#### PRINTED: 10/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A, BUILDING 8. WING 095015 08/11/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **CAROLYN BOONE LEWIS HEALTH CARE CENTER** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (XS) (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Carolyn Boone Lewis Health Care Center, F 000 INITIAL COMMENTS F 000 "CBL", is filing this Plan of Correction in accordance with the compliance requirements for federal and state An annual re-certification survey was conducted on regulations. This Plan of Correction August 2 through 11, 2010. The following constitutes the facility's written allegation of deficiencies were based on observations, staff and compliance for the deficiencies cited. resident interviews and record review. The sample However, submission of this Plan of size included 26 residents based on a census of Correction does not constitute admission of 167 the first day of survey, with 30 supplemental facts or conclusions cited. residents. Complaint #s DC00002000, DC00002001 and DC00002002 were also investigated during this The responses to the deficiencies in the Plan SULVEY. of Correction will be answered in the F 164 483.10(e), 483.75(I)(4) PERSONAL F 164 following numerical sequence: PRIVACY/CONFIDENTIALITY OF RECORDS SS=D 1. How will the corrective actions be accomplished for those residents The resident has the right to personal privacy and found to have been affected by the confidentiality of his or her personal and clinical deficient practice? records 2. How will you identify other residents having the potential to be affected by the same deficient practice and Personal privacy includes accommodations. what corrective action will be taken? medical treatment, written and telephone 3. What measures will be put in place communications, personal care, visits, and or what systematic changes you will meetings of family and resident groups, but this make to ensure that the deficient does not require the facility to provide a private practice does not occur. room for each resident. 4. How do you plan to monitor your performance to make sure that Except as provided in paragraph (e)(3) of this solutions are sustained? section, the resident may approve or refuse the release of personal and clinical records to any 483.10(e), 483.75(l)(4) PERSONAL individual outside the facility. PRIVACY/CONFIDENTIALITY OF RECORDS The resident's right to refuse release of personal Ftag 164 and clinical records does not apply when the It is this facility's practice to ensure that the resident is transferred to another health care facility's staff maintain resident privacy/ institution; or record release is required by law. confidentiality (records). Privacy/ Confidentiality and HIPAA is reviewed on The facility must keep confidential all information hire with new staff and at least annually with contained in the resident's records, repartless of the current staff. A notice of privacy practices the form or storage methods, except when release and resident rights is reviewed with residents is required by transfer to another healthcare and/responsible parties on admission via the Institution; law; third party payment admissions agreement packet. LABORATOR ECTOR'S OR PROVIDER/50PPLIER REPRESENTATIVE'S SIGNATURE (XS) DATI TITLE

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 declosable 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 perticipation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 164	This REQUIREMEN Based on observation four (4) of 26 sar	IT is not met as evidenced by: ons, record review and interview mpled residents, it was	F.	164	Continued From page 1 F tag 164 #1 - Resident #5 1. The corrective action achie Resident #5 was that Reside informed by the DON on priv measures to expect from the rendering of care.  2. All residents have the pote	nt #5 acy a staff	has been nd dignity during the	10/19/10
	determined that facility staff failed to maintain resident privacy: during wound treatments and by maintaining the medication administration record in the open position while unattended. Resident #5, 6, 12 and 19.  The findings include:  1. Facility staff failed to maintain privacy during a				affected by this practice. As action Unit Managers/design random monthly audits to entresident's privacy and confidits maintained during the provinch includes, however is now ound care treatment.	a cor ee wi sure t ential isions	rective Il complete hat ity (records) s of care,	
	treatment to Reside August 3, 2010 at 1 in his/her bed that w entry door.  The privacy curtain beds that occupied to was not was not dra	observed providing wound nt #5 's lower extremities on 1:10 AM. The resident was lying as positioned proximal to the was drawn between the two the room, however, the curtain wn to obscure visualization from The entry door of the room			3. The systematic change/me correct this practice have been staff has been educated on a 10/25/10 privacy/confidential the Educator and via the distribution of an education part 4. A report of the random res	en: eside ty (re ibutio ional party ords) v	ent cords) by on of a packet. education via the	10/25/10
	2. The facility staff fawound treatment ob Resident #6.	ailed to ensure privacy during a servation for			and confidentiality audit(s) we the DON/designee of any complemented and indications further education. The result will be reported by the DON/CQI committee monthly for the quarterly. A report of prand corrective actions implements	II be prective of the soft to Designation of the	provided to we actions e need for his audit nee to the nonths, his identified	

#### Continued From page 2

presented. The CQI committee will determine the need for other interventions and the frequency of further audits.

#### F tag 164 #2 - Resident #6

1. The corrective action achieved for Resident #6 was that they have been informed by the Unit Manager on privacy and dignity measures to expect from the staff duning the rendering of care.

10/23/10

- 2. All residents have the potential to be affected by this practice. As a corrective action Unit Managers/designee will complete random monthly audits to ensure that resident's privacy and confidentiality (records) is maintained during the provisions of care, which includes, however is not limited to wound care treatment.
- 3. The systematic change/measures taken to 10/25/10 correct this practice have been:

Staff has been educated on resident 10/25/10 privacy/confidentiality (records) by the Educator and via the distribution of a self-learning resource educational packet. and Resident and/responsible party education on privacy/confidentiality (records) via the distribution of an education packet.

10/28/10

4. A report of the random resident privacy and confidentiality audit(s) will be provided to the DON/designee of any corrective actions implemented and indications of the need for further education. The results of this audit will be reported by the DON/Designee to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits.

#### #3 - Resident #12

- 1. The facility is unable to implement corrective 10/ 19/10 action(s) for Resident#12due to them no longer residing at the facility.
- 2. All residents have the potential to be affected by this practice. As a corrective action Unit Managers/designee will complete random monthly audits to ensure that resident's privacy and confidentiality (records) is maintained during the provisions of care,

If continuation sheet Page 2 b of 212

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F 164	failed to ensure privaduring the wound tree.  On August 4, 2010 at Employee #32 had effe, (door remaining Resident #6 was part the waist, legs exposionstantly readjustine exposing more of his time (9:22 AM) aske Resident #6 brought #32 of another skin at Employee #32 left of additional items to addor open), cleaned covered the wound. Throughout the entire 2nd wound.  A face-to-face interved Employee #5 after reacknowledged that the closed during the word the door during a word the observation was 3. Facility staff failed to the door during a word the staff failed to the door during the word the staff failed to the door during the word the staff failed to the door during the word the staff failed to the door during the word the staff failed to the door during the word the staff failed to the door during the word the staff failed to the door during the word the staff failed to the door during the word the staff faile	acy by leaving the door open eatment.  at approximately 9:15 AM entered the room of Resident open) as he/she washed hands. It ally dressing from top down to sed, and in a disrobing manner of his/her clothing periodically sher body. Employee #5 at this does not not be attention of Employee enteration on his/her right leg. The tothe attention of the room to retrieve sees and treat wound (left the 2nd wound with solution and Door remained open a cleaning and dressing of the liew was conducted with eview of the process he/she he door should have been	F 16	F tag 164 which includes, however is now wound care treatment.  3. The systematic change/me correct this practice have been staff has been educated on a privacy/confidentiality (record Educator and via the distribution of an education pactor of the random resignant confidentiality audit(s) with the DON/designee of any confidential to reported by the DON/CQI committee monthly for the then quarterly. A report of presented. The CQI committee the need for other intervention frequency of further audits.	easures taken to en:  esident  s) by the  ion of a  ional packet.  party education  ords) via the  cket.  ident privacy  Il be provided to  rective actions  of the need for  s of this audit  Designee to the  iree months,  oblems identified  nented will be  be will determine	
	Employee # 32 was Medication Administ	at approximately 9:56 AM, observed leaving the ration Book open on medication ring medications to Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MI A. BUII		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 164	A face-to-face inter Employee #5 on Au 11:00AM. He/she a #32 should have clo Administration Reco	ge 3  view was conducted with  igust 4, 2010 at approximately acknowledged that Employee bed the Medication  ord before proceeding to t #12 's medications.	F	164	Continued From page 3  F tag 164  #4 - Resident #19  1. The corrective action achie Resident #19 was that they hinformed by the Unit Manage privacy and dignity measures the staff during the rendering  2. All residents have the pote	ave r on s to e of c	been 10/23/10 expect from eare.	10/23/10	
	wound care treatment area on August 10, AM. The resident only the shoulders. Employee #35 proceare further exposing pelvic areas. The resident of the resident	s observed in bed, during a ent to the abdominal umbilicus 2010 at approximately 10:55 s gown was adjusted to drape At the end of the treatment, eeded to do the left thigh wound ag her undraped abdomen and esident 's upper chest, ic areas were exposed			affected by this practice. As action Unit Managers/design random monthly audits to enresident's privacy and confid is maintained during the provinch includes, however is now wound care treatment.  3. The systematic change/metals.	a coree we sure entia	rrective vill complete that tlity (records) as of care, nited to	10/25/10	
	A review of the resiphysician's order of Cleanse abdominal solution and apply prover with dry dress normal saline, apply dry dressing. "  Facility staff failed to of body parts during treatment to Reside A face-to-face internemployee #5 on Au 1:00 PM. He/she a should have not be was "doing wound."	dent 's record revealed a dated July 20, 2010 directing " umbilicus with Normal saline polysporin and calcium alginate, sing. Clean left thigh wound with y silver hydrogen and cover with prevent unnecessary exposure the provision of wound care and #19.  View was conducted with gust 10, 2010 at approximately cknowledged that the resident en exposed while Employee #35 care and the area receiving the			Staff has been educated on a privacy/confidentiality (record Educator and via the distribut self-learning resource education and resident and/responsible on privacy/confidentiality (record distribution of an education part 4. A report of the random residentiality audit(s) with a DON/designee of any complemented and indications further education. The result will be reported by the DON/CQI committee monthly for the	en: reside ds) by tion ( tiona party rds) v cket. dident ill be rrecti of th s of th	ent y the of a l packet. r education via the  t privacy provided to ive actions ne need for this audit gnee to the months,	10/28/10	
	Facility staff failed to of body parts during treatment to Reside A face-to-face interembloyee #5 on Au 1:00 PM. He/she a should have not becwas " doing wound	wiew was conducted with agust 10, 2010 at approximately cknowledged that the resident en exposed while Employee #35 care and the area receiving the be exposed. "The record			on privacy/confidentiality (reco distribution of an education pa 4. A report of the random res and confidentiality audit(s) w the DON/designee of any co implemented and indications further education. The result will be reported by the DON/	rds) vicket. sidentially be rection of the content	t privacy provided to ive actions ne need for this audit gnee to the months, ms identified		

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F 166 SS=D	RESOLVE GRIEVA A resident has the facility to resolve grincluding those with residents.  This REQUIREME Based on observatinterview, it was de logged a grievance misappropriation of for an outpatient ap The findings includ  On August 4, 2010 was conducted with member]. Stated, however when more money from his draftom a scheduled a tank had not been that accompanied in that accompanied in the conduction of	right to prompt efforts by the prievances the resident may have, the respect to the behavior of other the facility failed to the for a complaint of of funds and availability of oxygen prointment for Resident #16.  The resident #16 is [family interview the Resident #16] enjoys Bingo, and the second to return appointment because the oxygen turned on, and the young lady him/her had no key to turn it on. "It is approximately 3:00 PM, and approximately 3:00 PM, a face-to-be conducted with Employee #5. The incident with the oxygen was approximated the oxygen was not it was working before he left. A the included the facility is	F 166	Continued From page 4 The CQI committee will determ the need for other interventions frequency of further audits.  483.10(f)(2) RIGHT TO PROM TO RESOLVE GRIEVANCES Ftag 166 It is the policy of this facility to resolution process that promptly grievance(s) of residents/responsistors/staff.  1. The corrective actions according the family member of Responsivity of the family member of Responsivity of the misappropriation and availability of oxygen.  Staff education was conducted nursing department at the time Resident#16's return to the factor management/ operation of the The grievance log has been up Administration to reflect the convariability and misappropriation follow-up to the concern made #16's family member.  2. All residents utilizing oxygen potential to be affected by this assessment of the key (wrench for oxygen tank management who the Central Supply Coordina corrective actions implemented providing additional keys to material.	ave a problem addresses the asible parties/ mplished for is that the communicated sident #16 in of funds  d by the expectation of funds  d by the expectation of funds in the parties of funds in the practice. An h) availability was completed ator and d entailed	

#### Continued From page 5

for staff managing oxygen tanks.

A review of the grievance log has been conducted to:

ensure that all documented grievances received reflect on the Grievance Log. Residents/ Responsible parties/Staff have been educated on the documentation of grievances and how to request a copy for confirmation.

3. The measures taken to correct this practice 10/19/10 are:

Education for the licensed and unlicensed nursing staff on the operation/management of oxygen tanks by the Director of Education during the facility's Competency Skills Fair. and

A review of the Grievance Policy and Procedures; the Concerns and Comments form was conducted on 09/09/10 and revisions have been made. Education was provided on the revised policy on 09/10/10 to residents in attendance at the Resident Council Meeting and on 09/30/10 to responsible parties/family members present during the Family Council Meeting. In addition policy to was distributed to residents and/family members/staff. The Grievance policy and procedure has been posted on each residential level at the facility.

4. Random audits of residents receiving oxygen going on appointments will be conducted by the Unit Managers/Designee monthly. A report of problems identified and corrective actions implemented will be presented to the CQI committee The grievance log will be reviewed on a monthly basis by the Director of Social Services /Designee to ensure that all concerns/grievances have been addressed in accordance with the facility's policy. Corrections that can be made upon discovery will be made. A report of the findings of this review and problems identified along with; along with corrective actions will be presented to the CQI committee on a monthly basis for the next three months. Quarterly reporting will be made to the CQI committee thereafter.

