DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096025	A. BUILDING ______ B. WING ______	05/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20016

(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 A recertification Quality Indicator Survey [QIS] was conducted on May 10 through 13, 2011. The following deficiencies were based on observations, staff and resident interviews and record review. The total sample was 26 residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	**F157 Notify of Changes (Injury/Decline/Room, etc)** **1. Immediate Response:** Upon discovery of the lapse in notification, the MD and the RP were immediately notified of change in skin condition. **2. Risk Identification:** The records of Residents with alteration in skin integrity were reviewed to assure that MD and RP's were notified of any changes. **3. Systemic Changes:** All licensed nursing staff was in-serviced on the importance of MD and RP notification of any alteration in Resident's skin integrity. **4. Monitoring:** The DON or designee will perform a random audit for MD/RP notification of skin alterations. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	4/18/11 7/13/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/22/11

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 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents, it was determined that facility staff failed to immediately notify the physician and responsible party when it was determined that the resident sustained an alteration in skin integrity. Resident #9 The findings include: A Review of the 24 Hour Report/Change of Condition Report dated April 15, 2011 revealed the following: "Remarks (Day): [Resident's Name] CNA brought to my attention that resident has non pressure ulcer on residents buttocks, skin sheet done, resident stable." "Remarks (Evening): Stable, alert and verbal. ADL [Activities of Daily Living] care provided. No complaints, Due meds [medications] given." "Remarks (Night): Resident care continued for pressure care." A Review of the Nurse ' s Notes dated April 15, 2011 at 3:00 PM revealed " ...C.N.A. (Certified Nursing Assistant) brought to my attention that while cleaning resident, noticed a non pressure ulcer on resident ' s Lt (left) buttock. Skin sheet completed, denies any pain or discomfort. Non-pressure ulcer 2cm (centimeter) width and 1 ½ length . " Further review of the clinical record revealed a Nurse's entry dated April 18, 2011 at 8:20 AM , " MD (Medical Doctor) gave new order for the open area on the (left) buttocks. Cleanse area	F 157		

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F 157	Continued From page 2 with wound cleanser, pat dry, apply Bacitracin ointment, cover with Allevyn dressing Q [every] 3 hours and prn [as needed]." A Nurse ' s Note dated April 18, 2011 at 3:20 PM revealed " ...(L) buttocks wound assessed by Wound Clinician, recommended Santyl ointment with dressing change daily, cleared by MD. [Responsible Party] notified. Denied pain/discomfort. " The clinical record and the 24 Hour Report/Change of Condition Report lacked evidence that the physician and the responsible party were immediately notified when the resident was assessed with an alteration in skin integrity. Approximately 3 days lapsed between the period the resident was initially assessed with an alteration in skin integrity on April 15, 2011 and the time of physician/family notification on April 18, 2011. Facility staff failed to immediately notify the physician and responsible party when it was determined that Resident #9 sustained an alteration in skin integrity. A face-to-face interview was conducted with Employees #1, 2, and 3 on May 13, 2011 at approximately 2:00 PM. Employee #2 acknowledged the aforementioned findings. The record was reviewed on May 13, 2011.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	**F279 Comprehensive Care Plans: Oxygen Use** **1. Immediate Response:** Resident #27's record was reviewed and a specific care plan to address this resident's use of oxygen was initiated.	

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F 279	Continued From page 3 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, residents and staff interviews for three (3) of 26 sampled residents, it was determined that facility staff failed to develop comprehensive care plans with interventions and measurable goals for dental/mouth care for two (2) residents, and for the use of oxygen for one (1) resident. Residents # 27, #34 and # 49. The findings include: 1. Facility staff failed to develop a comprehensive plan for the use of oxygen for Resident #27. According to an physician's interim order dated and signed April 30, 2011 directed, " Nasal [oxygen with] humidity titrate to maintain oxygen [saturation] at or above 94%."	F 279	**F279 Comprehensive Care Plans: Oxygen Use (continued)** **2. Risk Identification:** All residents currently using oxygen were identified and care plans reviewed for the presence of specific goals and approaches for the use of oxygen. **3. Systemic Changes:** Licensed nurses were in-serviced on how to initiate, develop and update an appropriate comprehensive plan of care with specific interventions and measurable goals for all residents using oxygen. **4. Monitoring:** The Director of Nursing or designee will perform a sample audit of records for residents requiring oxygen to assure that the comprehensive care plan is in place with specific interventions to meet the prescribed use. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting. **F279 Comprehensive Care Plans: Oral Care/Dentures** **1. Immediate Response:** Resident #34 and #49's records were reviewed and a specific care plan for oral and dental care including the use or non-use of dentures. **2. Risk Identification:** All residents with dentures were identified and care plans reviewed for specific goals and approaches for residents' oral care and use of dentures.	7/13/11

