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 _____	08/15/2014

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 008	3202.2 Nursing Facilities Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease. This Statute is not met as evidenced by: Based on review of 35 healthcare personnel records, staff interview, The District of Columbia Municipal Regulations for Nursing Facilities and the Centers for Disease Control's Recommendations and Reports for Morbidity and Mortality Weekly Report Guidance for Evaluating Healthcare Personnel for Hepatitis B Virus Protection, it was determined, that the Nursing Facility, in 15 of 35 healthcare personnel records, lacked documented evidence of Hepatitis B immunization and/or Hepatitis B immunization declination. The findings include: Centers for Disease Control (CDC's) Standard. The U.S. Department of Health and Human Services Centers for Disease Control (CDC's) Recommendations and Reports for Morbidity and Mortality Weekly Report Guidance for Evaluating HealthCare Personnel for Hepatitis B Virus Protection and for Administering Post exposure Management Volume. 62 / Number. 10 December 20, 2013 stipulates: "Pre-Exposure Management Education and Infrastructure At the time of hire or matriculation, health-care providers and health-care institutions should provide training to [HealthCare Personnel] to improve recognition and encourage timely	L 008	**L008 Nursing Facilities Personnel Policies** **1. Immediate Response:** The 15 health care contract personnel that lacked evidence of Hepatitis B immunization or Hepatitis B Immunization declination in their personnel file will receive blood borne pathogen training and will be offered the Hepatitis B immunization. A Hepatitis B immunization or Hepatitis B declination form will be placed in the personnel file as documentation. **2. Risk Identification:** The personnel files of health care contract staff will be reviewed for Hepatitis B declination or Hepatitis B immunization. If lacking blood borne pathogen training and documentation of Hepatitis B immunization or Hepatitis declination will be obtained and placed in the personnel file. **3. Systemic Changes:** Health care orientation packet for new contract personnel will be developed. This packet will include Hepatitis B training and a Hepatitis B Immunization/Declination form. Signed documentation will be placed in the personnel file. **4. Monitoring:** A monthly random sample of new contract files will be reviewed for documentation of Hepatitis B immunization or Hepatitis B declination. Results will be reported at quarterly QA meetings.	10/15/14 10/15/14 10/15/14 10/15/14

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

Susan Thargrave — HHA — Administrator — 10/2/14

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L 008	Continued From page 1 reporting of blood and body fluid exposures. The possibility that the post-exposure evaluation will cause the [HealthCare Personnel] to have time lost from work should not be a barrier to reporting. Institutions should ensure that [HealthCare Personnel] have rapid access to post-exposure testing and prophylaxis, including [Hepatitis Immunoglobulin] and [Hepatitis] B vaccine... Vaccination All [HealthCare Personnel] whose work-, training-, and volunteer-related activities involve reasonably anticipated risk for exposure to blood or body fluids should be vaccinated with a complete, =3-dose [Hepatitis] B vaccine series. [Occupational Safety and Health Administration] mandates that vaccination be available for employees within 10 days of initial assignment... [HealthCare Personnel] trainees should complete the series before the potential for exposure with blood or body fluids, when possible, as higher risk has been reported during professional training (e.g., residency training). Incompletely vaccinated [HealthCare Personnel] should receive additional dose(s) to complete the vaccine series...The vaccine series does not need to be restarted for [HealthCare Personnel] with an incomplete series; however, minimum dosing intervals should be heeded...Minimum dosing intervals are 4 weeks between the first and second dose, 8 weeks between the second and third dose, and 16 weeks between the first and third dose... [HealthCare Personnel] lacking documentation of [Hepatitis] B vaccination should be considered unvaccinated (when documentation for	L 008		

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L 008	Continued From page 2 [Hepatitis] B vaccine doses is lacking) or incompletely vaccinated (when documentation for some [Hepatitis] B vaccine doses is lacking) and should receive additional doses to complete a documented [Hepatitis] B series. Health-care institutions are encouraged to seek documentation of "missing" [Hepatitis] B doses..., when feasible, to avoid unnecessary vaccination. [Occupational Safety and Health Administration] mandates that [HealthCare Personnel] who refuse [Hepatitis] B vaccination sign a declination statement (http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10052&p_table=STANDARDS). [HealthCare Personnel] refusing [Hepatitis] B vaccination can obtain vaccination at a later date at no expense if the [HealthCare Personnel] is still covered under [Occupational Safety and Health Administration's] Bloodborne Pathogens Standard. Health-care institutions should encourage [Hepatitis] B vaccination among [HealthCare Personnel] to improve [[Hepatitis B Virus] protection and to achieve the Healthy People 2020 target of 90% vaccination..." The Nursing Facility failed to: Ensure it's personnel complied with applicable United States Department of Health and Human Services; Centers for Disease Control's recommendations for evaluating Health Care Personnel for Hepatitis B Virus Protection. Fifteen (15) of the thirty-five (35) personnel records reviewed, lacked documented evidence of Hepatitis B immunization or Hepatitis B	L 008		