10/28/10

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F 166	Continued From page 5  On August 5, 2010 at approximately 10:15 AM, a face-to-face interview was conducted with Employee #22. He/she stated, "When [Resident #16] was first admitted, he/she was in and out of the hospital frequently. I had not heard about money being left for him to play Bingo. I will call [the family] and discuss this with her. Moving forward, the family can give him/her the money and he/she will make sure [Resident #16] will attend Bingo. "  Observation made on August 10, 2010 at approximately 2:00 PM, Resident #16 was in the activity room playing Bingo with other residents.  According to the facility's policy titled "Grievance Policy and Procedure, Policy & Procedure No. 112, Revised 08/3/07, pp129", revealed "each grievance will be logged in an administrative record kept by the Administrator and maintained for at least three (3) years after the date of filing and shall be available to the Director of Human Services."  Although, Employees #5 and #22 pointed out that there was an investigation on the availability of oxygen and of misappropriation of funds for Resident #16, there was no formal grievance logged in the book. The record was reviewed August 6, 2010.		F	166	Continued From page 5b			
F 221 SS=G	483.13(a) RIGHT TO RESTRAINTS	BE FREE FROM PHYSICAL	F	221	483.13(a) RIGHT TO BE FR PHYSICAL RESTRAINTS. Ftag 221, #1	EE FI	ROM	
	physical restraints in	right to be free from any apposed for purposes of ence, and not required to treat al symptoms.			A corrective action was unachieved with Resident CBL resident no longer residing a	2 due	to this	0/19/10

, in the second		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SUF COMPLET	
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F 221	Based on observation interview, it was det to ensure freedom fresident who sustain and failed to identify restraint for eight (8)	ge 6  IT is not met as evidenced by:  ons, record review and staff fermined that facility staff failed from restraints for one (1) ned an injury while restrained of full bilateral siderails as a ) residents. Residents CBL2, cBL23, CBL24, CBL25, CBL26,	F 22	<ol> <li>All residents have the po affected. An audit was con residents using restraints for appropriateness of the restractions were implemented a 3. The Restraint Authorizati Resident Abuse, Neglect, N</li> </ol>	ducted of or the aint. Corrective as needed. on and the lisappropriation	10/19/10
	and CBL27 The findings include 1. Facility staff failed	e: d to protect Resident CBL2 from e resident sustained a right hand		of Property policies have be and updated. Staff has been the policies, the overall produse, and what constitutes at 4. A Restraint audit will be a by the Unit manager/design	n in-serviced on cess of restraint buse. completed monthly ee. A report will	10/28/10
	A review of the Mark Data Set (MDS) cor revealed that the 97 to the facility with di Alzheimer 's Diseas Hypertension and R 2009 MDS was cod (cognitive decision in memory problems. E1 and E4 (Mood/B Symptoms) indicate problems in these and A copy of an investiful allegation of Suspect Resident CBL2 was facility. The report in	ch 12, 2009 admission Minimum ntained in the clinical record year old female was admitted agnoses which included se, Dementia, Glaucoma, tenal Failure. The June 10, ed in Sections B2a and B2b making) with long and short term A score of zero (0) in Sections ehavior and Psychosocial ed that the resident had no reas.  gative report regarding an cited Abuse and Neglect of given to the survey team by the indicated that the resident		be provided to the Director Nursing/designee of problet. The results of the above aureported to the CQI commit the Director of Nursing/desi of problems identified and committee will be present committee will determine the interventions and need and further audits. Corrective a reviewed by the Administration plans will be implemented.	ns identified. dit will be tee monthly by gnee. A report orrective actions ted. The CQI e need for other frequency of ctions will be tor and corrective	
		of unknown origin (fracture of 5th metacarpal of the right				

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F 221	which was complete submitted to the Sta following information who was on duty on the alleged incident] and walking up and unsteady gait. The Someone said " Tie report continued, "T Nursing Assistant to [the CNA] got the charact time of the the resident and tied. The exact time of the but according to the as reported by the fathe evening shift Seldocumented by Emplication 1:30PM on Septembly who was monitoring charge nurse that the discomfort, was tied received any ADL [A assistance or care."  As documented on Sthe day staff and the informed that the resight, but no mention being tied down. Ho 1:30PM the resident chair in the day room the CNA monitoring sheet and informed that any ADL assistance	nclusion of Incident Report" d by Employee #2 and te Agency revealed the h. According to the supervisor September 19, 2009 [the day of the resident was very agitated down the hallway with an supervisor continued " her up and they did." The the supervisor asked a Certified get a recliner chair. He/she air and placed a sheet around I it to the back of the chair." the incident was not documented documentation of the incident documentation of the incident document 19, 2010. The report as alloyee #2 at approximately ther 20, 2009 stated, "The CNA the day room, reported to the the resident was, complaining of with a sheet and had not dictivities of Daily Living]  Sunday September 20, 2009, " In ursing supervisor were sident had been agitated all in was made of the resident wever, at approximately who was still in the recliner in complained of discomfort and the residents noticed the tied the charge nurse. At this time it the resident had not received or care." The report further londay September 21, 2009 the	F	221	483.13(a) RIGHT TO BE FR PHYSICAL RESTRAINTS Ftag 221, #2 a-h 2. A screen has been completed by the rehabilitation the residents #13, #21, C CBL 24, CBL25, CBL26 and Siderails have been remove appropriate and/ physician obeen obtained as needed. The residents identified above has reviewed and corrected to encoding.  2. An audit of current reside siderails have been completed the night shift supervisor and MDS's of these residents has been reviewed for MDS concorrections.  3. The Restraint Authorization been re-evaluated and update been in-serviced on the Use policies. Staff has also been the coding of the MDS in referent and modern in the coding of the MDS in referent and modern in the coding of the Restraint and MDS audit completed monthly by the UD Designee. A report will be ponce and the committee monthly by the Din Nursing/designee. A report of identified and corrective action in the results of the Restraint and modern in the results of the results of the reported to committee monthly by the Din Nursing/designee. A report of identified and corrective action interventions and need and for the results are results of the results of the results and need and for the results and need and	on de BL22 CBL das rders e MC ve be sure et de la control	partment , CBL23, 27. have S's for the een proper  ith / icy has Staff has estraint cated on e to  e anager/ ed to the ified.  CQI of blems he CQI I for other	10/19/10
	revealed that, "on M	londay September 21, 2009 the			implemented will be presente committee will determine the	ed. T	I for other	

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F 221	resident's right hand. The report concluderight hand that revea of the 5th metacarpa. Per the facility's report the recliner chair with shift on September sleep through the niar result the resident the distal 3rd of the also documented the adequate care." Per failed to provide ADI evening shift September 20, 2005.  Based on the evider and staff interview, if acility staff physical they tied him/her to allowed to sleep in the night and subserdistal 3rd of the 5th while he/she was in care or assistance us september 20, 2005.  A face-to-face internet Employee#2 at appr 10, 2010. He/she as the facility tied the reprevent him/her from sustained a fracture.	I was discolored and swollen." Id with an x-ray report of the aled a fracture of the distal 3rd al.  Ort, "the staff tied the resident to the a sheet [during the evening 19, 2009], allowed him/her to ght in the recliner chair; and as suffered an injury " [fracture of 5th metacarpal]. The report at the resident "did not receive er the documentation the staff L care to the resident from mber 19, 2010 until 1:30PM on 3.  Ince in the documents reviewed thas been determined that ly abused the resident when a recliner chair with a sheet. Evealed that the resident was the chair while restrained during quently suffered a fracture of the metacarpal of the right hand the chair and received no ADL intil 1:30PM on Sunday 3.  View was conducted with roximately 4:00PM on August cknowledged that employees of esident to a chair with a sheet to a walking and that the resident of the distal 3rd of the 5th ght hand while restrained. The	F	221				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	095015 NAME OF PROVIDER OR SUPPLIER			IG		08/11/2010		
		ALTH CARE CENTER		138	ET ADDRESS, CITY, STATE, ZIP CODE BO SOUTHERN AVE SE ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE	
F 221	2010, it was determidentify full bilateral them as the least resystematic process prior to their implem (8) residents:  a.) A review of the revealed facility state extended the full lear estraint and follo planning and evaluateam for the least reimplementation.  Resident #13 's diacardiovascular disecongestive heart fapulmonary disease arteriosclerotic cardiovascular disease arteriosc	tour of the facility on August 2, nined that facility staff failed to siderails as a restraint, identify estrictive device and follow a of evaluation and care planning nentation for the following eight clinical record for Resident #13 ff failed to identify side rails that ngth of both sides of the bed as w a systematic process of care ation by the interdisciplinary estrictive device prior to its agnoses included hypertensive ase, diabetes mellitus, dementia illure, chronic obstructive	F	221				
	wheelchair. Section resident sustained P, Devices and Resused."	a J, Accidents revealed the a fall in the past 30-days. Section straints was coded as "not dated July 2, 2010 directed						
	times as part of fall.  The resident was of	m activated when in bed at all s management to alert staff." bserved lying in bed on August nately 9:00 AM. Full side rails						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED		
	095015		B. WIN	IG_		08/11/2010		1/2010	
	ROVIDER OR SUPPLIER	LTH CARE CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE	CROSS-	(X5) COMPLETION DATE	
F 221	were observed on eposition.  The clinical record laidentified the side raevidence that the interpretation determine the side redevice. There was nand/or responsible pregarding the risks/brails.  (b). Facility staff failed a restraint and initial evaluation and care as a restraint. Resident #21 was of the facility on Augus 10:30 AM. He/she will will be sideralls up. Upon in a very long time, the up while I am in bed.  This statement was Employee #5. Employe	ach side of the bed in an upright acked evidence that facility staff ils a restraint. There was no rerdisciplinary team convened to ails were the least restrictive to evidence that the resident party had been counseled benefits of the use of the side as ea systematic process of planning prior to using siderails ent #21.  It is beserved during the initial tour of the teast approximately reas in bed with the two full interview, Resident #21 said, for by always have the two siderails so that I do not fall.	F	221					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095015  NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WIN	IG		08/11/2010			
	N BOONE LEWIS HEA	ALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE	
F 221	However, the Resid documented evider use of siderails as a systematic process prior to using sidera.  A face-to-face internemployee #5 on Au 2:30 PM. After a review of the certain and added The record was reviewed. A review of the certain and the record was reviewed as a restraint a of care planning and interdisciplinary teat prior to its implement.  Resident #CBL22' embolism/infarct, se fibrillation and transinfection.  The coding for Section the admission Minimuly 21, 2010 reveat extensive assistance assistance for bed in the side of the	dent #21's clinical record lacked are that facility staff: identified a restraint and initiated a of evaluation and care planning ails as a restraint.  View was conducted with agust 6, 2010 at approximately view of the resident 's clinical anowledged the aforementioned I will take care of it right away, iewed August 6, 2010.  Clinical record for Resident acility staff failed to identify side the full length of both sides of the and follow a systematic process devaluation by the m for the least restrictive device antation.  Is diagnoses included pulmonary epsis, dehydration, anemia, atrial mission based precautions for a side of the resident required the full facility. Bed rails were coded for a formation.	F	221				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 221	The resident was o 2, 2010 at approxin were observed on oposition.  The clinical record identified the side revidence that the ir determine the side device. There was and/or responsible regarding the risks/rails.  d.) A review of the #CBL23 revealed for rails that extended bed as a restraint a of care planning an interdisciplinary teaprior to its implemental with behavior and the coding for Sective quarterly Minim June 5, 2010 reveal dependent for transassistance for bed Restraints was cod	bserved lying in bed on August mately 9:00 AM. Full side rails each side of the bed in an upright each side of the was no exterdisciplinary team convened to rails were the least restrictive no evidence that the resident party had been counseled benefits of the use of the full side clinical record for Resident eacility staff failed to identify side the full length of both sides of the nd follow a systematic process devaluation by the m for the least restrictive device entation.  Is diagnoses included atrial prenia, cerebrovascular accident, eviors, and gastrostomy.  Ition G, Physical Functioning, of um Data Set (MDS) completed led the resident was totally effer and required extensive mobility. Section P, Devices and	F 2	221			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1` ′	ULTIP LDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	DULD E	BE CROSS-	(X5) COMPLETION DATE	
F 221	The resident was ob 2, 2010 at approxim were observed on exposition.  The clinical record laidentified the side ralevidence that the introduce. There was nand/or responsible pregarding the risks/brails.  e.) A review of the cardinary tear planning and interdisciplinary tear prior to its implement. Resident #CBL24's hypothyroidism, hyparteriosclerotic cardinary tear prior to its implement. The coding for Sectithe admission Minimum June 14, 2010 reveate dependent for bed massistance for transf. Restraints was code. The resident was ob 2, 2010 at approximation.	aserved lying in bed on August ately 9:05 AM. Full side rails ach side of the bed in an upright acked evidence that facility staff ils a restraint. There was no erdisciplinary team convened to ails were the least restrictive o evidence that the resident party had been counseled benefits of the use of the full side denefits of the use of the full side of the full length of both sides of the resident of the least restrictive device of the least	F	221					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	ALTH CARE CENTER	13	EET ADDRESS, CITY, STATE, ZIP CODE 880 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 221	identified the side revidence that the in determine the side device. There was rand/or responsible regarding the risks/rails.  f.) A review of the c #CBL25 revealed farails that extended the bed as a restraint a of care planning and interdisciplinary teat prior to its implement Resident #CBL25's Hypertension, deged dysfunction, gastrost The coding for Section Data Set (MDS) conthe resident was tot mobilization. Bed ramobility/transfer. Se was coded as "not Physician's orders of "Restraint: Siderails positioning in bed et and the resident was of 2, 2010 at approximate approximate approximate resident was of 2, 2010 at approximate approximate resident was of 2, 2010 at approximate and resident was of 2, 2010 at approximate resident was of 2, 2010 at 2, 2010 a	acked evidence that facility staff ails a restraint. There was no terdisciplinary team convened to rails were the least restrictive no evidence that the resident party had been counseled benefits of the use of the full side dility staff failed to identify side the full length of both sides of the nd follow a systematic process devaluation by the m for the least restrictive device intation.  diagnoses included nerative joint disease, feeding stomy and electrolyte imbalance.  tion G of the quarterly Minimum impleted May 19, 2010 revealed ally dependent for transfer and ails were coded for use as bed ection P, Devices and Restraints used."	F 221			
	•	acked evidence that facility				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE	CROSS-	(X5) COMPLETION DATE
F 221	no evidence that the convened to determ restrictive device. It resident and/or research the full side rails.  g.) A review of the #CBL26 revealed for rails that extended bed as a restraint a of care planning an interdisciplinary teaprior to its implement resident #CBL26's Hypotension, urinal cardiovascular disearch for the resident was to mobilization. Bed rails the resident was to mobilization. Bed rails turning every shift."  The resident was o 2, 2010 at approximate were observed on exposition.  The clinical record	side rails a restraint. There was e interdisciplinary team nine the side rails were the least here was no evidence that the ponsible party had been go the risks/benefits of the use of clinical record for Resident acility staff failed to identify side the full length of both sides of the and follow a systematic process and evaluation by the sim for the least restrictive device entation.  It diagnoses included by tract infection, dehydration and ease.  Ition G of the quarterly Minimum mpleted August 2, 2010 revealed tally dependent for transfer and easils were coded for use as bed ection P, Devices and Restraints to used. "  It diagnoses included the same and the same coded for use as bed ection P, Devices and Restraints to used."	F	221				
	isonimos trio side i	and a roomanne riloto was		Ì				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED		
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F 221	convened to determ restrictive device. The resident and/or responses	ge 16 interdisciplinary team ine the side rails were the least here was no evidence that the onsible party had been the risks/benefits of the use of	F	221		(		
	#CBL27 revealed fa rails that extended the bed as a restraint ar of care planning and	n for the least restrictive device						
	cerebrovascular acc	diagnoses included ident, diabetes mellitus, a, edema, psychotic behavior elemia.						
	the admission Minim May 26, 2010 revea extensive assistance	on G, Physical Functioning, of num Data Set (MDS) completed led the resident required e for transfer and bed mobility. and Restraints was coded as "						
	Physician 's orders Siderails up for turni	dated July 2, 2010 directed " ng and positioning."						
	2, 2010 at approxima	served lying in bed on August ately 9:25 AM. Full side rails ach side of the bed in an upright						
	identified the side ra	ncked evidence that facility staff ils a restraint. There was no erdisciplinary team convened to ails were the						

