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 _____	03/27/2008

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 An annual licensure survey was conducted on March 25 through 27, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 15 residents and five (5) supplemental residents.	L 000		
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; (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 three (3) supplemental residents, it was determined that the charge nurse failed to develop a care plan with goals and approaches	L 051	L-051 Plan of Correction Behaviors 1.) **Immediate Response:** A care plan was developed with goals and approaches for the identified resident with behaviors. 2.) **Corrective Action:** A record review will be conducted by the Director of Social Services of all Nursing Facility residents, identifying all residents with behaviors. The Director of Social Services will review all corresponding care plans to ensure goals and approaches are in place for all residents with behaviors. 3.) **Systemic Changes:** (i) The Director of Social Services or designee will review residents identified as having new behaviors or change in behavior, and a Care Plan will be put in place with goals and approaches. (ii) A Care Plan will be put in place, reviewed and updated upon admission to the facility, quarterly and with any change in resident condition for all residents with behaviors	3/26/08 4/25/08 4/25/08 5/11/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/17/08

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L 051	Continued From page 1 for one (1) resident with behaviors, one (1) resident with a pacemaker and assess one (1) resident's ability to swallow. Resident F1, F4 and JH1. The findings include: 1. The charge nurse failed to develop a care plan with goals and approaches for Resident F1 with behaviors. A review of the nurse's notes revealed the following: "December 4, 2007 at 11:53 PM, CNA reported that during PM care resident scratched her on her right forearm. Red linear area noted on CNA forearm about six (6) inches long with intact skin. First aid rendered to CNA." "January 19, 2008 at 9:30 AM, Resident bit primary CNA on Lt [left] breast while transferring form bed to chair..." A review of the care plan last updated/reviewed on January 31, 2008 lacked evidence of goals and approaches to address the resident's physical behaviors. A face-to-face interview was conducted with Employee #2 on March 26, 2008 at 2:25 PM. He/She reviewed the care plan section of the chart and acknowledged that there was no care plan developed to address the resident's physical behavior. The record was reviewed on March 26, 2008. 2. The charge nurse failed to develop a care plan with goals and approaches for Resident F4 with a	L 051	L-051 Plan of Correction, continued (iii) Staff will be in-serviced on reporting resident behaviors and care-planning of behaviors by the Director of Social Services 4.)**Monitoring:** (i) The Interdisciplinary Care Plan Team will review weekly reports of residents identified as having new or a change in behavior. (ii). The Director of Social Services or designee will conduct a sample record audit to monitor that residents with behaviors have a corresponding Care Plan in place with goals and approaches, and report findings to the Quality Assurance Committee, quarterly. Pacemaker 1.) **Immediate Response:** A care plan was developed with goals and approaches for the identified resident with a pacemaker. 2.) **Corrective Action:** A record review will be conducted by the MDS Coordinator of all Nursing Facility residents, identifying all residents with a pacemaker. The MDS Coordinator will review all corresponding care plans to ensure goals and approaches are in place for all residents with a pacemaker. 3.) **Systemic Changes:** (i)The MDS Coordinator or designee will review residents identified as having a pacemaker or newly-inserted pacemaker, and a Care Plan will be put in place with goals and approaches.	5/11/08 3/26/08 4/25/08 4/25/08 5/11/08