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F 279	Continued From page 4 A physician 's interim telephone order dated May 6, 2011 and signed May 11, 2011 directed, " Check [oxygen] saturation [every] shift. " A " Physician Order Record " dated and signed May 11, 2011 directed, " Special Medications ... Oxygen 2 L/Min[liters per minute]. Every shift special instructions: Nasal [oxygen] with humidity titrate to maintain O2 (oxygen) saturation at or above 94%. " The care plan section of the current clinical record contained a care plan for " Cardiac output, decreased, potential for cardiac failure, respiratory distress, and fluid imbalance. Goal: Resident safety will be maintained and resident will be free of discomfort. Interventions included: oxygen as needed. " The care plan indicated no goals and interventions for use of oxygen. There was no evidence that a care plan was developed for the use of oxygen for Resident #27. A face-to-face interview was conducted on May 13, 2011 at approximately 10:30 AM with Employee #6. After reviewing the care plans, he/she acknowledged that no care plan was initiated with goals and approaches for the use of oxygen. The clinical record was reviewed on May 13, 2011. 2. Facility staff failed to develop a comprehensive care plan with goals and approaches to address the oral health status for Resident #34. A " History and Physical Examination " signed	F 279	**F279 Comprehensive Care Plans: Oral Care/Dentures -continued** **3. Systemic Changes:** Licensed nurses were in-serviced on how to initiate, develop and update an appropriate comprehensive plan of care with specific interventions and measurable goals for all residents with dentures **4. Monitoring:** The Director of Nursing or designee will perform a sample audit of records to assure that the comprehensive care plan is in place with specific interventions to reflect that resident's individual oral and dental care needs including use of dentures. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	**7/13/11**

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F 279	Continued From page 5	F 279		

December 1, 2010 revealed, " ENT [Ear/Nose/Throat]: Edentulous [without teeth]. "

A review of the " Nursing Assessment Admission " dated November 30, 2010 revealed, " Dental: Denture in Mouth: Partial [upper/lower], Full [upper/lower] were both blank. Condition of Teeth: [greater than three (3) missing] was checked. "

A review of an admission MDS [Minimum Data Set] completed December 12, 2010 with revealed in Section L -Oral/Dental Status L0200 -A and B were checked indicating " broken or loosely fitting full or partial denture, no natural teeth or tooth fragment (s) (edentulous). " This care area triggered for Care Planning. Section G [Functional Status] G0110 revealed, Resident #34 required extensive assistance of one staff for personal hygiene and activities of daily living (ADL). "

According to a " Dental Assessment " treatment note dated [December 5, 2010] revealed, " Resident has denture that does not fit therefore [he/she] doesn ' t wear them. A subsequent note dated March 22, 2011 revealed, " dentures adjusted attempted. "

Review of the care plans initiated December 10, 2010, and updated March 16, 2011 revealed a " Self Care Deficit " care plan that did not include denture care or oral care.

Further review of the resident ' s clinical record lacked documented evidence that a comprehensive care plan was initiated for

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Resident #34 with appropriate goals and approaches for oral and dental care.

A face-to-face interview was conducted on May 13, 2011 with Employee #6 at approximately 1:41 PM. After review of the care plans he/she acknowledged the aforementioned findings. The record was reviewed on May 13, 2011.

