-underst comprehension and Section G [Functionalis coded as independent oversight at anytime] | der Section B [ent #34 was cont's speech patt lood and has cl able to underst al Status] show dent in eating (| Hearing, Speech ded as "0", which tern is clear, able ear tand others, ed the resident | | (#7 | |
| | Review of the Speed Discharge Summary goal met on 5/8/19, to to utilize compensate oral intake with mild impairment; risk of a residue and may need | note dated 5/8 he patient dem bry strategies to impairment (25 spiration on liqu | i/19 showed " constrates ability concrease safe i-50% uids mild oral | | | |

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|-----------|---|-----------------------------------|------------------------------------|------------------|---|------------------|
| | T OF DEFICIENCIES OF CORRECTION | | R/SUPPLIER/CLIA ICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY |
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| (X4) ID | SUMMARY ST | ATEMENT OF DEF | | (| PROVIDER'S PLAN OF CORRECTIO | Al |
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| TAG | 01(200102 | 14111 11140 1141 0141 | VIATION) | TAG | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | RIATE DATE |
| | | | | | | |
| L 051 | Continued From page | je 6 | | L 051 | | |
| | chopped; cueing and | d intermittent | supervision for | | | |
| | carry-over) | | , | | | |
| | | | | | | |
| | During a face-to-face | e interview w | ith the Speech | | | 1 |
| | Therapist on 5/16/19 | | | | | |
| | she stated, "The sta | ff were traine | d on swallowing | | | |
| | techniques, I know t | he staff are b | usy on the floor | | | |
| | but that they need to | intermittently | y supervise the | į | | |
| | resident when eating changes from solid to | g to be sure to a liquid to be | ne resident | | | |
| | residual food to caus | se chokina. th | ne staff all know to | | | |
| | do this." | 3. | | | | |
| | | | | | | |
| | During an intension | on E/16/10 at | | | | |
| | During an interview of 2:00 PM, Employee | on 5/16/19 at #13 (Certifie | approximately | | | |
| | states I have worked | with her a lo | ot, she is not a | | | |
| | feeder I don't superv | ise her or sit | in the room with | | | |
| | her I just bring in her | tray and she | can feed herself. | | | |
| | Facility staff failed to | undate/revis | e the resident's | | | |
| | care plan to include | | | | | |
| | recommendations: | " 25-50% imp | pairment risk of | | | |
| | aspiration on liquids; | mild oral res | idue and may | | | |
| | need meats ground | | | | ĺ | |
| | intermittent superivs | ion for carry-c | over | | | |
| | | | | | | |
| | During a face-to-face | | | | | |
| | AM, Employee #2 ac | | | | | |
| | states the care plan and specific to that re | | sident-centered | | | |
| | and shecilic to that to | coluents | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| L 099 | 3219.1 Nursing Facil | ities | | L 099 | | |
| | oz ro. i Huraniy i acii | HIÇO | | L 000 | | |
| | Food and drink shall | be clean, wh | olesome, free | | | |
| | | | | | | |

| Health Regulation & I | Licensing Administra | tion | | | |
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| STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION | | ER/SUPPLIER/CLIA FICATION NUMBER | (X2) MULTIPLE A BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HFD0 | 2-0015 | B WING | | 05/17/2019 |
| NAME OF PROVIDER OR SUI | PPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | |
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| (X4) ID SL | IMMARY STATEMENT OF DE | | | | |
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| L 099 Continued I | From page 7 | | L 099 | L099 Soiled Food Equipment | |
| from spoilar | ge, safe for human c | oncumption and | | 1. Immediate Response: The ide | ntified |
| served in a | ccordance with the re | equirements set | | grease fryer, steam table wells a | nd ovens |
| | 23, Subtitle B, D. C | | | were cleaned. | |
| Regulations | s (DCMR), Chapter 2 | 4 through 40 | | 2. Risk Identification: All other fo | ood |
| | e is not met as evid | | | equipment was checked for clear | nliness. |
| | bservations and inte | | | 3. Systemic Changes: Staff in-ser | viced on |
