STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(xı)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
/=-	127		A. BUILDING	
		HFD02-0015	B. WING	07/23/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP GODE

LISNER LOUISE DICKSON HUR HOME

6425 WESTERN AVE NW WASHINGTON, DC 20016

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	EMENT OF DEFICIENCIES E PRECEDED BY FULL REG	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OBFICIENCY)	(X5) COMPLETE DATE
ኒ 000	19, 20 and 23, 2010. were based on obset	survey was conducted The following defici vations, staff and res I review. The total si	d on July encies ident	000	L051 (1) Notification of Changes 1. Immediate Response: Resident #1's physician was informed of resident's change in depressive symptoms and behaviors. Resident	7/23/10
ļ		ed on a census of 60 here were four (4)			evaluated. 2. Risk Identification: All resident records were reviewed for documentation of significant change in depressive symptoms and behaviors and	9/3/10
L 051	3210,4 Nursing Facili	ties	LC	051	subsequent physician notification for the last quarter.	
	A charge nurse shall following:	be responsible for the	e		3. Systemic Changes: Social Service and licensed nurses were in-serviced on physician notification when	9/3/10
_		ent visits to assess pl and implementing an vention;			observing and documenting significant change in resident's symptoms of depression and/or behaviors.	
j	(b)Reviewing medica accuracy in the transc and adherences to st		eleteness, l orders.		4. Monitoring: The Director of Social Services or her designee will perform a sample audit of records to assure the physician was notified of residents with significant	9/15/10
,	(c)Reviewing resident appropriate goals and them as needed;	(s' plans of care for approaches, and re	vising		change in depressive symptoms and/or behaviors. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	
]	(d)Delegating respon direct resident nursing	gibility to the nursing g care of specific rest	staff for dents;		L051 (2&3) Develop Comprehensive	
1	(e)Supervising and er employee on the unit		g		Care Plans 1. Immediate Response: Care Plan for resident #3 was completed	7/23//10
	(f)Keeping the Director her designee informe This Statute is not me				for the use of 9 or more medications. Care plan for resident #5 was completed for self administration.	
	Based on record reviethree (3) of 15 sample that the charge nurse	ed residents, it was d				

Health Regulation Administration VATORY DIRECTOR'S OR PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

HKN711

If continuetion sheet 1 of 19

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 8 WING HFD02-0015 07/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5425 WESTERN AVE NW LISNER LOUISE DICKSON HUR THOME WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (L051 2&3 Develop Comprehensive L 051 Continued From page 1 L 051 Care Plans Continued) the physician of Resident #1's depressive symptoms and behaviors for one (1) resident failed to initiate a care plan for the potential adverse 2. Risk Management: 9/15/10 interaction of the use of nine (9) or more An audit was completed of the care medications for one (1) resident and failed to initiate plans for all residents (a) using 9 or a care plan for self administration of eye drops for more medications (b) self administering one (1) resident. medication. Care plans in place. Residents # 1, 3 and 5. 3. Systemic Changes: 9/2/10 Staff were in-serviced on the need to The findings include: care plan for residents on 9 or residents 1. The charge nurse failed to notify the physician of who self medicate. Resident #1's depressive symptoms and behaviors 4. Monitorina: A random sample of 10% of care plans 9/15/10 Resident #1 was admitted to the facility on January will be reviewed by DON/designees 6, 2010. According to an admission Minimum Data monthly to check for presence of care Sets [MDS] completed January 15, 2010, his/her diagnoses included: Cerebrovascular accident, plans for 9 or more meds and self Emphysema, Glaucoma, Cervical Stenosis, Ataxia, administering medications. Findings BPH, and peripheral neuropathy. will be reported at QA meeting. A review of the resident's clinical records revealed a L052 (1)Allergy "Physician Order Record" signed and dated June 1. Immediate Response: 29, 2010 that directed the following: medications: 7/27/10 Family contacted for clarification of fish allergy. Order written that states "Calcarb 600/D oral tablet 600-400 mg -unit 1 resident is allergic to fish, not shellfish. tablet PO [By mouth] before dinner 4 PM special 9/1/10 2. Risk Identification: instructions ..." Residents with food allergies reviewed. "Colace oral capsule 100mg 1 capsule PO 1 time a There were no other residents affected. day 9 AM ..." 3. Systemic Changes: "Ensure plus oral liquid 1 cans PO 3 times a day 9/15/10 Staff will be in-serviced on correctly "Ensure plus oral liquid 1 cans PO 3 times a day documenting food allergies, and need ...for a total of 6cans per day ..." to have allergies stated on POS. "Flomax oral capsule extended release 24 hour 0.4 4. Monitoring: 9/15/10 mg 1 capsule PO 8:00 PM ..." DON/designees to audit records and "Lasix ...oral tablet 20mg 1 tablet PO 1 time a report findings to QA committee.

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L 051	day" "Loratadine oral tab "Multi-minerals oral "Potassium chloride release 10 meg 1 tal "Acetaminophen Ex PO PRN every 6 hos temperature >100 A further review of the	let 1 tablet PO" tablet 1 tablet PO" crys CR oral table explet" tra strength 500mg 2 urs-PRN for"	xtended tablets	L 051	L052 (2)Labs 1. Immediate Response: Labs obtained. 2. Risk Identification: Audit of physician's progress no completed for past 90 days. C Nurse/DON to review physician after visits to assure orders are entered. 3. Systemic Changes: Physician in-served on procedu flagging orders when written.	harge 's charts correctly	7/13/10 9/10/10 8/31/10
	symptoms of depressive feelings of hopelessive decline in socializationResident also can swearing at nurses processive feelings of the resident's clinical evidence that the physical feeling feeli	ress Notes: Resident demonstratesion including irritable ness and uselessness on in the past 6 week become verbally aggiroviding care and male comments. These tested" If record lacked docur ysician was notified of itent's presentations. The physician's progres record lacked docur ysician addressed Revisions and the physician addressed Revision in the past 6 weeks and the physician addressed Revision in the past 6 weeks and the past 6 weeks 6 week	e mood, s, and a ressive, sking behaviors mented f the ss notes in hented		4. Monitoring: Audit of 10% of physician charts or designee done monthly and at quarterly QA meeting. L052 (3)Physician Order 1. Immediate Response: Order for self administration of edrops obtained. 2. Risk Identification: Records checked to make sure resident self-administering medinas orders in place. 3. Systemic Changes: Licensed nursing staff in-service need to obtain physicians order self-administered medications.	reported eye that any ications	9/15/10 7/22/10 7/23/10 9/15/10
	A face-to-face intervi 2010, at approximate and 11. After reviewi record, they both ack clinical record lacked physician was notifie	ptoms and behaviors. ew was conducted or ely 9:00 AM with Emp ng the resident's clinic mowledged that the re- documented evidence of Resident #1's de viors. According to En	n July 23, loyees #1 cal esident's ce that the pressive		4. Monitoring: DON/designee will audit the me record for all residents who self administer medication to assure physician order in place. Resul audit will be reported at Quarter Meetings.	Its of	9/15/10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUI		(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SU COMPL	ETED		
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L 051	11 after the face-to-fithe resident was see prescribed medication was reviewed July 20. The findings include: 2. The Charge Nurse	face interview [July 23, 2010], eh by a psychiatrist and was on for depression. The record 3, 2010.		L 051	L052 (4) Free of Accident Hazards/Supervision/Devices 1. Immediate Response: Resident #12 was immediately assessed to insure that safety mand assisted devices were in play protect against accidents. Safe measures include extensive assof two (2) persons for bed mobil transfer. Assisted devices incluhalf side rails on a specially order bariatric bed. All assisted devices afety measures were found to place and in compliance with phorders and assessments.	neasures ace to ety istance ity and ude two ered ces and be in	7/20/10		
	Resident #3 for July on July 2, 2010, reve orders: Aricept, Asp Sinemet, Vitamin D3	2010, signed by the p aled the following me birin, Colace, Ensure, , Zyprexa, Ativan, and	hysician dication Miralax, I Tylenol.		2. Risk Identification: The DON's RN designee went re room to inspect each resident be its side rails to assure compliant physician orders.	ed and	7/22/10		
	July 14, 2010, reveal identified and no care appropriate goals and	plan that were last up ed that there was no eiplan developed with d approaches for pote tions involving the use ons.	problem ential		The DON's RN designee review resident's MDS to assure all res are provided with the necessary assistance for bed mobility and to 3. Systemic Changes:	idents transfer.	9/15/10		
	Employee #4 on July 11:30 AM. After rev acknowledged that the identified or a care planteraction of the use medications. The re 2010	ew was conducted wi 19, 2010 at approximities of the care plans be record lacked a pro- an for the potential ac- of nine (9) or more cord was reviewed or failed to initiate a care and approaches for	nately he/she bblem dverse n July 19,		Rehab manager in-serviced staf resident #12's safe bed mobility techniques, need for extensive assistance during transfer, and placement on bed pan. DON spwith licensed nurses about supe of C.N.A. staff to follow amount assistance requirement to minimpotential for accidents	poke rvision of	7/22/10		

