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	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lisner Louise Dickson Hurthome	5425 Western Ave NW Washington, DC 20015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) of five (5) sampled residents, facility staff failed to report an incident of injury of unknown origin to the State Agency within 24 hours. Resident #5.The findings included: Resident #5 was admitted to the facility on [DATE] with multiple diagnoses that included: Repeated Falls, Difficulty Walking, and Seizures.Review of the resident's medical record revealed the following: A Modification Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 06, indicating severe cognitive impairment; no functional limitations in range of motion; used a walker and wheelchair mobility devices; required substantial/maximal assistance for toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene; and no falls since the prior MDS assessment.08/05/25 at 7:10 AM Nurses Note: Resident c/o (complained of) rt (right) hip pain, resident stated, 'I can't get OOB (out of bed), my rt hip hurts'. Upon assessment rt hip noted to be bigger than the left one, and it's warm to touch. PRN (as needed) Tylenol (pain medication) 500mg (milligrams) 2 tabs (tablets) given as ordered for pain with no relief.08/05/25 at 7:33 AM eInteract Situation Background Assessment Request (SBAR) Summary:- Situation: New or worsening edema and uncontrolled pain.- Primary care provider responded with the following feedback: X- ray of rt hip ordered.08/05/25 at 9:54 PM Radiology Results: - - Right Hip, Unilateral w/ Pelvis when performed, 1 View.- - Findings: There is an acute comminuted displaced intertrochanteric fracture involving the right femur with associated soft tissue swelling. A physician's order dated 08/05/25 directed, Transfer resident to hospital emergency department for evaluation of acute comminuted displaced intertrochanteric fracture involving the right femur with associated soft tissue swelling.08/06/25 at 6:31 AM Communication with Emergency Department: - - Call placed to [Hospital Name] emergency room (ER), spoke with the nurse at the ER who stated that the resident (Resident #5) has a femur fracture and is being admitted .A Facility Reported Incident (FRI), intake #2588424, submitted to the State Agency on 08/08/25 at 11:11 AM documented in part, On 8/5/2025 at approximately 7am resident c/o right hip pain and could not get out of bed. Hip site appeared swollen and warm to touch. X-ray was ordered and PRN pain medications were given. X-ray results returned with acute comminuted displaced intertrochanteric fx. (fracture) of right femur with associated soft tissue swelling.There has been no evidence or report of a fall.Full investigation is underway. The evidence showed that Resident #5 sustained an injury of unknown origin (right hip fracture) and that facility staff were aware of this on 08/05/25. However, this was not reported to the State Agency until 08/08/25, three (3) days later. During a face-to- face interview at 09/23/25 at 3:35 PM, Employee #2 (Director of Nursing/DON) acknowledged that facility staff failed to report of an injury of unknown origin to the State Agency within 24 hours and stated, I was having IT issues and couldn't send off the report. It was typed up and I had to wait until someone was able to help me to send it off.Cross Reference 22B DCMR Sec. 3232.4

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) of five (5) sampled residents, facility failed to ensure the physician signed and dated progress notes at the time of each visit. Resident #1. The findings included:Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Depression, Anxiety Disorder, Sepsis, Hyperlipidemia and Intrahepatic Bile Duct Carcinoma.Review of the resident's medical record revealed the following:An admission Minimum Data Set (MDS) assessment date 07/09/25 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15 indicating, intact cognitive status; Resident Mood Interview (PHQ-2 to 9 (C)) total severity score of 05 indicating mild depression; and received antianxiety and antidepressant medications.07/20/25 Initial Psych Consultation Note:- - Appetite decreased.- - Depression moderate.- - Gradual dose reduction: clinically contraindicated.- - Patient reports persistent feeling of low mood and lack of motivation. - - Recommendations and plan: continue antidepressant medication regimen; consider adjustment to address low motivation - Wellbutrin (type of antidepressant) 150 XL (extended-release) mg (milligrams) daily.- - Discussed risk and benefit of multiple antidepressants including serotine syndrome. 07/20/25 at 5:25 PM Nurses Note: Resident was seen by the Behavior MD (medical doctor) on unit, new order entered for Wellbutrin ER 24 hours 150 mg in am for depression. Resident (self RP) made aware of the new order. Review of the initial psych consultation note showed that the physician signed the note on 09/10/25 at 2:59 PM, 52 days later.The evidence showed that facility staff failed to ensure that the physician signed and dated Resident #1's progress note at the time of the visit.During a telephone interview on 09/19/25 at 10:52 AM, Employee #4 (Doctor of Nurse Practitioner - Psychiatric-Mental Health) acknowledged the findings and stated, This is a bad habit. I like to read over my notes and make sure I have everything documented and then I'll get pulled away and forget to sign.Cross Reference 22B DCMR Sec. 3207.10