STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095025	A. BUILDING _____ B. WING _____	06/12/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on June 10 through 12, 2009. The following deficiencies were based on observations, record review, and staff and resident interviews. The sample included 15 residents based on a census of 60 residents on the first day of survey and one (1) supplemental resident.	F 000		
F 253 SS=D	483.15(h) (2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour on June 11, 2009 between 9:00 AM and 12:45 PM, it was determined that housekeeping services were not adequate to ensure that the facility is maintained in a safe and sanitary manner as evidenced by: loose towel racks in resident bathrooms in six (6) of 19 observations, loose privacy curtains in five (5) of 19 observations, damaged ceiling tiles in two (2) of 19 observations, marred/damaged bathroom walls in two (2) of 19 observations and marred/damaged wall in the oxygen room in one (1) of 19 observations, dusty blinds in eight (8) of 19 observed, dusty shelves were observed in two (2) of 19 observations, dust on a sprinkler head in one (1) of 19 observations, damaged sink handles in one (1) of 19 observations and a loose closet door in one (1) of 19 observations. These observations were made in the presence of Employees #4 and 5 who acknowledged these findings at the time of the observation.	F 253	**F 253** **Loose Towel Bars** **1. Immediate Response:** 6/11/09 All loose fixtures identified were repaired. **2.Risk Identification:** 6/13/09 All towel racks in remaining rooms were checked and secured as needed. **3. Systemic Changes:** 6/11/09 Staff was in-serviced on checking all items on the checklist when performing preventative maintenance in resident rooms. Housekeeping staff was in-serviced on reporting loose fixtures found when completing cleaning duties. **4.Monitoring:** 7/22/09 Director of Engineering will begin a quality control program that will require follow-up on preventative maintenance tasks and work requests monthly. Findings of follow-up on preventative maintained tasks and work requests will be presented at the Quarterly Quality Assurance Meeting. **Dusty Items** **1.Immediate Response:** 6/15/09 The identified blinds, shelves and sprinkler heads were dusted and cleaned. **2. Risk Identification:** 6/22/09 All blinds, shelves and sprinkler heads in the nursing facility were inspected and cleaned as necessary. **3. Systemic Changes:** 6/22/09 Staff was in-serviced on the items needing dusting in resident rooms to include blinds and shelves. Staff was in-serviced to report dusty sprinkler heads to Engineering for specialized cleaning. **4. Monitoring:** 7/27/09 Director of Environmental Services or designee will inspect blinds, shelves and sprinkler heads on a monthly if basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Marquardt LNHA	Administrator	7/9/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 The findings include: 1. Towel racks were unsecured in resident rooms #112, 119, 123, 124, 127 and 131 in six (6) of 19 observed. 2. Window blinds were soiled with dust in rooms #106, 108, 111, 110, 102, 112, 123 and 120 in eight (8) of 19 observed. 3. Shelves over the resident's bed in rooms #106 and 122 in two (2) of 19 observed. 4. The sprinkler head in room #110 was dusty in one (1) of 19 observed. 5. Privacy curtains were hanging loose and off the tracks in rooms #108, 111, 110, 112 and 122 in five (5) of 19 rooms observed. 6. The bathrooms walls were marred and/or damaged in rooms #106, 124 in two (2) of 19 observed and the oxygen storage room on the first floor in one (1) of one (1) observed. 7. Water was leaking from the cold side of the hand washing sink and the hot water handle needed to be replaced in the bathroom in room #127 in one (1) of 19 observed. 8. Ceiling tiles were damaged and/or soiled in rooms #107 and 124 in two (2) of 19 observed. 9. The closet door in room #131 was loose in one (1) of 19 observed.	F 253	F253 Continued from page 1 Director will present findings of these inspections at the Quarterly Quality Assurance Meeting. **Privacy Curtains** **1. Immediate Response:** 6/15/09 The identified curtains hooks were tightened and placed on the track. **2. Risk Identification:** 6/19/09 All rooms were inspected for loose curtain hooks and those needing tightening or re-tracking were repaired. **3.Systemic Changes:** 6/22/09 Staff was in-serviced on observing and repairing loose curtain hooks during routine cleaning. **4. Monitoring:** 7/27/09 Director of Environmental Services or designee will inspect curtain hooks on a monthly basis. Director of Environmental Services will present findings of these inspections at the Quarterly Quality Assurance Meeting. **Bathroom Walls** **1. Immediate Response:** 6/12/09 Identified areas were painted and touched up. **2.Risk Identification:** 7/10/09 All bathroom walls were checked for marred and damaged walls. Those needing repair or painting were repaired or painted as needed. **3.Systemic Changes:** 7/7/09 An in-service was held for the maintenance staff on the importance of checking all items on the checklist when performing preventative maintenance in resident rooms to include marred and damaged bathroom walls.	
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 2 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 15 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set [MDS] for one (1) resident with a pressure ulcer and failed to code a diagnosis for one (1) resident with a Foley catheter. Residents #7 and 13. The findings include:	F 278	F253 Continued from page 2 **4. Monitoring:** Director of Engineering will begin a quality control program that will require follow-up on preventative maintenance tasks and work requests monthly. Findings of follow-upon preventative maintenance tasks and work requests will be presented at the Quarterly Quality Assurance Meeting. **Water Faucet** **1. Immediate Response:** The leaking faucet was repaired and the hot side was replaced. **2. Risk Identification:** All faucets in resident bathrooms were inspected and repaired if needed. **3. Systemic Changes:** An in-service was held for the maintenance technicians on the importance of checking all items on the checklist when performing preventative maintenance in resident rooms. Housekeeping staff was in-serviced on reporting maintenance concerns noted during cleaning to include faucets. **4. Monitoring:** Director of Engineering will begin a quality control program that will require follow-up on preventative maintenance tasks and work requests monthly with attention to faucets. Findings will be presented at the Quarterly Quality Assurance Meeting. **Ceiling Tiles** **1.Immediate Response:** Damaged/soiled ceiling tiles were replaced. **2.Risk Identification:** An inspection of ceiling tiles in resident rooms was made with replacements made as needed.	**7/27/09** **6/11/09** **7/7/09** **7/7/09** **7/27/09** **6/11/09** **6/12/09**