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L 051	administration of me According to an "Inte signed March 23, 20 self administer eye d A review of the plan problem identification for self administration A face-to-face intervi Employee #4 on July 3:00 PM. He/she ack lacked a care plan fo drops. The record was	dication for Resident erim Order Form" date 10, it directed "reside rop with nurse super of care for Resident # n, objectives and appropriate of eye drops. The was conducted with the resident the resident the resident to a serviewed on July 2 are reviewed on 2 are reviewed on 3 a	ed and nt may vision." 45 lacked roaches ith nately ecord of eye	i. 051	(L052 (4) Free of Accident Hazards/Supervision/Devices Continued) Rehab manager in-serviced num on safe bed mobility techniques residents. DON in-serviced nursing staff or necessity of providing extensive assistance for bed mobility or tra indicated. 4. Monitoring: Rehab manager will report any of to side rail orders at safety comm weekly. DON/ or RN designee conduct an audit of all beds and rails with corresponding physicia	sing staff for all the ansfer as changes mittee will side	8/30/10 9/15/10
	resident to ensure the receives the following (a)Treatment, medical supplements and fluir rehabilitative nursing (b)Proper care to min contractures and to possistants in daily resident is comfortable evidenced by freedom	Treatment, medications, diet and nutritional pplements and fluids as prescribed, and nabilitative nursing care as needed; Proper care to minimize pressure ulcers and intractures and to promote the healing of ulcers: Assistants in daily personal grooming so that the sident is comfortable, clean, and neat as idenced by freedom from body odor, cleaned and nimed nails, and clean, neat and well-groomed			orders. The findings will be reported the Quarterly QA meetings. Each resident will be reviewed on admission quarterly and as needed for level of assistance to maximize safety. The findings will be reported at weekly safe committee meetings. RN managers perform random observations of reside care every shift, every month to monit appropriate level of assistance provide for bed mobility and transfer. The DON or her designee will review Manager audits and report findings at quarterly QA.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SU COMP	JRVEY LETED
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L 052 Continued From pag self-care and group a (f)Encouragement an	ectivities;		L 052	L091 Infection Control (1) Storage of Waste Boxes 1. Immediate Response: The two infectious waste boxes		7/23/10
(1)Get out of the bed or her own clothing; a	and dress or be dres			immediately removed from the 2. Risk Identification: All areas of storage of waste be checked, no other boxes were	oxes were	7/23/10
shall be clean and in (2)Use the dining roo		; and		on the floor. 3. Systemic Changes: All nursing, environmental and		9/15/10
(3)Participate in mea activities; with eating;				housekeeping staff in-serviced proper storage of medical wast 4. Monitoring: ADON or designee will perform audits and report findings at the	e boxes. random	9/15/10
(g)Prompt, unhurried requires or request he requires or request he (h)Prescribed adaptive him or her in eating independently; (i)Assistance, if needed including oral acre; and including oral acre; and j) Prompt response to for help. A. Based on record resthree (3) of 15 samples that facility staff to proclarify allergy to shell follow through with photone (1) resident an order for self administration.	elp with eating; e self-help devices to ed, with daily hygiene nd an activated call belieview and staff intervi ed residents, it was de vide sufficient nursin fish for one (1) reside tysician's plan to obtain d to obtain a physicia	ew for etermined g time to ent, to ein labs an's		Quarterly Quality Assurance M L091 Infection Control (2) Hand Washing during Me Serving 1. Immediate Response: Identified employee and in-servinfectious control practices and washing technique. Employee reassessed for hand washing be residents while providing care. Employee was observed to washands between residents care. 2. Risk Identification: All nursing staff was observed/reassessed on hand washing p while providing care. 3. Systemic Changes: Staff in-serviced on infectious of	eeting. riced on hand was netween sh her	7/20/10 7/24/10 7/24/10
resident. Residents: The findings include: 1. Facility staff failed t	# 2, 3, and 5.			practices and hand washing be residents while providing care.	tween	

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	Continued From page for Resident #2. History and Physical 2009, directed "Sesibley [October 25, 2 [hospital] H&P dated 2009, revealed "Aller The "Initial Nutritional November 8, 2009, refish* tuna [and] shell According to the "Nutritional November 23, 2009, Allergy/intolerance to OK)" According to the "Nutritional Shell and tuna Other "Quarterly Nutritional May 24, 2020 fish, tuna/shellfish Office to A face-to-face intervision of the "Resident #2 is not a eaten shrimp with no have baked and fried	dated and signed Note H&P (History and P2009) and [May 29, 20 October 25, 2009 and gies: Shellfish." Al Assessment "complete vealed "*no baked fish OK." Itritional Risk Care Planevealed "Other: of fish (tuna OK and state)." Icon Review " dated a fight of the complete	evember 3, Physical] 1009]. The 1d May 29, leted d, fried an" dated hellfish and ad or fried lith ated, e has s not to ng the		CROSS-REFERENCED TO THE APPRO	a a nd ng care ings at epare/	9/15/10 7/19/10 7/19/10 7/27/10
	record lacked eviden allergy to shellfish. To 19, 2010. 2 Facility staff failed to physician's plan to ob	ord both acknowledgo ce of clarifying reside he record was review to follow through with crain labs on Residen	ent's led July l		to Tuesday cleaning schedule a signed off by cleaning personne Supervisor on Duty will check cleanliness and monitor aforement checklists. Director or designer audit and report findings at Qua QA.	nd II. entioned e will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPL	
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L 052	and signed April 13, labs; check CBC (co. A review of the phys lacked evidence of a A review of the nurse documented evidence. A review of the labor that a CBC was order to the complete that a CBC was order to the case of the cBC was order to the cBC was order	2010 indicated remplete blood count) ician's orders for April (CBC order. 's notes for April 201 that a CBC was ordered or drawn. ew was conducted or by 10:30 AM with Empreyiew of the clinical receipt that the CBC was of that the CBC was of that the CBC was of the clinical receipt that the clinical receipt that the CBC was of the clinical receipt that the clinical r	0 lacked dered. vidence 1 July 23, ployees record prd lacked prdered. 1 #3. 1 July 23, ployees record prd lacked prdered. 1 #3. 1 July 23, ployees record prd lacked prdered. 2 July 23, ployees record prd lacked prdered. 3 July 24, ployees record prd lacked prdered. 4 #3.	L 052	L099 Food Procure, Store/ Preserve – Sanitary (2) Rinse water in 3 compartmed was not holding water 1. Immediate Response: Maintenance repaired mechanic stopper. 2. Risk Management: All stoppers on sinks throughout kitchen were checked. 3. Systemic Changes: Dietary Staff was in-serviced on importance or reporting malfunction equipment to a supervisor immed. Monitoring: Dietary Personnel will check stoted daily and report any malfunction immediately. Work orders will be submitted to Maintenance. Direct report work orders submitted at Quarterly QA. L099 Food Procure, Store/ Preserve - Sanitary (3) Temperature of pot wash soon to make the management: Sink water temperatures were charted the water temperatures were charted to the submitted and refilled water temperatures were charted to the sub	the tioning diately. ppers ector will pare/ ink 104 with 110 hecked	7/19/10 7/19/10 7/27/10 9/15/10 7/19/10 7/19/10 7/27/10
	[MAR] for July 2010,	the resident					

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L 052	received Patanol Op 5 PM every day. A face-to-face interving Resident #5. He/sheye drops in my eye: A face-to-face interving 2010 at approximate and Employee #17.	hthalmic Solution at 9 iew was conducted we stated, "Yes, I put now, and it is for dry eye iew was conducted or ly 3:00 PM with Empl Both stated, "[Resigner eye drops." The	ith ny own s." n July 20, loyees # 4 dent #5]	L 052	(L099 Food Procure, Store/ Procure, Store/ Procure - Sanitary (3) Temperature of pot wash sometimed) 4. Monitoring: Temperature log implemented attemperature will be taken and rethree times per day. Director an supervisor on duty will monitor. Director will report findings at Quantum QA. L099 Food Procure, Store/ Preserved.	and ecorded d uarterly	9/15/10
	review for one (1) of determined that facili sufficient nursing tim measures and assist from accidents for or a fall with injury while Resident #12. The findings include: According to the ann Data Sets [MDS] dat 3, 2010 respectively, included Diabetes, H Osteoporosis, Allergi and Cancer. Section revealed the resident of two (2) persons for rails were coded for a mechanical lift was reresident had limited rof voluntary movemeside. Section K, Nutri	ation, interview and re 15 sampled residents ty staff failed to provide to implement safety ance devices to ensure (1) Resident who se being turned in bed ual and quarterly Mined February 1, 2010 a Section I, Disease Dypertension, Arthritis, es, Cardiovascular Disease To the arm and transferd mobility and transferd mobility and transferd mobility and transferd for transfer. The ange of motion and part of the arm and legitional Status revealed the was 60 inches and the same and the	imum and May iagnoses isease, ing ssistance nsfer. Bed efer and a the eartial loss on one		Serve – Sanitary (4) Rug in front of freezer stair soiled 1. Immediate Response: Rug was thrown away. 2. Risk Management: All floors were checked throughout kitchen. 3. Systemic Changes: Rubber safety mat was purchase replace rug. 4. Monitoring: Rubber safety mat was added to Tuesday heavy cleaning list to crips and soil. Director will report finding at Quarterly QA.	out out othe check for	7/19/10 7/19/10 7/28/10 9/15/10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(X2) MULTII A. BUILOING B. WING		(X3) DATE SURVEY COMPLETED	
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L 052	225 pounds. Physician's orders sthe use of two ½ sid According to the "Nutfor May and June 20 Requires total transf Resident #12 sustaine videnced by the fol June 19, 2010, 4:30 out of left side of bed [resident] on the bed prone [face down] or bleeding, skin tear (a obvious injury. Neupacks applied to injure sident's head injury, to bed by staff, head left brow/forehead (tilet) left brow is super " June 19, 2010, 3:00 headacheleft eye order to transfer to [face of two 1/2] and 1/2 to	igned June 2, 2010 per rails for safe bed mursing Monthly Summaro, "Ambulation/Refer by staff 2 (two) per ned a fall with injury a lowing nurse's notes: AM, "At 2:50 AM resident obsein, the floor. Hematomatic left eyebrow. No circochecks commencemed area. [Staff] reprailer as [resident] felling other obvious injurised area. [Staff] reprailer as [resident] felling other obvious injurised area. [Staff] reprailer as [resident] felling other obvious injurised area. [Staff] reprailer as [resident] felling other obvious injurised area. [Staff] reprailer as [resident] felling other obvious injurised area. [Staff] reprailer as [resident] felling supported. Ice pack in the supported of	obility. ary" report ehab: sons." s dent fell ng to put rved lying as with other d. Ice orted that I. Iry. Lifted applied to kin tear 2 cm wide.	L 052	L099 Food Procure, Store/ F Serve - Sanitary (5) Apple juice and Pineapple/carrot/raisin salar degrees 1. Immediate Response: Juice and pineapple/carrot/raisin were thrown away. 2. Risk Management: Cold temperatures were check other trays. 3. Systemic Changes: Food Service staff was in-serv proper point of service temper Juices will be poured from Vita Dispenser immediately after ea and put into refrigerator to chill the next meal. All cold items chilled and served in an insula Alladin cup. 4. Monitoring: Test Tray temperatures will be every week by Catering Assoc Director will report any finding Quarterly QA. L099 Food Procure, Store/ P Serve - Sanitary	sin salad 7/19/1 sin salad 7/19/1 sed on altires. ality Juice ach meal before will be ted 9/15/1 taken iate. at	10
	summary dated June sustained the followi forehead laceration, and multiple contusion	ergency department de 19, 2010, the resideing injuries: closed herfacial contusion, cervons.	nt ad injury, ical strain		 (6) Staff was not specific on properly test or verify the concentration of the sanitizing solution for the dishwasher. 1. Immediate Response: Test strips were replaced with Test Paper that was easier to it color. 	ng Chlorine 7/19/1	0