3. Facility staff failed to develop a comprehensive care plan with goals and approaches to address oral hygiene/denture care for Resident #49.
Resident #49 was admitted to the facility on April 10, 2008 with diagnoses that included Cervical Dystonia, Anemia and Dementia.
Review of the clinical record revealed a nurse ' s "Admission Asssessment " that indicated the resident had " complete upper and lower dentures. "
Review of the " Nursing Monthly Summary " sheets revealed the following:
July 2010: Oral Cavity: Dentures: Upper and Lower
August 2010: Oral Cavity: Dentures: Upper and Lower
September 2010: Oral Cavity: Dentures
November 2010: Oral Cavity: Dentures
December 2010: Oral Cavity: [Left blanked]
January 2011: Oral Cavity: [Left blanked]
February 2011: Oral Cavity: [Left blanked]
March 2011: Oral Cavity: [Left blanked]

Further review of the Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of March 16, 2011, revealed that Resident #49 required total assistance for activities of

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F 279	Continued From page 7 daily living in Section L. Review of the care plans revealed a " Self Care Deficit " care plan updated 12/28/10 and 3/28/11 revealed, " Approaches: Set up and assist with personal hygiene as needed. Evaluation: Dependent/extensive assist with ADL ' s (Activities of Daily Living). The care plan did not include denture care / oral care. During a family interview on May 5, 2011at approximately 11:38 AM, resident ' s [responsible party] stated [resident] does not wear dentures regularly ...[he/she) takes them out. " Observation of Resident #49 on May 9, 2011, May 12, 2011, and May 13, 2011 revealed that the resident was not wearing dentures. During an interview on May 13, 2011 at approximately 1:28 PM, at the time of the observation, Employee #6 stated " [Resident] does not wear dentures. I will ask the nurse who has him/her today. " CNA (Certified Nursing Assistant) was queried. He/she stated, " He/she does not to want to wear them, he/she removes them herself. " Employee #6 proceeded to resident ' s room; he/she found upper and lower dentures in denture container with water in resident ' s closet. A face-to-face interview was conducted on May 13, 2011 at approximately 2:00 PM with Employee #6. He/she acknowledged that the care plan did not include goals and approaches for oral hygiene and denture care. The clinical record was reviewed on May 3, 2011.	F 279		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	**F281 Services Provided Met Professional Standards-see next page**	

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F 281 SS=D	Continued From page 8 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 26 sampled residents, it was determined that facility staff failed to meet professional standards of quality as evidenced by timely documentation to initiate treatment for an alteration in skin integrity to Resident #9 ' s left buttock by the licensed nurse. The findings include: According to the "Lippincott Manual of Nursing Practice," Seventh edition, nursing assessments are indicated for assessing for risk factors for pressure sore development and alter those factors, if possible. Skin is to be inspected several times daily to prevent pressure sore development. According to the facility ' s policy on " Weekly Skin Assessment " , " Each resident will be assessed by a licensed nurse on a weekly basis. This assessment will consist of a visual assessment of the skin condition of the resident. Such assessment, including any abnormal findings, will be documented by the nurse in the Treatment Administration Record. " According to the facility ' s policy on " Skin Integrity Management, " " Each NF [Nursing Facility] resident ' s skin integrity status will be	F 281	**F281 Services Provided Met Professional Standards** **1. Immediate Response:** Treatment to left buttock of Resident #9 was documented and initiated. **2. Risk Identification:** The medical records of all residents with an alteration in skin integrity were reviewed to assure their treatment and documentation was initiated in a timely manner. **3. Systemic Changes:** All nursing staff was in-serviced on both assessing risk factors for pressure sore development and how to alter those factors if possible. Additionally, all nursing staff was in-serviced on reporting any alteration in skin integrity observed during daily care so that skin is assessed several times per day and the treatment is initiated in a timely manner. **4. Monitoring:** The DON or designee will perform a random audit of weekly skin assessment records and timeliness of initiation of treatment. Findings presented at the Quarterly Quality Assurance Meeting.	7/13/11