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 223 SS=G	least restrictive devithe resident and/or recounseled regarding the full side rails.  The observations fo 25, 26, 27 and Resign presence of Employ full siderails restricted stated the siderails of partially and only on re-educate my staff.  483.13(b), 483.13(b) ABUSE/INVOLUNT.  The resident has the sexual, physical, and punishment, and involved the siderails of the sexual physical abuse, corposeclusion.  This REQUIREMENT.  Based on record reversided the staff failed to the siderails of the sexual physical abuse.	ce. There was no evidence that responsible party had been the trisks/benefits of the use of the risks/benefits of the use of the risks/benefits of the use of the residents # CBL 22, 23, 24, dent #13 were made in the ee #7 who acknowledged the ed freedom of movement. S/he should have been applied only one side of the bed " I must "  O(1)(i) FREE FROM ARY SECLUSION  e right to be free from verbal, d mental abuse, corporal	F 2:	83.13(b), 483.13(b)(1)(i) FRE ABUSE/INVOLUNTARY SEF Ftag 223 #1  1. Resident CBL2 no longer facility. All staff involved in the remediated and corrective active active active at the time of the incident affected by the deficient practive of incidents have been computed to the incident of incidents have been computed to the incident active actions have been implemented as needed.  3. The Restraint Authorization Resident Abuse, Neglect and Misappropriation policy have re-evaluated and updated.	cesides at the his incident were stions were ent.  Intial to be tice. A review leted to ensure heen  In and the leten heen heen heen heen taff has	10/19/10
	abuse. Residents: C #23 . The findings include	BL2 and		been in-serviced on: the poli- inappropriate use of resident restrain residents, the overall restraint initiation, what const abuse,legalities of documents the importance of timing note process of shift change repor	property to process of itutes ation to stress s and on the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
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	ROVIDER OR SUPPLIER  N BOONE LEWIS HE	ALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
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F 223	Data Set (MDS) corevealed that the 9 to the facility with of Alzheimer's Diseat Hypertension and I 2009 MDS was con (cognitive decision memory problems. E1 and E4 (Mood/I Symptoms) indicat problems in these allegation of Susper Resident CBL2 was facility. The report sustained an injury the distal 3rd of the hand.)  A review of the "C which was completed to the St following information who was on duty of the alleged incident and walking up and unsteady gait. The Someone said "Tice report continued, Nursing Assistant to the resident and the The exact time of the tas reported by the state of the said t	rch 12, 2009 admission Minimum ontained in the clinical record 7 year old female was admitted liagnoses which included ase, Dementia, Glaucoma, Renal Failure. The June 10, ded in Sections B2a and B2b making) with long and short term A score of zero (0) in Sections Behavior and Psychosocial ed that the resident had no areas.  Itigative report regarding an exted Abuse and Neglect of s given to the survey team by the indicated that the resident of unknown origin (fracture of a 5th metacarpal of the right ate Agency revealed the con. According to the supervisor on September 19, 2009 [the day of the tresident was very agitated and down the hallway with an a supervisor continued " a her up and they did. " The "The supervisor asked a Certified to get a recliner chair. He/she chair and placed a sheet around and it to the back of the chair." The incident was not documented a documentation of the incident facility, the incident occurred on a September 19, 2009.	F 223	4. A documentation audit will monthly by the Medical Recordinator audit will be complete unit manager/designee. MDS Coordinator will conduct weekly audit of the shift charprocess. A report will be producted by Director of Nursing/ designer audits of problems identified corrective actions implement. The results of the above audited reported to the CQI committed three months, then quarterly Designee. A report of problems and corrective actions impleted be presented. The CQI committed the and corrective actions impleted by the presented of the results.	ords Clerk. A eted monthly by The Unit Manage of a random hige report evided to the e on all and ted.  it will be ee monthly for by the DON/ ms identified mented with mittee will interventions	10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 223	as documented by E 1:30PM on Septembronitoring the day rourse that the resided discomfort, was tied received any ADL [A assistance or care].  As documented on 3 "the day staff and the informed that the resident of the condition of the CNA monitoring informed the charge noted that the resident assistance or care. That, "on Monday Senoticed that the resident swollen." The hand revealed a fraction of the facility's report the facility's report the recliner chair with sleep through the night are sult the resident the distal 3rd of the salso documented the adequate care." Per failed to provide ADI evening shift on September 20, 20 and september	Employee #2, at approximately per 20, 2009 the CNA who was soom, reported to the charge ent was, complaining of with a sheet and had not activities of Daily Living  Sunday September 20, 2009, the nursing supervisor were sident had been agitated all in was made of the resident powever, at approximately the who was still in the recliner in complained of discomfort and noticed the tied sheet and nurse. At this time it was also ent had not received any ADL "The report further revealed eptember 21, 2009 the day shift dent's right hand was discolored report of an x-ray of the right course of the distal 3rd of the 5th cort, "the staff tied the resident to the a sheet, allowed him/her to ght in the recliner chair; and as suffered an injury" [fracture of 5th metacarpal]. The report at the resident "did not receive or the documentation facility staff L care to the resident from the per 19, 2010 until 1:30PM 2009.  The contraction of the documents reviewed the contraction of the documents reviewed the contraction of the documents reviewed the documents reviewed the contraction of the contraction	F	2223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUMENTS (X2) MULTIPLE CONSTRUMENTS (X3) MULTIPLE CONSTRUMENTS (X4) MULTIPLE CONSTRUMENTS (X4) MULTIPLE CONSTRUMENTS (X5) MULTIPLE CONSTRUMENTS (X6) MULTIPLE CONSTRUMENTS (X6) MULTIPLE CONSTRUMENTS (X7) MULTIPLE CONSTRUMENT	JCTION (X3) DATE SURVEY COMPLETED
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	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE CROSS- RENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
determined that facility staff physically abused the resident when they tied him/her to a recliner chair with a sheet. The evidence also revealed that the resident was allowed to sleep in the chair while restrained during the night and subsequently suffered a fracture of the distal 3rd of the 5th metacarpal of the right hand while he/she was in the chair and received no ADL care from the time of the incident until 1:30PM on Sunday September 20, 2009.  A face-to-face interview was conducted with Employee#2 at approximately 4:00PM on August 10, 2010. He/she acknowledged that employees of the facility tied the resident to a chair with a sheet to prevent him/her from walking. That the resident suffered a fracture of the distal 3rd of the 5th metacarpal of the right hand and that the staff failed to provide ADL care to the resident as of 1:30PM on September 20, 2009. The record was reviewed on August 9, 2010.  2. Facility staff failed to protect Resident #23 from verbal abuse.  A face-to-face interview was conducted with Resident #23 at approximately 11:00 AM on August 6, 2010. During the Interview the resident informed this investigator that a Certified Nursing Assistant (CNA) had spoken to him/her in what he/she described as "Rudely". The resident who is blind in his/her right eye stated, "This man/woman came up beside me and started talking to me. He/she was on my right side and I am blind in my right eye. I told him/her I was blind and could not see to [he/she should] come over to the other side. He/she inpleme committed in proving the committed in the proving the	tive actions were implemented for loyee identified in this incident.  Idit has been completed on visually diresidents to ensure that their rights to been violated.  In the policy has been reevaluated atted. Staff has been in-serviced on the legalities of importance of the policy has been in-serviced on the legalities of importance of the policy has been in-serviced on the legalities of importance of the policy has been in-serviced on the legalities of importance of the policy has been in-serviced on the legalities of importance of the policy has been do.  In the manager of the policy has been do.  In the policy has bee

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	OVIDER OR SUPPLIER	<u> </u>		13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE (ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	<b>‹</b>	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 223 F 225 SS=D	Employee #2 at app 10, 2010. He/she as occurred. He/she st spoke to the resident assured him/her that returning to the facilities employed through a called the agency ar The record was revision INVESTIGATE/REP ALLEGATIONS/IND The facility must not been found guilty of	riew was conducted with roximately 2:30 PM on August cknowledged that the incident ated, "The social worker and I it regarding the incident and the CNA would not be ity. He/she [the CNA] was nagency. We immediately not terminated his/her contract. ewed on August 10, 2010.  (c)(2) - (4) ORT IVIDUALS  employ individuals who have abusing, neglecting, or	F 2		Continued From page 21 483.13(c)(1)(ii)-(iii), (c)(2) - (INVESTIGATE/REPORT AL/INDIVIDUALS.  Ftag 225 1. A written report was provided the post of the	ded to the esident #23. ential to be ent abuse riewed to ensure te and other n completed.  Misappropriation re-evaluated n of an abuse as been	10/27/10 10/19/10 10/19/10
	mistreating residents a finding entered into concerning abuse, in residents or misapping report any knowledge law against an employengement of the State number of the facility must ensitively in the facility must ensitively including mistreatment injuries of unknown resident property are administrator of the faccordance with State procedures (including certification agency).	s by a court of law; or have had on the State nurse aide registry reglect, mistreatment of repriation of their property; and re it has of actions by a court of royee, which would indicate as a nurse aide or other facility researched in a leged violations and the source and misappropriation of the reported immediately to the facility and to other officials in the law through established go to the State survey and the evidence that all alleged goly investigated, and must			in-serviced on the policy and abuse with the emphasis on Staff education has also been the educator on reportable in timeliness of reporting incide nursing supervisory staff has by the DOH on the electronic documenting of incidents.  4. The DON/designee will comonthly audits of abuse investince incident reports to assure condocumentation, and appropring report will be provided to the of problems identified and complemented. The results of will be reported to the CQI comonthly for three months, the the Director of Nursing/designation.	verbal abuse. In completed by acidents and the ents. Training for been conducted reporting and and enduct random estigations and enterporting. A Administrator prective actions the above audit ommittee en quarterly by	10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095015	B. WING	·		08/1	1/2010	
	ROVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE	
F 225	The results of all inv the administrator or and to other officials (including to the Sta agency) within 5 wor	estigations must be reported to his designated representative in accordance with State law te survey and certification rking days of the incident, and if is verified appropriate	F 2	25	Continued From page 22  A report of problems identifications implemented will be CQI committee will determine other interventions and need of further audits.	presented. The ethe need for		
	Based on record rev (1) of 26 sampled re facility staff failed to verbal abuse to the state of the facility staff failed to verbal abuse to the state of the findings include. A face-to-face intervals Resident #23 at app 6, 2010. During the this investigator that (CNA) had spoken to described as "Rude in his/her right eyes up beside me and ston my right side and told him/her I was blover to the other side said, I don't have time.	iew was conducted with roximately 11:00 AM on August interview the resident informed a Certified Nursing Assistant o him/her in what he/she ly". The resident who is blind tated, "This man/woman came arted talking to me. He/she was I am blind in my right eye. I ind and could not see to come e. He/she ignored me then						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION  B	(X3) DATE SUF COMPLET	
		095015	B. WIN	G		08/1	1/2010
_	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	ALTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHI REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 225	Continued From page	ge 23	F 2	— 225			
	A face-to-face intended in the control of the contr	view was conducted with proximately 2:30 PM on August acknowledged that the incident there was no notification of the abuse sent to the state agency, iewed on August 10, 2010.			483.13(c) DEVELOP/IMPLN ETC POLICIES F tag 226	MENT ABUSE/NE	GLECT,
F 226 SS=F	ABUSE/ŃEGLECT,  The facility must de	, ETC POLICIES  velop and implement written	F2	226	Resident Abuse and Neglethisappropriation of Property been updated to reflect the Prevention.	Policy has	10/19/10
	neglect, and abuse misappropriation of				2. All residents have the pote affected by this practice. Re and Neglect, Misappropriatio Policy has been re-evaluated reflect a component on preven	sident Abuse on of Property d and updated to	10/19/10
	This REQUIREMEN	NT is not met as evidenced by:		ı	renect a component on preve	stidoti.	
	was determined tha	of the facility 's abuse policy, it it facility staff failed to develop procedures for "Prevention" of			<ol> <li>The Resident Abuse, Neglinian Misappropriation of Property reevaluated and updated to restaff has been in-serviced or what constitutes abuse and the services and the services are serviced.</li> </ol>	Policy has reflect prevention on the policy and	10/19/10
	The findings include	<b>:</b> :			components of the abuse policesignee will conduct random	-	
	The census on the f 2010) was 167 resid	first day of survey (August 2, dents.			audits of staff regarding the c the abuse policy. A report wi the Administrator of problems	ill be provided to	
	Misappropriation of	cy "Resident Abuse, Neglect and Property: Policy and Procedure			corrective actions implement	ed.	
	Practice Guidelines: Component II: Train Identification, Comp Component V: Prote Reporting/Response	ponent IV: Investigation, ection, Component VI: e " .		9	4. The results of the above a reported to the CQI committee the Director of Nursing/desig of problems identified and do implemented will be presented committee will determine the	ee quarterly by nee. A report orrective actions ed. The CQI	10/28/10
		documented evidence that the nd operationalize procedures					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SU	
		095015	B. WIN	IG		08/1	1/2010
	OVIDER OR SUPPLIER	LTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		380 SOUTHERN AVE SE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 241 SS=D	for "Prevention".  A face-to-face intervent Employees #1 and 3 approximately 10:50 all aspects of the "Misappropriation of acknowledged that were not included in 483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an elenhances each residence of the end of the prevent of the findings included the presence of Employers. The findings included During tray line observation to available to servent on the prevent of the prevent of the findings included the prevent of the findings included the prevent of the prevent of the findings included the prevent of the prevent of the findings included the prevent of the prevent of the findings included the prevent of the pr	view was conducted with 3 on July 29, 2010 at 9 PM. The employees reviewed Resident Abuse, Neglect and Property "policy and procedures for "Prevention" the policy.  AND RESPECT OF  Immote care for residents in a navironment that maintains or dent's dignity and respect in full her individuality.  It is not met as evidenced by:  It is not met as evid		241	interventions and need and further audits.  483.15(a) DIGNITY AND REINDIVIDUALITY  F tag 241  1. Food Services Director or of china (total 48 plates) and pieces of silverware to ensur quantity of china are available the residents' meals on at all 2. The director of the departre maintain weekly inventory of silverware to make sure their supply for all resident's meals.  3. A physical inventory will be a weekly basis to ensure that silverware levels are sufficient residents meal. The par level plates, 8 dozen silverware piestock.  4. A monthly food safety aud the auditing of china and silverware inventory, which will be reported the silverware for three months to the reafter.	dered 5 cases 12 dozen e a sufficient e to serve all of times.  nent will china and e is sufficient s. e conducted on t china and it to serve all el of 3 cases of eces will be in  t will include erware ted to the CQI	8/11/10 10/19/10 10/19/10
		on, record review and staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION  DING	COMPLETED			
		095015	B. WING		08/11/2010		
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	· -		
(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 CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	OULD BE CROSS-	(X5) COMPLETION DATE	
F 241	failed to promote dignity during dining for one (1) of 30 supplemental residents. Resident CBL #18.  The findings include:  Facility staff failed to promote dignity during dining for Resident #CBL 18.  On August 3, 2010 at approximately 12:45PM, Employee #19 was assisting Resident CBL #18 to eat the lunch meal. Employee #19 stood over the resident while assisting the resident.  Facility staff failed to promote dignity as evidence by employee standing over resident during the lunch meal while assisting him/her to eat 483.15(e)(1) REASONABLE ACCOMMODATION		F 24	Continued From page 25			
F 246 SS=D			F 24	F tag 241 Resident CBL#18  1. The staff was remediated survey and corrective action implemented.  2. All residents have the pot affected by this deficient prayof meal services were component or meal services were component.	s were ential to be ctice. An audit leted and	8/11/10 10/19/10	
				<ol> <li>The Educators have in-semaintaining resident dignity</li> <li>Unit Managers will condute ensure that meal dignity is report will be provided to the of corrective actions implemed for further education.</li> </ol>	while feeding. ct random audits s maintained. A DON/designee	10/19/10	
				The results of the above aut to the CQI committee for the quarterly by the Director of I A report of problems identifications implemented will be CQI committee will determine further actions.	ee months, then lursing/designee. ed and corrective presented. The		

#### Continued from page 26

# 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES F tag 246

- 1. Call bells in rooms 318A, 314P, and 328A 8/10/10 where placed in reach and repaired or replaced during survey.
- 2. All residents have the potential to be 10/19/10 affected by this practice. Call bells have been audited by the Maintenance staff for operability and safety.
- 3. The Educator has in-serviced the staff on 10/19/10 the accommodation of resident needs in the regards to placement of call bells within resident's reach. The Unit Managers via his/her daily rounds will assess compliance with this process.
- 4. The Unit secretaries will complete random audits of call bells bi-weekly. A report will be provided to the DON/designee of problems identified and corrective actions implemented and indications of need for further education.