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUI HFD02-0015		(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SURV COMPLET	red
NAME OF DE	OWNER OR CURRUER		STREET ADD	RESS CITY ST	ATE, ZIP CODE	011201	20.0
	OUISE DICKSON HUR	тноме	5425 WES	TERN AVE I	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES (3E PRECEDED BY FULL REC INTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD 8E	(X5) COMPLETE DATE
L 052	Resident #12 on Juli 3:45 PM. Resident s weeks ago. The nurs bedpan, when I turn me to hold onto. So, fell and hit my head. get another pair. I has	ge 10 y, 20, 2010 at approxing tated, "I fell out of the se was trying to put med [an] there was no self tried grabbing the work and a cut over my eye as and my head was hu	bed 2-3 te on the side rail for rall, and I to I had to and I was	L 052	(L099 Food Procure, Store/ P Serve - Sanitary (6) Staff was not specific on h properly test or verify the concentration of the sanitizin solution for the dishwasher. Continued)	now to	7/19/10
	Employee #1 on July 11:30 AM. He/she somplaining about the had one long side ral assisted onto the beautiful assisted on the beautif	•	nately d been cement hile being		Ecolab was called immediately PPM. PPM was correct. 3. Systemic Changes: All Dietary Personnel were in-secon how to use new Chlorine Test. 4. Monitoring:	to check erviced st Paper.	7/27/10 9/15/10
	prescribed ½ side ra extensive assistance mobility and transfer quarterly MDS comp The record lacked ev were implemented in	ical record, Resident in its for bed mobility and of two (2) persons for in accordance with the letted May 3, 2010. If dence that two (2) significance with physical end with bed mobility in accordance with physident with bed mobility.	d or bed le de rails sician ' s		Supervisor will continue to moni Director will report any findings Quarterly QA. L099 Food Procure, Store/ Pro Serve - Sanitary (7) Staff unable to state the ex- temperature of the wash solu	at epare/ xpected	
	Additionally, there was utilized the number of resident with bed more accident safety from accidents.	as no evidence that st in individuals to assist bility. implement safety me ses to ensure the resic in The resident sustain	aff the asures dent's ned a fall		the 3 compartment sink 1. Immediate Response: Dietary Director informed the Di Personnel that the correct tempo is 110 degrees or higher. Sink we emptied and refilled. 2. Risk Management: Water was emptied from sink ar refilled with water and temperations.	etary erature vas	7/19/10 7/19/10
L 091	3217.6 Nursing Facil	ities		L 091	tested with thermometer.		

The Infection Control Committee shall ensure that infection control policies and procedures are

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU HFD02-0015		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION		PLETED
	ROVIDER OR SUPPLIER		5425 WES	PRESS, CITY, ST STERN AVE STON, DC 2			23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	A EMENT OF DEFICIENCIES GE PRECEDED BY FULL REI NIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETÉ DATE
L 091	services, including h	all ensure that enviro ousekeeping, pest co pply are in accordanc chapter.	ntrol,	L 091	(L099 Food Procure, Sto Serve - Sanitary (7) Staff unable to state temperature of the wash the 3 compartment sink	the expected	
	A. Based on observa environmental tours 23, 2010, it was dete provide a safe, sanita environment as evide	ations made during of the facility on July t rmined that the facilit	y falled to r storage		will be taken three times precorded on log.	emperature	7/27/10 9/15/10
		fectious waste boxes rectly on the floor in ti			4. Monitoring: Supervisor will check log of will report findings at Quark L161 Expired Drugs 1. Immediate Response:	rterly QA.	9/10/10
		were made in the pres 9 who acknowledged urvey.			Identified expired and disc medications and removed medication carts.	continued	7/23/10
	(2) of 15 sampled res supplemental resider facility staff failed to v	nts, it was determined wash hands after dire	that ct		Risk Management: Medications were checked areas to make sure there expired or discontinued makes.	were no	9/15/10
	resident contact durin 4, A1, A2, A3, and A4 The findings include:		ems #3,		 Systemic Changes: Education to nursing staff about necessity of removing discharge or expiration. 		9/15/10
	Residents #3, 4, A1, during dinner in the s July 19, 2010 at appr Resident #3 was obshimself/herself.	pecial care unit's day eximately 4:05 PM	room on		4. Monitoring: Supervisor to monitor carts expired/discharge medicat Findings will be reported b designee at QA committee	tions. by DON or	9/15/10
	Resident # 4 was obs	served seated on by a	table				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SUI COMPL		
		HFD02-0015		B. WING_		07/0	0(0040	
		HFD02-0015	expert 400	DCCC CUDY OF	THE TIP COPE	07/2	3/2010	
NAME OF PE	ROVIDER OR SUPPLIER				ATE, ZIP CODE			
LISNER !	LOUISE DICKSON HUR	тноме		TERN AVE TON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NITIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO 8E	(X5) COMPLETE DATE	
L 091	by himself/herself.	3, and A4 were obser	ved	L 091	L206 Documentation of Injury 1. Immediate Response: Corrected incident report sent to authorities. 2. Risk Identification:		9/2/10 9/4/10	
c	their dinner trays. Aft out some of the trays Residents #4, A1, A2	observed serving the ter he/she completed s, he/she moved betw 2, A3, and A4 and ass g up their dinner trays	passing een sisted the		Other incident reports involving were reviewed for correct documentation of injury and pro transmission. 3. Systemic Changes:		9/15/10	
	He/she stood next to Resident #4 and fed him/her for approximately five:(5) minutes. Returned Resident # 4's tray to the cart, outside the dayroom. Employee #4 returned to the dayroom with Resident A1's dinner tray. Resident A1 presented with difficulty keeping food on his/her fork. Employee # 10 stood by Resident A1 and fed him/her. Resident A2 expressed frustration opening his/her			Licensed nursing staff in-service proper documentation and trans of incident reports. 4. Monitoring:	smission	9/15/10		
			vith ployee # g his/her		A random audit will be done mo safety committee meetings. Th findings will be reported at the QA meetings.	ne l		
	drinking straw. Emp assist Resident A2.	oloyee #10 left Reside	ent A1 to		L410 Housekeeping and Main Services (1) Privacy Curtains Stained	tenance		
	Employee #10 touched the end point of the straw that Resident A2 put in his/her mouth with his/her unwashed hands. Employee #10 left Resident A2 to assist Resident A3 back to the dayroom from the hallway. He/she gave Resident A3 a cup of ice cream and returned to Resident A1.			A2 put in his/her mouth with his/her		Immediate Response: Unable to remove ink stains from privacy curtains in room 105 and 123 therefore privacy curtains were		7/20/10
ļ			He/she		replaced. 2. Risk Identification: All other privacy curtains were in	rspected	7/20/10	
					and replaced if indicated. 3. Systemic Changes:		9/1/10	
	room. He/she went to from the nurses 'stati dinner tray from the f	ed Resident #4 to his the community kitch on to collect Resident lood warmer. He/she in Resident #3's dinner to the resident	en across l t #3's returned		Staff in-serviced on checking pri curtains for cleanliness and lack stains. 4. Monitoring: Privacy curtains will be inspecte monthly basis and findings will b reported at Quarterly QA meeting	of d on a be	9/15/10	

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER. A. BUILDING B. WING_ HFD02-0015 07/23/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5425 WESTERN AVE NW LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L410 Housekeeping and Maintenance L 091 L 091 Continued From page 13 Services and fed him/her. (2) Ceiling Vent Dripping Water Throughout the period of the above observations, 1. Immediate Response: 7/20/10 Employee #10 failed to wash his/her hands after Vent closed and water dripping ceased. direct residents contact during dinner meal on July 2. Risk Identification: 7/20/10 2010 at approximately 4:05 PM. All other ceiling vents on unit checked for water dripping and fixed if indicated. He/she failed to wash his/her hands between 3. Systemic Changes: residents 'care: He/she provided care for multiple Staff in-serviced to check ceiling vents 9/3/10 residents at the same time without washing his/her for dripping water during scheduled hands. room checks. 4. Monitoring: A face-to-face interview conducted at with Engineering will monitor ceiling vents for 9/15/10 Employee #10 on July 23, 2010 at approximately dripping water on scheduled PM room 1:20 PM. He/she acknowledged the above checks and will report findings at observation. He/she said, "I was trying to hurry-up Quarterly QA Meeting. with the feeding. All the residents required my help as you can see. I know better than that. " L410 Housekeeping and Maintenance Services L 099 L 099 3219.1 Nursing Facilities (3) Damaged AC Cover & Grill in **Room 134** Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and 1. Immediate Response: served in accordance with the requirements set Cover and grill removed, repaired and 8/25/10 forth in Title 23, Subtitle B, D. C. Municipal replaced. Regulations (DCMR), and Chapter 24 through 40. 2. Risk Identification: 8/25/10 This Statute is not met as evidenced by: All other grills and covers checked on Based on observations made during tours of the unit and repaired if necessary. dietary services on July 19 and 20, 2010, it was 3. Systemic Changes: determined that the facility failed to prepare and Engineering staff was in-serviced on 9/3/10 serve food under sanitary conditions as evidenced need to check condition of air by: one (1) of one (1) soiled toaster oven, one (1) of conditioner covers and grills. one (1) soiled convection oven, and one (1) of one 4. Monitoring: (1) soiled gas stove; out of range temperatures on Air conditioner covers and grills will be the test tray; a leak in the three-compartment sink, a 9/15/10 monitored by engineering staff during stained and soiled rug in front of the freezer and on scheduled PM room checks and finding one (1) of one (1) occasion a staff member failed will be reported at quarterly QA to correctly state the expected temperature of the Meetings. washing solution

