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 _____	07/28/2017

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

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Lisner-Louise-Dickson- Hurt Home from July 24, 2017 through July 28, 2017. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 21 sampled residents during Stage 2. The following deficiencies are based on observation, record review, 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 AMS - Altered Mental Status ARD - Assessment Reference Date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF- Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team 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) 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 Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments,	F 242		

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F 242	Continued From page 2 and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on a resident interview for one (1) of (21) sampled residents it was determined that facility staff failed to accommodate one (1) resident's preference/preferred time to receive morning care (Resident #67). The findings include: On July 7, 2017, at 11:30 AM, a resident interview conducted with Resident #67, in response to the question "Do you choose when to get up in the morning? The resident stated, "No, they are really strict about times. They tell me that I have to get up because they have other residents to take care of. I understand, but it does not mean that I like it." On July 27, 2017, at 12:30 PM, during a face-to-face review interview conducted with Employee #12, the employee stated: "Yes, I typically have [him/her] because [he/she] is usually assigned to me and we start care at 7:00 AM." On July 27, 2017, at 2:30 PM, during a face-face-interview with Resident #67, in the	F 242	**F242 Right to Make Choices** **1. Immediate Response:** Resident's morning preferences were immediately communicated to the direct line staff to ensure they are to be honored going forward. **2. Risk Identification:** All residents were interviewed to ensure all morning preferences were being honored. All residents verbalized that they were able to choose their preferred time of care. **3. Systemic Changes:** All staff were in-serviced as to the importance of honoring residents' choice for morning care and other personal preferences. **4. Monitoring:** The Director of Nursing or her designee will conduct monthly random audits by interviewing residents on all shifts to ensure they are able to choose the time they prefer for AM care. Monthly random audits of admission assessments of all new admissions to long term care will be performed to ensure personal preferences are being documented. Audit findings will be reported and tracked at the quarterly QA meetings.	10-02-17

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F 242	Continued From page 3 presence of Employee#6, the resident stated: "I would like to wake up later in the morning because I like to stay up to watch the late night news. But they get me up too early, and they are in a rush, but I like to take my time." Facility staff failed to honor Resident #67's preference to receive morning care at a time that coincides with his/her lifestyle in the facility. Employee #6 acknowledged the findings.	F 242	**F253 Housekeeping and Maintenance Services – Exhaust Vents Soiled w/Dust** **1. Immediate Response:** The exhaust vents were cleaned on the inside and outside of the identified rooms. **2. Risk Identification:** All exhaust vents were checked on the inside and outside for cleanliness. **3. Systemic Changes:** An in-service was held for housekeeping and maintenance staff on quarterly cleaning of the inside and outside of exhaust vents. An audit tool was established to monitor the cleaning of vents. **4. Monitoring:** Findings of the vent cleaning audits will be reported by the Director of Environmental Services and the Engineering Director at the quarterly QA Meetings.	10-02-17
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations made on July 25, 2017 at approximately 10:00 AM and on July 27, 2017 at approximately 10:00 A.M., it was determined that the facility failed to maintain resident environment in a clean manner as evidenced by exhaust vents in five (5) of 15 resident's bathrooms soiled internally and externally, dusty window blinds in five (5) of 15 resident's rooms and soiled shower floors in two (2) of two (2) resident's shower rooms. The findings include: 1. Exhaust vents soiled with dust on the inside and outside in seven (7) of 15 resident's rooms including rooms 101, 107, 108, 128, 130, 132 and 134. 2. Window blinds dusty in five (5) of 15 resident's rooms including rooms #101, 107, 115, 121, 126.	F 253	**F253 Housekeeping and Maintenance Services- Window Blinds Dusty** **1. Immediate Response:** The identified dusty window blinds were cleaned. **2. Risk Identification:** All window blinds were checked for cleanliness. **3. Systemic Changes:** An in-service was held for housekeeping staff on routine cleaning of the window blinds. An audit tool was established to monitor the routine cleaning of window blinds. **4. Monitoring:** Findings of the window blinds cleaning audits will be reported by the Director of Environmental Services at the quarterly QA Meetings.	10-02-17

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F 253	Continued From page 4 3. Shower room floors on the Dickson Drive unit and the Louise Terrace unit soiled, two (2) of two (2) resident's shower rooms. These observations made, in the presence of Employee #10 and Employee #11, were acknowledged.	F 253	**F253 Housekeeping and Maintenance Services – Shower Room Floors Soiled** **1. Immediate Response:** The identified soiled shower room floors were cleaned. **2. Risk Identification:** All shower room floors were checked for cleanliness. **3. Systemic Changes:** An in-service was held for housekeeping staff on routine cleaning of shower room floors. An audit tool was established to monitor the routine cleaning of shower room floors. **4. Monitoring:** Findings of the shower room floors cleaning audits will be reported by the Director of Environmental Services at the quarterly QA Meetings.	10-02-17
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F 278	**F278 Assessment Accuracy/Coordination/Certified** **1. Immediate Response:** Discrepancy in coding of ADLs related to bed mobility (section G) for resident #56 was noted and acknowledged. **2. Risk Identification:** All residents' MDS section G was checked for accuracy for bed mobility. **3. Systemic Changes:** All MDS and Nursing staff were in-serviced on proper coding for bed mobility. **4. Monitoring:** The Director of Nursing or designee will conduct monthly random audits of MDS section G bed mobility for accurate coding. Audit findings will be reported and tracked at the quarterly QA meetings.	10-02-17

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F 278	Continued From page 5	F 278		

and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for one (1) of 21 sampled residents, the facility staff failed to accurately code the Minimum Data Set (MDS) under Section G Functional Status- Bed Mobility for Resident #56.