The results of the above audit will be reported to the CQI committee quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095015		A. BUIL		LE CONSTRUCTION	COMPLETED  08/11/2010		
		B. WIN	G				
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
	accessible to the re 328A. The call bell who occupied room were frayed for the 318A.  The findings were of presence of Employ 483.15(g)(1) PROV RELATED SOCIAL	I bell was on the floor and not esident who occupied room was not present for the resident a 314P and the call bell wires resident who resided in room observed and confirmed in the yee #7.  ISION OF MEDICALLY SERVICE		246	F-250 #1 Resident#3		
	services to attain or	ovide medically-related social maintain the highest practicable and psychosocial well-being of			1. The medical record of Res reviewed and documented by Social Services to reflect the re elopement risk and facility's "E which was reviewed to ensure elopement risk residents.	the Director of esident's lopement Policy",	10/19/10
	Based on record re (2) of 26 sampled re the social worker fa	NT is not met as evidenced by: view and staff interview for two esidents, it was determined that iled to address resident's ate discharge planning for one			2 Review of new and current discharge plans has been co Social Workers. Corrective a been implemented as needed 3. A Weekly Discharge Plant	mpleted by the actions have d.	10/19/10
	<ul> <li>(1) resident and init</li> <li>(1) resident who was than a nursing facilis</li> <li>The findings include</li> <li>1. The social workes attempted elopem</li> <li>A review of residen</li> </ul>	iate discharge planning for one inted to live somewhere other ty. Residents #3 and 23.			has been initiated to address current resident needs, concidentify residents that are eligible discharge and their discharge Administrator/designee will a monthly problems identified a actions implemented and indineed for further education withe CQI Committee.	the new and erns, and to gible for e plan. The udit this process and corrective ications of the	
	the following:  An admission Minin	num Data Set (MDS)			4. The results of the above a reported to the CQI committee		10/28/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	. 095015		B. WING				08/11/2010		
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER				13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		OULD BE CROSS- COMPLÉTION		(X5) COMPLETION DATE	
F 250	completed November	ge 27 er 2, 2009 coded in Section AB rmation: Date of entry as	F 2	50	Continued From page 27				
·	A nursing note dated January 28, 2010 at 3:00 PM noted: "Resident left facility [without medical advice [AMA]. Release form of responsibility signed. All personal belongings sent [with] resident andmedication [for] seven (7) days sent [with] instructions also sent."				the Administrator/designee. problems identified and corn implemented will be present committee will determine the interventions and need and further audits.	ective ed. T e need	actions he CQI for other		
Ţ	" Admission noteF fromvia ambular	arch 10, 2010 at 2:00 PM noted: Resident admitted to room nce. Resident admitted with mental status secondary to							
	" Initial care plan me [Interdisciplinary care	te dated March 17, 2010 noted eting was held today by IDT e committee]Goal is to and assist in stabilizing living dent "							
	noted "Resident e	July 24, 2010 at 2:50 PM elopement attempt at 2:50 PM tervene and escort resident in							
	Resident #3 on Augu 2:00 PM. He/she sai was retired from the not anymore. I can s worked at Saint Eliza health specialist. I ar rest of my life. I am r If I leave again, I will	iew was conducted with ust 2, 2010 at approximately d "My right is being denied. I air force. I used to go out but ee if I am mentally ill, I am not. I abeth for 24years as a mental in not going to be here for the not going to be like this for long. not come back. If someone I'll hurt the person. This is like worker							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	095015			G		08/11/2010		
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER				1	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032			
(X4) ID PREFIX TAG				ID PROVIDER'S PL PREFIX (EACH CORRECTIVE A TAG REFERENCED TO THE		OULD BE CROSS-	(X5) COMPLETION DATE	
F 250	has not done anythin brick. This is a nursi like one. I used to live the lease. I need my  A further review of the lease. I need my  A further review of the lease. I need my  A further review of the lease. I need my  A further review of the lease. I need my  A further review of the lease. I need my  A face-to-face interved approximately 9:30 are sident's clinical reduced the resident's clinical reduced that the resident were added to leave the resident left. January 2010 and a facility. He/she added looking into the residential my and the intention of leave the intention of leave his/her rights continuely he/she threatens to him/her. The record  2. Facility staff failed for Resident #23 who other than a nursing  A face-to-face interved the face-to-face interved his/her his he/she has been seen and the lease the lea	ing for me. It is like talking to any home and should be treated by with my girlfriend but we lost of own housing."  The social worker notes dated and 6, 2010, May 12, 2010 and 6 documented evidence that the incerns were addressed.  The was conducted with any and a documented evidence that the incerns were addressed.  The was conducted with any any any and a documented evidence that I record lacked documented evident's concerns and attempted any and attempted the facility AMA sometime in the facility AMA sometime in the facility and any	F:	250				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	•	095015	B. WIN	3		08/1	1/2010	
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER				13	EET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHERN AVE SE 1ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE	
F 250	A review of the clinic documentation about and/or pending disc.  A face-to-face interview Employee #21 at ap 6, 2010. He/she ac the resident's application has been approved acknowledged that any information registatus and/or his/he	ne social worker has agreed to an apartment."  cal record failed to reveal any ut the resident's housing status	F 2	250				
F 253 SS=E	The facility must promaintenance service sanitary, orderly, and This REQUIREMEN Based on observation was determined that maintenance service that the facility is made as evidenced by: so one (1) observation, residents non mobilil lounge were observed by in three (3) of and damaged wheel	exide housekeeping and es necessary to maintain a d comfortable interior.  It is not met as evidenced by: ons during the survey period it thousekeeping and es were not adequate to ensure aintained in a safe and sanitary illed wheelchairs in one (1) of the spoken frame surfaces of ize wheelchairs in the first floor ed to be soiled with dust and f seven (7) observation worn lichairs, the armrests and seat is wheelchairs were observed to	F2	:53				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET			
		095015	B. WING		08/1	08/11/2010		
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			s	STREET ADDRESS, CITY, STATE, ZIP COL 1380 SOUTHERN AVE SE WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS-	(X5) COMPLETION DATE		
F 253	damaged in the first (7) observations, the sofas and chairs in the dayrooms were damaged in two (2) observations worn and soiled sofasills floor in two (2) of floor surfaces at the (1) of one (1) observation, . Heating Conditioning [HVAC accumulated dust in 's lobby in one (1) ocabinets in the Utility observation, the interval of the conditioning close (1) of one (1) observation, the interval of the conditioning close (1) of one (1) observations, the interval of the conditioning close (1) of one (1) observations, the interval of the conditioning close (1) of one (1) observations, the interval of the conditioning close (1) of one (1) observations (3) of 20 observations of bed fram observations, soiled six (6) of six (6) observations, soiled six (6) of six (6) observation of the condition of the condition of the condition of the condition of the conditions of the co	floor lounge in four (4) of seven a back and seat surfaces of the first and second floor maged and worn in two (2) of a soiled baseboard heaters, as and chairs, soiled window of two (2) observations, soiled entrance to the facility in one vation, marred hand rails at the ling in one (1) of one (1) and Ventilation and Air louvers were soiled with the ante-area outside of facility of one (1) observation soiled with round and	F 25	483.15(h)(2) HOUSEKEEF MAINTENANCE SERVICE  Ftag 253#1 The correctivare:  1.Mobile wheelchair identification of.  2.Residents on the 1st floor were cleaned.  3.Armrests and seat surfact residents' wheelchairs were replaced. Two wheelchairs were replaced. Two wheelchairs deleaned and were repaired so the state of the surfact cleaned and were repaired so the surfact cleaned and real surfact cleaned and rooms will be repland chairs have been ord 10/12/10. Allow 8 weeks 6. First floor day room winder have been cleaned.  7. Entrance floor tile surfact cleaned and replaced. Rewere installed.  8. Hand rails outside the enpainted.  9. Heating Ventilation and Allouvers have been cleaned.  10. Floor surfaces and exhibit the medication and treatment have been cleaned.  11. The interior area of the the sink in the soiled utilities been cleaned.  12. The interior areas of the housekeeping closet has 13. The horizontal and vertified bedside rails and bed from the surface of the su	re actions taken ied was disposed wheelchairs ces of first floor ere repaired and res were ordered. ces have been ed. rst and second placed. Sofas ered as of for receipt. ow sill surfaces es will be deplacement tiles aust vents in ment room cabinet under ry room has es sink in the se been cleaned. cal surfaces of ames in rooms 1, 208, 210, 220, 1,340 were cleaned or jams for rooms the second floor			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
095015			B. WING	3		08/11/2010			
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER				13	EET ADDRESS, CITY, STATE, ZIP CODE 880 SOUTHERN AVE SE /ASHINGTON, DC 20032	•			
(X4) ID PREFIX TAG				ĸ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE		
F 253	observations, clother or damaged in room five (5) of 20 observed furnishings in reside and damaged in room four (4) of 20 observed to be soiled 1. A mobile wheelch resident 's lounge wone (1) observation 2. The spoken frame mobilize wheelchairs observed to be soiled (3) of seven (7) observed to be soiled (3) of seven (7) observed in the first (7) observations at 34. The top and frontheaters were soiled (2) observations at 35. The back and seather first and second and worn in two (2) PM on August 2, 20 2010.  6. The window sill st dayroom and lounge two (2) observations 7. Floor tile surfaces	s hamper covers were missing is 135,239, 321, 324 and 336 in ations the frontal surfaces of ints were observed to be marred ims 221, 236, 308, and 321 in vations. These observations esence of the Maintenance # 13 and 31.	F 2	253	Continued From page 30  15. Interior and exterior surface werts were cleaned in result and common areas in first medication room, third floand residents' rooms 130  16. Elevator doors and elevator cleaned on all floors.  17. Ceiling tile in resident room in the laundry room have and/ replaced.  18. Excessive personal beloweresident rooms 140, 143, have been reorganized at 19. Threshold was replaced to door and bathroom door 20. Wall surfaces in resident 344 and the activity room repaired and painted.  21. Clothes hamper covers for 239, 321, 324 and 336 how replaced.  22. The facility will replace the damaged furnishings that owned in rooms 221, 236. Furnishings that are resident owned in rooms 221, 236. Furnishings that are resident on the purposes. Furnisheen ordered. Delivery weeks.  Ftag 253  All residents have the potent by this practice. The following actions have been implement. An audit of all in-house was conducted to determine repair needs of all in-house was conducted to ensure that an another that a surface implemented to ensure that an another that a surface in the surface	sident's bathroo st floor shower re por shower room 0, 143, and 239. ator tracks were oms 208;308 and been repaired ongings for 308 and 309 and/ removed. under entrance of room 135. t rooms 218, 239 have been for rooms 135, have been se marred and t are facility 6, 308 and 321. dent owned will hal value/a sens shings have s expected in 8  tial to be affecte ng corrective nted: wheelchairs the wheelchairs. lule has been	ms pom, 10/19/10 d 10/19/10 10/19/10 8/12/10 9, 8/12/10 10/19/10 10/19/10 e		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SUF COMPLET			
095015			B. WIN	IG			08/11/2010		
	N BOONE LEWIS HEA	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			D PROVIDER'S PLAN OF COR EFIX (EACH CORRECTIVE ACTION SHO AG REFERENCED TO THE APPROPRIA			E CROSS-	(X5) COMPLETION DATE	
F 253	entrance to the facilii observation at 3:20 l 8. Handrails were observation at 3:20 l 8. Handrails were observation at 3:20 l 9. Heating Ventilatio louvers were soiled ante-area outside of one (1) observation at 3:10. Floor surfaces at the medication and t (1) observation at 3:11. The interior area the soiled utility roor (1) observation at 3:12. The interior area housekeeping close (1) of one (1) observation at 3:12. The interior area housekeeping close (1) of one (1) observation at 3:12. The horizontal arails and bed frames spillages in rooms 1:210, 220, 230 236, 3 of 20 observations b 2010 and 12:00 PM 14. The frontal surfadoors and door jams rooms 112, 140, 214 room in four (4) of two between 3:15 PM or on August 4, 2010. 15. The interior and	ty in one (1) of one (1) PM on August 2, 2010. PM on August 3:20 PM on August In and Air Conditioning [HVAC] With accumulated dust in the In facility 's lobby in one (1) of PM on August 2, 2010. PM on August 3, 2010. PM on August 4:05 PM on August 2, PM on August 3:15 PM on August 2, PM on August 4, 2010. PM on August 4, 2010. PM on August 5:15 PM on August 2, PM on August 6:15 PM on August 2, PM on August 7:15 PM on August 2, PM on August 8:15 PM on August 2, PM on August 9:15 PM on August 1:15 PM on August 2, PM on August 1:15 PM on August 2, PM on August 2:15 PM on August 2, PM on August 3:15 PM on August 2, PM on August 4, 2010. PM on August 3:15 PM on August 2, PM on August 3:15 PM on August 2, PM on August 3:15 PM on Aug	F	253	are cleaned on a routine bas that are identified or discover more than monthly cleaning as required to ensure that the wheelchairs are maintained is sanitary manner.  Wheelchairs are spot cleaner each day by nursing staff. A committee has been formed Meeting will be conducted on basis.  3. The initial wheelchair repaired been scheduled to start on 10 and end on 10/15/10.  4. All baseboard heaters were cleanliness. Baseboard heater be in need of cleaning were discovery.  5. Day room furnishings for all have been ordered as of 10/10/10/10/10/10/10/10/10/10/10/10/10/1	red to will be eresided at the wheeles of a qualification of the factors will be otentiated.	require e cleaned dents' ean ne end of elchair 10/4/10. arterly nic has 10 essed for entified to ed upon mon areas 0. An 8 aning has cility. ed for loose enance ons to oe reported al to be nthly	10/19/10 10/19/10	

Facility ID: HCI

Event ID: 4WTJ11

PRINTED: 10/18/2010 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING	з		08/1	1/2010
	OVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 253	room, third floor sho	or shower room, medication wer room, and resident 's	F 2	ĺ	9. Heating Ventilation and A louvers have been cleaned f 10. Floor surfaces and exha	acility wide.	10/19/10
	between 3:40 PM or and 3:30 M on Augu 16. The frontal surfa	9 in eight (8) of 20 observations in 3:15 PM on August 2, 2010 list 4, 2010. lices of elevator doors were in the basement , 1st, 2nd, and			medication and treatment rocleaned facility wide.  11. The interior area of the cannot in the soiled utility room	oms have been abinet under the	10/19/10
	3rd floors, in addition	n, elevator tracks were soiled ebris between 3:15 PM on			cleaned. 12. The interior areas of the housekeeping closets have I		10/19/10
	six (6) of six (6) observed 17. Ceiling tiles in re	esident 's rooms and common			13. The horizontal and vertibedside rails and bed frame 112, 120, 127, 128, 146, 208	eal surfaces of s in rooms 3, 210, 220,	10/19/10
	third floor housekee laundry room in four	nd stained in rooms 208, 308, ping closet, and the main r(4) of 20 observations between 2, 2010 and 3:30 PM on August			230, 236, 313, 318 and 340 14. Other entrance door jam inspected for marring and da when identified as needed. reported to CQI committee.	s were	10/19/10
,	18. Excessive perso on the floors and be impeding access are 140, 143, 308, and 3	side the resident 's beds, bund resident 's bed in rooms 309 in four (4) of 25 en 3:15 PM on August 2, 2010			15. Interior and exterior surfavents were cleaned in reside and common areas in first flomedication room, third floors and residents' rooms 130, 14	ent's bathrooms oor shower room, shower room,	10/19/10
	and 3;30 PM on Aug 19. Thresholds were	gust 4, 2010. e missing under the entrance			16. Elevator doors and elevate cleaned on all floors.		10/19/10
	observation at 10:10 20. Wall surfaces in	in room 135 in one (1) of one (1) AM on August 3, 2010. resident 's rooms and common			17.A ceiling tile audit was co wide and those in need of re replaced.		10/15/10
	rooms 218, 239, 344 of 20 observations b 2010 and 11:50 AM 21. Clothes hamper	d to be marred and damaged in 4, and activity room in three (3) between 3:15 PM on August 2, on August 4, 2010. covers were missing or 135,239, 321, 324 and 336 in			18. A review/inspection of all was conducted to ensure the belongings have been reorgeneatly stored. Family was coregard to removal of some brequested to be removed.	at excessive anized and ontacted in	10/19/10
	August 2, 2010 and 22. The frontal surfa	ations between 3:15 PM on 12:40 PM on August 4, 2010. Ices of furnishings in residents marred and damaged in rooms			19. Facility wide entrance an thresholds were audited. Are in need of replacement and/completed.	eas identified	10/19/10
	221, 236, 308, and 3				20. Wall surfaces in resident common areas were audited damage. Corrective actions implemented and completed	for marring and identified were	10/19/10

Facility ID: HCI

#### Continued from page 34

21. Clothes hampers were ordered for all 10/19/10 resident rooms.

22. Replacements have been ordered for 10/19/10 facility owned furnishings in resident's rooms which were observed to be marred and damaged.