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L 051	Continued From page 2 pacemaker. A review of the annual Minimum Data Set completed April 10, 2007 revealed that in Section I [Disease Diagnoses] the resident was coded for status post pacemaker. A review of the care plan last updated/reviewed on January 16, 2008 lacked evidence of goals and approaches to address the resident with a pacemaker. A face-to-face interview was conducted with Employee #3 on March 26, 2008 at 2:25 PM. He/she reviewed the care plan section of the chart and acknowledged that there was no care plan developed for a resident with a pacemaker. The record was reviewed on March 26, 2008. 3. The charge nurse failed to assess Resident JH1 for the ability to swallow medications. On Tuesday, March 25, 2008, at approximately 11:00 AM, during the morning medication pass, Resident JH1 was unable swallow one (1) tablet. The resident was administered medications with pudding and water. Even though the resident consumed a can of Ensure, a glass of orange juice and another glass of water the resident did not swallow one (1) tablet, later identified as Slow Mag. Employee #7 removed the tablet from the resident's mouth, after waiting 25 minutes for the resident to swallow the medication. During a face-to-face interview, on March 26, 2008, at approximately 12:00 PM, Employee #7 acknowledged that the resident had difficulty swallowing some medications. However, he/she	L 051	L 051 Plan of Correction, continued (ii) A Care Plan will be put in place, reviewed and updated upon admission to the facility, quarterly and with any change in resident condition for all residents with a pacemaker. (iii) Staff will be in-serviced on reporting changes/use of pacemakers and care-planning for residents with pacemakers. 4.)**Monitoring:** (i) The Interdisciplinary Care Plan Team will review weekly reports of residents identified as having a new pacemaker or need for pacemaker care. (ii). The MDS Coordinator or designee will conduct a sample record audit to monitor that residents with pacemakers have a corresponding Care Plan in place and report findings to the Quality Assurance Committee, quarterly. Ability to Swallow Medication **1.) Immediate Response:** Resident #JH1's difficulty in swallowing medications was reported to physician and physician ordered to crush all crushable medications. **2.) Corrective Action:** The Charge Nurse will observe all residents for ability to swallow medication and report any with swallowing difficulties to the physician. The Charge Nurse or designee will obtain a physician order to crush all crushable medications and to obtain liquid medications whenever possible, for all residents identified.	5/11/08 3/25/08 4/18/08

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L 051	Continued From page 3 did not report it to the charge nurse. A face-to-face interview was conducted on March 26, 2008 at approximately 12:00 PM with Employee #8. He/She stated, " When I administered medication to the resident, (prior to this date), the resident spit out the medication and would sometimes refuse the medications." He/she did not report it to the charge nurse. During a face-to-face interview, on March 26, 2008, at approximately 12:00 PM, Employee #3 was not aware that the resident spit out and refused medication and had difficulty swallowing. An interim order dated November 8, 2007 documented that the resident was to receive a pureed diet. The speech therapist evaluated Resident JH1 on November 30, 2007 for cognition. There was no evidence that the speech therapist evaluated the resident for swallowing. According to the, "Speech Evaluation Form," the area entitled "Swallowing" was marked, "not applicable." The following sections and the area of evaluations were not completed (left blank) on the "Speech Evaluation Form": Oral: Stasis, Pocketing, Labial Loss, Mastication Pharyngeal: Swallow Delay, Gurgly Vocal Quality, Cough/Throat Clear, Stasis/Multiple Swallows Risk Of: Choking, Aspiration, Dehydration, Malnutrition The record was reviewed on March 26, 2008.	L 051	L 051 Plan of Correction Continued **3.) Systemic Changes:** Licensed nurses were in-serviced on swallowing evaluations, crushed medications and notifying physician of resident swallowing problems. In-service SLP on proper completion on the entire SLP Evaluation Form. Licensed nurses will report to the Charge Nurse any resident having difficulty in swallowing their medication. The Charge Nurse or designee will notify the physician and obtain orders to crush all crushable medications and obtain liquid medications whenever possible. 4.) Monitoring: The Charge Nurse or designee will perform random audits of residents during medication administration, to check resident ability to swallow medications, compliance with crush medication orders and report findings to the Quality Assurance Committee quarterly.	4/9/08 4/25/08 5/11/08 5/11/08