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F 281	Continued From page 9 identified along with the need for prevention or treatment. " Resident #9 sustained a pressure ulcer to the left hip subsequent to an alteration in skin integrity on April 15, 2011 as evidenced by the following nursing note: April 15, 2011 at 3 PM, " Resident alert [and] verbally responsive. ...noticed a non pressure ulcer on resident [left] buttock. Skin sheet completed, denies any pain or discomfort. Non pressure ulcer 2cm width and 1 ½ [one and one half] length. " A succesive nurse's entry dated April 18, 2010 at 8:20 AM read, " MD [Medical Doctor] gave new order for the open area on the [left] buttock. Cleanse area with wound cleanser, pat dry, apply Bacitracin ointment, cover with Allevyn dressing Q [every] 3 [three] hours and prn as needed]." The subsequent nurse's entry on April 18, 2011[no time indicated] revealed, " [Left] buttock wound assessed by [Wound Nurse], recommended Santyl ointment [with] dressing [change] daily, cleared by [Medical Doctor]. [Daughter ' s name] notified. " The clinical record lacked evidence that facility staff failed to initiate treatment to the left buttock when the resident was initially assessed with an alteration in his/her skin integrity. The findings were reviewed and confirmed during a face-to-face interview with Employees #2 and #3 on May 13, 2011 at approximately 11:00 AM. The clinical record was reviewed on May 13, 2011.	F 281		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	**F309 Provide Care/Services for Highest Well Being- see next page**	

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F 309 SS=D	Continued From page 10 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents it was determined, that facility staff failed to hold Coumadin on April 21, 2011 in accordance with the physician ' s order for Resident #34. The findings include: Further review of an individual laboratory (lab) report dated April 20, 2011 indicated that the resident ' s INR was 3.90. Physician documentation on the lab report directed, " Decrease dose [Coumadin] by 1mg (one). Hold one dose today. " The physician ' s order dated April 21, 2011 which directed, " Hold Coumadin orders today. D/C previous Coumadin Orders. Coumadin 1 (one) mg. po (by mouth) daily at 6:00 PM for A-fib (Atrial-fibrillation). Give with Coumadin 2.5mg daily. " The physician's order dated April 22, 2011	F 309	**F309 Provide Care/Services for Highest Well Being** **1. Immediate Response:** Attending Physician for Resident # 34 was informed of med error on 4/21. MD wrote orders to hold Coumadin on 4/22 and orders were followed as given. **2. Risk Identification:** Medical records for residents receiving Coumadin reviewed to ensure orders were followed as given. **3. Systemic Changes:** Licensed nursing staff were in-serviced on Coumadin therapy; medication administration and physician orders. **4. Monitoring:** DON or designee will audit medical records of residents on Coumadin and report findings of any med error related to this treatment at the Quarterly Quality Assurance Meeting.	4/21/11 7/13/11

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directed, " Hold Coumadin today April 22, 2011. " According to the physician ' s orders Coumadin should have been held on April 21 and April 22, 2011.

A review of documentation in the Nurse ' s Notes dated April 23, 2011 at 5:00 PM revealed the following; " Med (Medication) error report: On 4/21/11 6pm, Resident was given a dose of Coumadin 3.5mg that was ordered to be held that evening. The error was caused by wrong dose entered on the computer. No adverse reaction noted, 0 (no) s/s (sign/symptom) of Coumadin toxicity. Resident ' s general condition is baseline. MD (Medical Doctor) notified, new order received to hold Coumadin 3.5mg on 4/22/11 - 6pm. R/P (Responsible Party, (name) made aware. Med error report completed. VS (Vital signs) .... "

A review of the resident ' s Anticoagulant Flow Sheet revealed the following:

Date: 4/20/11
PT/INR: 49.8/3.90
Current Coumadin Dose: 4.5 mg
New Order: Coumadin 3.5mg on 4/21/11
Next Lab Date: 4/27/11

Date: 4/27/11
PT/INR: 37.7/2.99
Current Dose: Coumadin 3.5 mg
New Order: No New Order
Next lab date: 5/4/11

A review of the Anticoagulant Flow Sheet revealed that the PT/INR decreased from 49.8/3.90 on April 20, 2011 to 37.7/2.99 on April

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LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

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F 309	Continued From page 12 27, 2011 despite the administration of the Coumadin on April 21, 2011. A review of the Medication Administration Record for April 2011 revealed a nurse ' s signature in the 6:00 PM box on April 21, 2011 which indicated that the resident received one (1) mg of Coumadin with 2.5 mg instead of Coumadin (3.5) mg at that time; despite the physician ' s order to hold the medication. A face-to-face interview was conducted with Employee #3 at approximately 1:41 PM. During the interview the employee reviewed the aforementioned documents and acknowledged that the facility staff failed to hold the Coumadin on April 21, 2011 in accordance with the physician ' s order. The record was reviewed on May 13, 2011.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 26 sampled residents, it was determined that facility staff failed to	F 314	**F314 Treatment/SVCS to Prevent/Heal Pressure Sores** **1. Immediate Response:** The wound to the left buttock of Resident #9 was treated and healed. **2. Risk Identification:** All residents were assessed during a facility wide skin check. All alterations in skin integrity were identified. Those with alteration in skin integrity received record review for treatments to promote healing, prevent infection and prevent new alterations from developing, **Continued on next page**	