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPL	
		HFD02-0015		B. WING		07/2	3/2010
	ROVIDER OR SUPPLIER LOUISE DICKSON HUR	THOME	5425 WES	RESS, CITY, ST TERN AVE I TON, DC 2	NW		
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L 099	in the three-compart (2) occasions staff mand verify the conce solution in the dishw	ment sink and on two lembers failed to com ntration of the sanitizing shing machine.	rectly test ing	L 099	L426 Maintains Effective Pest Program 1. Immediate Response: Room was cleaned and the percompany was called. 2. Risk Identification: Pest Control Company came of checked all areas and treated appropriately. 3. Systemic Changes: Staff educated as to how to present the program of the control company.	st control out and	7/20/10 7/20/10 9/15/10
	2. Test tray temper pineapple/carrots/rai degrees Fahrenheit (limit of forty-one deg 3. The temperature three-compartment swas far below the ex of 110 degrees F.	atures for apple juice sins salad were forty- (F) and exceeded allo rees F. of the wash solution ink was 104 degrees pected minimum tem	eight owable in the F and		3. Systemic Changes: Staff educated as to how to prevent fruit flies and other insects and proper reporting of insect sightings so that areas can be treated. 4. Monitoring: Pest control rounds will be conducted 3X monthly with action items addressed and results will be reported at Quarterly QA meetings.		9/15/10
	 5. The rug in front of soiled. 6. One (1) of one (state the expected te solution for the three two (2) of two (properly test and ver 	ink was constantly le se water solution effi of the freezer was sta 1) staff member was imperature of the was compartment sink ar 2) staff members fall ify the concentration of the dishwashing ma	unable to shing ad to of the chine.				

Health Negulation Administrati	1011				
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	HFD02-0015		B. WING	07/23/2010	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STATE, ZIP CODE		
LISNER LOUISE DICKSON HURTHOME		5425 WESTERN AVE NW			

-1011611	OUISE DICKSON HURTHOME WASHING	TON, DC 2	0015	
(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 161	Continued From page 15	L 161		
L 161	3227.12 Nursing Facilities	L 161	1	
	Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed to remove four (4) expired medications from two (2) of three (3) medication carts observed.			
	The findings include:			
	The facility staff failed to remove expired medications and discontinued medications from the medication carts.			
	On July 19, 2010, between 10:00 AM and 4:30 PM, during the inspection of the medication storage areas, expired and drugs were observed in the medication carts as follows:			
	Expired Medications: 1 Bottle of Guaituss 100 gm /5ml syrup, expired June 22, 2010 1 Bottle of Diabetic Tussin syrup, expired June 30, 2010 1 Bottle of Tussin CF 100gm/ 5ml syrup, expired July 11, 2010 1 Bottle of Nitro stat 40 mg capsule expired July 4,			
	The above findings for the medication carts were acknowledged by Employee #4 on July 19, 2010, at the same time of the observation.			
L 206	3232.4 Nursing Facilities	L 206		
	Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of			

Health Regulation Administration STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	HFD02-0015	B. WING	07/23/2010
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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 206	result in harm to a resilicensing agency with occurrence. This Statute is not me 22DCMR 3232.4 Bas interview for one (1) r facility staff failed to in resident who fell sust #12. The findings include: 22 DCMR 3232.4 stip be documented in the reported to the licens (48) hours of occurrence accidents that result in the state of	at incidents and accidesident shall be reported in eight (8) hours of as evidenced by: ed on record review are asident, it was determinform State Agency the ained an injury. Resident	of to the staff ned that at a dent shall dent and hall be	L 206		
	facility on June 19, 20 to the floor while the 0 Assistant] was trying the bed pain. " The nurse 's note da documented, " At 2: side of her bed while	ent report completed by 10, "Resident fell ou DNA [Certified Nursing to put [his/her] (resider led June 19, 2010 at 4 50AM resident fell out [Certified Nursing Assion the bedpan. Resident	at of bed at) on 30AM, of left stant]			
	observed lying prone bleeding, skin tear [at obvious injury. Neur packs applied to injur resident's head hit wa head injury, no other staff, head supported	on the floor. Hematom left eyebrow. No oth ochecks commenced. ed area. CNA reporte alker as she fell. Besic obvious injury. Lifted to lee pack applied to le 20 minutes. Skin tea	as with ler lce d that des b bed by		·	

(X3) DATE SURVEY

Health Regulation Administration

STATEMENT OF DEFICIENCIES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NU	-	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE S COMI	URVEY PLETED
		HFD02-0015		B. WING		07/	23/2010
	ROVIDER OR SUPPLIËR LOUISE DICKSON HUR	тноме	5425 WES	RESS, CITY, STA TERN AVE N TON, DC 20	W		
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L 410	4cm [long] x 0.2 cm. The record lacked evergarding the head in incident report. A face-to-face interved Employee #2 conduct approximately 10:00 injury was not documed the record was revied 3256.1 Nursing Facility shall promaintenance service exterior and the intersanitary, orderly, commanner. This Statute is not mean as evidenced by soiled on observation environmental tour owas determined that effective maintenance as evidenced by soiled of 13 rooms surveyed ceiling vent on one (faulty call bell cord in and a damaged air cone(1) of 13 rooms service. The findings include: 1. Privacy curtains rooms # 105 and # 1. 2. Water was dripping in the service of t	wide. " vidence that the incident of the facility on July 23 at AM. Both acknowledged on the incident of the facility in a service and attractive tas evidenced by: ns made during an fithe facility on July 2 the facility failed to preservice in resident of three (3) units stated privacy curtains in do, water was dripping to three (3) units stated on the cover and	and ain the safe, we 0, 2010, it rovide ts rooms two (2) I from a curveyed, a surveyed grill in	L 206			
	special care dayroom						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU HFD02-0015		(X2) MULTIPLE A. BUILDING B. WING	ECONSTRUCTION		URVEY PLETED 23/2010
	ROVIDER OR SUPPLIER LOUISE DICKSON HU		5425 WES	RESS, CITY, STATE TERN AVE NV TON, DC 200	1	VIII	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 410	3. The cover and system in room #13 These findings were 4 and # 9 who were at the time of obser	grill to the air condition 4 were damaged. acknowledged by Er present vation.		L 410			
L 426	that the premises at and shall be kept climight provide harboth This Statute is not in Based on observation tours of the facility of determined that the effective pest contropresence of crawling different areas in the The findings include Flying insects were environmental service.	e constructed and main refree from insects and and free from debut and free from debut as evidenced by: ons made during environ July 20 and 23, 201 facility failed to maintabliprogram as evidenced and flying pests observed in room #1 ces area.	od rodents, ons that odents. ronmental 0, it was ain an ed by the erved in	L 426			

PRINTED: 08/24/2010 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0015 07/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5425 WESTERN AVE NW LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) TAG L 000 Initial Comments L 000 L051 (1) Notification of Changes 1. Immediate Response: 7/23/10 An annual licensure survey was conducted on July Resident #1's physician was informed of 19, 20 and 23, 2010. The following deficiencies resident's change in depressive were based on observations, staff and resident symptoms and behaviors. Resident interviews and record review. The total sample evaluated. was 15 residents based on a census of 60 on the 2. Risk Identification: 9/3/10 first day of survey. There were four (4) All resident records were reviewed for supplemental records. documentation of significant change in depressive symptoms and behaviors and L 051 3210.4 Nursing Facilities L 051 subsequent physician notification for the last quarter. 3. Systemic Changes: A charge nurse shall be responsible for the 9/3/10 Social Service and licensed nurses were following: in-serviced on physician notification when observing and documenting significant (a)Making daily resident visits to assess physical change in resident's symptoms of and emotional status and implementing any depression and/or behaviors. required nursing intervention: 4. Monitoring: 9/15/10 The Director of Social Services or her (b)Reviewing medication records for completeness, designee will perform a sample audit of accuracy in the transcription of physician orders, records to assure the physician was and adherences to stop-order policies; notified of residents with significant change in depressive symptoms and/or (c)Reviewing residents' plans of care for behaviors. Findings of this audit will be appropriate goals and approaches, and revising presented at the Quarterly Quality them as needed: Assurance Meeting. (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;

Health Regulation Administration

TITLE

1. Immediate Response:

for self administration.

L051 (2&3) Develop Comprehensive

Care Plan for resident #3 was completed

Care plan for resident #5 was completed

for the use of 9 or more medications.

Care Plans

(X6) DATE

7/23//10

that the charge nurse failed to notify

This Statute is not met as evidenced by:

(e)Supervising and evaluating each nursing

(f)Keeping the Director of Nursing Services or his or

her designee informed about the status of residents.