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L 080	Continued From page 4	L 080		
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute is not met as evidenced by: Based on observation, staff and resident interviews and record review for three (3) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to identify a seatbelt as a restraint for four (4) residents. Residents # 2, 4, 8, and A1. The findings include: 1. Facility staff failed to identify a seatbelt as a restraint. Resident #2. Resident #2 was observed in the day room on March 25, 2008, at approximately 10:10 AM and March 26, 2008 in the day room across from the nursing station seated in a wheelchair and wearing a padded seat belt. On March 26, 2008 at approximately 10:10 AM, an interview was conducted with the resident and Employees #10 and 12. The resident was asked if he/she was able to open the seat belt. The resident tugged at the seat belt, shook his/her head and stated, "No". Both employees responded, "The resident is unable to self-release the seatbelt. It's to keep him/her from falling." A review of the physician's orders dated September 25 and November 20, 2007, and March 1, 2008, directed: "Treatments: May have air mattress, 2 large side rail pads ...seatbelt, [and] bed alarm for safety..." A review of the "Resident Interdisciplinary Care Plan" dated March 14, 2008 checked "No" for	L 080	**L 080 — Plan of Correction** 1.) **Immediate Response:** Resident #2's seat-belt use was re-assessed and the seat-belt was changed to a Velcro self-releasing seat-belt, which resident can self-release. The physician order is in the chart and the Care Plan for this resident was reviewed and updated to reflect this change. Resident #4's, #8's, and #A1's seat-belt use was re-assessed and dis-continued secondary to residents not needing the device. The physician orders are in the chart and the Care Plans for these residents have been reviewed and updated to reflect these changes. **2.) Corrective Action:** All residents having a seat-belt will be re-evaluated by the Rehabilitation Department. (i) Based on the re-evaluation, residents who no longer require the use of a seat-belt will have the seat-belt discontinued by the physician and their Care Plans will be updated. (ii) Based on the re-evaluation, residents who require a seat-belt but are unable to self-release a seat-belt will be identified as using a restraint. In all cases, the physician order and the Care Plan will be updated and put in place.	4/15/08 4/25/08

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L 080	Continued From page 5 physical restraint. A face-to-face interview was conducted on March 26, 2008, at approximately 2:30 PM with Employees #1and 11. Both acknowledged that the resident's use of a seatbelt was not identified as a restraint. The record was reviewed on March 26, 2008. 2. Facility staff failed to identify a seatbelt as a restraint. Resident #4. Resident #4 was observed on March 25, 2008, 2008 at 11:35 AM and March 26, 2008, 2008 at 12:4 0 PM in the day room across from the nursing station seated in a wheelchair and wearing a padded seat belt. An interview was conducted with the resident and Employee #13 on March 25, 2008 at approximately 11:35 AM. The resident was asked if he/she was able to open the seat belt. The resident tugged at the seat belt, shook his/her head and stated, "No", the resident's fingers were contracted. Employee #13 responded; "The seat belt is for safety. The resident is unable to self-release the seatbelt. " According to a review of the physician's orders dated January 7, 2008, "Restraint / Safety Devices: May have 2 [two] small side rail pads ...seatbelt, to support safety and independence..." A review of the "Resident Interdisciplinary Care Plan" dated March 8, 2008 checked "No" for physical restraint. A face-to-face interview was conducted on March 26, 2008, at approximately 2:30 PM with	L 080	L 080 Plan of Correction, Continued 3.) **Systemic Changes**: In-service staff on seat-belt use, use of restraints, and proper identification of seat-belts as a restraint. In-service staff on obtaining a physician order whenever seat-belts or restraints are ordered. The Rehabilitation Department will evaluate residents upon admission for appropriatenesss of seat-belt use. If a seat-belt is necessary, residents will be re-evaluated quarterly, with any significant change and as needed for the use of a seat-belt. Residents who require a seat-belt but are unable to self-release will be identified as using a restraint. Where seat-belts or restraints are necessary, physicians' orders will be obtained and a corresponding Care Plan reflecting the use of a restraint will be put in place and updated as required. Residents who require the use of a seat-belt or restraints will be re-evaluated for the least-restrictive device to maintain the highest practicable well-being and to treat medical symptoms. Seat-belt use will be reduced, eliminated, or changed to a least-restrictive device whenever possible. 4.) **Monitoring:** The Safety committee will review all new and changed orders for seat-belt and restraint use weekly.	5/11/08 **5/11/08**