#### Ftag 253

#### #3. Measures/systematic changes are as follows:

#### **Environmental Services**

Environmental Services staff have been 10/19/10 in-serviced to identify and correct any deficiencies in cleaning at the time of discovery if possible. A daily task cleaning checklist for each staff member was developed for completion on their assigned shift.

### #4. Monitoring to assure that solutions are sustained:

Monthly rounds are conducted by the 10/19/10 Department Director to assure compliance with standards. A secondary check is conducted by the EMS Contractor's corporate office for 3 months, then on a quarterly basis. The Environmental Services Director will report findings to the CQI committee on a monthly basis.

#### #3. Measures/systematic changes are as follows:

#### **Maintenance Staff**

Maintenance staff was in-services on the 10/19/10 need to identify and correct any deficiency at the time of the discovery as possible. If immediate correction is not possible, staff has been educated on necessary steps to address the area of concern.

Monthly rounds are conducted by Maintenance staff at the beginning and end of the month. Items identified as requiring correction are immediately corrected or arrangements are made. The check at the end of the month identifying those items still requiring attention.

### #4. Monitoring to assure that solutions are sustained:

Maintenance staff will perform monthly 1019/10 audits. Findings will be reported to the CQI committee on a monthly basis by the Maintenance Director/designee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	G		08/1	1/2010
	N BOONE LEWIS HEA	LTH CARE CENTER	·	138	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 253 F 272 SS=E	(4) of 20 observation 2, 2010 and 12:40 F 483.20, 483.20(b) C ASSESSMENTS  The facility must concomprehensive, accomprehensive, accomprehensiv	ns between 3:15 PM on August PM on August PM on August 4, 2010. COMPREHENSIVE  Induct initially and periodically a surate, standardized iment of each resident's  In a comprehensive assessment is, using the RAI specified by the ment must include at least the immographic information;  In a patterns; and structural problems; and structural problems; and health conditions; all status;  In and procedures; and procedures; and procedures; and procedures; and procedures information regarding is ment performed through the		253			
		T is not met as evidenced by:					
	pased on record rev	riew and staff interview for 10					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/1	1/2010
	N BOONE LEWIS HE	ALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 272	of 26 sampled res supplemental resignacility staff failed Assessment Protof # 3, 4, 7,11, 15,16. The findings include Facility staff failed Residents # 3, 4, 7 CBL5.  "According to MDS alone does not protogenessessment. Rath preliminary screen problems, strength are problems, strength are problem-orient assessment based (triggered condition decisions about caprovide guidance of the supplemental residuance of the supplemental resid	dents and one (1) of 30 dents, it was determined that to complete the Resident col (RAP) summaries. Residents , 17, 21, 24, 25 and CBL5.	F 272	Continued From page 35  483.20, 483.20(b) COMPRE ASSESSMENTS  Ftag 272  1. Care Area Assessments (completed as a part of the Completed as a part of the Completed on the medical #3, 11,15,16,17,21,24,25, at been printed and filed on the 2. A random audit of resident completed to ensure RAP supresent for all comprehensive A new MDS Coordinator has identified, who has attended 2010 three day AANAC train additional 1.0 FTE has been support the completion of the MDS's.	CAA) were omprehensive RAP summaries record. Resident nd CBL 5 have resident records will be mmaries are e assessments.  been the 10/18/10 ing. Also, one approve to	
	that are addressed resident's care pla MDS and review of is made by the inter-	Al cover the majority of areas in a typical nursing facility n. Following completion of the f the triggered RAPs, a decision erdisciplinary team to proceed to each of the triggered RAPs.		3. A review of the CAA proce been conducted with all disc in the MDS process. Policies procedures will be initiated in discipline responsibilities tow completion.	plines involved s and lentifying	10/19/10
	triggered areas; the confounding factor reversible). Use the	further assessment of the ey help staff to look for casual or s (some of which may be e RAPs to chart your assessment chart your thinking.		4. Results of the random more be submitted to the CQI comfor the next six months and of by the DON/designee. A repidentified and corrective action will be presented. The CQI determine the need for other and need and frequency of file.	mittee monthly quarterly thereafte ort of problems ons implemented committee will interventions	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•		095015	B. WIN	IG		08/1	11/2010
	OVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 272	Continued From pag	ye 36	F	272			
	the interdisciplinary	documents the decisions from team on which of the triggered ressed in the care plan.			1		
	7,11, 15, 16,17, 21, documented evidence the required RAP su	cal record for Residents # 3, 4, 24, 25 and CBL5 lacked be that facility staff completed ammaries when the residents' mum Data Set (MDS) completed.					
	Employee #4 on Auç 11:45 AM after revie records; he/she acki had not been comple	iew was completed with gust 9, 2010 at approximately wing the residents' clinical nowledged that RAP summaries eted for the aforementioned ds were reviewed August 9,					
F 273 SS=D	483.20(b)(2)(i) COM 14 DAYS AFTER AL	PREHENSIVE ASSESSMENT DMIT	F	273			
	after admission, exc there is no significan physical or mental or section, "readmission	ident within 14 calendar days luding readmissions in which at change in the resident's condition. (For purposes of this n" means a return to the facility y absence for hospitalization or					
	Based on observation interviews for one (1)	T is not met as evidenced by: ons, record reviews and staff ) of 26 sampled residents, it if facility staff failed to complete sessment. # 3.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095015	B. WING			08/11/2010	
_	ROVIDER OR SUPPLIER	EALTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 273	Continued From p		F2	273	483.20(b)(2)(i) COMPREHE ASSESSMENT 14 DAYS A		-
	assessment one radvice and was a	If to complete a comprehensive resident who left the facility against dmitted to the facility after spitalization. Resident # 3.			Ftag 273 1. Resident #3 is no longer a facility 2. A random audit of resident		10/19/10
		ent #3 's clinical record revealed			over the past ninety days will to ascertain the completion of assessment. Any records lac documented evidence will be	be completed f the admission king	
	November 2, 200 Demographic Info 23, 2009.	nimum Data Set (MDS) completed 9 coded in Section AB 1 ormation: Date of entry as October atted January 28, 2010 at 3:00 PM			3. Comprehensive assessments completed timely according to MDS schedule identified in the Documentation of the complete comprehensive assessments.	o the mandated ne CAA process. etion of the s will be	10/19/10
	noted: "Resident advice. Release for personal belongin medication [for]	t left facility [without medical orm of responsibility signed. All ligs sent [with] resident and seven (7) days sent [with]			submitted to the DON/design basis by the MDS Coordinate 4. A monthly audit of MDS compliance will be completed	ompletion	10/19/10
to the facility within 24 hours,		Advice Policy #906 effective ember 9, 2000], revised st 3, 2007], 7/20/2010 [July If the resident is does not return in 24 hours, he/she is considered Resident/ responsible party will be			of the audit will be submitted committee monthly for the ne and quarterly thereafter by the A report of problems identifie actions implemented will be CQI committee will determine other interventions and need of further audits.	ext six months the DON/designed and corrective bresented. The the need for	·.
	" Admission notefromvia ambu	March 10, 2010 at 2:00 PM noted:Resident admitted to room lance. Resident admitted with ed mental status secondary to					
		of the resident 's clinical record					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095015	B. WING		08/1	1/2010
	N BOONE LEWIS HEA	LTH CARE CENTER	\$	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 274 SS=D	MDS assessment wresident's admission 2010.  A face-to-face intervence interve	as completed 14 days after the on to the facility. on March 10, when the facility is a completed with a complete the compl	F 27		ent will be per 19.2010 on a accuracy of a udes a evaluation linary team. If a I, a Significant completed.  view will be litant on all ted within the will determine if been completed. deemed bers was be	10/19/10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	G			08/1	1/2010
	N BOONE LEWIS HEA	LTH CARE CENTER	·	13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD E	E CROSS-	(X5) COMPLETION DATE
F 274	1. Facility staff faile " reassessment for two (2) or more area According to the Re Resident Assessme Version 2.0 A " sign improvement in a re normally resolve its or by implementing interventions, is not 2. Impacts more the health status 3. Re and /or revision of th  A review of the Nutr no time indicated re resident weighed 20 (times) 30 days, dec  A review of the Qua 2010 showed that th more areas in Sectio Structural Problems (a) Bed mobility wer Extensive Assistanc (g) Dressing went fr Extensive Assistanc Independent (0) with Extensive Assistanc assist; (i) Toilet use (2) to Extensive Assistanc A face-to-face intervent Employee #6. After	d to code a " significant change a resident that had a decline in as. Resident #14.  Evised Long-Term Care Facility and Instrument User's Manual difficant change " is a decline or esident's status that: 1. Will not self without intervention by staff standard disease-related clinical " self-limiting " an one area of the resident's quires interdisciplinary review the care plan.  Sition Note dated May 18, 2010 eare plan.  Sition Note dated May 18, 2010 eare self-limiting and pounds, weight gain 5.6% x crease 8.5% x 90 days.  Stretrly MDS completed June 9, the resident had change in two or on G Physical Functioning and eare (2) to be (3); on Limited Assistance (2) to be (3); (h) Eating went from he one (1) setup help only to be (3) with 2 one person physical went from Limited Assistance sistance (3) and (j) Personal Limited Assistance (2) to	F2	274	3. During daily stand-up mee changes were discussed. Re experiencing a decline or im status will be reviewed to de significant change has occur assessments were conducte RAI guidelines. The MDS C part of the team, will receive each resident identified from team member within 48-72 h determine if a significant change Assessment. Docu Significant change assessments submitted to the DON/design 4. Documentation of resident a decline or improvement of reviewed to determine if the permanent change. If a change the MDS Coordinator will secomplete a SCSA within 14 determining this change is permanent of the comparative resubmitted to the CQI commit the next six months and quant A report of problems identifications implemented will be CQI committee will determine other interventions and need of further audits.	esider prove terminated accoordinate accoordinate account in the a	ement in a ment in a ment in a ment in a modern and a mas a mation of a mave been a monthly.  Deriencing as will be a monthly for thereafter, and a corrective anted. The need for	10/19/10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER	1:	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 274		=	F 274	Continued From page 40		
F 276 SS=D		d on August 5, 2010. RLY ASSESSMENT AT LEAST	F 276	483.20(c) QUARTERLY ASS LEAST EVERY 3 MONTHS	SESSMENT AT	
	review instrument sp	ss a resident using the quarterly pecified by the State and not less frequently than once		Ftag 276  1. A completed locked quarte for Resident #CBL14 was loc AccuCare, the facilities comp A copy of this assessment ha in the clinical record.	cated in outerized system	10/19/10
	Based on record rev (1) of 30 supplement determined that facil	IT is not met as evidenced by: view and staff interview, for one ntal residents, it was lity staff failed to complete a Data Set [MDS] assessment for		2. A random audit of resident' records was completed by 10 evaluating for the presence of assessments. Any assessments was retrieved and placed on the record.	)/19/10 If the appropriate ents not located	10/19/10
	1, "The OBRA regular of assessments that facility resident at active whenever the reside change in status, an	MDS User 's Manual " page 2- ulations have defined a schedule t will be performed for a nursing dmission, quarterly, annually, ent experiences a significant and whenever the facility identifies a prior assessment. These are		3. The OBRA defined schedul assessments was placed on the record following completion in MDS Coordinator. The MDS Coordinator of the MDS Coordinator. The MDS Coordinator. The MDS Coordinator of the MDS Coordinator. The MDS Coordinator	the clinical dentified by the Coordinator is DS assessment ch month a list ill be provided apliance of the clinical ce of completed	10/19/10
	revealed that the res assessment Septem assessment in Dece	cal record for Resident CBL #14 sident had an annual heer 9, 2009, quarterly ember 2009 and March 2010. tional MDS assessments in the		4. Reports of the random aud presented to the CQI committed the next six months and quarted by the DON/designee. A report of the control of t	tee monthly for terly thereafter ort of problems ons implemented	10/28/10
	The clinical record la assessment for June	acked evidence that a quarterly e 2010		determine the need for other i and need and frequency of fu		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	G		08/11/2010	
	ROVIDER OR SUPPLIER	EALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 278 SS=E	.was completed.  A face-to-face interemployee #4 on A 2:00 PM. He/she assessment was necord was review 483.20(g) - (j) ASS ACCURACY/COO The assessment meresident's status.  A registered nurse assessment with the health professiona  A registered nurse assessment is come Each individual whassessment must state portion of the activity and knowing statement in a resicivil money penalty each assessment; knowingly causes a material and false assessment is sub not more than \$5,000.	erview was conducted with august 9, 2010 at approximately acknowledged that the quarterly not completed for June 2010. The red August 9, 2010. SESSMENT ORDINATION/CERTIFIED  Instruction and conduct or coordinate each the appropriate participation of alls.  In must sign and certify that the inpleted.  In completes a portion of the sign and certify the accuracy of assessment.  Ind Medicaid, an individual who ingly certifies a material and false ident assessment is subject to a yof not more than \$1,000 for or an individual who willfully and another individual to certify a statement in a resident opect to a civil money penalty of 2000 for each assessment.		278			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING			10010
		093013			08/11	/2010
	OVIDER OR SUPPLIER  N BOONE LEWIS HEA	LTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 278	Based on record rev 26 sampled resident resident, it was deter accurately code: on (#2), two (2) resident (3) residents for falls for behavior, (#7), of swallowing (#9), on (#24), one (1) resident resident for MRSA if	ge 42  IT is not met as evidenced by:  view and staff interview, for 11 of ts and one (1) supplemental emined that facility staff failed to e (1) resident 's sleep pattern its for restraints (#4 & 21), three is (#6, 8, 20), one (1) resident ine (1) resident for foley and for ine (1) resident for incontinent ent for pressure ulcer (#12), one in urine (#19) and one (1) onia, C.diff and hepatitis C (# #2, 4, 6, 7, 8, 9, 12, 19, 20, 21,	F 278	483.20(g) - (j) ASSESSMENACCURACY/COORDINATOR Ftag 278 #1  1. The assessments address section were opened assess requiring a correction requestor Resident #2 has been coannual MDS assessment wit to accurately reflect the presinsomnia exhibited.  2. A random audit of resident over the past ninety days was	sed in this sments and not st. Section E1 (k) rected in th ARD 09/01/10 ence of	10/19/10
The findings include:  1. The Social Worker Section E1(k) Insome		er failed to accurately code nnia/change in usual sleep essment Reference Date June		to ascertain the accuracies of Any assessment that does not reflect the resident status has a review of the importance assessments was completed.	ot accurately s been corrected e of accuracy in l on 10/19/10	10/19/10
	signed June 4, 2010awake and OOB ( w/c (wheelchair). R down hallway. Did moving furniture ardSeveral attempts b back to bed, she ref  Nursing Progress N 2010 10:40 PM " R Ambien 10mg "	rsing Progress Notes dated and at 7:00 AM Resident #2 " out of bed) @ (at) 2:30 AM in esident wheeling herself up and not go back to bed. Noted bund in room at 3:00 AM were made to get resident to go fused. "  ote dated and signed June 6, esident alert oriented, order for ote dated and signed June 11,		with the interdisciplinary tear member responsible for an a held accountable for accurace completion. The RN Coordin section completion. Each tear completing an assessment with completed with a signature assection AA8 and section Z or 4. A monthly audit of MDS compliance will be completed of the audit will be submitted committee quarterly DON/dereport of problems identified actions implemented will be CQI committee will determine other interventions and need	assessment is by in section action will verify and member will list sections and date in mMDS 3.  Completion d and the results to the CQI asignee. A and corrective presented. The ethe need for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 278	responsive slept in lewheelchair. "  A face-to-face interved Employee #8 on August After review of the Motes, he/she acknown was not accurately of record was reviewed.	riew was conducted with gust 3rd, 2010 at 12:11 PM. MDS and Nursing Progress owledged that the quarterly MDS coded in Section E1 (k). The d on August 3, 2010.	F 278	of further audits.  F tag 278 #2  1. The assessments addressed section were opened assessmerequiring a correction request. S for Resident #4 has been correction subsequent quarterly assessmeresident has been completed to	ents and not Section P4(a) cted in the ent dated nent of the	10/19/10
	assessment comple was coded in Sectio Restraints) as "0" fo of bed. Indicating the	arterly Minimum Data Set (MDS) ted May 19, 2010, the resident n P4 (a) (Devices and or full bed rails on all open sides are resident had not used full beding the day or night over the last		usage of side rails.  2. A 100% audit of resident's as over the past ninety days will be to ascertain the accuracies of a Any assessment that does not a reflect the resident status will be	e completed assessment. accurately e corrected.	10/19/10
	dated May 11, 2010 "Restraints Side with turning and pos and night], side rails "  A face-to-face intervent to the side of	sician 's Order Form signed and , directed the following: rails utilized to assist resident itioning D-E-N [ day, evening, X4, only in bed due to mobility.		3. A review of the importance of assessments was completed or with the interdisciplinary team. member responsible for assess accountable for accuracy in section. The RN Coordinatic section completion. Each team completing an assessment will completed with a signature and section AA8 and section Z on N	n 10/19/10 Each team sment is held ction on will verify member list sections date in	10/19/10
	9:15 AM. He/she ad MDS was not coded reviewed on August 3a. Facility staff faile (a) and (b) Accidents	knowledged that the quarterly for restraints. The record was 3, 2010.		4. A monthly audit of MDS com compliance will be completed a of the audit will be submitted to committee quarterly DON/desig of problems identified and corre implemented will be presented. committee will determine the ne	nd the results the CQI Inee. A report ective actions The CQI	10/28/10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		095015	B. WING	G		08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 278	Continued From page	ge 44	F 2	278	Continued from page 44		
	completed on March (Assessment Refere	arterly MDS assessment n 30, 2010 with an ARD ence Date) of March 24, 2010 d coding for a fall occurring in			interventions and need and further audits.  F tag 278 #3a & 3b Reside		
	signed March 23, 20 following: "Reside	rsing Progress Note dated and 010 3:00 PM revealed the nt alert and verbal. s/p changes in mental status noted			1. The assessments address section were opened assess not requiring a correction recassessment with ARD of 9/4 J4 (a) and (b) has been corrected af all in the past 31-180 days	ments and quest. An annual /10, sections npleted to reflect	10/19/10
	According to the Nursing Progress Note dated and signed March 3, 2010 at 8:00 AM, "Resident was observed sitting on floor in dayroom and stated, I just fell"				2. A 100% audit of resident's over the past ninety days wi ascertain the accuracies of assessment that does not acresident status has been con	I be completed to assessment. Any ccurately reflect th	
	assessment comple ARD of June 24, 20	te next quarterly MDS ted on June 30, 2010 with an 10 Section J4 (b) lacked coding ted in the past 31-180 days.			3. A review of the importance assessments was completed with the interdisciplinary tear member responsible for asses accountable for accuracy in	e of accuracy in d on 10/19/10 m Each team essment is held section completio	
5, 2010 with Employee AM. After review of the acknowledged that Seconding for fall in the past 31-180 days. The reco		view was conducted on August vee #6 at approximately 8:50 the two quarterly MDS he/she Section J4 (a) and (b) lacked past 30 days and in the past ecord was reviewed on August			The RN Coordinator will vericate team member completed will list sections completed with date in section AA8 and section AA8 a	ing an assessme vith a signature ar tion Z on MDS 3.0 ompletion	nt nd
	5, 2010.  4. Facility staff failed to accurately coded Resident #7 for indicators of depression, anxiety, sad mood, mood persistence, and behavioral symptoms.				of the audit will be submitted committee quarterly DON/de of problems identified and complemented will be present committee will determine the interventions and need and further audits.	to the CQI esignee. A report prrective actions ed. The CQI e need for other	