Based on record review and staff interviews for three (3) of 15 sampled residents, it was determined

employee on the unit, and

NAME OF PROVIDER OR SUPPLIER LISNER LOUISE DICKSON HURTHOME STREET ADDRESS, CITY, STATE, ZIP CODE 5425 WESTERN AVE NW WASHINGTON, DC 20015 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) L 051 Continued From page 1 the physician of Resident #1's depressive symptoms and behaviors for one (1) resident failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for one (1) resident and failed to initiate a care plan for self administration of eye drops for one (1) resident. Residents # 1, 3 and 5. The findings include: 1. The charge nurse failed to notify the physician of Resident #1's depressive symptoms and behaviors STREET ADDRESS, CITY, STATE, ZIP CODE 5425 WESTERN AVE NW WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) L 051 (L051 2&3 Develop Comprehensive Care Plans Continued) 2. Risk Management: An audit was completed of the care plans for all residents (a) using 9 or more medications. Care plans in place. 3. Systemic Changes: Staff were in-serviced on the need to care plan for residents on 9 or residents who self medicate. 4. Monitoring: A random sample of 10% of care plans		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLI		(X2) MULTI A. BUILDIN 8 WING_	PLE CONSTRUCTION		LETED
LISMER LOUISE DICKSON HURTHOME SAZE WESTERN AVE NW WASHINGTON, DC 20015		_	HFD02-0015				07/2	23/2010
L 051 Continued From page 1 the physician of Resident #1's depressive symptoms and behaviors for one (1) resident a care plan for the potential adverse interaction of the use of nine (9) or more medications for one (1) resident and failed to initiate a care plan for self administration of eye drops for one (1) resident. Resident #1's depressive symptoms and behaviors for one (1) resident and failed to initiate a care plan for self administration of eye drops for one (1) resident. Resident #1's and 5. The findings include: 1. The charge nurse failed to notify the physician of Resident #1's depressive symptoms and behaviors Resident #1's depressi			RTHOME	5425 WES	TERN AVE	NW		
the physician of Resident #1's depressive symptoms and behaviors for one (1) resident adverse interaction of the use of nine (9) or more medications for one (1) resident and failed to initiate a care plan for self administration of eye drops for one (1) resident. Residents #1, 3 and 5. The findings include: 1. The charge nurse failed to notify the physician of Resident #1's depressive symptoms and behaviors Resident #1 was admitted to the facility on January 6, 2010. According to an admission Minimum Data Sets [MDS] completed January 15, 2010, his/ber diagnoses included: Cerebrovascular accident, Emphysema, Glaucoma, Cervical Stenosis, Ataxia, BPH, and peripheral neuropathy. A review of the resident's clinical records revealed a "Physician Order Record" signed and dated June 29, 2010 that directed the following: medications: "Calcarb 600/D oral tablet 600-400 mg -unit 1 tablet PO (By mouth) before dinner 4 PM special instructions" "Colace oral capsule 100mg 1 capsule PO 1 time a day 9 AM" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE DATE
symptoms and behaviors for one (1) resident failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for one (1) resident. Residents # 1, 3 and 5. The findings include: 1. The charge nurse failed to notify the physician of Resident #1's depressive symptoms and behaviors Resident #1 was admitted to the facility on January 6, 2010. According to an admission Minimum Data Sets [MDS] completed January 15, 2010, his/her diagnoses included: Cerebrovascular accident. Emphysema, Glaucoma, Cervical Stenosis, Ataxia, BPH, and peripheral neuropathy. A review of the resident's clinical records revealed a "Physician Order Record" signed and dated June 29, 2010 that directed the following: medications: "Calcarb 600/D oral tablet 600-400 mg -unit 1 tablet PO (By mouth) before dinner 4 PM special instructions" "Colace oral capsule 100mg 1 capsule PO 1 time a day 9 AM" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a dayfor a total of 6cans per day" "Ensure a care plan for the potential adverse interaction of the potential adverse interaction of the potential adverse interaction of the use of the care plans for all residents (a) using 9 or more medications (b) self administering medications. Care plans who self medicate. 4. Monitoring: A random sample of 10% of care plans will be reviewed by DON/designees monthly to check for presence of care plans for 9 or more medications. Care plans two self medicate. 4. Monitoring: A random sample of 10% of care plans will be reviewed by DON/designees monthly to check for presence of care plans for 9 or more medications. Care plans two self medicate. 4. Monitoring: A random sample of 10% of care plans will be reviewed by DON/designees monthly to check for presence of care plans for 9 or more medications. 5. Risk lemicate. 4. Monitoring: A random sample of 10% of care plans will be reviewed by DON/designees. 5. Lists (all residents. 5. Risk lemicate.	L 051	Continued From pag	ge 1		L 051	1 '	hensive	
"Physician Order Record" signed and dated June 29, 2010 that directed the following: medications: "Calcarb 600/D oral tablet 600-400 mg -unit 1 tablet PO [By mouth] before dinner 4 PM special instructions" "Colace oral capsule 100mg 1 capsule PO 1 time a day 9 AM" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral liquid 1 cans PO 3 times a day" "Ensure plus oral capsule extended release 24 hour 0.4 mg 1 capsule PO 8:00 PM" "Lasixoral tablet 20mg 1 tablet PO 1 time a		symptoms and behat to initiate a care plar interaction of the use medications for one a care plan for self at one (1) resident. Residents # 1, 3 and The findings include. 1. The charge nurse Resident #1's depresent	ryiors for one (1) reson for the potential and of nine (9) or more (1) resident and failed ministration of eye of 5. failed to notify the passive symptoms and mission Mined January 15, 2010 Cerebrovascular accoma, Cervical Stendinguropathy.	sident failed dverse e led to initiate e drops for physician of d behaviors on January imum Data 0, his/her ecident, esis, Ataxia,		2. Risk Management: An audit was completed of the plans for all residents (a) using more medications (b) self adm medication. Care plans in pla 3. Systemic Changes: Staff were in-serviced on the neare plan for residents on 9 or who self medicate. 4. Monitoring: A random sample of 10% of cawill be reviewed by DON/design monthly to check for presence plans for 9 or more meds and administering medications. Fire	9 or inistering ce. eed to residents are plans nees of care self andings	9/15/10
		"Physician Order Re- 29, 2010 that directe "Calcarb 600/D oral tablet PO [By mouth] instructions" "Colace oral capsuld day 9 AM" "Ensure plus oral liq " "Ensure plus oral liq " "Ensure plus oral liq for a total of 6cans "Flomax oral capsul mg 1 capsule PO 8:0	cord" signed and da cl the following: me lablet 600-400 mg before dinner 4 PA e 100mg 1 capsule luid 1 cans PO 3 tin per day" e extended release 10 PM"	ated June dications: -unit 1 M special PO 1 time a nes a day nes a day 24 hour 0.4		1. Immediate Response: Family contacted for clarification allergy. Order written that statement is allergic to fish, not soon allergies resident is allergic to fish, not soon allergies residents with food allergies residents with food allergies residents. 3. Systemic Changes: Staff will be in-serviced on correduction allergies, and to have allergies stated on POS 4. Monitoring: DON/designees to audit record	es hellfish. eviewed. affected. ectly d need	9/1/10 9/15/10

Health Regulation Administration STATE FORM

07/23/2010

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

HFD02-0015

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PE	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
LISNER	LOUISE DICKSON HURTHOME	5425 WESTERN AVE WASHINGTON, DC 2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	ULATORY 1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	day" "Loratadine oral tablet 1 tablet PO"	L 051	L052 (2)Labs 1. Immediate Response: Labs obtained. 2. Risk Identification:	7/13/10
	"Multi-minerals oral tablet 1 tablet PO" "Potassium chloride crys CR oral table ex release 10 meg 1 tablet" "Acetaminophen Extra strength 500mg 2 t PO PRN every 6 hours-PRN for temperature >100"	xtended	Audit of physician's progress notes completed for past 90 days. Charge Nurse/DON to review physician's charts after visits to assure orders are correctly entered. 3. Systemic Changes: Physician in-served on procedure of flagging orders when written. 4. Monitoring: Audit of 10% of physician charts by DON or designee done monthly and reported at quarterly QA meeting.	9/10/10
	A further review of the resident's clinical recrevealed the following:	cord		8/31/10 9/15/10
	Social Service Progress Notes: "April 20, 2010 "Resident demonstrates some symptoms of depression including irritable mood, feelings of hopelessness and uselessness, and a	mood,		
	decline in socialization in the past 6 weekResident also can become verbally aggre swearing at nurses providing care and mak sexually inappropriate comments. These beare also easily redirected"	ting	L052 (3)Physician Order 1. Immediate Response: Order for self administration of eye drops obtained.	7/22/10
	The resident's clinical record lacked docume vidence that the physician was notified of aforementioned resident's presentations.		Risk Identification: Records checked to make sure that any resident self-administering medications has orders in place. Systemic Changes:	7/23/10
	A further review of the physician's progress notes in the resident's clinical record lacked documented evidence that the physician addressed Resident #1's depressive symptoms and behaviors.	ented	Licensed nursing staff in-serviced on need to obtain physicians order for all self-administered medications. 4. Monitoring:	9/15/10
	A face-to-face interview was conducted on 2010, at approximately 9:00 AM with Employed and 11. After reviewing the resident's clinical record, they both acknowledged that the recollinical record lacked documented evidence physician was notified of Resident #1's dep symptoms and behaviors. According to Employed.	oyees #1 al sident's that the ressive	DON/designee will audit the medical record for all residents who self administer medication to assure physician order in place. Results of audit will be reported at Quarterly Meetings.	5. 15. 15

Health Regulation Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 07/23/2010 HFD02-0015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LISNED LOUISE DICKSON HURTHOME

5425 WESTERN AVE NW

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	SULATORY ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	re for the nine (9) r hysician dication Miralax, 3 Tylenol. dated on problem ential e of nine the nately he/she	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	7/20/10 9/15/10
		bblem dverse		
	3. The charge nurse failed to initiate a care with appropriate goals and approaches for		potential for accidents	