| | that facility staff faile in sanitary condition | | | the need to clean food service ed | quipment |
| soiled equip | oment such as one (1 | 1) of one (1) grease | | after use and the Dietary Supervi | sor will |
| fryer, five (5 | 5) of five (5) steam ta | ble wells in the | | do daily inspections of food equi | oment. |
| Nursing Fac | cility kitchen and two | (2) of two (2) | | 4. Monitoring: Dietary Manager | |
| | dented utensils such hotel pans, two (2) | | | designee will conduct weekly aud | lits of 7/1/19 |
| | pans and four (4) of f | | | food equipment and findings will | be |
| hotel pans. | , , | . , | | reported at Quarterly QAPI meet | ings. |
| Findings in | cluded | | | F812 Dented Pans | |
| The following | a observations was | and the second s | | 1. Immediate Response: Identifie | -d |
| | ng observations were n of dietary services | | | dented pans were disposed of. | |
| | . or alotally convious | 511 Way 10, 2010 | | 2. Risk Identification: All pans we | re |
| | ipment such as one | | | checked to ensure that they were | |
| grease frye the Nursing | r, five (5) of five (5) s | team table wells in | | free. | |
| | and two (2) of two (2 |) ovens were | | 3. Systemic Changes: Staff in-ser | viced on |
| soiled | (=, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, | ., | | disposing of dented pans and rep | |
| 0. 18== 70 | -4-1 (0) + | | | to Supervisor for replacement of | 0 |
| | of nine (9) two-inch h -third three-inch pans | | | ones. | |
| (4) | ama unee-mon paris | and lour (4) of lour | | 4. Monitoring: Dietary Manager | or |
| | th hotel pans were de | ented throughout. | | designee will conduct weekly aud | lits of $\frac{7/1/19}{}$ |
| During a fac | ce-to-face interview of | on May 13, 2019, at | | pans and findings will be reported | d at |
| approximate | ely 11:00 AM, Emplo ged these findings. | | | Quarterly QAPI meetings. | |
| | | | | | |
| L 128 3224.3 Nurs | sing Facilities | | L 128 | | |
| The supervi | sing pharmacist sha | ll do the | | | |

| Health R | egulation & Licensin | g Administration | | | FURM APPROVED |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER | A BUILDING | | COMPLETED |
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| NAME OF PR | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY ST | ATE, ZIP CODE | |
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| L 128 | Continued From page | ge 8 | L 128 | L 128 Pharmacy in-services | |
| | | | | 1. Immediate Response: Pharmac | y to |
| | following: | | | provide another in-service educati | ion to |
| | (a)Review the drug | regimen of each resident at | | ensure compliance. | |
| | least monthly and re | eport any irregularities to the | | 2. Risk Identification: All schedule | d |
| | | dministrator, and the Director of | | pharmacy in-services shall be prop | perly |
| | Nursing Services; | | | provided including one session that | ' |
| | (b)Submit a writter | report to the Administrator on | | includes indications, contraindicat | |
| | the status of the pha | armaceutical services and staff | | and possible side effects of commo | only |
| | performances, at lea | ast quarterly: | | used medications. Each in-service | e shall |
| | (c)Provide a minimu | ım of two (2) in-service sessions | | have separate sign in sheets. | |
| | per year to all nursing | ng employees, including one (1) | | 3. Systemic Changes: Nursing staff | f shall |
| | session that include | s indications, contraindications | | be mandated to attend two separa | ate |
| | | fects of commonly used | | pharmacy educational in-services | |
| | medications; | | | including indications, contraindica | tions |
| | (d)Establish a syste | m of records of receipt and | | and possible side effects of commo | · · |
| | disposition of all cor | ntrolled substances in sufficient | | used medications and shall sign se | parate |
| | detail to enable an a | accurate reconciliation; and | | documents of attendance. | |
| | (e)Determine that de | rug records are in order and that | | 4. Monitoring: Director of Nursing | or 7/1/19 |
| | | ntrolled substances is | | designee will conduct audits of all | //1/19 |