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F 278	Continued From page 3 1. Facility staff failed to accurately code Resident #7's pressure ulcer on the quarterly MDS. The "Weekly Pressure Ulcer Healing Record " revealed, "...Site/location: Coccyx ...date May 4, 2009, "Stage- III ulcer, Size-1.2 x 0.8 cm, Depth-none, Exudate type -serous, wound bed - slough 80%...". A review of the quarterly MDS completed May 8, 2009 revealed, "Section M1 Ulcers - b. Stage 2 ..." The MDS lacked evidence that it was accurately coded to reflect the current stage of the pressure ulcer for Resident #7. A face-to-face interview was conducted with Employee #3 on June 12, 2009 at 10:00 AM. He/she acknowledged that the quarterly MDS was not coded to reflect current stage of the pressure ulcer. The record was reviewed June 12, 2009. 2. Facility staff failed to code a diagnosis for the use of a Foley catheter for Resident #13. According to the Physician's Order sheet dated June 1, 2009 signed by the physician on June 2, 2009 the resident had a diagnoses which included Urinary Retention. Additional physician orders included the following: "...Treatment/procedure change Foley catheter with #18 FR[French] /30 ml balloon monthly on Friday [Original order date February 27, 2009]... Foley care every shift [original order date November 20, 2008]..." A review of the above cited MDS assessments	F 278	F253 Continued from page 3 **3.Systemic Changes:** **7/7/09** An in-service was held for the maintenance technicians on the importance of checking all items on the checklist when performing preventative maintenance including ceiling tiles in resident rooms and common areas. Housekeeping staff was in-serviced on reporting maintenance concerns noted during cleaning to include ceiling tiles. **4.Monitoring:** **7/27/09** Director of Engineering will begin a quality control program that will require follow-up on preventative maintenance tasks and work requests monthly to include ceiling tiles. Findings of follow-up on preventative maintenance tasks and work requests will be presented at the Quarterly Quality Assurance Meeting. **Closet Door:** **1.Immediate Response:** **6/11/09** The loose closet door was repaired. **2.Risk Identification:** **6/12/09** All closet doors were checked for proper functioning and repairs made as needed. **3.Systemic Changes:** **7/7/09** An in-service was held for the maintenance technicians on the importance of checking all items on the checklist to include closet doors when performing preventative maintenance in resident rooms. Housekeeping staff was in-serviced on reporting maintenance concerns noted during cleaning. **4. Monitoring:** **7/27/09** Director of Engineering will begin a quality control program that will require follow-up on preventative maintenance tasks and work requests including closet doors monthly. Findings of follow-up on preventative maintenance tasks and work requests will be presented at the Quarterly QA Meeting.	

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F 278	Continued From page 4 revealed that there was no diagnosis listed in Section I3 [Other current diagnosis and ICD-9 Codes] for the use of the indwelling Foley catheter. A face-to-face interview was conducted on June 12, 2009 at approximately 3:00 PM with Employee #10. He/she acknowledged that the MDS was inaccurately coded for a diagnosis for Foley catheter usage. The record was reviewed June 12, 2009.	F 278	**F278** **Pressure Ulcer** **1. Immediate Response:** Stage verified by visual inspection and skin records. MDS coordinator to modify MDS. **2. Risk Identification:** All stages were verified on wound rounds to assure proper coding on the MDS. **3. Systemic Changes:** MDS coordinator in-serviced to verify stage of pressure ulcer by consulting skin care records prior to completing MDS. Director of Nursing or designee to verify staging of pressure ulcer on MDS prior to submission. Wound nurse consultant to educate staff as needed. **4. Monitoring:** Director of Nursing or designee to audit all MDS/skin care records to insure accuracy of information on a quarterly basis. The Director of Nursing or her designee will report these findings at the Quarterly Quality Assurance Meeting. **Foley Catheter** **1. Immediate Response:** The MDS Coordinator will include the code for the diagnosis of urinary retention on all future MDS's for the identified resident. **2. Risk Identification:** No other resident was identified as using an indwelling catheter and therefore there were no other identified risks for miscoding in this area. **3. Systemic Changes:** The MDS Coordinator was in-serviced on section I(3) of the MDS and the necessity to have corresponding diagnosis for the use of Foley catheter.	**6/19/09** **6/15/09** **6/11/09** **7/27/09** **7/27/09** **6/11/09** **6/11/09**
F 279 SS=D	483.20(d), 483.20(k) (1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b) (4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for	F 279		