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F 314	Continued From page 13 accurately assess and implement interventions with timeliness to care for a facility acquired pressure sore for Resident #9. The findings include: A review of the clinical record for Resident #9 revealed an alteration in skin integrity was identified on April 15, 2011. A period of approximately 3 days lapsed before the physician was notified and treatment initiated to care for the alteration in skin integrity. The wound worsened during the period of April 15, 2011 through April 18, 2011. The facility acquired wound was assessed as an " unstageable pressure sore of the left buttocks on April 18, 2011. According to the history and physical examination signed by the physician on February 9, 2011, the resident ' s diagnoses included "Brittle IDDM (insulin dependent diabetes mellitus) , diabetic nephropathy, neuropathy, PAD (peripheral artery disease), CAD (coronary artery disease), S/P CABG (coronary artery bypass graft), lumber spinal stenosis with myelopathy, and rectal fissure". According to the quarterly Minimum Data Set signed and dated March 9, 2011, Resident #9 was coded as totally dependent for transfer, bathing and personal hygiene and required extensive assistance for bed mobility, locomotion and dressing in Section G, Functional Status. According to Section H, Urinary/Bowel, the resident was incontinent of bowel and bladder. Section M, Skin, revealed the resident had a history of resolved pressure sores.	F 314	**F314 Treatment/SVCS to Prevent/Heal Pressure Sores - continued** to include; accurate assessment of the wound, review of timeliness of physician notification and Initiation of orders, family notification, updated care plans, current and accurate use of the Braden scale, notification of interdisciplinary team members for input, use of any pressure relieving device, and notation for follow-up in 24-hour report. **3. Systemic Changes:** Facility treatment protocol of skin was instituted to assure expedited treatment order of wounds upon discovery. In-service with RN supervisors was held reviewing the following: 1. Protocol for skin assessment and documentation; 2. RN management of all skin assessment and reported alterations in integrity in a timely manner; 3. The importance of inclusion of any skin changes on 24-hour report to insure proper communication and follow up. Additionally, an in-service was held for all licensed staff on the following: 1. Prevention of alterations in skin integrity; 2. Timeliness, frequency and accuracy of assessment; 3. Interventions that promote healing; 4. Ongoing review and knowledge of care plans and use of assessment tools such as the Braden scale.	

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F 314	Continued From page 14	F 314	**F314 Treatment/SVCS to Prevent/Heal Pressure Sores (continued)**	

A review of Resident #9 ' s care plan revealed the interdisciplinary team identified " Skin breakdown " related to immobility, incontinence, diabetes and decreased sensation as a problem on April 18, 2011.

A review of nurse ' s notes dated April 15, 2011 at 3:00 PM, revealed: " ...CNA [certified nursing assistant] brought to my attention that while changing resident, noticed a non pressure ulcer on resident ' s Lt [left] buttocks ... non-pressure ulcer 2 cm width x 1½ cm length. "

The successive nurse ' s entry dated April 18, 2011 at 8:20 AM read, " MD (Medical doctor) gave new order for the open area on the [left] buttocks. Cleanse area with wound cleanser, pat dry, apply Bacitracin ointment, cover with Allevyn dressing Q [every] 3 hours and prn [as needed]. "

The subsequent nurse ' s entry on April 18, 2011 at 3:30 PM read, " Buttocks wound assessed by wound clinician. Recommended Santyl ointment with dressing change daily, cleared by MD. Daughter [named] notified. "

The record revealed licensed staff initiated a document entitled "Skin Condition Record for Non-Pressure Ulcer Skin Conditions " that read: "Date of onset -April 15, 2011; comments - wound on Lt buttocks is pink with red lining on the outside of wound; size - length 1½ cm by 2cm width; " 0 " depth; exudate type - none; exudate amount - none; odor - none; wound bed - pink/beefy red; surrounding skin color - bright red; surrounding tissue/wound edges - normal for

4. Monitoring:
The DON or designee will perform a random audit of the treatment of resident's with alteration in skin integrity for compliance with the facility treatment protocol and report findings at the Quarterly Quality Assurance.