F 278 Continued From page 45 A review of Resident #7 's quarterly MDS completed on July 23, 2010 with an Assessment Reference Date [ARD] (last date for observations) of July 16, 2010 revealed varied indicators depression, anxiety, sad mood, mood persistence, and behavioral symptoms in last 7 days prior to the ARD. Section E 1, 2 and 4. [He/she was coded as exhibiting one or more indicators of making: expressions of what appear to be unrealistic fears, repetitive health complaints, sad pained worried  F 278  Continued From page 45  F tag 278 #4 Resident 7  1. The assessments addressed in this section were opened assessments and not requiring a correction request. A quarterly assessment with ARD of 10/14/10 will include updated information regarding the behavioral status of Resident #7. A SW note of 10/13/10 will support the clarified		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mu A. BUIL		LE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
Tag Southern Ave se Washington, DC 20032    (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DPREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERIXED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERIXED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERIXED TO THE APPROPRIATE DEFICIENCY)   COMPANY TAG   PROVIDER'S PLAN OF COMPANY TAG   PROVIDENCE AND TAG   PROVIDER'S PLAN OF COMPANY TAG   PROVIDER'S PLAN O			095015	B. WING	G			08/1	1/2010
F 278  Continued From page 45  A review of Resident #7 's quarterly MDS completed on July 23, 2010 with an Assessment Reference Date [ARD] (last date for observations) of July 16, 2010 revealed varied indicators depression, anxiety, sad mood, mood persistence, and behavioral symptoms in last 7 days prior to the ARD. Section E 1, 2 and 4. [He/she was coded as exhibiting one or more indicators of making: expressions of what appear to be unrealistic fears, repetitive health complaints, sad pained worried  F 278  Continued From page 45  F tag 278 #4 Resident 7  1. The assessments addressed in this section were opened assessments and not requiring a correction request. A quarterly assessment with ARD of 10/14/10 will include updated information regarding the behavioral status of Resident #7. A SW note of 10/13/10 will support the clarified			ALTH CARE CENTER		13	80 SOUTHERN AVE SE			
F 278  A review of Resident #7 's quarterly MDS completed on July 23, 2010 with an Assessment Reference Date [ARD] (last date for observations) of July 16, 2010 revealed varied indicators depression, anxiety, sad mood, mood persistence, and behavioral symptoms in last 7 days prior to the ARD. Section E 1, 2 and 4. [He/she was coded as exhibiting one or more indicators of making: expressions of what appear to be unrealistic fears, repetitive health complaints, sad pained worried  F 278  F tag 278 #4 Resident 7  1. The assessments addressed in this section were opened assessments and not requiring a correction request. A quarterly assessment with ARD of 10/14/10 will include updated information regarding the behavioral status of Resident 7	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY	PREFIX	×	(EACH CORRECTIVE ACTION SH	OULD BE C	CROSS-	(X5) COMPLETION DATE
and presentations with ' not easily altered' persistent mood, physically abusive behavior and care resistance.]  A further review of Resident #7's Clinical record including the "Nurses' notes" for June and July 2010 lacked documented evidence of the aforementioned behaviors.  A face-to-face interview was conducted with Employees #7 on August 4, 2010 at approximately 9:20 AM. After a review of Resident #7's clinical record he/she acknowledged that the resident's clinical record lacked documented evidence for indicators of depression, anxiety, sad mood, persistence and behavioral symptoms. The record was reviewed August 4, 2010.	F 278	A review of Resider completed on July 2 Reference Date [AF of July 16, 2010 revidepression, anxiety and behavioral sym ARD. Section E 1, 2 exhibiting one or mexpressions of what repetitive health confacial expressions, and presentations with persistent mood, phonormal presentations with persistent persistence and behavior a fall on the quality of the clinical review of the clinical revealed the resider portion and March 23 persistence and persistence a	nt #7 's quarterly MDS 23, 2010 with an Assessment RD] (last date for observations) realed varied indicators repetitive placed worried repetitive physical movements repetitive physical record repetitive physical movements repetitive physical record repetitive physical movements repetitive physical record resident #7 's Clinical record resident resident 's red documented evidence for resion, anxiety, sad mood, mood reavioral symptoms. The record record resident #8 record	F 2		F tag 278 #4 Resident 7  1. The assessments address section were opened assess requiring a correction reques assessment with ARD of 10 include updated information behavioral status of Reside of 10/13/10 will support the information.  2. A random audit of reside over the past ninety days with the accuracies. Any assessment that does reflect the resident status with a scentain the accuracies. Any assessment swas complete interdisciplinary team. Each member responsible for assaccountable for accuracy in completion. The RN Coordinated with a signature of the audit will be succompleted with a signature.  4. A monthly audit of MDS compliance have been completed with a signature of the audit will be succommittee quarterly DON/dof problems identified and complemented will determine the interventions and need and	sments a st. A qua st. A qua 1/14/10 w regardir nt #7. A st clarified nt's assess not accur ill be console of accur in a m mem will list seand date completed are ubmitted esignee. Orrective ted. The eneed for accurate the seand of th	and not arterly vill ng the SW note SW note SSW	

#### Continued from page 46

#### F tag 278 #5 Resident #8

- 1. The assessments addressed in this section were opened assessments and not requiring a correction request. Section J4 has been corrected on a subsequent Annual Assessment with ARD of 9/12/10 to reflect a fall within the last 31-180 days for Resident #8.
- 2. A random audit of resident's assessments 10/19/10 over the past ninety days will be completed to ascertain the accuracies of assessment.

  Any assessment that does not accurately reflect the resident status will be corrected.
- 3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date
- 4. A monthly audit of MDS completion 10/28/10 compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SUF COMPLET	
		095015	B. WING_		08/1	1/2010
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	LTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 278	Continued From pag	ge 46	F 27	8 F tag 278 #6 Resident #9		
	completed March 29 (accidents) - "0" in 180 days.  A face-to-face interved Employee #4 on Aug 11:30 AM, who acknown MDS did not reflect to for March. The record of March. The record failed to accura Minimum Data Set [completed March 1, Section H, Continen Oral/Nutritional State the admission and quant According to the nur dated February 17, 2 with an indwelling un record revealed the managed during the there was no eviden Additionally, the initial Pathologist [SLP] as 2010, revealed Residysphagia character	us was inaccurately coded on juarterly MDS assessments.  rsing admission assessment 2010, Resident #9 was admitted rinary catheter in place. The indwelling catheter had been entirety of his/her stay and ace of catheter malfunction.  al Speech and Language ssessment dated February 22, ident #9 had "profound rized by pocketing and poor oral		1. The assessments address section were opened assess requiring a correction request quarterly assessment with A corrected for Resident #9 to continence in the presence of catheter and swallowing difference of a gastrostomy to ascertain the accuracies of Any assessment that does not reflect the resident status with a review of the importance assessments was completed interdisciplinary team. Each responsible for assessment if for accuracy in section completed assessment will list sections a signature and date.  4. A monthly audit of MDS of compliance will be completed of the audit will be submitted committee quarterly DON/de of problems identified and complemented will be presents	ments and not st. A subsequent RD was indicate of a Foley culty in the ube.  It's assessments I be completed of assessment, ot accurately I be corrected.  It's an eccuracy in the completion of an eccurate is held accountable of accurate is held accountable on completion, ing an ecompleted with eccurate is to the CQI esignee. A report prective actions	10/28/10
	dated February 26, 2	equent SLP progress note 2010 revealed a gastrostomy February 26, 2010 for the trition and		committee will determine the interventions and need and f further audits.	need for other	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING	(X3) DATE SUI COMPLET	
		095015	B. WING	9	08/1	1/2010
	OVIDER OR SUPPLIER	EALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE ACTIO REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETION DATE
F 278	hydration enterally The annual and quinclude the indwel continence in Sec swallowing proble reviewed August 4 7. Facility staff fail 12 's quarterly ME Ulcer.)  A review of the questive 2010 with an Asse 22, 2010, reveale zero (0) pressure review of the weed Documentation For and April 20, 2010 documented as be a face-to-face interestive face interestive for August 5, 2010 8. Facility staff fail quarterly MDS assert #19.  A review of the questive face in the quarterly MDS assert #19.  A review of the questive face in the quarterly MDS assert #19.  A review of the questive face in the questive face in the questive face in the problem of the question for the question face in	uarterly MDS ' were not coded to ling urinary catheter and tion H; and failed include m in section K. The record was I, 2010.  ed to accurately code Resident # DS for Section M, (Pressure arterly MDS completed May 3, essment Reference Date of April d that the resident was coded for ulcer (s) in Section M1 and M2. A kly "Pressure Area orm "revealed that on April 23, a right heel ulcer was eing assessed weekly.  Inview was conducted with August 5, 2010 at approximately ployee acknowledged the indings. The record was reviewed in th	F 2	F tag 278 # 7 Resident  1. Residents' #12, 24, ar discharged and no further made.  2. A random audit of resiover the past ninety days to ascertain the accuracing Any assessment that does reflect the resident status.  3. A review of the import assessments was complianter disciplinary team. Eresponsible for assessment or accuracy in section or Coordination will verify seach team member commassessment will list section as signature and date.  4. A monthly audit of MD compliance will be composed from the audit will be submate committee quarterly DOI of problems identified and implemented will be presecommittee will determine interventions and need a further audits.  F tag 278 # 8 Resident and section were opened assection were opened assection were opened assection.	ident's assessments will be completed es of assessment. es not accurately will be corrected.  ance of accuracy in eted on with the fach team member ent is held accountation pletion. The RN ection completion. In the completion on scompleted with the completion of the CQI N/designee. A report of corrective actions sented. The CQI ethe need for other and frequency of the seed in this	10/19/10 10/19/10 ble 10/28/10
	completed July 20	, 2010, coded Resident #19 for				

#### Continued from page 48

Resident #19 on a subsequent quarterly 1 assessment has been updated to include the presence of MRSA.