| | maintained and peri | odically reconciled. | | pharmacy educational in-services | to |
| | This Statute is not | met as evidenced by: | | ensure proper documentation of | |
| | | | | attendance at both. Audit finding | |
| | Based on staff inten | view and a review of records, it | | be tracked and reported at Quarte | rly |
| | was determined that | t the facility failed to ensure that | | QAPI meetings. | |
| | | ining for nursing personnel was | | | 1 |
| | conducted by a pha | rmacist. | | | |
| | The findings include | : | | | |
| | According to the Dis | trict of Columbia Municipal | | | |
| | Regulations for Nurs | sing Facilities: 3224 Supervision | | | |
| | of Pharmaceutical S | ervices (3c) | | | |
| | "The supervising ph | armacist shall provide a | | | |
| | minimum of two (2) | n services sessions per year to | | | |
| | all nursing employee | es, including one (1) | | | |

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING B WING HFD02-0015 05/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5425 WESTERN AVE NW** LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L201 Resident Records - Identifiable L 128 | Continued From page 9 L 128 Information session that includes indications, contraindications 1. Immediate Response: Resident's and possible side effects of commonly used personal inventory sheet was completed medications..." and placed in the medical record. A review of the in-service training files revealed one 2. Risk Identification: All medical records (1) pharmacy in-services was provided during the for admission personal inventory sheets survey look back period. were audited for signatures and dates. There was no evidence a second pharmacy in-service was provided. 3. Systemic Changes: All nursing staff were in-serviced regarding proper During a face-to-face interview conducted on May admission protocol for dates and 17, 2019 at 1:00 PM, Employee # 12 acknowledged signatures on personal inventory sheets. the findings. 4. Monitoring: The Director of Nursing or 7/1/19 her designee will conduct monthly audits L 201 3231.12 Nursing Facilities L 201 of all newly admitted residents to ensure personal inventory sheets have been Each medical record shall include the following properly dated and signed. Audit information: findings will be tracked and reported at (a) The resident's name, age, sex, date of birth, race, the quarterly QAPI meetings. martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor: (c)Medicaid, Medicare and health insurance numbers: (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge: (g)Hospital discharge summaries or a transfer

| nealth | requiation & Licensing | Administration | | | | |
|--------------------------|---|---|----------------------------|---------------------|--|-------------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIES IDENTIFICATION N | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | HFD02-0015 | | B WING | | 0.0147/2015 |
| | | 711 202-0013 | | | | 05/17/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDR | RESS CITY STA | ATE_ZIP CODE | |
| LISNER I | LOUISE DICKSON HUR | RTHOME | | TERN AVE N | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE NTIFYING INFORMATION) | GULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETE |
| L 201 | Continued From pag | ge 10 | | L 201 | | |
| | form from the attend | ling physician; | | | | |
| | (h)Medical history, a diagnosis, prognosis | illergies, physical exa s and rehabilitation; | mination, | | | |
| | (i)Vaccine history, if information about im vaccine preventable | applicable, and other imune status in relation disease; | pertinent on to | | | |
| | (j)Current status of r | esident's condition; | | | | |
| | at the time of observe changes in the reside medication or treatment. | es notes which shall by vation to describe sign ent's condition, when ent orders are chang e resident's condition status quo condition; | nificant led or | | | |
| | discharge, which sha attending physician a diagnoses, course o essential information | dical experience upor all be summarized by and shall include fina f treatment in the faci n of illness, medicatio on to which the reside | the I lity, ns on | | | |