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L 008	Continued From page 3 immunization declination. The findings were reviewed, acknowledged and confirmed in a face-to-face interview with Facility Personnel # 8 on August 14, 2014 at approximately 12:40 PM.	L 008	**L 052 Nursing Facilities- Sufficient nursing time to allow for care** **1. Immediate Response:** An amendment was made to the resident's skin condition record on April 21, 2014, and was properly documented on the proper form from that time forward.	8/15/14
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: (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;	L 052	**2. Risk Identification:** The facility had no other residents with acquired pressure ulcers. **3. Systemic Changes:** Staff was in-serviced on the need to document pressure ulcers on the skin condition form designated for pressure ulcers. **4. Monitoring:** DON or her designee will conduct random audits of the documentation on residents with pressure ulcers to assure documentation is on the form designated for pressure ulcers. Findings will be reported at the quarterly QA meeting.	8/15/14 10/1/14 10/15/14

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L 052	Continued From page 4 (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 observation, record review and staff interview for one (1) of 23 sampled residents, it was determined that the facility staff failed to ensure that sufficient nursing time was given to maintain complete, accurate and organized clinical records as evidenced by failure to document the status of one (1) resident ' s pressure ulcer on the facility ' s form designated for pressure ulcers. Resident #44. The findings include: 1. The charge nurse failed to document the status of Resident #44's pressure ulcer on the skin condition form designated for pressure ulcers. A review of the clinical record for Resident #44 revealed that on April 13, 2014 the facility staff identified and documented an open area on the	L 052		

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L 052	Continued From page 5 resident ' s sacrum on a " Skin Condition Record for Non-Pressure Ulcer Skin Conditions " (not a pressure ulcer.). On April 13, 2014 the wound was described as, " An open area, left upper buttock, proximal to gluteal cleft 2cmx1.5cmxo0. " On April 15, 2014 the area was again documented on a " Skin Condition Record for Non-Pressure Ulcer Skin Conditions. " The wound was further described as an, " Open area with 90% slough 2cmx3cmx0. " On April 21, 2014 the same area was classified as an unstageble Pressure Ulcer and documented as, " 2cmx1.5cmx0, covered with 100% slough, " on a " Weekly Pressure Ulcer Healing Record. " A face-to-face interview was conducted with Employee #3 on August 14, 2014 at approximately 3:30PM. The employee was queried about the discrepancy in the documentation of the wound. He/she responded that the Wound Nurse came in to the facility, assessed the wound and classified it as an Unstageble Pressure Ulcer. " We always defer to the Wound Nurse ' s assessment. " The record was reviewed on August 14, 2014. The facility staff failed document the pressure ulcer on the skin condition form designated for pressure ulcers.	L 052		
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education	L 056		

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L 056	Continued From page 6 and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that the Nursing Facility failed to meet the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on two (2) of the seven (7) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on August 5, 2014 at approximately 2:30 PM. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/Advanced Practice Registered Nurse for two (2) of seven (7) days reviewed as outlined below. On Saturday, August 9, 2014 it was determined that the facility provided RN coverage at a rate of 0.3 hours.	L 056	**L 056 Nursing Facilities – Sufficient nursing time to allow for care** **Immediate Response:** 8/14/14 **1.** The schedule was reviewed for Aug 9 and 10 and both days were noted to not meet the .6 hour based on regulatory definition of "direct nursing care" for RN. **2. Risk Identification:** 8/15/14 Staff reviewed the staffing for the present schedule and noted .6 hours of direct nursing care for RN currently in place. **3. Systemic Changes:** The staffing coordinator was in-serviced on the definition of "direct nursing care" for RNs and educated on the .6 hours of direct nursing care for RN regulatory mandate. 10/1/14 Strategies for recruiting and hiring available and competent RN's were examined. **4. Monitoring:** DON or her designee will conduct random staffing audits to ensure compliance. 10/15/14 Findings will be reported at the quarterly QA meeting.	

