Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0015	A. BUILDING: ______ B. WING ______	08/25/2016

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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L 000	Initial Comments The Annual Licensure Survey was conducted at Lisner-Louise-Dickson- Hurt Home from August 22, 2016 through August 25, 2016. Survey activities consisted of a review of 29 sampled residents. The following deficiencies are based on observation, record review and staff interviews. 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 HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass)	L 000	**L051 Care Plan Amendment** **1. Immediate Response:** Care Plan for resident #51 was updated with specific goals and interventions for resident's refusal to wear splints. **2. Risk Identification:** The care plans of all residents who have bilateral hand splints were audited to ensure care plans with specific goals and interventions were in place. **3. Systemic Changes:** Licensed nursing staff were in serviced on the necessity to amend care plans with specific goals and interventions of all residents who have bilateral splints for refusal of care. **4. Monitoring:** Random sample of care plans will be audited quarterly by the Director of Nursing or her designee for the presence of current care plans with specific goals and interventions for refusal to wear bilateral splints. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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L 000	Continued From page 1 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	L 000	**L052 Meal Not Served In Unison** **1. Immediate Response:** Resident received her meal tray and ate her lunch. **2. Risk Identification:** No other resident was identified without tray service while tablemates were being served meals. **3. Systemic Changes:** Staff was in serviced on the need for all residents seated at a table to be served together. **4. Monitoring:** The Director of Nursing or her designee will conduct quarterly random observations of staff serving residents to ensure compliance. Observation findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
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;	L 051	**L052 Call Bell Not Reachable** **1. Immediate Response:** Call bell was placed within reach of resident. **2. Risk Identification:** All resident call bells were checked to ensure proper placement in reach of resident. **3. Systemic Changes:** All nursing staff were in serviced as to the importance of placing a call bell within reach of each resident.	

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L 051	Continued From page 2 (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 employee on the unit; and (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: Based on record review and staff interview for one (1) 29 sampled residents, it was determined that facility staff failed to amend the care plan [related to the resident's refusal to wear splints] with specific goals and interventions for application of bilateral splints. Resident #51. The findings include: During the course of the survey, Resident #51 was observed on August 23 and 24, 2016 during the hours of 10:00 AM to 4:00 PM with bilateral splints applied to his/her upper extremities. According to an interim physician order dated June 7, 2016 directed, " OT (Occupational Therapy) order: Resident fitted for (B- bilateral) resting hand splints. Resident to don splints throughout day; can remove at night, to protect hand joints. " A physician's order dated August 10, 2016 directed, " ... Special Instructions: Resident fitted for bilateral resting hand splints. Resident to wear splints all throughout the day; can remove at	L 051	**L052 Call Bell Not Reachable (cont'd)** **4. Monitoring:** The Director of Nursing or her designee will do quarterly random observations of resident rooms to ensure proper call bell placement. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016** **L052 Bilateral Splints per Physician's Orders** **1. Immediate Response:** Resident #51 was offered her bilateral hand splints. **2. Risk Identification:** Residents with MD orders for bilateral hand splints were checked for compliance. **3. Systemic Changes:** Staff was in serviced on the need to educate residents with MD orders to wear bilateral hand splints and about the importance of communicating the benefits of wearing them. **4. Monitoring:** The Director of Nursing or her designee will perform random quarterly observations of residents who have MD orders for bilateral hand splints for compliance. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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L 051	Continued From page 3 night, to protect hand joints. An occupational therapy plan of care dated June 7,2016 revealed: " Therapy necessary for orthotic fitting to reduce further contractures on [bilateral] PIPs (Proximal interphalangeal joints) and DIPS (Distal interphalangeal Joints) ... " The comprehensive care plan lacked evidence of a revision to include the specific interventions to manage Resident #51's bilateral contractures and the application of adaptive devices (splints). Facility staff failed to amend Resident #51 ' s care plan to include specific interventions for his/her bilateral resting hand splints. A face-to-face interview was conducted with Employees #3 and #6 on August 25, 2016 at approximately 1:00 PM regarding the aforementioned findings. Both acknowledged there was a care plan regarding resident ' s refusal to wear splints at times; however, it did not include specific interventions. The clinical record was reviewed on August 25, 2016.	L 051	**L052 No Restorative Care Implemented in Clinical Record** **1. Immediate Response:** Order clarified with MD and resident noted to not be appropriate for restorative nursing program. Physician order was discontinued. **2. Risk Identification:** Clinical records for residents with physician orders for restorative nursing services were assessed for proper restorative documentation. **3. Systemic Changes:** Staff were in serviced on proper restorative documentation as directed by physician order. **4. Monitoring:** Director of Nursing or her designee will conduct random monthly audits of medical records for residents receiving restorative nursing services to ensure proper documentation. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:	L 052	**L099 Convection Oven Soiled** **1. Immediate Response:** Convection oven was cleaned immediately after observation. **2. Risk Identification:** All other ovens were checked for burnt food residue and cleaned as appropriate.	