7/13/11

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F 314	Continued From page 15 skin. " The record revealed a document entitled "Weekly Pressure Ulcer Healing Record " that included the following: "Date of onset - April 18, 2011; site - [Left] buttocks; comments - covered with 100% yellow slough and no surrounding redness; stage - unstageable; size - 1x1x0; exudate type - serous; exudate amount - scant; odor - none; wound bed - slough 100%; surrounding skin color - normal; surrounding tissue/wound edges - normal; progress - new; treatment - changed. " The record lacked evidence that interventions were implemented during the period of April 15 - 18, 2011 to care for the left buttocks facility-acquired wound sustained by the resident. The worsening of the site is evidenced by the progression of the wound, as documented in the nursing assessments; from a " beefy red " wound bed to a 100% slough covered wound bed as follows: " Skin Condition Record for Non-Pressure Skin Conditions " dated April 15, 2011 - wound bed [left buttocks] " pink/beefy red. " " Weekly Pressure Ulcer Healing Record " dated April 18, 2011 - wound bed " slough 100%. " Further review of the clinical record revealed the resident had a history of resolved pressure ulcers affecting the left buttocks. According to Weekly Pressure Ulcer Healing Records, the resident was treated for a Stage 2 pressure ulcer of the	F 314		

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left inner buttocks October 4 - 19, 2010. During the period of January 2 - 25, 2011, treatment was implemented for a Stage 2 ulcer of the left buttocks.

A review of the facility ' s pressure ulcer risk tool, the Braden Scale, revealed licensed staff assessed Resident #9 as a " mild risk " for the development of pressure ulcers. The scoring of the scale depicts high risk: 10-12; moderate risk: 13-14 and mild risk 15-18. The assessment dates and correlating scores for Resident #9 are as follows:

September 1, 2010 - total score: 15; December 8, 2010 - total score: 15; March 10, 2011 - total score: 18 and April 17, 2011 - total score 16. The risk factor identified as " sensory perception, " was assessed as " 4 " no impairment. However, the score lacked evidence that the assessor considered " decreased sensation " [noted in care plan] and the medical diagnoses of neuropathy and diabetic neuropathy [H&P] in the scoring since the scale reflected no impairment.

Licensed staff failed to accurately assess the alteration in skin integrity at the time of initial identification on April 15, 2011. The wound was assessed as a " non-pressure ulcer " of the left buttocks. The location of the wound, in a pressure-bearing area [the buttocks] and the resident ' s history of pressure ulcer(s) in the same and/or similar site would have lead the assessor to consider the wound to be of pressure in origin. The assessment conducted by the facility ' s wound specialist on April 18, 2011 identified the wound as a pressure ulcer.

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F 314	Continued From page 17 The record revealed the most recent dietary assessment was documented March 9, 2011 and the resident ' s skin was intact. There was no evidence that the dietician was notified regarding the resident ' s alteration in skin integrity. The nutrition care plan was not updated with goals and approaches to address the resident's skin impairment from a nutritional perspective. A review of physician ' s orders dated May 2, 2011 revealed an order for the use of an air mattress for pressure relief. According to documentation on the care plan that identified Non-compliance as a problem, a notation dated May 9, 2011 revealed the air mattress was in place. The pressure-relieving device was implemented approximately 3 weeks post identification of the facility acquired pressure ulcer. A face-to-face interview was conducted with Employees #1, 2 and 3 on May 13, 2011 at approximately 2:00 PM. Employee #2 acknowledged the findings and stated that a corrective action plan had been implemented once the administration identified concerns with the management of Resident #9 ' s facility acquired wound. Facility staff failed to accurately assess and implement interventions with timeliness to care for a facility acquired pressure ulcer. The record was reviewed May 13, 2011.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	**F329 Unnecessary Drugs; Psychotropic Medication Side Effects** **1. Immediate Response:** Resident #77's record was reviewed and a behavioral monitoring tool was put into place to monitor for adverse side effects for the use of Seroquel and Sertraline HCL.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 18	F 329		

drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview of two (2) of 26 sampled residents, it was determined that facility staff failed to monitor a resident on psychotropic medications for side effects and failed to administer as needed (prn) pain medication consistent with prescribed parameters. Residents #77 and #84.