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F 279	Continued From page 5 one (1) of nine (9) sampled residents, it was determined that facility staff failed to initiate a care plan to address the potential for adverse interactions for the use of nine (9) or more medications. Resident #1. The findings include: A review of the " Physician ' s Order Sheet" dated May 27, 2009, revealed that Resident #1 was to receive the following medications: Digoxin, Albuterol, Clonazepam, Fludrocortisone, Lamotrigine, Levetiracetam, Metroprolol, Midodrine, Multivitamins, Senna Plus, Tramadol-APAP, Vitamin C, and Warfarin Sodium. A review of the May 2009 Medication Administration Record revealed that Resident #1 received the aforementioned medications as directed by the physician. A review of care plans lacked evidence that a care plan was initiated to address the potential for adverse interactions for the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #3 on June 10, 2009 at 9:00 AM. He/she acknowledged that a care plan was not initiated for the use of nine (9) or more medications. The record was reviewed June 10, 2009.	F 279	F278 Continued from page 5 **4. Monitoring:** 7/27/09 The MDS Coordinator will audit MDS' for residents using Foley catheter and corresponding diagnosis quarterly. The Director of Nursing or her designee will report these findings at the Quarterly Quality Assurance Meeting. **F279** **Missing care plan for nine + meds** **1. Immediate Response:** 6/11/09 Care plan for identified resident having nine or more medications was written and initiated. **2. Risk Identification:** 7/22/09 Care plans were audited for residents who have nine plus medications to ensure care plans were in place. **3. Systemic Changes:** 7/15/09 Licensed nursing staff was in-serviced on the necessity to care plan all residents who have nine or more medications ordered. **4. Monitoring:** 7/27/09 Ten percent (10%) of medical records to be audited monthly by Director of Nursing or designee on the presence of needed care plan for residents who have nine or more medications ordered. Findings will be reported at Quarterly QA Meetings.	
F 280 SS=D	483.20(d) (3), 483.10(k) (2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	**F280** **Comprehensive Care Plans** **1. Immediate Response:** 6/15/09 Identified Care plans were immediately updated for adaptive utensils and Foley catheter.	

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F 280	Continued From page 6 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 15 sampled residents, it was determined that facility staff failed to update the Nutritional Risk care plan for one (1) resident using adaptive utensils and one (1) resident with a Foley catheter. Residents #4 and 13. The findings include: 1. Facility staff failed to update the "Nutritional Risk" care plan for use of adaptive utensils for Resident #4. On June 1, 2009 Resident #4 was observed having breakfast in his/her room in bed. While having breakfast, Resident #4 was observed to have two (2) cups with a lid, and a built up spoon on the breakfast tray.	F 280	F280 Continued from page 6 **2. Risk Identification:** 7/8/09 Care plans for all residents who use adaptive utensils and Foley catheter were reviewed for appropriateness, and clarified and updated as needed. **3. Systemic Changes:** 7/16/09 Care plan team members to be in-serviced on necessity of care planning for adaptive equipment and Foley catheter procedures. **4. Monitoring:** 7/27/09 Care plan for residents with Foley catheters or adaptive equipment will be reviewed quarterly by designated care plan team members and results reported to the Director of Nursing. Findings will be reported at Quarterly QA Meetings by Director of Nursing or designee. **F309** **Catheter Orders** **1. Immediate Response:** 6/15/09 Order confirmed with physician and changed accordingly to include 10ml of fluid into Foley balloon. Size clarified. Care plan updated and amended to include Foley size. **2. Risk Identification:** 6/11/09 No other residents were affected, as no other resident has a Foley catheter. **3. Systemic Changes:** 7/27/09 Staff to be educated as to necessity of clear orders for use of Foley catheter, including diagnosis, Foley size, ml in balloon, and routine catheter care. In addition, training is to be given regarding appropriate documentation of changes in urine color, consistency visible in collection bag.	