| | | nich shall be kept in a redical assessment a rig service; | | | | |
| | ongoing reports of pl therapy, speech ther | sident's assessment hysical therapy, occu apy, podiatry, dental, in, dietary, and social | pational | | | |
| | | | | | | |

| Health R | Regulation & Licensin | g Administration | | | |
|--------------------------|--|--|-----------------------------------|---|-------------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A BUILDING: | DNSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | HFD02-0015 | B WING | | 05/17/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS CITY STATE | ZIP CODE | |
| LISNER L | LOUISE DICKSON HUI | RIHOME | VESTERN AVE NW INGTON, DC 2001 | 5 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUS | TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETE |
| L 201 | Continued From pa | ge 11 | L 201 | | |
| | (o)The plan of care; | | | | |
| | (p)Consent forms a | nd advance directives; and | | | |
| | (q)A current invento clothing, belongings | ory of the resident's personal s and valuables. | | | |
| | This Statute is not | met as evidenced by: | | | |
| | interview for one (1) charge nurse failed | riew, record review and staff of 26 sampled records, the to complete the personal of the date and signature for | | | |
| | Findings included | | | | |
| | Procedures for Res encourage each res to complete an initia completed upon adr | cility's policy titled "Policy and ident Belongings" the facility will be sident or resident representatival inventorylist should be mission and updated periodical will be stored in the medical | /e | | |
| | 4/17/19 with diagno Unspecified, Emphy Pneumonia and Nor Infarction. Admissio Section C [Cognitive | admitted to the facility on ses to include Pneumothorax, rsema Unspecified, Lobar n-ST Elevation Myocardial n Minimum Data Set [MDS] e Patterns] showed a Brief Status score of "15" which r intact. | | | |
| | PM showed Resider List without a date of | cal record on 5/1519 at 12:30 nt # 225's Personal Inventory or signature of the resident e form showed a staff signaturn. | re | | |

| | Equiation & Licensing | (X1) PROVIDER/SUPPLIER/CLIA | (VD: 441.0 T-D) | E CONSTRUCTION | | |
|---------------|---|---|------------------------------|---|-------------------------------|-----|
| | OF CORRECTION | IDENTIFICATION NUMBER | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | A BOILDING | | | |
| | | HFD02-0015 | B WING | | 06/47/0040 | |
| NIAME OF S | 20VIDEO OD CURSUISE | | | | 05/17/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | ADDRESS CITY ST | | | |
| LISNER L | OUISE DICKSON HUP | RTHOME | /ESTERN AVE I NGTON, DC 2 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | | | | |
| PREFIX TAG | (EACH DEFICIENCY MUST | T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLE | ETE |
| L 201 | Continued From page | ge 12 | L 201 | L410 8 Exhaust Fans without suct | ion | |
| | | | | 1. Immediate Response: One roof | top | |
| | During a face-to-fac | e interview on 5/15/19 at 12:2 | 0 | exhaust fan that handled the effec | cted 8 | |
| | | tated, "I am working on the | 0 | rooms was repaired. | | |
| | personal inventory f | orm; the corrected form is in n | ny | 2. Risk Identification: All other ex | haust | |
| | office." At the time of | of the medical record review | | fans which were linked to rooftop | | |
| | Employee #4 ackno | wiedged the finding. | | exhaust fan were checked. | | |
| 1 440 | 0050441 | | | 3. Systemic Changes: Staff in-serv | iced on | |
| L 410 | 3256.1 Nursing Fac | ilities | L 410 | exhaust fans preventive maintena | nce | |
| | Each facility shall pr | ovide housekeeping and | | and repair and schedule changed | from | |
| | maintenance service | es necessary to maintain the | | quarterly to monthly for audits. | | |
| | | rior of the facility in a safe. | | 4. Monitoring: Audit of exhaust fans | | |
| | sanitary, orderly, commanner. | mfortable and attractive | | be done by Facility Manager and | 7/1/1 | .9 |
| | 5.6 | met as evidenced by: | | reported at Quarterly QAPI meeting | ngs. | |
| | | ons and interview, it was | | | | |
| | determined that faci | lity staff failed to provide | | L410 Hopper Broken | | |