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(X2) MULTIS A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SUI	ETED
		HFD02-0015	WT-0	meco ora: c=	ATT. ZID OODE	07/2	3/2010
NAME OF PROVIDER	OR SUPPLIER	тноме	5425 WES	TERN AVE NOTED TO THE STATE OF	NW ·		
(X4) ID PREFIX (EACH TAG	H DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE TIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETÉ DATÉ
Acco signe self a	rding to an "Inte d March 23, 20' dminister eye d	e 4 dication for Resident rim Order Form" date 10, it directed "reside rop with nurse super of care for Resident #	ed and ent may vision."	L 051	(L052 (4) Free of Accident Hazards/Supervision/Devices Continued) Rehab manager in-serviced nur on safe bed mobility techniques residents. DON in-serviced nursing staff of	rsing staff s for all	8/30/10
proble for se A fac Empl 3:00 l lacke	em identification elf administration e-to-face intervio oyee #4 on July PM. He/she ack d a care plan fo	, objectives and app	rith mately record of eye		necessity of providing extensive assistance for bed mobility or tr indicated. 4. Monitoring: Rehab manager will report any to side rail orders at safety com	e ansfer as changes	9/15/10
Suffice residence in the supplemental contraction of the suppl	ent to ensure the ves the following eatment, medical ements and fluic pilltative nursing oper care to minactures and to p	e shall be given to ea at the resident	ionał d s and f ulcers:	L 052	weekly. DON/ or RN designee conduct an audit of all beds and rails with corresponding physici orders. The findings will be repthe Quarterly QA meetings. Earesident will be reviewed on adroquarterly and as needed for level assistance to maximize safety. findings will be reported at week committee meetings. RN manaperform random observations of care every shift, every month to appropriate level of assistance of for bed mobility and transfer. The DON or her designee will re-	will I side an ported at ach mission, el of The kly safety agers will f resident monitor provided	
reside evide trimm hair,	ent is comfortabl nced by freedon ed nails, and ck	e, clean, and neat as from body odor, clean, neat and well-gracident, injury, and in	s eaned and roomed		Manager audits and report finding quarterly QA.	I	

9999

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

WASHINGTON DC 20015

WASHINGTON DC 20015

STREET ADDRESS, CITY, STATE, ZIP CODE

WASHINGTON DC 20015

WASHINGTON DC 20015

IAME OF PR	OVIDER OR SUPPLIER		SIKEELADDI	RESS, CHY, SI	ATE, ZIP CODE	
LISNER LOUISE DICKSON HURT		ТНОМЕ		STERN AVE NW GTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST 8	TEMENT OF DEFICIENCIE BE PRECEDED BY FULL F ITTEYING INFORMATION)	:S	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
L 052	Continued From page	e 5		L 052	L091 Infection Control	
1	, 7		1		(1) Storage of Waste Boxes	
	self-care and group a	Clivides,			1. Immediate Response:	7/23/1
(f)Encouragement	(f)Encouragement an	d assistance to:			The two infectious waste boxes were	
	(I)Encodiagement an	a assistance to.			immediately removed from the floor. 2. Risk Identification:	7/23/1
	(1)Get out of the bed	and dress or be dr	essed in his		All areas of storage of waste boxes were	1,23,1
	or her own clothing; a				checked, no other boxes were observed	
- 1	shall be clean and in				on the floor.	
(2)Use the dining r					3. Systemic Changes:	9/15/1
	(2)Use the dining roo	m if he or she is ab	ole; and		All nursing, environmental and	
					housekeeping staff in-serviced on the	
	(3)Participate in meaningful social and recreation activities; with eating;(g)Prompt, unhurried assistance if he or she requires or request help with eating;	ecreational		proper storage of medical waste boxes.	9/15/1	
]				4. Monitoring: ADON or designee will perform random	9/15/1	
		-1		audits and report findings at the		
		sne		Quarterly Quality Assurance Meeting.		
	(h)Prescribed adaptiv	e self-help devices	to assist		L091 Infection Control	
	him or her in eating				(2) Hand Washing during Meal	
	independently;				Serving	7/20/1
					1. Immediate Response: Identified employee and in-serviced on	1/20/1
	(i)Assistance, if need		ne,		infectious control practices and hand	
	including oral acre; ar	nd			washing technique. Employee was	
	() O	Cara antimetral and the			reassessed for hand washing between	
	 j) Prompt response to for help. 	an activated call b	ell or call		residents while providing care.	
	ioi noip.				Employee was observed to wash her	
	A. Based on record re				hands between residents care.	7/24/1
	three (3) of 15 sample				2. Risk Identification: All nursing staff was observed/	7724/1
1	that facility staff to pro				reassessed on hand washing practice	
	clarify allergy to shell follow through with pl				while providing care.	
	for one (1) resident ar				3. Systemic Changes:	7/24/1
	order for self administ				Staff in-serviced on infectious control	
	resident. Residents		`		practices and hand washing between	
					residents while providing care.	
	The findings include:					
	1. Facility staff failed	to clarify allergy to	sheilfish			
			31101111311			

Health Regulation Administration

6899

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING_ 07/23/2010 HFD02-0015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

5425 WESTERN AVE NW

LISNER LOUISE DICKSON HURTHOME		WASHINGTON, DC 20015				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR USC IDENTIFYING INFORMATION)	DRY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
L 052	Continued From page 6 for Resident #2.	L 052	(L091 Infection Control (2) Hand Washing during Meal Serving Continued)			
	History and Physical dated and signed November 2009, directed "See H&P [History and Physics Sibley [October 25, 2009] and [May 29, 2009]. [hospital] H&P dated October 25, 2009 and May 2009, revealed "Allergies: Shellfish." The "Initial Nutritional Assessment "completed"	cal] The y 29,	4. Monitoring: ADON or designee will perform a monthly staff observation for hand washing practices while providing care during mealtime and report findings at the Quarterly QA Meeting.	9/15/10		
	November 8, 2009, revealed "*no baked, fried fish* tuna [and] shellfish OK."	d	L099 Food Procure, Store/ Prepare/ Serve - Sanitary			
	According to the "Nutritional Risk Care Plan" da November 23, 2009, revealed "Other: Allergy/intolerance to fish (tuna OK and shellfis OK)"		(1) Soiled Toaster Oven and Convection Oven 1. Immediate Response: Convection oven, toaster and stove were cleaned.	7/19/10		
	According to the "Nutrition Risk Care Plan" date February 17, 2010, revealed "Intolerance to fish (shellfish and tuna OK)."		2. Risk Management: All cooking equipment was checked for cleanliness.	7/19/10		
	The "Quarterly Nutrition Review" dated and signed May 24, 2020, revealed " no baked or fish, tuna/shelifish OK."	fried	3. Systemic Changes: All Dietary staff was in-serviced on cleaning cooking equipment. Every Cook will be responsible for cleaning.	7/27/10		
	A face-to-face interview was conducted with Employees #4 and Employee #17, both stated, "Resident #2 is not allergic to shellfish, she has eaten shrimp with no problem, she prefers not thave baked and fried fish." After reviewing the resident's clinical record both acknowledged the record lacked evidence of clarifying resident's allergy to shellfish. The record was reviewed July, 2010.	to e	equipment after every meal. 4. Monitoring: Cooks will sign daily "Opening Procedures" and "Closing Procedures" checklist. Heavy cleaning will be added to Tuesday cleaning schedule and signed off by cleaning personnel. Supervisor on Duty will check cleanliness and monitor aforementioned	9/15/10		
	2 Facility staff failed to follow through with physician's plan to obtain labs on Resident #3.		checklists. Director or designee will audit and report findings at Quarterly QA.			
	A review of the physician's progress note dated	1				