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F 280	Continued From page 7 A review of the Physician's Order Sheet dated April 20, 2009 and signed by the physician on April 24, 2009 directed, "...adapted utensils inner lip plate, cup with lid lift pad to support independence ..." [There was no physician's order for the use of the spoon]. A review of the "Nutritional Risk" care plan revealed, "...Approaches/Interventions ...Adaptive equipment: _ [was left blank]". The care plan failed to identify the type of adaptive equipment to be used to support independence for Resident #4 during meals. A face-to-face interview was conducted on June 11, 2009 at 12:34 PM with Employee #11. He/she acknowledged that the type of adaptive equipment was not addressed on the Nutritional Risk care plan. The record was reviewed June 11, 2009. 2. Facility failed to update the care plan for "Incontinence... Neurogenic Bladder" for Resident #13 with a Foley catheter. The word "Bowel" was incorrectly circled on the care plan for approaches and interventions developed by the facility for the resident's Neurogenic bladder. On June 12, 2009 at approximately 2:00 PM, Resident #13 was observed in his/her room with an indwelling Foley catheter in place. A review of the Physician's Orders dated June 1, 2009 and signed by the physician on June 2, 2009 revealed, "...Treatment/procedure change Foley catheter with #18 FR[French] /30 ml balloon monthly on Friday [Original order date February 27, 2009]... Foley care every shift [original order	F 280	F309 Continued from page 7 **4. Monitoring:** Quarterly audits of resident records who have Foley catheters will be performed by the Director of Nursing to verify accuracy and appropriate documentation and findings will be reported at the Quarterly QA meeting. **F323** **Grab Bars** **1.Immediate Response:** All loose fixtures identified were repaired. **2.Risk Identification:** All fixtures in remaining rooms were checked and secured as needed. **3.Systemic Changes:** An in-service was held for the maintenance technicians on the importance of checking all items on the check list when performing preventative maintenance in resident rooms to include grab bars. Housekeeping staff was in-serviced on reporting any loose fixtures found when completing their cleaning duties. **4. Monitoring:** Director of Engineering will begin a quality control program that will require follow-up on preventative maintenance tasks and work requests monthly to include grab bars. Findings of follow-up on preventative maintenance tasks and work requests will be presented at the Quarterly Quality Assurance Meeting. **0xygen Storage** **1.Immediate Response:** Existing bracket that holds the chain that secures the oxygen cylinders was immediately reattached to the wall. Welded brackets were fabricated and installed to prevent a future failure.	**7/27/09** **6/11/09** **6/12/09** **7/7/09** **7/27/09** **6/11/09**

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F 280	Continued From page 8 date November 20, 2008]..." A review of the care plan entitled "Incontinence...Neurogenic Bladder" last updated April 24, 2009 lacked evidence that the aforementioned treatment procedures were included as the approach(s) on the resident's care plan. A face-to-face interview was conducted on June 12, 2009 at 2:34 PM with Employee #3. He/she acknowledged that the care plan was not updated to include the aforementioned treatment procedures. The record was reviewed June 12, 2009.	F 280	F323 Continued from page 9 **2.Risk Identification:**	**6/11/09**
			Other area used to store oxygen was checked for proper secured storage.	
			3. Systemic Changes:	**6/30/09**
			An in-service was held with maintenance staff on the critical importance of safe oxygen storage and monitoring. The oxygen logbook was re-located to the Engineering office to allow constant monitoring by facility engineer.	
			4.Monitoring:	**7/27/09**
			Director of Engineering will review the logbook and make rounds to view the secure areas on a weekly basis. Director of Engineering will report on his findings at the Quarterly Quality Assurance Meeting.	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to follow physician's orders to change Resident #13's Foley bag weekly and clarify the order for the amount of millimeters of fluid to fill the Foley balloon. The findings include: 1. Resident #13's Foley bag was observed on	F 309	**Eyewash Station** **1.Immediate Response:**	**7/8/09**
			The identified, expired eye wash solution was replaced.	
			2.Risk Identification:	**7/8/09**
			All eye wash solution was inspected and if found to be expired was replaced.	
			3.Systemic Changes:	**7/7/09**
			Quarterly eyewash station inspection was added to the preventative maintenance system. Maintenance staff was in-serviced on checking for expired eyewash solution and replacing when needed.	
			4.Monitoring:	**7/27/09**
			Director of Engineering will inspect eye wash station on a quarterly basis. Director of Engineering will report on his findings at the Quarterly Quality Assurance Meeting.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 June 12, 2009 at 2:30 PM with a date marked on the bag as June 3, 2009. The tubing had changed from transparent to opaque and was coated with a whitish substance on the interior of the tubing. According to a physician's order dated June 2, 2009, "Change urine collection/bedside bag every week on Wednesday." There was no evidence in the resident's record that the Foley bag was changed on June 10, 2009 (Wednesday) as per physician's order. A face-to-face interview was conducted at the time of the observation with Employee #3 who acknowledged that the Foley should have been changed on June 10, 2009. The record was reviewed June 12, 2009. 2. Facility staff failed to clarify the order for the amount of millimeters (ml)/centimeters (cm) of fluid to fill the Foley balloon. A review of Resident #13's record revealed a physician's order dated January 6, 2009 that directed, "Change Foley catheter with #16 FR (French)/ 30 ml balloon filled with 10 ml fluid monthly on Friday." A physician's telephone order dated January 28, 2009 and signed by the physician on February 3, 2009, directed, "Irrigate Foley catheter if not draining. Increase size of catheter to #18 with 30cc bag." Facility staff failed to clarify if "bag" was referring to the balloon size of the Foley. Additionally, facility staff failed to clarify the amount of fluid to	F 309	**F371** **Improper labeling and expired food items:** **1. Immediate Response:** 6/10/09 Items identified were discarded. **2. Risk Identification:** 6/10/09 All other food items were checked for proper labeling and expiration dates and items were discarded as needed. **3. Systemic Changes:** 6/23/09 Employees were in-serviced on proper completion of food labels and on the importance of checking expiration dates regularly and discarding expired products. A sample of a completed label was posted on all refrigerators and freezers in the kitchen. **4. Monitoring:** 7/27/09 Cooks will be responsible for checking for completed labels and expiration dates daily per Opening and Closing checklist. Director of Dietary Services or designee will audit and report findings of checklist at Quarterly QA Meetings. **Soiled dusty areas** **1. Immediate Response:** 6/10/09 Ceiling vent, cereal dispensers and sprinkler head were cleaned. **2. Risk Identification:** 6/10/09 Entire kitchen was checked for dust and cleaned as needed. **3. Systemic Changes :** 6/23/09 Staff was in-serviced on new procedure of daily/weekly dusting schedule and included on sanitation checklist. **4. Monitoring:** 7/27/09 Sanitation checklist will be turned in weekly to Director of Dietary Services or designee who will report on findings at quarterly QA meetings.	