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L 080	Continued From page 6 Employees #1 and 11. Both acknowledged that the resident's use of a seatbelt was not identified as a restraint. The record was reviewed on March 26, 2008. 3. Facility staff failed to identify a seatbelt as a restraint. Resident #8. Resident #8 was observed on March 26, 2008 at approximately12:10 AM in the day room across from the nursing station seated in a wheelchair and wearing a padded seat belt. An interview was conducted with the resident and Employees #1, 7 and 11 on March 26, 2008, at approximately 10:40 AM. The resident was asked if he/she was able to open the seat belt. The resident tugged at the seat belt, shook his/her head and stated, "No." Employee #7 responded; "The resident cannot open the seatbelt ". According to the resident's care plan dated January 25, 2008: "Approaches/ Interventions", included...Application of safety support devices... self-releasing seat belt with alarm ..." The same care plan was checked "No" for physical restraint. The resident's record lacked a physician's order for use of a restraint. A face-to-face interview was conducted on March 26, 2008, at approximately 2:30 PM with Employees #1and 11. Both acknowledged that the resident's use of a seatbelt was not identified as a restraint. The record was reviewed on March 26, 2008.	L 080		

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L 080	Continued From page 7 4. Facility staff failed to identify a seatbelt as a restraint. Resident A1. Resident A1 was first observed during initial tour of the facility on March 25, 2008 at approximately10:10 AM in own room seated in a wheelchair and wearing a padded seat belt. The resident was also observed on March 27, 2008 at approximately 8:30 AM in the special care unit's day room, seated in a wheelchair and wearing a padded seat belt. A face-to-face interview was conducted with the resident and Employees #1 and 10 on March 27, 2008 at approximately 8:30 AM. The resident was asked if he/she was able to open the seat belt. The resident stared at the surveyor. The employees responded; "He/she can not undo the seatbelt." A review of the physician's orders dated February 18, 2008 indicated: "May have 2 large side rail pads ...seatbelt ...to support safety and independence." A review of the "Resident Interdisciplinary Care Plan" dated February 18, 2008 checked "No" for physical restraint. A face-to-face interview was conducted on March 27, 2008, at approximately 8:35 AM with Employees #1 and 2. Both acknowledged that the resident's use of a seatbelt was not identified as a restraint. The record was reviewed on March 26, 2008.	L 080		
			L 083 Plan of Correction	
L 083	3216.4 Nursing Facilities Physical restraints shall not be applied unless:	L 083	1.) **Immediate Response:** Resident #8's seat-belt was re-assessed and discontinued by the physician secondary to residents not needing the device.	4/15/08

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L 083	Continued From page 8 (a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful; (b)The restraint has been ordered by a physician for a specified period of time; (c)The resident is released, exercised and toileted at least every two (2) hours, except when a resident's rest would be unnecessary disturbed. (d)The use of the restraint doe not result in a decline in the resident's physical, mental psychological or functional status; and (e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition. This Statute is not met as evidenced by: Based on observation, staff and resident interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to obtain a physician's order for the use of a restraint (seatbelt) for Resident #8. The findings include: Resident #8 was observed on March 26, 2008 at approximately 12:10 AM in the day room across from the nursing station seated in a wheelchair and wearing a padded seat belt. A face-to-face interview was conducted with the resident and Employee #7 on March 26, 2008, at approximately 10:40 AM. Employee #7 and the resident were asked if the resident was able to release the seat belt. The resident tugged at the seat belt, shook his/her head and stated, "No." Employee #7 added, "The resident is unable to	L 083	L 083 Plan of Correction, Continued **2.) Corrective Action:** All residents having a seat-belt will have their chart reviewed to check for physician orders for the seat-belt. Any resident with a seat-belt that does not have a physician order for the device will have a physician order obtained and put in place. **3.) Systemic Changes:** In-service staff on obtaining physician orders for seatbelts. 4.) **Monitoring:** The Charge Nurse or designee will perform random audits of medical records for residents using seat-belts for proper physician orders and report findings to the Quality Assurance Committee, quarterly.	4/18/08 4/25/08 5/11/08