The findings include:

1. A review of Resident #77 ' s MR (Medication Record) revealed that the resident is receiving

F329 Unnecessary Drugs; Psychotropic Medication Side Effects-continued

2. Risk Identification:
All records for residents prescribed psychotropic medications were reviewed for use of behavioral monitoring tools including documentation of adverse side effects.

3. Systemic Changes:
Licensed staff was in-serviced on the use of psychotropic medications and adverse side effects of the use of such medication. Staff was in-serviced on how to complete behavioral monitoring tools when residents are prescribed such medication.

4. Monitoring:
The Director of Nursing, Consultant Pharmacist or designee will perform a sample audit of records for residents' prescribed psychotropic medication to assure that there is a behavioral monitoring tool including documentation of adverse side effects present. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.

Completion date: 7/13/11

F329 Unnecessary Drugs; PRN Medication Parameters

1. Immediate Response:
Resident #84 record was reviewed for physician orders related to the use of PRN Tylenol #3 and parameters for administration. DON initiated medication error reporting for administration of incorrect dose.

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F 329	Continued From page 19 Seroquel Oral Tablet 25 mg PO (by mouth) at bedtime 9:00 PM for Dementia, and Sertraline HCL Oral Tablet 25 mg PO one (1) time a day for Depression. The order date for both medications was February 15, 2011. Review of the CAA (Care Area Assessment) for Resident #77 signed on February 22, 2011 number 17, Psychotropic Drug Use: Note...Resident on psychotropic meds (medications) will monitor for side effects" and "to be on the lowest therapeutic dose possible.." Further review of the clinical record including nurses notes lacked evidence of a behavioral monitoring tool for adverse side effects of the medications. Facility staff failed to monitor a resident on psychotropic medications for side effects for Resident #77. A face-to-face interview was conducted on May 13, 2011 at approximately 9:30 AM with Employee #3. A request was made for the behavioral monitoring tools for the current and previous month. Employee #3 was unable to produce the behavioral monitoring tools. The record was reviewed May 13, 2011. 2. Facility staff failed to administer as needed (prn) pain medication consistent with prescribed parameters for Resident #84. A review of the resident ' s clinical record revealed a physician ' s order dated May 4, 2011 which directed the following " Tylenol #3 (Acetaminophen with Codeine) 300-30MG one (1) tablet by mouth every four hours prn for mild - moderate pain " and " Tylenol #3 two tablets po prn for pain (Pain - severe). "	F 329	**F329 Unnecessary Drugs; PRN Medication Parameters – continued** **2. Risk Identification:** The Physician Orders and the MAR's for residents receiving PRN Tylenol #3 were reviewed for compliance that over the past 30 days the pain reported by the resident on the pain scale matched the recommended parameters as noted in the Physician's Order. **3. Systemic Changes:** Licensed staff were in-serviced on the following: (1) use of the facility pain scale, assessment of the resident and interpretation of pain severity; (2) documentation of their clinical assessment of the pain; (3) the use of PRN pain medication and physician defined parameters. **4. Monitoring:** The Director of Nursing, Consultant Pharmacist or designee will perform a sample audit of records for residents using PRN pain medication for parameter compliance. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	7/13/11

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F 329	Continued From page 20 A review of the Medication Administration Record (MAR) for May 5, 2011 revealed that facility staff administered two (2) Tylenol #3 tablets to the resident for mild pain at 8:00AM on May 5, 2011. Review of the computerized documentation revealed that the pain scale rating was documented as 2-3 (mild pain). According to the pain scale that was utilized by the facility a rating of 2 - 3 was indicative of mild pain. According to the physician ' s order one (1) Tylenol #3 was recommended for mild pain. The record was reviewed on May 12, 2011. A face-to-face interview was conducted with Employee #3 at approximately 1:00 PM on May 13, 2011. During the interview the employee reviewed the record and acknowledged that the resident should have received one (1) Tylenol #3 tablet for mild pain as was ordered by the physician.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	**F428 Drug Regimen Review, Report Irregular, Act On** **1. Immediate Response:** The pharmacy's 'drug regimen review sheet' for Resident #77 was faxed to the physician for review. Physician reviewed and addressed the issues. **2. Risk Identification:** "Drug Regimen Review Sheet" for other residents identified by the Consultant Pharmacy was reviewed to make sure all suggestions had been addressed by MD as requested.	