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L 052	Continued From page 4 (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on an isolated dining observation on August 22, 2016 at approximately 12:30 PM, it was determined that sufficient nursing time was not given to maintain/enhance dignity for three (3)	L 052	**L099 Convection Oven Soiled (cont'd)** **3. Systemic Changes:** In serviced staff on cleaning process for convection oven. Convection oven added to weekly master cleaning list and opening and closing checklist. Convection oven to be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the convection oven cleanliness monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016** **L099 Grease Fryer Soiled** **1. Immediate Response:** Grease fryer was cleaned immediately after observation. **2. Risk Identification:** All other cooking appliances were checked for leftover food particles and cleaned as appropriate. **3. Systemic Changes:** In serviced staff on cleaning process for grease fryer. Grease fryer added to weekly master cleaning list and opening and closing checklist. Grease fryer to be monitored by staff and management on a daily basis.	

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L 052	Continued From page 5 of 29 sampled residents as evidenced by failing to serve Resident #13's lunch meal in unison with other residents in his/her company; the resident sat in the presence of others that dined; to ensure that the resident's call bell was readily accessible as evidenced by the call bell observed wrapped around the bed side rail and out of reach for use by Resident #10; failed to apply splints in accordance with physician's orders for Resident #51; failed to ensure that Resident #51 received treatment and services to increase range of motion and/or prevent further decrease in range of motion as evidenced by a failure to follow through on a physician ' s order for restorative nursing care; The findings include: 1. Sufficient nursing time was not given to maintain/enhance dignity for Resident #13 by failing to serve their lunch meal in unison with other residents in his/her company; the resident sat in the presence of others that dined. At approximately 12:30 PM Resident #13 was observed seated at a dining table with another resident who was served his/her lunch and began eating. By 12:40 PM all of the residents in the dining room except Resident #13 had received their meals and were eating. At approximately 12:43 PM Employee #10 was queried why Resident #13 had not received a tray? The employee responded " I do not know what happened but we will get [him/her] a tray. [He/she] probably wanted a different meal. " A	L 052	**L099 Grease Fryer Soiled (cont'd)** **4. Monitoring:** Findings of the grease fryer cleanliness monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016** **L099 Dented Pans** **1. Immediate Response:** Identified pans were removed from service area. **2. Risk Identification:** All pans were inspected for dents and removed if appropriate. **3. Systemic Changes:** In serviced staff on identifying pots and pans with excessive wear and tear. Inspection of pans added to opening and closing checklist and will be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the pan inspections will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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L 052	Continued From page 6 few minutes later at approximately 12:45 PM the employee removed a tray from the meal cart and served it to Resident #13. A face-to-face interview was conducted with Employee #10 at approximately 1:30PM on August 22, 2016. The employee was again queried why Resident #13 had not received [his/her] lunch tray in unison with others in the dining room. In response, the employee stated, " I do not know but the tray had been sitting at the back of the meal cart while we were looking for it. " 2. Sufficient nursing time was not given to ensure that the resident's call bell was readily accessible as evidenced by the call bell observed wrapped around the bed side rail and out of reach for use by Resident #10. During a resident observation conducted on August 22, 2016 at approximately 3:11 PM it was observed that Resident #10 's call bell was wrapped around the side rail of his/her bed. The resident was sitting in his/her wheelchair which was positioned in front of the bedrail and the call bell was out of reach of the resident. The observation was made in the presence of Employee #7 who acknowledged the findings on August 22, 2016. 3. Sufficient nursing time was not given to apply splints in accordance with physician's orders for Resident #51. During the course of the survey, Resident #51 was observed on August 25, 2016 at	L 052	**L099 Expired Cottage Cheese** **1. Immediate Response:** Expired cottage cheese in milk box was disposed of immediately. **2. Risk Identification:** All food stored in refrigerators was checked for expiration dates. **3. Systemic Changes:** In serviced staff on proper monitoring of all refrigerated food items' expiration dates as well as FIFO. Checking expiration dates was added to the opening and closing checklist and will be monitored by management on a daily basis. **4. Monitoring:** Findings of the food items' expiration dates monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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L 052	Continued From page 7 approximately 10:00 AM sitting in his/her wheelchair in the activity room. The resident was not wearing bilateral splints on his/her upper extremities. A review of the physician's order signed August 10, 2016 directed, " Special Instructions: Resident fitted for bilateral resting hand splints. Resident to wear splints all throughout the day; can remove at night, to protect hand joints. A face-to-face interview was conducted with Employee #9 (staff assigned to resident) on August 22, 2016 at approximately 10:15 AM. When asked if the resident's splints were applied? He/she stated, that the resident did not want the splints applied until after lunch. Facility staff failed to apply Resident #51's bilateral splints to upper extremities in accordance with physician's orders. A face-to-face interview was conducted with Employees #1 and #6 on August 22, 2016 at approximately 3:00 PM regarding the observation. Both stated, they honor resident's preference to not wearing the splint(s). The observation and clinical record review were conducted on August 22, 2016. 4.Sufficient nursing time was not given to ensure that Resident #51 who was observed with limited range of motion of upper extremities received treatment and services to increase range of motion and/or prevent further decrease in range of motion as evidenced by a failure to follow through on a physician ' s order for restorative nursing care.	L 052	**L099 Coffee Machine Soiled** **1. Immediate Response:** Coffee maker was cleaned immediately after observation. **2. Risk Identification:** All other coffee makers were checked for cleanliness. **3. Systemic Changes:** In serviced staff on cleaning process for coffee brewing machine. Coffee maker was added to master cleaning list and opening and closing checklist. Coffee maker to be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the coffee maker cleanliness monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016** **L214 Unsecured Surge Protector** **1. Immediate Response:** The identified unsecured surge protector was secured to the desk. **2. Risk Identification:** All surge protectors in the facility were inspected to assure they are secured. **3. Systemic Changes:** Monthly room checks on surge protectors will be conducted to make sure they are secured. An in-service was held with employees conducting these room checks to ensure all surge protectors in the facility are secured.	