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L 083	Continued From page 9 self-release the seatbelt, the seatbelt is for the resident's safety. " There was no evidence of a physician's order for the use of a seatbelt in the resident's record. A face-to-face interview was conducted on March 26, 2008 at approximately 2:30 PM with Employees #2. He/she acknowledged that the resident's record lacked evidence of the physician's order for the use of the seat belt. The record was reviewed on March 26, 2008.	L 083		
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 and staff interviews during the dietary tour, it was determined that facility staff failed to serve food under sanitary conditions as evidenced by soiled: grill, deep fryers, convection ovens, stove, a shelf in the cook's prep area and soiled floors in the walk-in refrigerator and freezer. These observations were observed in the presence of Employee #4 in the main kitchen on March 25, 2008 from 8:45 AM through 9:35 AM. The findings include: 1. The grill was observed soiled with accumulated grease in one (1) of one (1) grill observed. 2. The deep fryer was observed soiled with accumulated grease in one (1) of one (1) deep fryers observed.	L 099	**L 099 Plan of Correction** **1.) Immediate Response:** All equipment was immediately cleaned. Floors in walk-in refrigerator and walk-in freezer were immediately swept and mopped. 2.) **Corrective Action:** All equipment will be cleaned daily by cooking personnel. Floors will be thoroughly swept and mopped daily. **3.) Systemic Changes** In-service all cooking staff on how to properly clean equipment. Cleaning of equipment was added to the "Cook's Opening and Closing Checklist" which is signed upon cleaning completion. In-service for stocking personnel on how to properly clean floors. Cleaning of the floors was added to the "Stock Persons' Cleaning List"	3/25/08 3/26/08 4/10/08 4/10/08

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L 099	Continued From page 10 3. Two (2) of two (2) convection ovens were observed soiled on the exterior with grease. 4. The stove was observed soiled with grease in one (1) of one (1) stove observed. 5. The shelf under the cook's prep area was soiled in one (1) of one (1) shelf observed. 6. The floors of the walk-in refrigerator and freezer were observed soiled in one (1) of one (1) refrigerator and freezer observed. Employee #4 acknowledged the above findings at the time of the observations.	L 099	L 099 Plan of Correction, continued **4.) Monitoring**: Supervisor will monitor checklists for both equipment and floors weekly and retain records in office. Director of Dietary Services will report findings at Quality Assurance Committee quarterly.	5/11/08
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws, regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to ensure that an unauthorized employee was supervised while in the medication storage area The findings include: On Tuesday, March 25, 2008, between 11:45 AM and 12:00 PM, it was observed that an unauthorized employee (Employee #9) entered into the medication room to fax information on two occasions unsupervised. Employee #9 had access to the unlocked medication refrigerator and the interim box.	L 167	L 167 Plan of Correction 1.) **Immediate Response:** Unauthorized employees were prohibited from using the medication storage area without appropriate licensed staff. 2.) **Corrective Action:** A lock was installed on the refrigerator in the medication room and keys provided to appropriate licensed staff. Interim box will be exchanged for an enclosed, locked box. 3.) **Systemic Changes:** Staff were in-serviced as to proper medication storage and appropriate access. Nursing Supervisor or designee will audit proper locks in place on Walking Round Work Sheet. **4.) Monitoring:** The DON or designee designee will audit proper locking of medication, and the results will be reported to the Quality Assurance Committee, quarterly.	3/26/08 4/11/08 4/30/08 5/11/08 5/11/08

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 _____	03/27/2008

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 167	Continued From page 11 Employee #9 did not have a key, but was admitted by an authorized employee to the medication storage area to use the fax machine. During a face-to-face interview on March 26, 2008 at approximately 10:30 AM, Employee #2 stated that Employee #9 was allowed access into the medication storage room by nurses to use the fax machine.	L 167		
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to ensure that an expired medication was removed from the narcotic emergency box. The findings include: On Wednesday, March 26, 2008, at approximately 11:00 AM, during the inspection of the facility's medication storage area, the narcotic box was observed locked with an expiration date of June 6, 2008 on the exterior of the box. When opened, five (5) packages of ETH Oxydose 20mg/ml syringes were observed with an expiration date of October 2007. According to a receipt that the narcotic box, the pharmacy exchanged the box on February 16, 2008. There was no evidence that residents required the above sited narcotic from February 16, 2008	L 168	L 168 Plan of Correction **1.) Immediate Response**: The narcotic emergency box containing expired medication was exchanged immediately. 2.) **Corrective Action:** Pharmacy will exchange box at least monthly and by request of facility. 3.) **Systemic Changes:** The Pharmacist Pharmacist Consultant or designee will audit the emergency box monthly for medication about to expire and exchange medication prior to expiration date. 4.) **Monitoring:** The Pharmacist Consultant or designee will audit the emergency box for medication expiration dates and report results quarterly to the Quality Assurance Committee.	3/26/08 3/26/08 4/30/08 5/11/08