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F 309	Continued From page 10 be instilled into the balloon. The above cited order was continued on the 60-day preprinted orders and signed by the physician on April 20 and June 2, 2009. A face-to-face interview was conducted with Employee #3 on June 12, 2009 at 3:00 PM. He/she acknowledged that facility staff failed to clarify the above cited order. The record was reviewed June 12, 2009.	F 309	F371 Continued from page 10 **Uncovered Trashcans** **1.Immediate Response:** Trash can lids were replaced. **2. Risk Identification:** All trashcans were checked for proper lids. **3. Systemic Changes:** Staff was in-serviced on proper procedure to clean trashcans one at a time keeping lids on all other appropriate trash cans. **4. Monitoring:** Precaution to keep appropriate lids in place was added to weekly cleaning checklist and will be monitored by Director of Dietary Services or designee. Findings will be reported at Quarterly QA meetings	**6/10/09** **6/10/09** **6/23/09** **7/27/09**
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour on June 11, 2009 between 9:00 AM and 12:45 PM, it was determined that proper measures were not taken to ensure that residents were protected from accidental injury in the facility as evidenced by unsecured grab bars in seven (7) of 19 resident rooms, unsecured oxygen tanks in 17 of 32 observations and expired eye wash solution in two (2) of two (2) observations. These observations were made in the presence of Employees #4 and 5 who acknowledged these findings. The findings include:	F 323	**Soiled Pots and Pans** **1. Immediate Response:** Rewashed soiled pots and pans then air dried **2. Risk Identification:** All pots and pans were checked for residue and stains and cleaned as needed. **3. Systemic Changes:** Dietary Staff was in-serviced on proper cleaning of pots and pans. **4. Monitoring:** Designated dietary staff will check pots and pans 3 times per week and fill out log to be posted by pots and pans rack. Director of Dietary Services or designee will monitor log monthly and report findings at Quarterly QA meetings. **Sanitizer Solution** **1. Immediate Response:** A test of the sanitizer solution concentration was immediately performed. **2. Risk Assessment:** Other stations using sanitizer solution were checked to ensure proper concentration.	**6/10/09** **6/10/09** **6/23/09** **7/27/09** **6/10/09** **6/10/09**