Health Regulation Administration STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		HFD02-0015		07/23/2010				
NAME OF PR	ROVIDER OR SUPPLIER				ATE, ZIP CODE			
I LIGNED I OTHER DICKSON HIDTHOME			WASHING?	TERN AVE : TON, DC 2				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BÊ	(X5) COMPLETE DATE	
L 052	labs; check CBC (con A review of the physical lacked evidence of a serview of the nurse documented evidence. A review of the laboration of	2010 indicated r emplete blood count) idian's orders for Apri a CBC order. e's notes for April 201 be that a CBC was order eatory sheets lacked e	0 lacked dered. vidence 1 July 23, bloyees record ord lacked ordered. 1 July 23, bloyees record ord lacked ordered. 1 July 23, bloyees record ordered.	L 052	L099 Food Procure, Store/ Proserve – Sanitary (2) Rinse water in 3 compartmed was not holding water 1. Immediate Response; Maintenance repaired mechanic stopper. 2. Risk Management; All stoppers on sinks throughout kitchen were checked. 3. Systemic Changes; Dietary Staff was in-serviced on importance or reporting malfunct equipment to a supervisor immed. Monitoring; Dietary Personnel will check stodaily and report any malfunction immediately. Work orders will be submitted to Maintenance. Dire report work orders submitted at Quarterly QA. L099 Food Procure, Store/ Preserve - Sanitary (3) Temperature of pot wash s 1. Immediate Response; Water was emptied and refilled to	ent sink tal the tioning diately. ppers ector will pare/ ink 104	7/19/10 7/19/10 7/27/10 9/15/10	
	A review of an Interim Order dated and signed June 22, 2010 directed, "Patanolol eye drops, ii gtts [two drops] ou [both eyes] twice a day [bid]." According to "Physician Order Record "dated July 16, 2010, directed, "Patanol Ophthalmic Solution 0.1% [two] drops both eyes [two] times a day". According to the Medication Administration Record [MAR] for July 2010, the resident				degree water. 2. Risk Management: sink water temperatures were ch		7/19/10	
			olution lay".		throughout kitchen. 3. Systemic Changes: Food Service Staff was in-service temperature of water will be ove degrees.	I	7/27/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		HFD02-0015		B. WING _	B. WING			
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE				
LISNER	LOUISE DICKSON HUR	THOME		TERN AVE TON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FISE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
L 052	Continued From pagreceived Patanol Op 5 PM every day. A face-to-face interv Resident #5. He/sheye drops in my eye A face-to-face interv 2010 at approximate and Employee #17. self administers his/h was reviewed July 2010. B. Based on observative for one (1) of determined that facil sufficient nursing tim measures and assist from accidents for ora fall with injury while Resident #12. The findings include: According to the ann Data Sets [MDS] data 3, 2010 respectively, included Diabetes, HOsteoporosis, Allergiand Cancer, Section revealed the resident of two (2) persons for the service of the servi	iew was conducted whe stated, "Yes, I put now and it is for dry eye iew was conducted or ally 3:00 PM with Employers and it is for dry eye iew was conducted or ally 3:00 PM with Employers eye drops." The 0, 2010. In a stated, "[Resident eye drops." The 0, 2010. It is a sampled residents it is staff failed to provide to implement safety ance devices to ensure (1) Resident who see being turned in bed in yearlension, Arthritis, es, Cardiovascular Di G, Physical Functionit required extensive at bed mobility and trainal and trainal and trainal extensive at bed mobility and trainal extensive at bed mobility and trainal extensive at bed mobility and trainal extensive at the extensiv	ith my own s." n July 20, oyees # 4 dent #5) record cord s, it was de re safety ustained for imum and May iagnoses isease, ing ssistance nsfer. Bed	L 052		and ecorded and ec	9/15/10 7/19/10 7/19/10 7/28/10	
	mechanical lift was re resident had limited r of voluntary moveme side. Section K, Nutri	bed mobility and trans equired for transfer. The ange of motion and point of the arm and leg itional Status revealed the was 60 inches and v	he artial loss on one		ríps and soil. Director will report finding at Quarterly QA.	any		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		HFD02-0015		8. WING _		07/2	3/2010	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE, ZIP CODE				
	LOUISE DICKSON HUR	RTHOME	5425 WES	TERN AVE I	NW			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REI NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
L 052	Continued From page 9		L 052					
	225 pounds.				Serve - Sanitary			
					(5) Apple juice and			
	Physician's orders si	igned June 2, 2010 pr	rescribed		Pineapple/carrot/raisin salad	were 48		
Ì		rails for safe bed me			degrees			
			,		1. Immediate Response:		7/19/10	
	According to the "Nu	rsing Monthly Summa	ary" report [Juice and pineapple/carrot/raising	n salad		
		10, " Ambulation/Re			were thrown away.			
		er by staff 2 [two] per			2. Risk Management:		7/19/10	
					Cold temperatures were checke	d on		
		ned a fall with injury a	s		· ·	d OII		
	evidenced by the foll	lowing nurse's notes:			other trays.		7/27/10	
				3. Systemic Changes: Food Service staff was in-serviced on proper point of service temperatures. Juices will be poured from Vitality Juice			1721710	
		AM, "At 2:50 AM resid						
		while [staff] was trying						
		pan. Resident obser						
		the floor. Hematoma			Dispenser immediately after each	h meal		
		it] left eyebrow. No o			and put into refrigerator to chill to	efore	ł	
		rochecks commenced red area. [Staff] repo			the next meal. All cold items w			
		alker as (resident) fell			chilled and served in an insulate	-		
		no other obvious inju			Alladin cup.	-		
		supported. Ice pack a			4. Monitoring:		9/15/10	
		rnes] 20 minutes. Sk			Test Tray temperatures will be to	nkan	0, 10, 10	
	[at] left brow is super	ficial, 4cm [long] x 0.2	2 cm wide.		every week by Catering Associa		[
	"				, ,			
					Director will report any finding a			
		PM "continues to co			Quarterly QA.			
		swollen and dark colo lospital) emergency re			L099 Food Procure, Store/ Pre	pare/	ĺ	
	10:50 AM."	iospital) emergency re	Join at		Serve - Sanitary			
	IONO UNI				(6) Staff was not specific on h	ow to		
	According to the eme	argency department d	ischarge		properly test or verify the			
	According to the emergency department discharge summary dated June 19, 2010, the resident				concentration of the sanitizing	,		
		ng injuries: closed hea			solution for the dishwasher.			
		facial contusion, cervi			1. Immediate Response:			
	and multiple contusion				Test strips were replaced with C	hlorine	7/19/10	
					Test Paper that was easier to ide	I		
	A face-to-face intervi	ew was conducted wi	th		color.	si Rii y		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0015		(X2) MULTI A BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED 07/23/2010			
		AFD02-0015	ATD 557 400		07/2	23/2010			
	PROVIDER OR SUPPLIER LOUISE DICKSON HUI	RTHOME	5425 WES	EET ADDRESS, CITY, STATE, ZIP CODE 25 WESTERN AVE NW ISHINGTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
L 052	Resident #12 on Ju 3:45 PM. Resident and weeks ago. The numbedpan, when I turn me to hold onto. So fell and hit my head get another pair. I he bleeding into my eyo A face-to-face interved my face and hit my head get another pair. I he bleeding into my eyo A face-to-face interved my face and assisted onto the beta assisted onto the beta face assisted onto the beta face and assisted onto the beta face and assisted onto the beta face and assist the interved in the prescribed 1/2 side rate and assist the interved in the prescribed in the prescribed interved in the prescribed interved in the prescribed in the prescribed in the prescribed in the prescribed interved in the prescribed in the prescribed in the prescribed	ly 20, 2010 at approxistated, "I fell out of the rewas trying to put med [an] there was now, I tried grabbing the volume of a cut over my eye and my head was head a cut over my eye and my head was head a cut over my eye and my head was head a cut over my eye and my head was head at the fall occurred volume of two (2) persons for the accordance with the plated May 3, 2010. Invidence that two (2) so accordance with the plated May 3, 2010. Invidence that two (2) so accordance with phy resident with bed mobras no evidence that so individuals to assist obtility. Implement safety medical to essential equent injuries. The resident sustail equent injuries. The resident was no evidence that so is accordance with phy resident with bed mobras no evidence that so individuals to assist obtility.	e bed 2-3 ne on the side rail for vail, and I e. I had to and I was urting. " vith mately d been accement while being #12 was nd or bed he lide rails ysician 's politzation. ttaff it the easures dent's ined a fall	L 052	(L099 Food Procure, Store/ P Serve - Sanitary (6) Staff was not specific on the properly test or verify the concentration of the sanitizing solution for the dishwasher. Continued) 2. Risk Management: Ecolab was called immediately PPM. PPM was correct. 3. Systemic Changes: All Dietary Personnel were in-secon how to use new Chlorine Test. 4. Monitoring: Supervisor will continue to mone Director will report any findings Quarterly QA. L099 Food Procure, Store/ Proserve - Sanitary (7) Staff unable to state the extemperature of the wash soluting the 3 compartment sinksing. 1. Immediate Response: Dietary Director informed the Director process or higher. Sink we emptied and refilled. 2. Risk Management: Water was emptied from sink as refilled with water and temperature of the management.	to check erviced st Paper. itor logs. at epare/ expected tion on ietary erature vas	7/19/10 7/27/10 9/15/10 7/19/10		
L 09 ⁻	L 091 3217.6 Nursing Facilities			L 091	refilled with water and temperat tested with thermometer.	ure was			
		ol Committee shall ens							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU HFD02-0015		(X2) MULTI A BUILDIN B. WING _	PLE CONSTRUCTION G	(X3) DATE SU COMPL			
	ROVIDER OR SUPPLIER	RTHOME	5425 WES	T ADDRESS, CITY, STATE, ZIP CODE WESTERN AVE NW HINGTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
L 091	services, including haundry, and linen surequirements of this. This Statute is not m. A. Based on observations and the provide a safe, sanite environment as evide of medical waste both the findings included. Two (2) of four (4) in stored upright and district utility room. These observations are Employees #8 and #findings during the set supplemental resider facility staff failed to resident contact during 4, A1, A2, A3, and A. The findings included: Residents #3, 4, A1, during dinner in the set supplemental resider supplemental resider that the findings included the set of th	iall ensure that environgusekeeping, pest coupply are in accordance chapter. Interest as evidenced by: ations made during of the facility on July sermined that the facility ary and comfortable enced by the improperties in the soiled utility. If ectious waste boxes ir ectly on the floor in the ware made in the presence was and staff intervisidents and four (4) ofts, it was determined wash hands after directly dinner meal. Residents	antrol, ce with the 20 and . y failed to er storage or room. were the soiled sence of these ew for two if that ct dents #3,	L 091	(L099 Food Procure, Store/ Serve - Sanitary (7) Staff unable to state the temperature of the wash so the 3 compartment sink Cord. 3. Systemic Changes: Dietary Personnel was in-serve correct temperatures. Temperatures of the mession of the taken three times per directed on log. 4. Monitoring: Supervisor will check log daily will report findings at Quarterly will report findings at Quarterly of the taken three times per directed on log. 4. Monitoring: Supervisor will check log daily will report findings at Quarterly will report findings at Quarterly of the taken three times per directed on the taken three times per directed or discontinued medical or the taken to make sure there were expired or discontinued medical or the taken to mursing staff was about necessity of removing medical or the taken to monitor carts for expired/discharge medications. 4. Monitoring: Supervisor to monitor carts for expired/discharge medications. Findings will be reported by Dedesignee at QA committee.	expected lution on intinued) riced on perature lay and r. Director y QA. rued in lail storage eno ation. done ineds upon	7/27/10 9/15/10 7/23/10 9/15/10 9/15/10		
	Resident # 4 was ob	served seated on by a	a table						