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 _____	03/27/2008

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 168	Continued From page 12 until March 26, 2008. Employee #3 acknowledged the medication in the emergency narcotic box was expired and telephoned the pharmacy to exchange the box, immediately.	L 168		
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 during the survey period, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: laundry detergent, rubbing alcohol, mouthwash and a shaving razor was observed in resident rooms. These observations were made on March 25, 2008 in the presence of Employees #2, 3, 5 and 6 from 9:45 AM through 11:55 AM. The findings include: 1. A container of laundry detergent and a bottle wintergreen rubbing alcohol 70% was observed in room 110. 2. Chlorhexidine 0.12% oral rinse was observed in a bathroom cabinet in room 127. 3. A shaving razor was observed on a shelf in the bathroom in room 134. Employees #2, 3, 5 and 6 acknowledged these findings at the time of the observations.	L 214	L 214 Plan of Correction 1.) **Immediate Response:** Staff immediately removed the identified items from the residents' rooms at the time of observation during the survey. 2.)**Corrective Action:** The Charge Nurse conducted a room-to-room inspection of all resident rooms to identify, remove, and/or secure hazardous items to ensure that resident rooms were a hazard free environment. 3.) **Systemic Changes** to prevent future occurrences: Nursing staff were in-serviced on maintaining a hazard-free environment. The Charge Nurse or designee will conduct daily rounds of resident rooms for hazardous items in order to maintain a hazard-free environment using the Daily Monitoring Log. **4.) Monitoring:** The Charge Nurse or designee will conduct random audits of all resident rooms to identify, remove or secure hazardous items. The results of the room to room inspections will be reported to the Quality Assurance Committee quarterly.	3/25/08 3/26/08 4/9/2008 5/11/08

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 _____	03/27/2008

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 419	Continued From page 13	L 419		
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 during the environmental tour, it was determined that facility staff failed to maintain a sanitary, orderly, and comfortable interior as evidenced by marred/scarred doors, damaged chair rails in residents' rooms and tiles in the shower rooms and soiled hair rollers in the beauty shop. These observations were made on March 25, 2008 between 9:45 AM through 11:55 AM in the presence of Employees #5 and 6 who acknowledged the findings at the time of the observations. The findings include: 1. Resident room doors were observed marred/scarred in the following areas: Rooms 106, 108, 109, 111, 118, and 120 in six (6) of 14 doors observed. 2. The following items were observed damaged: A. Chair rails in resident rooms: 103, 108, and 125 in three (3) of 14 rooms observed. B. Tiles in the shower rooms: Louise Terrace and Dickson Lane in two (2) of three (3) shower rooms observed. 3. Hair rollers were observed to be soiled with hair and a greasy substance in three (3) of three (3) roller drawers observed in the facility beauty shop.	L 419	L419 Plan of Correction 1.) **Immediate Response:** All doors observed as marred and scarred were touched up. Cracked tiles were repaired. Hair rollers identified as being soiled were immediately cleaned. Damaged chair rail is being repaired by a contractor. 2.) **Corrective Action:** All doors were inspected and will be touched up as required. All chair rails were inspected and damage to be repaired as necessary. All tiles were checked and repaired as necessary. All other hair rollers were checked for soil and cleaned. 3.) **Systemic Changes:** Condition of doors will be added to the monthly Room Inspection/Repair Checklist. Condition of chair rails will be added to the monthly Room Inspection/Repair Checklist. Condition of tiles will be added to the monthly Room Inspection/Repair Checklist. Hair rollers will be soaked and cleaned after each use and on a weekly basis. A check-off sheet will be instituted for weekly cleaning. 4.) **Monitoring:** The Engineering Dept will perform quarterly audits of the Room Inspection/ Repair Checklist and report findings to the Quality Assurance Committee. The Beauty Shop operator will perform quarterly audits of the hair roller checklist and report findings to the Quality Assurance Committee.	4/2/2008 3/23/08 5/11/08 **5/11/08** **5/11/08** 5/11/08