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F 323	Continued From page 11 1. Grab bars were unsecured in resident rooms #107, 114, 120, 122, 127, 128 and 131 in seven (7) of 19 resident rooms observed and one (1) of two (2) shower rooms observed. 2. Oxygen tanks were observed stored unsecured in the oxygen storage room [downstairs] in 16 of 32 tanks observed and one portable oxygen tank was observed unsecured in one (1) of one (1) portable tank observed. 3. Eyewash solutions were expired as of April 2008 in the oxygen storage room downstairs and in the boiler room in two (2) of two (2) eye wash stations observed.	F 323	F 371 Continued from page 11 **3. Systemic Changes:** **6/23/09** All dishwashers and supervisors were in-serviced on proper testing procedure. A log was placed to note daily sanitizer test. **4. Monitoring:** **7/27/09** Director of Dietary Services or designee will check daily for proper solution concentration on sanitizer log. Director of Dietary Services will report findings at Quarterly QA meeting. **Incomplete Temperature Logs** **1. Immediate Response:** **6/10/09** Checked identified freezer for proper temperature. **2. Risk Assessment:** **6/10/09** Checked all refrigerators and freezers in kitchen for proper temperatures and made sure logs were in place. **3. Systemic Changes:** **6/11/09** Cooks were in-serviced on proper temperature procedures for refrigerators and freezers, and daily use of temperature log. Supervisor in-serviced on reporting temperatures that do not meet standards immediately to Director of Dietary Services or designee for appropriate action. **4. Monitoring:** **7/27/09** Director of Dietary Services or designee to check refrigerators and freezers temperature logs weekly and report findings at Quarterly QA meeting. **F411: Dental services** **1. Immediate Response:** **7/27/09** Dentist contacted so that identified residents were prioritized and will be seen as soon as possible.
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations during the dietary services inspection conducted on June 10, 2009 between 9:05 AM and 2:45 PM, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: Open food items observed improperly labeled; Foods stored beyond the expiration date;	F 371		

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F 371	Continued From page 12 Sanitizing solution for the dish washing machine not verified for correct concentration; Three (3) of five (5) trash cans left uncovered; Dust particles in areas such as ceiling vents, food warmer and cereal dispensers; Incomplete temperature logs on two (2) of three (3) observations. These observations were made in the presence of Employees #6 and 7 who acknowledged these findings. The findings include: 1.Open food items such as a one (1) of one (1) jar of salad dressing, two (2) of two (2)bottles of juice and one (1) of one (1) container of liquid seasoning were opened and not labeled with an expiration date. 2. One-half loaf of wheat bread and one (1) bag of hamburger rolls were stored beyond their expiration date of June 8, 2009 in two (2) of 15 loaves and hamburger roll packages observed. 3. One (1) of one (1) jar of mayonnaise used as a temperature tester and labeled with an expiration date of April 4, 2009 was stored in the salad refrigerator. 4. The top of the food warmer, the ceiling vents, the fire sprinkler in the cooking area and six (6) of six (6) cereal dispensers were soiled with dust particles. 5. Three (3) of five (5) trash cans were observed uncovered. 6. Six (6) of approximately thirty-five (35) pots and	F 371	F411 Continued from page 12 **2. Risk Identification:** Immediate audit was completed by Director of Nursing to determine status of dental visits for other residents. Appointments scheduled if needed. **3. Systemic Changes:** A new dental practice has been contracted by the facility. Every resident will be given a comprehensive exam with appropriate plan of care and record keeping to ensure visits are within required timeframe. **4. Monitoring:** The Assistant Director of Nursing or designee will randomly audit 10% of resident medical records for dental services on a monthly basis. Findings will be reported at Quarterly QA Meetings. **F431** **Expired and Unlabeled Medication** **1. Immediate Response:** Expired meds or loose medication in identified carts were discarded per pharmacy policy. **2. Risk Identification:** All remaining medication storage areas were checked for expired or loose medication and disposed of appropriately if found. Removal was verified by two licensed nurses. **3. Systemic Changes:** Staff to be educated on necessity to remove expired, loose or discharged resident's medication from carts or medication storage areas.	**7/27/09** **7/27/09** **7/27/09** **6/11/09** **6/11/09** **7/22/09**

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F 371	Continued From page 13 pans were observed to be soiled and stained with food residue and/or water stains. 7. The sanitizing solution in the dishwashing machine was not tested to verify the manufacturer's recommended concentration of 50 Parts Per million (PPM). There was no evidence that the facility maintained temperature records/logs for the wash/rinse cycles of the dish machine. 8. The temperature logs entries were incomplete and missing entries dates for the freezer. Additionally, the temperature ranges were above facility set values of zero (0) to ten (10) degrees with no written corrective actions taken	F 371	F431 Continued from page 13 **4. Monitoring:** Nursing supervisors to monitor carts and storage areas weekly and report findings to Director of Nursing or designee who will report findings at Quarterly QA meeting. **F456** **Damaged Door Handle** **1. Immediate Response:** Handle was repaired. **2. Risk Assessment:** All other refrigerator door handles were checked for good working condition. **3. Systemic Changes:** Maintenance Contractor will check all refrigerator door handles during their scheduled Quarterly Preventive Maintenance inspections.	**7/27/09** **6/20/09** **6/11/09** **7/2/09**
F 411 SS=D	483.55(a) DENTAL SERVICES - SNF The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for	F 411	**4. Monitoring:** Director of Engineering or designee will check handles during Quarterly Safety and report finding at quarterly QA meeting. **F 492** **Missing History and Physical** **1. Immediate Response:** Physician faxed copy of missing History and Physical which was replaced in the resident's medical record. **2. Risk Identification:** Complete audit of all medical records was completed to assure that medical records were current for H/P. **3. Systemic Changes:** In-service given to QA Assistant for process on maintaining current H/P on medical records.	**7/28/09** **6/11/09** **6/26/09** **7/27/09**