10/19/10

- 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment.

  Any assessment that does not accurately reflect the resident status will be corrected.
- 3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date.
- 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILD!	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/1	1/2010
	NOVIDER OR SUPPLIER	LTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 278	having no infections  A review of the phys July 2, 2010, initiate Isolation Precaution -Resistant Staphylor  A face-to-face interv 6, 2010 at approxim #4. He/she acknowle inaccurately coded freviewed August 6,  9. Facility staff failed (b) Accidents for occ 31-180 days on t assessments. Resid	in Section I2 [Infections].  sician's orders dated and signed d March 22, 2010 directed, " severy shift - MRSA [Methicillin coccus Aureus]/ Urine.  siew was conducted on August ately 4:15 PM with Employee edged that the MDS was for Infections. The record was 2010.  It to accurately code Section J4 curring in past the Quarterly MDS dent #20 quarterly MDS assessment	F 27	1. The assessments addres section were opened assess requiring a correction requerquarterly assessment with A for Resident #20 has been a to reflect a fall within the las 2. A random audit of resider over the past ninety days with ascertain the accuracies of Any assessment that does reflect the resident status with 3. A review of the importance assessments was completed interdisciplinary team. Each responsible for assessment for accuracy in section complete interdisciplinary in secti	sments and not st. A subsequent RD of 10/16/10 accurately coded t 31-180 days.  It's assessments be completed of assessment, ot accurately be corrected.  It is a corrected.  It is a corrected on with the team member is held accountable betion. The RN	10/19/10 10/19/10 10/19/10
	(Assessment Re Section J4 (b) lacke occurring in the p	ast 31-180 days.  Nursing Progress Notes dated		Coordination will verify secting Each team member completed assessment will list sections a signature and date.  4. A monthly audit of MDS compliance will be completed.	ting an completed with completion	10/28/10
	" C.N.A. (Certifie to resident stated " pt (patient) in bed the ground. Fall was C.N.A. stated passhe fell on her buttoon A face-to-face into August 5, 2010 with approximately 3:5	d Nursing Assistant) assigned while she was putting I from his/her wk (work), slid to s " witnessed ient did not hit her head that cks. "		of the audit will be submitted committee quarterly DON/de of problems identified and or implemented will be present committee will determine the interventions and need and further audits.	to the CQI signee. A report prrective actions ed. The CQI need for other	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/1	1/2010
	ROVIDER OR SUPPLIER	ALTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 278		cked coding for fall in the past	F 278	F tag 278 # 10 Resident #2	1	
	on August 5, 201  10. Facility staff fail as a restraint for Resident #21 was of the facility on August 10:30 AM. He/she wup. Upon interview, the two side rails upon to fall.  This statement was Employee #5. Employee #5. Employee #5. Employee and care plan at A further review of the Data Set assessme and a quarterly assection 2010 revealed that use of side rails as A face-to-face interemployees 4 and 5 approximately 10:30 resident's clinical racknowledged that use of side rails as not aware of the prathat he/she will follow	ed to code for use of side rails esident #21.  Observed during the initial tour of st 2, 2010 at approximately was in bed with the two side rails he/she said, they always have of while I am in bed so that I do made in the presence of oyee #5 added I will take note of occordingly.  The resident 's annual Minimum ints completed on April 5, 2010 essment completed on June 28, the resident was not coded for a restraint to prevent falls  View was conducted with on August 6, 2010 at 0 AM. After a review of the ecord, Employee #4 the resident was not coded for a restraint and that he/she was actice. Employee #4 concluded w-up with an appropriate resident 's use of side rails. The		1.The assessments address section were opened assess requiring a correction request assessment to determine the rails will be completed and desuch will be included to accurate open assessment for Resider over the past ninety days with to ascertain the accuracies of Any assessment that does not reflect the resident status with assessments was completed interdisciplinary team. Each responsible for assessment for accuracy in section completed conditions will verify section assessment will list sections a signature and date.  4. A monthly audit of MDS or compliance will be completed of the audit will be submitted committee quarterly DON/defor problems identified and complemented will be presented.	ments and not at. A functional a need for side ocumentation of rately code the nt #21.  It's assessments I be completed of assessment of accurately I be corrected.  I on with the team member is held accountabletion. The RN on completion ing an completed with ompletion and the results to the CQI signee. A report orrective actions ed. The CQI	10/28/10
		ed to accurately code Resident		committee will determine the interventions and need and further audits.	· · · · · · · · · · · · · · · · · · ·	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUI COMPLET	
		095015	B. WIN	3		08/1	1/2010
	OVIDER OR SUPPLIER	ALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 278	6, 2010 at approxin #28. He/she stated bowel and bladder  A review of the qua 2010, Section H1b as "0" indicating control of bladder.  A face-to-face inter 6, 2010 at approxin #4. He/she acknow was coded incorred August 6, 2010.  12. Facility staff fac CBL 13's for pneum Diff.) and Hepatitis  The Resident was a 22, 2009.  A review of the resithe followings:  Nursing note March and responsive CX to] coughing."  A nursing note date "Rt [Right] upper PMD [Primary docts sent to the nearest	quarterly MDS.  view was conducted on August nately 11:45 AM with Employee d, "He/she was incontinent of we had to change him/her."  Interly MDS completed May 5, [Bladder Continence] was coded that the resident is in complete  view was conducted on August nate 12:15 PM with Employee yiedged that the admission MDS of the record was reviewed on the illed to accurately code Resident nonia, Clostridium difficile (C. C virus.  admitted to the facility on June  dent's clinical record revealed  17, 2010 at 3:00 PM: "Alert R (Chest X-ray) done [Related and March 17, 2010 at 3:00 PM: lung field pneumonia infiltrate. For ordered the resident to be ER. [Emergency Room] The	F 2	278	1. Residents' #12, 24, and 0 discharged and no further comade.  2. A random audit of resident over the past ninety days witto ascertain the accuracies of Any assessment that does not reflect the resident status with a review of the importance assessments was completed interdisciplinary team. Each responsible for assessment for accuracy in section completed assessment will list sections a signature and date.  4. A monthly audit of MDS of compliance will be completed of the audit will be submitted committee quarterly DON/derof problems identified and complemented will determine the interventions and need and further audits.	BL13 have been brections can be t's assessments I be completed of assessment. ot accurately II be corrected. The contract of accuracy in the decountable of accuracy in the seam member is held accountable on completion. The RN on completion ing an completed with the CQI signee. A report or active actions and the CQI recedifications according to the CQI and the CQI	10/19/10 10/19/10 ble
	hospital. "	nd took the resident to the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	NOVIDER OR SUPPLIER	NLTH CARE CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 278	March 17, 2010 "Tr "Past history:He "Medications: Thian daily, Levaquin 500r days" "Diagnostic impress C virus"  A nursing note dated stated: "Readmitted A telephone interim 11:20 PM that direct P.O. QD [Daily] x100 An untimed telephor that directed "Stool stated to the stated of the	ransfer Summary Form ": epatitis C virus " mine 100mg P. O. [By mouth] mg P.O. daily for the next 7 sion: Right pneumonia, hepatitis d March 30, 2010 at 3:30 PM	F 278	F tag 278 # 12 Resident #C  1. Residents' #12, 24, and C discharged and no further co made.  2. A random audit of resident over the past ninety days will to ascertain the accuracies o Any assessment that does no reflect the resident status will  3. A review of the importance assessments was completed interdisciplinary team. Each responsible for assessment is for accuracy in section completed coordination will verify sector Each team member complete assessment will list sections a signature and date.	BL13 have been brections can be t's assessments I be completed of assessment. Ot accurately I be corrected. The of accuracy in I on with the team member is held accountabletion. The RN on completion. Ing an	10/19/10 10/19/10 ble
	2:00 PM that directe Dx [Diagnosis] Pneu An telephone interim 2:00 PM that directe isolation for C. Diff. i [Three times daily] x Transfer resident to A nursing note dated "Resident had a la	n order dated April 16, 2010 at ed "Resident on contact in stool, Flagyl 250 mg TID x10 PO days Dx. C. Diff, roomfor contact isolation."  d April 15, 2010 at 8:00 AM arge slimy jelly stool [with] no ool specimen [obtained] for C.		4. A monthly audit of MDS co- compliance will be completed of the audit will be submitted committee quarterly DON/de- of problems identified and co- implemented will be presente committee will determine the interventions and need and fr further audits.	d and the results to the CQI signee. A report prective actions ed. The CQI need for other	10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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CAROLY	N BOONE LEWIS HEA	ALTH CARE CENTER			380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
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F 278	MD] made aware.	culture was positive for C. Diff New orders given for resident tion. Resident to start Flagyl 250	Fí	278			
	revealed that a quar	he resident's clinical record rterly MDS completed on April ode the resident in Section I2 ff., Pneumonia, and viral		1			
	Employee # 4 on Au 12:00 PM. After revi record, he/she ackn	view was conducted with ugust 10, 2010 at approximately iewing the resident's clinical cowledged the above findings. iewed August 10, 2010.					
, ,		o accurately code Resident CBL of April 16, 2010 for pneumonia, s C virus.					
	Employee #4 on Au 12:15 PM. After revi record, he/she ackn	view was conducted with gust 9, 2010 at approximately iewing the resident's clinical owledged the above findings. ewed August 9, 2010.					
F 279 SS=E	1 <del></del>		F2	279			
ı		he results of the assessment to I revise the resident's n of care.					
	plan for each reside objectives and timet	velop a comprehensive care int that includes measurable tables to meet a resident's and mental and psychosocial					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 279	needs that are ident assessment.  The care plan must	ified in the comprehensive describe the services that are to	F 2	:79	Continued From page 53 483.20(d), 483.20(k)(1) DEV COMPREHENSIVE CARE P Ftag 279 #1 Resident #2			
	highest practicable p psychosocial well-be and any services that under §483.25 but a resident's exercise of including the right to	n or maintain the resident's obysical, mental, and eing as required under §483.25; at would otherwise be required are not provided due to the of rights under §483.10, orefuse treatment under		1	An assessment note reflect absence of infection for Residual completed on 10/18/10. A call address this concern is not a call 2. A random audit of resident	dent : re pla eede	#2 is an to d	10/19/10 10/19/10
		IT is not met as evidenced by:			over the past ninety days will to ascertain the accuracies of assessment. Any care plan of the resident's status will be	be c f the ackin	ompleted care plan g evidence	
	for 12 of 26 sampled supplemental reside facility staff failed to irritation for one (1) resident, altered skill multiple medications incontinence for one resident, diagnoses of side rails for one planning for one (1) 7, 12, 15, 16, 19, 21.  The findings include				3. Care Area Triggers identific completion of the comprehent assessments will be care plate seven days. The MDS Coord ensure supporting documents to support care planning deciand location of the supporting will be entered on the CAT stagged by the MDS Coordina completion. Care plans will prevised according to an estate that meets the objectives are set forth in each individualize	nsive nned linato ation isions g doc ummi tor in e rev olishe d app	within or will is available s. The date cumentation ary and dicating iewed and ed timetable roaches	
	According to a Nurs time April 10, 2010 a eye redness noted in				4. A random review of the cal completed monthly evaluating of goals and approaches assassisting the residents to attathe resident's highest practic mental, and psychosocial we	g the ociat ain ar al ph	inclusion ed with nd maintain ysical,	10/28/10

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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at 11:15 AM. Physic and have NP (Nurse and have NP (Nurse and have NP) (Nurse and have NP) (Nurse and have NP) (Nurse and and and and and and assessments and May 19, 2010, t Section H as incontine at 11:15 April 13, 2010 at 11:15 April 14:15 April 14:15 April 15, 2010 at 11:15 April 15, 2010 a	cian notified to just monitor eye e Practitioner see on Monday  :00 PM "Right eye sclera "  :00 AM "ABT (Antibiotic) eyes in progress "  :lans initiated since April 2010 a care plan initiated for right eye  view was conducted with gust 5, 2010 at approximately v of the care plans he/she above findings. The record was 15, 2010.  :d to develop a care plan for falls r Resident #4.  :sident 's admission Minimum sessment completed November uarterly Minimum Data set is completed February 24, 2010 the resident was coded in	F 2	279	of the audit will be submitted committee monthly. A report identified and corrective action will be presented. The CQI of determine the need for other and need and frequency of full the following of the second se	of problems ons implemented committee will interventions urther audits.  I precaution owel and ident #4 was 's assessments be completed f the care plan acking evidence	10/18/10
directed, "Treatmer review of the nursing revealed; Resident on June 9, 2010.  A review of the resident review of the revie	nts Fall Precautions. " A g notes dated June 9, 2010 #4 sustained a fall without injury dent 's care plans lacked			completion of the comprehen assessments will be care plan seven days. The MDS Coord ensure supporting documents to support care planning deciand location of the supporting	sive nned within inator will ation is available sions. The date g documentation	10/19/10
	CORRECTION  OVIDER OR SUPPLIER  N BOONE LEWIS HEAR  SUMMARY ST  (EACH DEFICIENCY MUS'OR LSC IDE  Continued From page at 11:15 AM. Physicand have NP (Nurse and have NP (Nurse and have NP) (Nurse and NP) (Nurse and NP) (Nurse are and NP) (Nurse and NP) (Nurse are and NP) (Nurse and Nurse and NP) (Nurse and Nurse	OSTITICATION NUMBER:  OSTITICATION  OR ISTITICATION  OR ISTITICATION  OR LSCIOLATORY  OR LSCIOLA	OVIDER OR SUPPLIER  N BOONE LEWIS HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 54 at 11:15 AM. Physician notified to just monitor eye and have NP (Nurse Practitioner see on Monday "April 11, 2010 at 11:00 PM " Right eye sclera redness clearing"  April 13, 2010 at 8:30 AM "ABT (Antibiotic) Gentamycin to both eyes in progress "  Review of all care plans initiated since April 2010 lacked evidence of a care plan initiated for right eye redness.  A face-to-face interview was conducted with Employee #6 on August 5, 2010 at approximately 3:40 PM after review of the care plans he/she acknowledged the above findings. The record was reviewed on August 5, 2010.  2. Facility staff failed to develop a care plan for falls and incontinence for Resident #4.  According to the resident 's admission Minimum Data Set (MDS) assessment completed November 25, 2009, and the quarterly Minimum Data set (MDS) assessments completed February 24, 2010 and May 19, 2010, the resident was coded in Section H as incontinent of bowel and bladder function.  Physician 's orders dated and signed June 2, 2010 directed, "Treatments Fall Precautions." A review of the nursing notes dated June 9, 2010 revealed; Resident #4 sustained a fall without injury on June 9, 2010.  A review of the resident 's care plans lacked	OVIDER OR SUPPLIER  N BOONE LEWIS HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 54 at 11:15 AM. Physician notified to just monitor eye and have NP (Nurse Practitioner see on Monday  April 11, 2010 at 11:00 PM " Right eye sclera redness clearing"  April 13, 2010 at 8:30 AM "ABT (Antibiotic) Gentamycin to both eyes in progress "  Review of all care plans initiated since April 2010 lacked evidence of a care plan initiated for right eye redness.  A face-to-face interview was conducted with Employee #6 on August 5, 2010 at approximately 3:40 PM after review of the care plans he/she acknowledged the above findings. The record was reviewed on August 5, 2010.  2. Facility staff failed to develop a care plan for falls and incontinence for Resident #4.  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Physician notified to just monitor eye and have NP (Nurse Practitioner see on Monday  April 11, 2010 at 11:00 PM " Right eye sclera redness clearing"  Review of all care plans initiated since April 2010 lacked evidence of a care plan initiated for right eye redness.  A face-to-face interview was conducted with Employee #6 on August 5, 2010 at approximately 3:40 PM after review of the care plans he/she acknowledged the above findings. The record was reviewed on August 5, 2010.  2. Facility staff failed to develop a care plan for falls and incontinence for Resident #4.  According to the resident 's admission Minimum Data Set (MDS) assessments completed November 25, 2009, and the quarterly Minimum Data set (MDS) assessment completed February 24, 2010 and May 19, 2010, the resident was coded in Section H as incontinent of bowel and bladder function.  Physician's orders dated and signed June 2, 2010 directed, "Treatments Fall Precautions." A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked	ONDER OR SUPPLIER  NOONE LEWIS HEALTH CARE CENTER  SUMMARY STATEMENT OR DEFCIENCIES  (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION).  Continued From page 54  at 11:15 AM. Physician notified to just monitor eye and have NP (Nurse Practitioner see on Monday  April 11, 2010 at 11:00 PM " Right eye sclera redness clearing"  April 2010 at 11:00 PM " Right eye sclera redness.  A face-to-face interview was conducted with Employee 46 on August 5, 2010 at approximately 3:40 PM after review of the care plans he/she acknowledged the above findings. The record was reviewed on August 5, 2010 at approximately 3:40 PM after review of the care plans he/she and incontinence for Resident #4.  According to the resident 's admission Minimum Data Set (MDS) assessments completed November 25, 2009, and the quarterly Minimum Data set (MDS) assessment completed November 25, 2009, and the quarterly Minimum Data set (MDS) assessments completed February 24, 2010 and May 19, 2010, the resident was coded in Section H as incontinent of bowel and bladder function.  A review of the nursing notes dated June 9, 2010 revealed: Resident #4 sustained a fall without injury on June 9, 2010.  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked  A review of the resident 's care plans lacked

#### Continued from page 55

signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized assisting the residents to attain and maintain revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area.