| | necessary housekee | eping services in resident area | | 1. Immediate Response: Identified | | |
| | as evidenced by exh | naust fans that were inoperativesident's rooms, one (1) of one | /e | hopper has been scheduled for re | • | |
| | (1) hopper located in | n the Soiled Utility room on the | 2 | 2. Risk Identification: All other ho | | |
| | Dickson Drive unit th | nat was out of order, ten (10) o | of | were checked for proper function. | | |
| | ten (10) sixteen-oun | ce bottles of alcohol that were | | 3. Systemic Changes: Staff in-serv | | |
| | thirty fluid ounce und | ary 2018, and one (1) of one (opened container of Prosource | 1) | reporting broken hoppers to facili- | ties | |
| | protein drink with an | expiration date of November | 3 | management. | | |
| | 17, 2018 | | | 4. Monitoring: Facilities Manager | | 9 |
| | Findings institute (| | | monthly audits on all hoppers and | Will | |
| | Findings included | | | report findings at the quarterly QA | (PI | |
| | During a walk-throu | igh of the facility on May 14. | | meetings. | | |
| | 2019, between 9:48 | | | | | |
| | did not provide any s resident rooms | cated in the resident bathroom suction in eight (8) of 15 | | | | |
| | | | | | | |
| | | | | | | |

| Health R | equiation & Licensing | Administration | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE L 410 L410 10 Alcohol bottles expired 1. Immediate Response: Expired bottles of bulk alcohol were disposed of. 2. Risk Identification: All other storage rooms were checked for expired bottles of bulk alcohol and none were found. 3. Systemic Changes: Facility will no longer store bottles of bulk alcohol and staff were in-served on expiration dates. 4. Monitoring: The Director of Nursing or her designee will conduct monthly audits to storage closets to ensure there are no bottles of alcohol being stored. Audit findings will be tracked and reported at the quarterly QAPI meetings. L440 Prosource expired 1. Immediate Response: Expired container of Prosource was disposed of. 2. Risk Identification: All other storage rooms were checked for expired bottles | | | | | | | | |
|--|--|--|---|---|---------------|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | | | | | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER | A BUILDING | | COMPLETED | | | | | | |
| | | | | | | | | | | | |
| | | LIEDON ANAE | B WING | | | | | | | | |
| | | HFD02-0015 | DESS. CITY. STATE, ZIP CODE STERN AVE NW STON, DC 20015 D | | | | | | | | |
| NAME OF PE | ROVIDER OR SUPPLIER | STREET ADD | RESS CITY ST | ATÉ, ZIP CODE | | | | | | | |
| FACE IMPORTED IN A VICTOR AND A | | | | | | | | | | | |
| LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 | | | | | | | | | | | |
| (X4) ID PREFIX TAG | (ÉACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | BE COMPLETE | | | | | | |
| L 410 | Continued From pag | ge 13 | L 410 | L410 10 Alcohol bottles expired | | | | | | | |
| | One (1) of one (1) hopper located in the Soiled Utility room on the Dickson Drive unit was broken. | | | 1. Immediate Response: Expired I | oottles | | | | | | |
| | | | | of bulk alcohol were disposed of. | | | | | | | |
| | Othing room on the D | ickson brive drift was broken. | | · · | rage | | | | | | |
| | 3: Ten (10) of ten (1 | 0) sixteen-ounce bottles of | | | | | | | | | |
| | alcohol stored in the storage room on the Dickson Drive unit were expired as of February 2018. 4. One (1) of one (1) thirty fluid ounce unopened container of Prosource protein drink stored in the | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | · - · | | | | | | | |
| | | | | _ | | | | | | | |
| | | | | staff were in-served on expiration | dates. | | | | | | |
| | | | | 4. Monitoring: The Director of Nu | rsing or | | | | | | |
| | storage room | | | her designee will conduct monthly | audits //1/19 | | | | | | |
| | on the Dickson Drive unit had an expiration date of November 17, 2018. During a face-to-face interview on May 14, 2019, at approximately 11:00 AM, Employee #10 and /or Employee #11 acknowledged the findings. | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | .eu at | | | | | | |
| 3, , | | 3 3 | | L410 Prosource expired | | | | | | | |
| | | | | | | | | | | | |
| L 442 3258 13 Nursing Facilities | | L 442 | | | | | | | | | |