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L 056	Continued From page 7 On Sunday, August 10, 2014 it was determined that the facility provided RN coverage at a rate of 0.3 hours. A face-to-face interview/review was conducted with Employee # 17 on August 15, 2014 at approximately 10:45 AM. He/she acknowledged the findings. The record was reviewed on August 15, 2014.	L 056	**L 099 Nursing Facilities – Equipment** **4 Soiled sprinkler heads** **1. Immediate Response:** Sprinkler heads were cleaned. **2. Risk Identification:** All equipment above cooking area was checked for cleanliness. **3. Systemic Changes:** All cooks were in-serviced. Caps were ordered from Fire Suppression System Co. for easy detection of dirt or grease. Added to master cleaning schedule to be cleaned weekly by cooks. **4. Monitoring:** Food Service Director or designee will monitor cooks master cleaning tool and will report findings at quarterly QA.	8/12/14 8/12/14 9/11/14 10/15/14
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 August 11, 2014 at approximately 9:30 AM, it was determined that the facility failed to store and prepare food under sanitary conditions as evidenced by four (4) of four (4) soiled sprinkler heads from the fire suppression system, two (2) of two (2) broken thermometers in the walk-in refrigerator and freezer, a missing thermometer in one (1) of two milk boxes, a missing temperature log for one (1) of two (2) milk boxes and eight (8) of 15 soiled hotel half-pans located in the pots and pans clean area. The findings include: 1. Four (4) of four (4) sprinkler heads from the fire suppression system located above the grill were soiled with dust particles	L 099	**L 099 Nursing Facilities - Equipment** **2 broken thermometers in the walk in refrigerator/freezer** **1. Immediate Response:** Thermometers were replaced immediately. **2. Risk Identification:** All thermometers were checked in every refrigerator/freezer. **3. Systemic Changes:** In-serviced all staff that inside thermometers must be checked and logged daily by cooks. **4. Monitoring:** Food Service Director or designee will check monthly log and report findings at quarterly QA.	8/12/14 8/12/14 9/11/14 10/15/14

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L 099	Continued From page 8 and grease. 2. One (1) of one (1) tube thermometer located in the walk-in refrigerator and one (1) of one (1) tube thermometer located in the walk-in freezer were broken and needed to be replaced. 3. There was no thermometer in the milk box located accross from the walk-in refrigerator. 4. There was no temperature log for the milk box located accross from the walk-in refrigerator. 5. Eight (8) of 15 two-inch hotel half pans located in the clean area, were soiled with leftover food residue. These observations were made in the presence of Employee #10 who acknowledged the findings.	L 099	**L 099 Nursing Facilities - Equipment Missing Thermometer in the milk box** **1. Immediate Response:** Thermometer was immediately replaced. 8/12/14 **2. Risk Identification:** All other refrigerators/freezers were checked for thermometers. 8/12/14 **3. Systemic Changes:** Staff in-serviced to record daily temperatures and sign log that thermometer is in place. 9/11/14 **4. Monitoring:** Food Service Director or designee will check monthly log and report findings at the quarterly QA. 10/15/14 **L 099 Nursing Facilities - Equipment Missing temperature log in 1 milk box** **1. Immediate Response:** Log was immediately replaced. 8/12/14 **2. Risk Identification:** All other boxes were checked for temperature logs. 8/12/14 **3. Systemic Changes:** All staff in-serviced. Opening/Closing checklist will ensure that all temperature logs are in place. 9/11/14 **4. Monitoring:** Food Service Director or designee will monitor log and report findings at quarterly QA. 10/15/14	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made on August 11, 2014 at approximately 9:30 AM, it was determined that the facility failed to maintain essential equipment as evidenced by: one (1) of two (2) steamers	L 442		

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L 442	Continued From page 9 observed with dripping water and one (1) of one (1) food warmer observed with a torn gasket. The findings include: 1. One (1) of two (2) steamers, in use in the main kitchen was dripping water from the bottom. 2. The door gasket to one (1) of one (1) food warmer was torn in several areas. These observations were made in the presence of Employee #10 who acknowledged the findings.	L 442	**L 099 Nursing Facilities - Equipment Soiled hotel half pans** **1. Immediate Response:** All pans identified as soiled were immediately rewashed. **2. Risk Identification:** All other pans on shelf were checked for cleanliness. **3. Systemic Changes:** All employees in-serviced on proper pot and pan washing techniques. **4. Monitoring:** Food Service Director or designee will check monthly log and report findings at the quarterly QA. **L 442 Nursing Facilities – Equipment one of 2 steamers observed with dripping water** **1. Immediate Response:** GCS was called to service steamer and fix leak. **2. Risk Identification:** All steamer doors were checked for leaks. **3. Systemic Changes:** In-serviced Dietary employees on reporting leaks to management. Added to checklist. **4. Monitoring:** Food Service Director or designee will monitor checklist and report findings at the quarterly QA meeting. **(L442 Continued on next page)**	8/12/14 8/12/14 9/11/14 10/15/14 8/12/14 8/12/14 9/11/14 10/15/14