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F 428	Continued From page 21 by: Based on record review and staff interview for one (1) of 26 sampled residents, it was determined that the physician failed to act upon pharmacy communication associated with a medication regimen review related to the use of antipsychotic medication for Resident #77. The findings include: A review of Resident #77's record revealed that a communication dated March 3, 2011 documented by the consultant pharmacist, entitled "Comment/Suggestions". The comment/suggestion to the physician read as follows: " A review of the drug regimen review sheet dated March 3, 2011 revealed the pharmacy written comment " This resident is on the anti-psychotic agent Seroquel as currently there is no approved psychiatric diagnosis noted on the chart for its use. Please document that one of the following exists to justify use of this agent: 1. Schizophrenia, H2-affective disorder, 3. Delusional Disorder, 4. Mood Disorder (including mania, bipolar disorder, depression/psychotics features, and treatment refractory major depression, 5. Schizophreniform Disorder, 6. Psychosis, 7. Atypical Psychosis, 8. Dementing illness with behavioral symptoms, 9. Medical illness or delirium with mania or psychotic symptoms and/or treatment related mania/psychosis (e.g., thyotoxicosis, neoplasm, high dose steroids)." A concurrent review of the medical record lacked evidence that the physician addressed the pharmacist comments/suggestions on the drug	F 428	**F428 Drug Regimen Review, Report Irregular, Act On (continued)** **3. Systemic Changes:** Licensed nursing staff was in-serviced on "Drug Regiment Review Sheet" and necessary physician documentation. **4. Monitoring:** DON or designee will monitor "Drug Regimen Review Sheets" for physician documentation on a monthly basis and report findings at the Quarterly Quality Assurance Meeting.	7/13/11

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F 428	Continued From page 22 regimen review sheet dated March 3, 2011. There was no evidence that he/she disagreed or agreed with the pharmacist comment/suggestion. A face-to-face interview was conducted on May 13, 2011 at approximately 1:00 PM with Employee #2. He/she acknowledged the findings. The record was reviewed on May 13, 2011.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F441 Infection Control, Prevent Spread, Linens** **1. Immediate Response:** Employee # 9 was immediately in-serviced on hand washing during dressing change and good infection control practices. **2. Risk Identification:** Random observation of staff hand washing and infection control practices during dressing changes were conducted on licensed staff by DON and ADON. **3. Systemic Changes:** Licensed nursing staff was in-serviced on infection control practices and proper hand washing technique during dressing changes. **4. Monitoring:** DON or designee will continue to randomly observe licensed staff infection control and hand washing techniques during dressing changes and will report findings to the Quarterly Quality Assurance Meetings.	7/13/11

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hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, and staff interview of one (1) of 26 sampled residents, it was determined that the facility staff failed to maintain appropriate infection control practices during a wound treatment for Resident #9.

The findings include:

During a wound treatment observation of resident #9 ' s left buttocks, it was observed that the nurse failed to maintain appropriate infection control practices during a wound treatment when he/she failed to cleanse his/her hands during the wound treatment.

During the wound treatment observed on May 12, 2011 at approximately 11:10 AM, the nurse changed his/her gloves several times during the treatment but at no time did he/she washed his/her hands or utilize hand sanitizer during the treatment. He/she was observed to wash hands before starting the treatment.

The observations were shared with Employee #3 during a face-to-face interview on May 12, 2011 at approximately 1:00 PM. He/she stated that

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 ____	05/13/2011

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 441	Continued From page 24 Employee #9 was a new hire and that he/she had not had the opportunity to observe the employee's treatment practice.He/she provided documentation that Employee #9 completed a competency for treatments and infection control. However, he/she acknowledged the aforementioned findings and stated the employee would be inserviced. .	F 441		