4. A random review of the care plans will be 10/28/10 completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUP COMPLET	
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F 279	A face-to-face intenda, 2010 at approxim#5. He/she reviewed and acknowledged lacked evidence that incontinence and fathe care plan right a reviewed on August 3. Facility staff failed potential drug interamore medications for Section O, Medicati Data Set (MDS) conthat Resident #5's thirteen (13) different Physician's orders following medication Norvasc, Aricept, Visulfate, Lasix, Hydr Percocet, Ammoniu powder.  The care plan most lacked problem idento address the potentian of the potential drug interaction.	nd approaches for bowel and e and fall.  view was conducted on August pately 2:30 PM with Employee and the resident 's clinical record that the resident 's record at a care plan was initiated for alls. He/she said, "I will initiate away." The record was at 3, 2010.  If to develop a care plan for actions for the use of nine (9) or a resident #5.  ons, of the quarterly Minimum ampleted June 4, 2010 revealed and medication regimen included and medications.  If the quarterly Minimum and the first of the resident in the first of the resident: it amin C, Fentanyl, Ferrous alazine, Megace, Multivitamins, and lactate and Polysporin  recently updated June 3, 2010 antification, goals and approaches antial interactions associated with medications. The record was	F 279	F tag 279 #3 Resident #5  1. The care plans for Resident have been updated to reflect adverse reactions associated medication usage on 10/18/10 have been assessed and no reactions are noted.  2. A random audit of resident over the past ninety days will to ascertain the accuracies of assessment. Any care plan a of the resident's status will be  3. Care Area Triggers identific completion of the comprehent assessments will be care plan seven days. The MDS Coordi ensure supporting documentato support care planning dedicand location of the supporting will be entered on the CAT susigned by the MDS Coordinate completion. Care plans will be revised according to an estab that meets the objectives and set forth in each individualized residents to attain and maintal according to an established that meets the objectives and set forth in each individualized.	the potential for with multiple D. Residents associated sassociated sassociated sassociated the care plancking evidence corrected. The trium is available sions. The date documentation mary and or indicating ereviewed and lished timetable approaches disassisting the in revised metable approaches approaches	
	4. The facility staff f	ailed to initiate a care plan for appropriate goals and		4. A random review of the car completed monthly evaluating of goals and approaches assisting the residents to attaithe resident's highest practical.	the inclusion ociated with n and maintain	10/28/10

#### Continued from page 56

mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

#### F tag 279 # 4 Resident #6

- 1. The plan of care for Resident #6 is updated 10/19/10 to reflect appropriate goals and approached for skin alterations on 10/18/10. Resident #6 skin alterations are now resolved.
- 2. A random audit of resident's assessments 10/19/10 over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's status will be corrected.
- 3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area.
- 4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the interventions and need and frequency of further audits.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					RVEY
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE A		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	JLD BE CROSS-	(X5) COMPLETION DATE		
F 279	July, signed June 2: w/NS (with Normal shift and leave oper According to the No Form first initiated J July 30, 2010 revealeg shin wound no to Review of the care particles and signed acknowledged that care plan with approximate a right leg skin alternon August 5, 2010.  5. Facility staff faile hypertension, and completed on April resident presented was Section C (Commun His/her diseases in (Disease Diagnoses). A further review of revealed that his/he updated on July 20,	nent record for the month of 5 revealed "Right Leg - cleanse Saline) apply Neosporin every in to air until healed."  In-Pressure area Documentation une 19, 2010 and last updated led that Resident #6 has a right type and staging identified.  In plans last updated June 22, ce of a care plan initiated for a last.  In plans last updated June 22, ce of a care plan initiated for a last.  In plans last updated June 22, ce of a care plan initiated for a last.  In plans last updated June 22, ce of a care plan she/she the record lacked evidence of a last opriate goals and approaches for ation. The record was reviewed led to develop a care plan ommunication for Resident #7.  In Data Set (MDS) assessment last 16, 2010 revealed that the with impaired communication in nication/Hearing Patterns). Cluded hypertension Section I	F	279	F tag 279 # 5 Resident #7  1. Care plans for Resident #7 updated to reflect goals and a impaired communication on 10 Resident #7 does not have a chypertension. Resident #7 use language understood by staff wishes/needs.  2. A random audit of resident's over the past ninety days will be ascertain the accuracies of assessment. Any care plan lad of the resident's status was considered.  3. Care Area Triggers identified completion of the comprehensions will be care planned within sex MDS Coordinator will ensure sedocumentation is available to splanning decisions. The date are	pproaches for 0/18/10. diagnosis of es body to indicate her assessments be completed the care plancking evidence prrected. d through vive assessment yen days. The supporting support care and location of	10/19/10 10/19/10
					the supporting documentation on the CAT summary and sign Coordinator indicating completivity be reviewed and revised as	ned by the MDS tion. Care plans	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY . COMPLETED	
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	OVIDER OR SUPPLIER	LTH CARE CENTER	]	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
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F 280	A face-to-face intervention and a face-to-face intervention would be a face of the face of	riew was conducted with gust 3, 2010 at 3:00 PM. S/he ician 's plan of care did not try testing and that the re removed from the nursing	F 280	F tag 280 #2 Resident #5		
	2010.  2. Facility staff failed nutritional risk and can a.) The nutritional risk march 4, 2010. The convened and upda	sk care plan was last updated interdisciplinary care team ted the resident 's plan of care wever, the nutritional risk care		1. The plan of care for Resider updated to reflect the physician no added salt and no concentr. The nutritional risk and diabete have been specifically address these items. Resident # 5 has assessed by the dietician and remain necessary for continuer.	n's order for ated sweets. es care plans sed to reflect been these items	
	2010 and included a calories with no con According to physicidiet was liberalized concentrated sweet:  Facility staff failed to include the currer resident. The record 3. The facility staff falls appropriate goals and A review of the care	ian 's orders, Resident #5 's to " no added salt no s" on February 4, 2010.  amend the diabetes care plan of the was reviewed August 2, 2010.  ailed to review and revise a care swith ad approaches for Resident #6.  plans last updated June 22, he care plan lacked evidenced		2. A random audit of resident's over the past ninety days will be to ascertain the accuracies of the assessment. Any care plan lad of the resident's current status corrected.  3. Care Area Triggers identified completion of the comprehension will be care planned within sevential became planned within sevential documentation is available to a planning decisions. The date at the supporting documentation on the CAT summary and sign Coordinator indicating complet will be reviewed and revised as established timetable that meetand approaches set forth in eatriggered area.	the care plan cking evidence have been  d through ive assessments en days. The upporting support care ind location of will be entered ed by the MDS ion. Care plans ccording to an ets the objectives	

#### Continued from page 65

4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

10/28/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	095015 B. WING		08/11/2010			
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			] ·	REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(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 CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 280	Continued From pa approaches for a fa March 23, 2010 and	ill occurring March 3, 2010,	F 280	F tag 280 #3 Resident #6		
	signed March 3, 20 "Resident was obs	erved sitting on floor in dayroom		The care plan for Resident updated to incorporate goals regarding multiple falls.		10/19/10
	23, 2010 3:00 PM r	lotes dated and signed March evealed the following: " verbal. s/p (status/post) fall, no		<ol> <li>A random audit of resident over the past ninety days will to ascertain the accuracies of assessment. Any care plan is of the resident's current statu corrected.</li> </ol>	be completed f the care plan acking evidence	10/19/10
	2010 at 9:00 PM re sitting on the floor in like to sit on the floor			Care planning is an on-go Each member of the interdisc will introduce topics for care MDS coordinator will coordinate.	ciplinary team clanning. The ate the	10/19/10
	5, 2010 with Employ approximately 8:50 plans he/she ackno	AM. After review of the care		completion of care plans utilicomprehensive assessment subsequent changes in the recondition.	and any	
	and approaches for			A random review of the ca completed monthly evaluating of goals and approaches ass	g the inclusion ociated with	11/19/10
	revealed facility state amend the Fall Prev	linical record for Resident #9 ff failed to vention Care Plan to include erventions for transfer and		assisting the residents to atta the resident's highest practic mental, and psychosocial we of the audit will be submitted committee monthly. A report	al physical, Il-being. Results to the CQI of problems	
	" section of the " F with transfers and a	" approaches and interventions alls " care plan was " assist mbulation as follows: " The allotted for interventions		identified and corrective action will be presented. The CQI conditions the need for other and need and frequency of fulfilling.	ommittee will interventions	
	The plan lacked evi	dence of approaches and		F tag 280 #4 Resident #9		

#### Continued from page 66.

1. The Fall Prevention Care plan has been reviewed and revised to include approaches and interventions to guide staff in measures to assist Resident #9 in transfer and ambulation.

10/19/10

- 2. A random audit of resident's assessments 10/19/10 over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's current status have been corrected.
- 3. Care planning is an on-going process. Each member of the interdisciplinary team will introduce topics for care planning. The MDS coordinator will coordinate the completion of care plans utilizing the comprehensive assessment and any subsequent changes in the resident's condition.

10/19/10

4. A random review of the care plans will be 11/19/10 completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095015		i		08/11/2010		
	ROVIDER OR SUPPLIER  N BOONE LEWIS HEA	ALTH CARE CENTER	,	1380 SOL	DRESS, CITY, STATE, ZIP CODE UTHERN AVE SE NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION SHO EFERENCED TO THE APPROPR	ULD BE CROSS-	(X5) COMPLETION DATE	
F 280	interventions that st resident with transfer.  The findings were reface-to-face intervieure, 2010 at 4:30 PM.  5. Facility staff failed plan with appropriate.	er and ambulation.  eviewed and confirmed during a ew with Employee #5 on August  d to review and revise a care	F 2	F tag  1.The upda dress The r comp	280 # 5 Resident #10 e care plan for Resident ted to include removal of sing from the graft site por resident has been asses plications have been ider imentation of pressure di	f a pressure ost dialysis. sed and no ntified. ressing removal	10/19/10	
	During an observati approximately 2:00 observed in his/her dressing noticed on covering the AV site	on on August 3, 2010 at PM, Resident #10 was wheelchair with a pressure the left upper arm		2. A rover to asses	ted on the Treatment Re random audit of resident' the past ninety days will certain the accuracies of ssment. Any care plan a e resident's current statu-	s assessments be completed the care plan acking evidence	10/19/10	
	dated July 2, 2010 on M-W-F (Monday AM, Assess AV Shu Remove pressure to site at 11:00 PM on Review of the Nurs	-Wednesday-Friday) at10:00 unt every shift, ape from AV (arterial venous) dialysis days. "  ing Progress Note Identified that d from dialysis on August 2,		Each will in MDS comp comp subsecondi		iplinary team blanning. The late the sing the and any esident's	10/19/10	
	Review of the care lacked evidenced or pressure tape from days "  A face-to-face intervent Employee #7 on Au approximately 2:10 plans and the reside	plans last updated July 13, 2010 f revisions to include "Remove AV site at 11:00 PM on dialysis		comp of go: assis the re menta of the comn identi will be deter	random review of the car pleted monthly evaluating als and approaches assi- ting the residents to atta esident's highest practica al, and psychosocial well a audit will be submitted inittee monthly. A report iffed and corrective action e presented. The CQI comine the need for other	g the inclusion ociated with in and maintain al physical, I-being. Results to the CQI of problems ns implemented ommittee will interventions		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	ALTH CARE CENTER	1:	EET ADDRESS, CITY, STATE, ZIP COD 380 SOUTHERN AVE SE VASHINGTON, DC 20032	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE	
F 280	2010.  He/she also acknowled evidence of revision removal of pressur was reviewed on A cording to the N signed May 14, 20 "C.N.A. (Certified resident stated " vin bed from her wkwas witnessed C.N head, that she fell Review of the cardlacked evidence of appropriate goals and A face-to-face inte 5, 2010 with Employment of the PM. After review of the The record was review and revise approaches and in related to Resident.	lay and that it removed last night August 2, owledged that the care plan lacked ons to include re tape post dialysis. The record August 3, 2010.  Ided to review and revise a care dentified goals and esident #20.  Itursing Progress Notes dated and 10 at 8:30 PM I Nursing Assistant) assigned to while she was putting pt (patient) is (work), slid to the ground. Fall N.A. stated patient did not hit her on her buttocks. "  The plans last up dated May 5, 2010 of identification of the fall with and approaches.  Triew was conducted on August by the care plans he/she above. The plans h	F 280	F tag 280 #6 Resident #20  1. The care plan for Reside reviewed and revised to income and interventions for fall sat May 14, 2010 has been do Fall Assessment Record.  2. A random audit of reside over the past ninety days we to ascertain the accuracies assessment. Any care plan of the resident's current state corrected.  3. Care planning is an onegeach member of the interdigible will introduce topics for care MDS coordinator will coord completion of care plans ut comprehensive assessment subsequent changes in the condition.  4. A random review of the completed monthly evaluate of goals and approaches a assisting the residents to a the resident's highest practimental, and psychosocial work the audit will be submitted committee monthly. A report identified and corrective activities and need and frequency of and need and frequency of and need and frequency of the audit need and frequen	ant #20 has been clude approaches fety. The fall of cumented on the cumented on the nt's assessments as a sessments as a sessment of the care plan lacking evidence tus have been oing process. Sciplinary team a planning. The inate the lizing the and any resident's care plans will be ing the inclusion sociated with tain and maintain ical physical, well-being. Results and to the CQI ort of problems tions implemented I committee will er interventions	10/19/10 10/19/10 11/19/10	