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F 411	Continued From page 14 three (3) of 15 sampled residents, it was determined that facility staff failed to ensure that routine dental examinations were performed and/or offered to residents. Residents #3, 4 and 7. The findings include: 1. Facility failed to provide a dental screen for Resident #3. A review of the clinical record revealed that Resident #3 was readmitted to the facility January 23, 2008. The Physician Order sheet and Plan of Care form read, "Dental consult, reason yearly and PRN (as needed)." No records for dental consultation between April 2008 and June 2009 were found on Resident #3's clinical record. A face-to face interview was conducted with Employee #3 on June 10, 2009 at 9:55AM. He/she acknowledged after reviewing the clinical record that no dental consult was found and they will check to see if it was with medical records office. A follow up face-to-face interview was conducted with Employee #3 on June 11, 2009 at 1:30 PM. He/she acknowledged that they could not find a dental consult for Resident #3. This record was reviewed June 11, 2009. 2. Facility staff failed to ensure that a routine dental screen was offered and/or performed for Resident #4. A review of Resident #4's clinical record revealed	F 411	F492 Continued from page 14 **4. Monitoring:** Monthly audits to be performed on a random sample of 10% of medical records for current H/P. Findings to be reported to Director of Nursing or designee who will report at Quarterly QA meetings. **F514** **Clinical Records** **1.Immediate response:** Clinical records were updated where appropriate for identified issues. **2.Risk Assessment:** Resident clinical records were audited to assure that allergies, insulin amounts administered and fall notification to families were appropriately documented. **3. Systemic Changes:** Licensed nursing staff were in-serviced on the importance of documenting in the clinical record allergies, insulin amounts administered and notification to families when a resident falls. **4. Monitoring:** An audit will be performed by the DON or designee to insure that allergies and insulin amounts administered are appropriately documented on a quarterly basis. Fall notification to families will be checked at Safety Committee held weekly to insure that there is appropriate documentation in the clinical record of said notification. Results will be reported at Quarterly QA Meetings.	**7/27/09** **6/12/09** **7/27/09** **7/22/09** **7/27/09**

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F 411	Continued From page 15 a "Report of Consult" form dated May 8, 2007 ...Dental Consult ..." Further review of the record lacked evidence that a dental screen was performed since May 2007. A face-to-face interview was conducted on June 11, 2009 at approximately 2:40 PM with Employee #2. He/she stated, "[Resident #4] stated that he/she did not want that to be seen by the dentist; and acknowledged that a dental screening was not performed and/or offered since May 2007. The record was reviewed on June 11, 2009. 3. Facility staff failed to ensure that routine dental screens were performed for Resident #7. A review of Resident #7 ' s clinical record revealed a " Report of Consult " - Dental Examination dated October 16, 2007. Further review of the record lacked evidence that a dental screen was performed since October 2007. A face-to-face interview was conducted on June 12, 2009 at approximately 10:00 AM with Employee #3. He/she acknowledged that a routine dental screening has not been performed since October 2007. The record was reviewed on June 12, 2009.	F 411		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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F 431	Continued From page 16 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed in two (2) of three (3) the medication carts and one (1) of one (1) treatment cart, to remove two (2) of four (4) expired medications, six (6) of six (6) unlabeled medications, three (3) of three (3) discontinued medications and in an isolated incident personal medication for Resident JH1.	F 431		

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F 431	Continued From page 17 The findings include: 1. The facility staff failed to remove expired, unlabeled (no patient's name on medications) and/or discontinued drugs form the medication carts and the treatment cart. On June 11, 2009, between 10:00 AM and 4:30 PM, during the inspection of the medication storage areas, expired, unlabeled (no patient's name on medications) and/or discontinued drugs were observed in the medication carts and the treatment cart as follows: Team A Medication Cart: Guaifenesin 100 gm /5ml syrup, discontinued April 11, 2009 Diabetic Tussin syrup, discontinued April 4, 2009 Guaifensin 100gm/ 5ml syrup, discontinued February 2, 2009 USP Sterile Water, expired 6/2009 Xalantan eye drops, opened April 2, 2009 (1) Pantroprazole 40 mg capsule (1) Spironalactone 25 mg tablet (3) Furosemide 20 mg tablet (1) Metoprolol 25 mg tablet (1) Metolazone 2.5 mg tablet (1) Tobradex 3.5gm ointment Team B Medication Cart: Xalantan eye drops, opened April 2, 2009 Treatment Cart: Ketoconazole cream 2% 60 gm, discontinued May 12, 2009 The above findings for the medication and treatment carts were acknowledged by Employee	F 431		