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L 052	Continued From page 8 A physician's progress note dated June 15, 2016 revealed Resident #51's diagnoses included the following: " ... remains with bilateral hand contractures ... contractures and bilateral upper extremity paresis ... cervical spine stenosis [with] Quadra paresis ... " An interim physician's order signed July 20, 2016 [no time indicated] directed: "D/C (Discontinue) of orders from therapy for positioning [and] self-care. PT (Patient) remaining on restorative nursing care. " A face-to-face interview was conducted with Employee #13 on August 25, 2016 at 2:00 PM. He/she stated that the resident is not on restorative. The clinical record lacked evidence that restorative nursing care was implemented to manage Resident #13 ' s functional limitations as directed by the physician ' s order of July 20, 2016. A face-to-face interview was conducted on August 25, 2016 at approximately 5:00 PM with Employee #12. He/she acknowledged the findings. The record was reviewed on August 25, 2016.	L 052	**L214 Unsecured Surge Protector cont'd** **4. Monitoring:** Findings of the monthly checks of surge protectors will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016** **L419 Marred Bathroom and Bedroom Walls** **1. Immediate Response:** The identified marred bathroom and bedroom walls in the two rooms were painted. **2. Risk Identification:** All rooms were inspected for any marred bathroom and bedroom walls and touched up if needed. **3. Systemic Changes:** An in-service was held with employees conducting room checks to ensure that any marred walls are touched up. Monthly room checks will be conducted to ensure all walls are in good condition. **4. Monitoring:** Findings of the monthly room checks will be reported and tracked at the quality assurance meetings held quarterly.	
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:	L 099	**5. Completion: October 5, 2016**	