| | Th. (22) 1 0 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | | · | | | | | | | |
| | The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. | | | | - 1 | | | | | | |
| | | | | · | | | | | | | |
| | This Statute is not | met as evidenced by: | | | | | | | | | |
| | Based on observations and staff interview, facility | | | 3. Systemic Changes: Unit Suppor | t | | | | | | |
| | staff failed to mainta | in mechanical and electrical | | | | | | | | | |
| | | perating condition as evidenced | | importance of rotating stock of Pr | osource | | | | | | |
| | | f one (1) ice machine in the main | | | | | | | | | |
| kitchen that lacked a protective grill cover, one (1) of one (1) Robot Coupe machine with a broken 'OFF' | | | | | | | | | | | |
| | | | | reing or | | | | | | | |
| | switch and a missing slat from the air curtain in one (1) of one (1) walk-in refrigerator. | | | | | | | | | | |
| | | | | | | | | | | | |
| | Findings included | | | _ | | | | | | | |
| | r mangs moladed | | | | ored. | | | | | | |
| | During observations | in Dietary Services on May 13. | | Audit findings will be tracked and | | | | | | | |
| 2019, at approximately 9:20 AM: | | | | reported at the quarterly QAPI me | etings. | | | | | | |
| | , FF. 2 | , | | | | | | | | | |
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| | requiation & Licensing | | | | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER HFD02-0015 | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | | B WING | | |
| | | HFD02-0015 | | | 05/17/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | FATE, ZIP CODE | |
| ISNERI | OUISE DICKSON HUR | 5425 WES | TERN AVE | NW | |
| | LOUISE DICKSON HUR | | TON, DC 2 | 20015 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLE |
| L 442 | Continued From pag | ge 14 | L 442 | L442 Ice Machine Cover missing | |
| | 1. One (1) of one (1) ice machine lacked a cover/grill to prevent access to its internal parts. | | | 1. Immediate Response: Identified ice | |
| | | | | machine cover was reinstalled. | |
| | | | | 2. Risk Identification: All ice mach | ines |
| | 2. One (1) of one (1) Robot Coupe machine used to puree foods had a broken 'OFF' switch.3. The air curtain in the walk-in refrigerator was missing a slat. | | | checked to ensure a cover was in | place. |
| | | | | 3. Systemic Changes: Staff in-serv | |
| | | | | reporting any missing ice covers to | |
| | | | | Supervisor for replacement/instal | |
| | | | | 4. Monitoring: Dietary Manager o | |
| | During a face-to-face interview on May 13, 2019, at | | | designee will conduct weekly audi | |
| | approximately 11:00 | AM, Employee #9 | | ice machine covers and findings w | 13.01 |
| | acknowledged these | e findings. | | reported at Quarterly QAPI meeting | |
| | | | | L442 Puree Machine Off switch b | 0 |
| | | | | 1. Immediate Response: Identified | |
| | | | | | |
| | | | | Coupe machine off switch was repaired. | |
| | | | | 2. Risk Identification: This is the o | |
| | | | | Robot Coupe machine in the Hom | |
| | | | | 3. Systemic Changes: Staff in-serv | |
| | | | | reporting to Supervisor any malfu | |
| | | | | of Robot Coupe machine so that it | , |
| | | | | be repaired. Weekly audits of Rob | |
| | | | | Coupe machine will be conducted | by the |
| | | | | Dietary Director or designee. | |
| | | | | 4. Monitoring: Dietary Manager o | r |
| | | | | designee will conduct weekly audi | ts and 7/1/1 |
| | | | | findings will be reported at Quarte | erly |
| | | | | QAPI meetings. | |
| | | | | | |
| | | | | ***L442 CONTINUED ON NEXT PA | \GE*** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

- L 442 Air Curtain missing a slat
- **1. Immediate Response:** Missing slat was replaced on the air curtain for the walk in refrigerator.
- **2. Risk Identification:** No other walk in refrigerator in the Home.
- **3. Systemic Changes:** Staff in-serviced on reporting any missing slats to Supervisor for replacement of new ones. Weekly audits of walk in refrigerator curtains will be conducted by the Dietary Manager or her designee.
- **4. Monitoring:** Dietary Manager or her designee will conduct weekly audits and findings will be reported at Quarterly QAPI meetings.

7/1/19