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F 431	Continued From page 18 #8 and 9 on June 11, 2009, at the same time of the observation. 2. The facility failed to remove a resident's personal medication from the medication cart. On June 11, 2009, between 10:00 AM and 4:30 PM, during the inspection of the medication carts, a bag of medication in vials were observed stored in Team A's medication cart. The medications were Amlodipine10 mg tablets, Aricept 10 mg tablets, Simvastin 40 mg tablets, Lisinopril 20 mg tablets, Phenazopyridine100 mg tablets, and Primidone 50 mg tablets were identified by Employee #8 as Resident JH1's personal medications. A face-to-face interview was conducted at the same time of the inspection with Employee #8. He/she stated that the resident's own medications should have been given to the family or discarded.	F 431		
F 456 SS=D	483.70(c) (2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during a tour of the main kitchen on June 10, 2009 between 9:05 AM and 2:45 PM, it was determined that facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by one (1) of two (2) refrigerator door handles was observed damaged.	F 456		

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F 456	Continued From page 19 These observations were made in the presence of Employees #6 and 7 who acknowledged these findings. The findings include: One (1) of two (2) door handles to the salad refrigerator was observed damaged.	F 456		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that the physician failed to complete a History and Physical (H&P) examination annually for Resident #6. The findings include: A review of the record revealed an H&P dated March 15, 2008. District of Columbia, Title 22, Chapter 32, "Nursing Facilities, Physician Services and Medical Supervision of Residents", Section 3207.11. states that "Each resident shall have a comprehensive medical examination and evaluation of his/her health status at least every twelve (12) months, and documented in the	F 492		

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F 492	Continued From page 20 resident's medical records". The H&P due in the month of March 2009 was not found on Resident #6's clinical record. A face-to-face interview was conducted with Employee #3 on June 10, 2009 at 10:00 AM. He/she checked the record and acknowledged that the H&P dated March 15, 2008 was the only H&P on the record. A follow up face-to-face interview conducted with Employee #3 on June 11, 2009 at 12:30 PM. He/she stated, "I called the physician's office and a copy of the H&P dated March 11, 2009 was faxed to the facility." The record was reviewed on June 11, 2009.	F 492		
F 514 SS=D	483.75(l) (1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviewed of three (3) on 15 sampled residents it was determined that facility staff failed to document the amount of insulin administered on the	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095025	A. BUILDING _____ B. WING _____	06/12/2009

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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F 514	Continued From page 21 medication administration failed to document allergies on the interim orders for one (1) resident and failed to document that the family was notified of a fall for one (1) resident. Residents #5 and 12. The findings include: 1. Facility staff failed to document the sliding scale insulin amount given to Resident #5 when his/her blood sugar [BS] levels were greater than 150. A review of the Medication Administration Record for April 2009 revealed that on April 1, 2009 at 1100 - BS = 166 and no sliding scale cover was documented as begin given. April 16, 2009 at 1100 - BS= 255 and no sliding scale cover was documented as begin given. April 24, 2009 at 1100 - BS= 189 and no sliding scale cover was documented as begin given. April 27, 2009 at 1100 - BS= 211 and no sliding scale cover was documented as begin given. A face-to-face interview was conducted on June 12, 2009 at approximately 1:00 PM with Employee #8. He/she stated, "The computer system failed, not allowing me to add the amount of insulin given to the resident. I gave the correct amount of insulin but I didn't document it in the computer system." The record lacked documented evidence of the amount of insulin given when Resident #5's blood sugar levels were greater than 150. The record was reviewed on June 12, 2009. 2. Resident #5 allergies not documented on interim order sheet.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 22 A review of the interim order sheet dated June 4, 2009 revealed, "...Allergies:" were left blank. According to quarterly Minimum Data Set completed March 23, 2009, Resident #5 was coded for allergies. A review of the care plan entitled "Allergies" Resident #5 was allergic to Penicillin and Carbapenem. The record lacked documented evidence that the Resident #5's allergies were listed on the interim order sheet. A face-to-face interview was conducted on June 12, 2009 at approximately 1:00 PM with Employee #8. He/she acknowledged that the allergies were not listed on the interim order sheet. The record was reviewed June 12, 2009. 3. Facility staff failed to document in the clinical records that Resident #12's family was notified after a fall. A review of the clinical records revealed a nurse's note dated June 2, 2009 at 10:45 PM that read "... Resident was observed on the floor in his/her bedroom in a sitting position beside the bed." There was no documentation in the nursing notes that the family was notified of the resident's fall on/after June 2, 2009. A face-to-face interviewed was conducted with Employee #3 on June 11, 2009 at 8:55 AM. He/she acknowledged that there was no documentation that	F 514		

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F 514	Continued From page 23 the resident fell. A follow up face-to-face interview was conducted with Employee #1 on June 11, 2009 at 1:30 PM. He/she acknowledged that they could not find a notification to family that the resident fell in the chart but a copy of the incident report that is not part of the resident's record showed a check mark at statement that prompted "yes, family was notified" was offer as proof that the family was notified. This record was reviewed June 11, 2009.	F 514		