Health Regulation Administration

	Health R	egulation Administrat	ion				1 0100	ATTOVED
	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-		(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/23/2010	
					B. WING			
Г	NAME OF PROVIDER OR SUPPLIER STREET		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
	LISNER L	OUISE DICKSON HUR	THOME		TERN AVE 1 TON, DC 2		_	
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLET		
	L 091	Continued From pag	je 12		L 091	L206 Documentation of Injury 1. Immediate Response:	,	9/2/10
			3, and A4 were obser ne same table.	ved		Corrected incident report sent to authorities.	proper	0,4/40
	Employee # 10 was observed serving the residents their dinner trays. After he/she completed passing out some of the trays, he/she moved between Residents #4, A1, A2, A3, and A4 and assisted the residents with setting up their dinner trays and feeding He/she stood next to Resident #4 and fed him/her		passing reen sisted the		Risk Identification: Other incident reports involving were reviewed for correct documentation of injury and pro		9/4/10	
					transmission. 3. Systemic Changes: Licensed nursing staff in-service proper documentation and trans		9/15/10	
		Resident # 4's tray to	e (5) minutes. Returne to the cart, outside the	dayroom.		of incident reports. 4. Monitoring: A random audit will be done mo	nthly at	9/15/10
Employee #4 returned to the dayroom with A1's dinner tray. Resident A1 presented widifficulty keeping food on his/her fork. Emp 10 stood by Resident A1 and fed him/her. Resident A2 expressed frustration opening		with nployee #		safety committee meetings. The findings will be reported at the QA meetings.	ne			
		drinking straw. Emp assist Resident A2.	oloyee #10 left Reside	ent A1 to		L410 Housekeeping and Main Services (1) Privacy Curtains Stained	tenance	
			ed the end point of the in his/her mouth with			Immediate Response: Unable to remove ink stains fror privacy curtains in room 105 and therefore privacy curtains were		7/20/10
Employee #10 left Resident A2 to assist Resident A3 back to the dayroom from the hallway. He/she gave Resident A3 a cup of ice cream and returned to Resident A1.			replaced. 2. Risk Identification: All other privacy curtains were in and replaced if indicated.	nspected	7/20/10 9/1/10			
				[3. Systemic Changes:	ļ	

Employee #10 assisted Resident #4 to his/her

from the nurses 'station to collect Resident #3's

to the dayroom with Resident #3's dinner tray.

He/she stood next to the resident

room. He/she went to the community kitchen across

dinner tray from the food warmer. He/she returned

9/15/10

Staff in-serviced on checking privacy

Privacy curtains will be inspected on a

curtains for cleanliness and lack of

monthly basis and findings will be reported at Quarterly QA meetings.

stains.

HKN711

4. Monitoring:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,			DATE SURVEY COMPLETED		
		HFD02-0015		8 WING_		07/2	3/2010		
NAME OF PE	ROVIDER OR SUPPLIER	7 202 00.0	STREET ADD	RESS, CITY, STATE, ZIP CODE					
	LOUISE DICKSON HUR	тноме		STERN AVE NW STON, DC 20015					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
L 091	Continued From page 13		L 091	L 091 L410 Housekeeping and Maintenance Services					
	and fed him/her.		,		(2) Ceiling Vent Dripping Wate	er			
	Throughout the period of the above observations, Employee #10 failed to wash his/her hands after direct residents contact during dinner meal on July 19, 2010 at approximately 4:05 PM. He/she failed to wash his/her hands between residents 'care: He/she provided care for multiple residents at the same time without washing his/her hands. A face-to-face interview conducted at with Employee #10 on July 23, 2010 at approximately 1:20 PM. He/she acknowledged the above observation. He/she said, "I was trying to hurry-up with the feeding. All the residents required my help as you can see, I know better than that."			Immediate Response: Vent closed and water dripping ceased.		7/20/10			
				2. Risk Identification: All other ceiling vents on unit ch for water dripping and fixed if in		7/20/10			
				3. Systemic Changes: Staff in-serviced to check ceiling for dripping water during scheduroom checks. 4. Monitoring:		9/3/10			
				Engineering will monitor ceiling dripping water on scheduled PN checks and will report findings a Quarterly QA Meeting.	î room	9/15/10			
					L410 Housekeeping and Main	tenance			
L 099	3219.1 Nursing Facil			L 099	Services (3) Damaged AC Cover & Grill Room 134	in			
	from spoilage, safe f	be clean, wholesome or human consumption with the requiremen	n, and		Immediate Response: Cover and grill removed, repaire	nd and			
	forth in Title 23, Subt	title B, D. C. Municipa			replaced.	iu anu	8/25/10		
	This Statute is not m Based on observatio	ns made during tours	of the		Risk Identification: All other grills and covers check unit and repaired if necessary.	ed on	8/25/10		
	dietary services on Júly 19 and 20, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: one (1) of one (1) soiled toaster oven, one (1) of one (1) soiled convection oven, and one (1) of one			 Systemic Changes: Engineering staff was in-service need to check condition of air conditioner covers and grills. Monitoring: 	d on	9/3/10			
	the test tray; a leak in stained and soiled ru one (1) of one (1) o	out of range temperal of the three-compartment of in front of the freeze ocasion a staff memb expected temperature	ent sink, a er and on er failed		Air conditioner covers and grills monitored by engineering staff d scheduled PM room checks and will be reported at quarterly QA Meetings.	luring	9/15/10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI. A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0015		8 WING 07/23/20			3/2010
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
LISNER L	OUISE DICKSON HUR	тноме		TERN AVE I TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 099	Ontinued From page 14 in the three-compartment sink and on two (2) of two (2) occasions staff members failed to correctly test and verify the concentration of the sanitizing		L 099	L426 Maintains Effective Pest Control Program 1. Immediate Response: Room was cleaned and the pest control company was called.		7/20/10	
	The findings include:	ion in the dishwashing machine.			Risk Identification: Pest Control Company came of checked all areas and treated appropriately.	ut and	7/20/10
	 The convection oven, the toaster oven and the gas stove were soiled. Test tray temperatures for apple juice and pineapple/carrots/raisins salad were forty-eight degrees Fahrenheit (F) and exceeded allowable limit of forty-one degrees F. The temperature of the wash solution in the three-compartment sink was 104 degrees F and was far below the expected minimum temperature of 110 degrees F. 			3. Systemic Changes: Staff educated as to how to prevent fruit flies and other insects and proper		9/15/10	
				reporting of insect sightings so areas can be treated. 4. Monitoring: Pest control rounds will be cond 3X monthly with action items and results will be reported at QA meetings.	ducted ddressed	9/15/10	
	4. The rinse water of three-compartment should not hold the rin				·		
	5. The rug in front of soiled.	of the freezer was sta	ined and				
	state the expected te solution for the three- two (2) of two (properly test and veri sanitizing solution for	f one (1) staff member was unable to cted temperature of the washing three-compartment sink and of two (2) staff members failed to not verify the concentration of the tion for the dishwashing machine.					
	These observations were made and acknowledged by Employee #7 who was present at the time of the observations.						·

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/23/2010 HFD02-0015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5425 WESTERN AVE NW LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 161 L 161 Continued From page 15 L 161 3227,12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed to remove four (4) expired medications from two (2) of three (3) medication carts observed. The findings include: 1. The facility staff failed to remove expired medications and discontinued medications from the medication carts. On July 19, 2010, between 10:00 AM and 4:30 PM, during the inspection of the medication storage areas, expired and drugs were observed in the medication carts as follows: Expired Medications: 1 Bottle of Guaituss 100 gm /5ml syrup, expired June 22, 2010 1 Sottle of Diabetic Tussin syrup, expired June 30. 2010 1 Bottle of Tussin CF 100gm/ 5ml syrup, expired July 11, 2010 1 Bottle of Nitro stat 40 mg capsule expired July 4, 2010 The above findings for the medication carts were acknowledged by Employee #4 on July 19, 2010, at the same time of the observation. L 206 L 206 3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within

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forty-eight (48) hours of

PRINTED: 08/24/2010 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING HFD02-0015 07/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5425 WESTERN AVE NW LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 206 Continued From page 16 L 206 occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: 22DCMR 3232.4 Based on record review and staff interview for one (1) resident, it was determined that facility staff failed to inform State Agency that a resident who fell sustained an injury. Resident #12. The findings include: " Each incident shall 22 DCMR 3232.4 stipulates, be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence." According to an incident report completed by the facility on June 19, 2010, "Resident fell out of bed to the floor while the CNA [Certified Nursing Assistant) was trying to put [his/her] (resident) on the bed pain. ' The nurse 's note dated June 19, 2010 at 4:30AM, documented, "At 2:50AM resident fell out of left side of her bed while [Certified Nursing Assistant] was trying to put her on the bedoan. Resident

left brow is superficial,

observed lying prone on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other obvious injury. Neurochecks commenced. Ice packs applied to injured area. CNA reported that resident's head hit walker as she fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported lice pack applied to left brow/forehead [times] 20 minutes. Skin tear [at]

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD02-0015 07/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5425 WESTERN AVE NW LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUSTIBE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 206 Continued From page 17 L 206 4cm [long] x 0.2 cm wide. " The record lacked evidence that the incident regarding the head injury was documented on the incident report A face-to-face interview with Employees #1 and Employee #2 conducted on July 23 at approximately 10:00AM. Both acknowledged the injury was not documented on the incident report. The record was reviewed July 20, 2010. L 410 3256.1 Nursing Facilities L 410 Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 20, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by soiled privacy curtains in two (2) of 13 rooms surveyed, water was dripping from a ceiling vent on one (1) of three (3) units surveyed, a faulty call bell cord in one (1) of 13 rooms surveyed and a damaged air conditioner cover and grill in one(1) of 13 rooms surveyed.

unit.

The findings include:

rooms # 105 and # 123.

1. Privacy curtains were soiled and stained in

Water was dripping from the ceiling vent in the special care dayroom located in the Lisner Lane

FORM APPROVED Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/23/2010 HFD02-0015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5425 WESTERN AVE NW LISNER LOUISE DICKSON HURTHOME WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD 8E CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 410 L 410 Continued From page 18 3. The cover and grill to the air conditioning system in room #134 were damaged. These findings were acknowledged by Employees # 4 and # 9 who were present at the time of observation. L 426 L 426 3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of crawling and flying pests observed in different areas in the facility. The findings include: Flying insects were observed in room #123 and environmental services area. These findings were acknowledged by Employees # 8 and # 9 who were present at the time of observation.