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L 099	Continued From page 9 Based on observations made on August 22, 2016 at approximately 9:15 AM, it was determined that the facility failed to prepare foods under sanitary condition as evidenced by one (1) of one (1) soiled convection oven, one (1) of one (1) soiled grease fryer, two (2) of five (5) dented one-third pans, one (1) of one (1) five-pound container of cottage cheese that was stored beyond its expiration date and one (1) of one (1) soiled coffee brewing machine in the nursing facility kitchen. The findings include: 1. One (1) of one (1) convection oven in the main kitchen was soiled with burnt food residue. 2. One (1) of one (1) grease fryer in the main kitchen was soiled with leftover food particles. 3. Two (2) of five (5) one-third pans in the main kitchen were dented. 4. One (1) of one (1) five-pound container of 1% small curd cottage cheese stored in the milk box in the main kitchen was expired as of August 10, 2016. 5. One (1) of one (1) coffee brewing machine in the nursing facility (NF) kitchen was soiled in several areas. These observations were made in the presence of Employee # 4 who acknowledged the findings.	L 099	**L419 Exhaust Vents Not Functioning** **1. Immediate Response:** Replacement parts were ordered immediately and delivered the following day. Upon delivery the parts were installed and exhaust vents functioning properly. **2. Risk Identification:** All rooms were inspected for properly functioning exhaust vents. **3. Systemic Changes:** Monthly room checks on exhaust vents will be conducted to make sure they are functioning properly. An in-service was held with employees conducting these room checks to ensure all exhaust vents are functioning properly. **4. Monitoring:** Findings of the monthly checks of exhaust vents will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on August 22, 2016 at approximately 10:45 AM, it was determined that the facility failed to maintain resident	L 214	**L419 Two Torn Privacy Curtains** **1. Immediate Response:** The two identified torn privacy curtains were removed and replaced. **2. Risk Identification:** All rooms were inspected for torn privacy curtains.	

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L 214	Continued From page 10 environment free of accident hazards as evidenced by a surge protector that was observed on the floor of one (1) of one (1) family room next to the Louise Terrace unit. The findings include: A surge protector was observed on the floor and unsecured in the family room next to the Louise Terrace unit. This observation was made in the presence of Employee # 5 who acknowledged the findings.	L 214	**L419 Two Torn Privacy Curtains (cont'd)** **3. Systemic Changes:** An in-service was held with employees conducting room checks to ensure that privacy curtains found to be torn will be replaced. Monthly room checks will be conducted on privacy curtains. **4. Monitoring:** Findings of the monthly room checks will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
L 419	3256.10 Nursing Facilities The facility shall develop policies and procedures relating to the operation of housekeeping and maintenance services. This Statute is not met as evidenced by: Based on observations made on August 22, 2016 at approximately 10:45 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary environment as evidenced by marred bathroom and bedroom walls in two (2) of 20 resident ' s rooms, non-functioning exhaust vents in three (3) of 20 resident ' s rooms, torn privacy curtains in two (2) of 20 resident ' s rooms and a marred footboard in one (1) of 20 resident ' s rooms. The findings include: 1. Bathroom walls were marred under the toilet paper holder in room #101 and the walls in resident room #106 were also marred. 2. Exhaust vents in resident ' s rooms #129, 131 and #133 were not functioning, three (3) of 20 resident ' s rooms surveyed.	L 419	**L419 Housekeeping & Maintenance Marred Footboard** **1. Immediate Response:** The identified marred footboard was temporarily patched and a new footboard ordered. **2. Risk Identification:** All footboards were inspected and repaired if needed. **3. Systemic Changes:** An in-service was held with employees conducting room checks to ensure that any marred footboards are reported and touched up. Monthly room checks will be conducted to make sure all footboards are in good condition. **4. Monitoring:** Findings of the monthly checks of footboards will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0015	A. BUILDING: ______ B. WING ______	08/25/2016

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) COMPLETE DATE
L 419	Continued From page 11	L 419		

3. Privacy curtains were torn in resident room #105 (bed A) and #106 (Bed B), two (2) of 20 resident ' s rooms surveyed.

4. The footboard from the bed in resident room #117 was marred and scarred with scuff marks. These observations were made in the presence of Employee # 5 who acknowledged the findings.