The findings include:

A closed medical record review conducted on July 27, 2017; at approximately 9:00 AM revealed resident was admitted to the facility on May 9, 2017, with a diagnosis which included, Hypertension, difficulty walking, and muscle weakness.

On July 27, 2017, at approximately 9:00 AM, review of the certified nursing assistant documentation dated May 9, 2017, revealed Resident #56 required extensive assistance from staff with weight bearing support and one person assistance for repositioning while in bed.

According to the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of May 16, 2017, Section G 0110A- (Activities of Daily Living- Bed Mobility) was coded as the resident

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F 278	Continued From page 6 required supervision and set-up help only. During a face-to-face interview conducted on July 27, 2017, at 3:00 PM with Employee #13, he/she stated: "Resident # 56 required extensive assistance with bed mobility when he/she was admitted to the facility." Employee #12 stated, during a face- to- face interview, that "Resident #56 always required extensive assistance with his/her bed mobility during his/her time in the facility." The facility failed to accurately code the Minimum Data Set to reflect the level of assistance needed for Activities of Daily Living related to bed mobility for Resident #56. On July 28, 2017, at 11:00 AM, Employee #2 acknowledged the findings, after a review of the ADL documentation.	F 278		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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	F 371		

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F 371	Continued From page 7 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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations made on July 25, 2017, at approximately 9:15 A.M., and on July 26, 2017, at approximately 10:30 A.M., it was determined that the facility failed to maintain kitchen utensils and the dietary environment under sanitary conditions as evidenced by missing slats from two (2) of two (2) air curtains located in the walk-in refrigerator (1) and the walk-in freezer (1), 15 of 15 one-half pint of fat free skim milk located in the milk box that were expired as of July 24, 2017, two (2) of seven (7) half hotel pans that were stored wet and one (1) of seven (7) half hotel pan that was soiled with food deposits, two (2) of two (2)) one-third, four-inch pans and two (2) of two (2) one-third six-inch pans that were dented. The findings include: 1. The air curtain from the walk-in refrigerator had a torn slat and the air curtain from the walk-in freezer was missing	F 371	**F371 Food Procure, Store/Prepare/Serve-Sanitary-Slats** **1. Immediate Response:** Removed damaged slat and replaced missing slat on the walk-in refrigerator and walk-in freezer air curtains. **2. Risk Identification:** No other slats were found to be damaged or missing in the facility. **3. Systemic Changes:** In-service was held with dietary staff and a management tool was developed to check slats daily by the manager on duty. **4. Monitoring:** The findings of the management tool will be reported at the quarterly QA meetings. **F371 Food Procure, Store/Prepare/Serve Sanitary- Milk** **1. Immediate Response:** The identified expired milk was discarded. **2. Risk Identification:** All other milk in the facility was checked for expiration date. **3. Systemic Changes:** In-service was held with dietary staff and a management tool was developed to check milk expiration dates daily by the manager on duty. **4. Monitoring:** The findings of the management tool will be reported at the quarterly QA meetings.	10-02-17 10-02-17

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F 371	Continued From page 8 a slat. 2. Fifteen of fifteen one-half pint of fat free skim milk located in the milk box were expired as of July 24, 2017. 3. Two (2) of seven (7) half hotel pans were stored wet and one (1) of seven (7) half hotel pan was soiled with food deposits. 4. Two (2) of two (2) one-third, four-inch pans and two (2) of two (2) one-third six-inch pans were dented. These observations were made in the presence of Employee #8 and Employee #9, who acknowledged the findings.	F 371	**F371 Food Procure, Store/Prepare/Serve-Sanitary- Wet and Soiled Pans** **1. Immediate Response:** The identified wet and/or soiled pans were cleaned and dried. **2. Risk Identification:** All other pans were checked for cleanliness, dryness and condition. **3. Systemic Changes:** In-service was held with dietary staff and a management tool was developed to check pans daily by the manager on duty. **4. Monitoring:** The findings of the management tool will be reported at the quarterly QA meetings. **F371 Food Procure, Store/Prepare/Serve-Sanitary-Dented Pans** **1. Immediate Response:** The identified dented pans were discarded. **2. Risk Identification:** All other pans were checked for dents. **3. Systemic Changes:** In-service was held with dietary staff and a management tool was developed to check pans daily by the manager on duty. **4. Monitoring:** The findings of the management tool will be reported at the quarterly QA meetings.	10-02-17 10-02-17