STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/11/2010	
	ROVIDER OR SUPPLIER	ALTH CARE CENTER	1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, 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 CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIATION	JLD BE CROSS- COMPLÉTION	
F 280	Continued From pa		F 280	Continued From page 68		
F 281 SS=D	updated June 9, 20 Smoking care plan engaged in more the around smoking. According to a faci 1, 2010 and based #CBL3 was engag resident altercation A review of the clin lacked evidence the and/or revised to in interventions to ad role in smoking ass The findings were face-to-face intervi 10, 2010 at approx reviewed August 6 483.20(k)(3)(i) SEF PROFESSIONAL 3 The services proviewed an esident 's skin personal services are sident 's skin personal s	RVICES PROVIDED MEET	F 281	483.20(k)(3)(i) SERVICES PR PROFESSIONAL STANDARI Ftag281 1. Staff was remediated at the survey. 2. All residents have the potential practive wound competency has been on the licensed staff; remediate made as needed. 3. Wound competencies will be on licensed staff during oriente quarterly by the Educator. A recompetency results have been DON/Designee. 4. Results the audit will be sub CQII committee monthly for the then quarterly. A report of providentified and corrective action implemented will be presented committee will determine the residentified and reside	e time of 8/11/10 Intial to be ice. Iconducted tion has been 10/19/10 The completed ation and report of in provided to the ree months, oblems is d. The CQI need for other 10/28/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		095015	B. WING _		08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER		REET 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	DULD BE CROSS-	(X5) COMPLETION DATE
F 286 SS=D	treatment on Reside 11:30 AM. Physician's orders Ammonium Lactate both legs and feet w." Employee #16 remore Resident #5's lowe Ammonium Lactate of the wound. The stapplication of the cresident wand minimize the extension by failing to prior to the application of the cream. [http://www.chttp://www.surgerye/www.sur	cobserved performing a wound ent #5 on August 3, 2010 at dated July 7, 2010 directed 12% cream "moisturize skin on with cream every day as directed. Eved Kerlix bandage from rextremities and applied to the skin surrounding the site kin was not cleansed prior to the eam. Exprevent the accumulation of vastes excreted from the skin posure to a potential source of cleanse the resident 's skin on of a prescribed topical cdc.gov/mmwr and encyclopedia.com] Eviewed with Employee #6 interview on August 6, 2010 at PM. He/she acknowledged that should have been cleansed on of the cream. N 15 MONTHS OF RESIDENT ain all resident assessments a previous 15 months in the	F 286	F 286	, 22010, June 16, 2010, try forms for), and July 7, placed on the	10/19/10

Continued from page 57

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 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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
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	OVIDER OR SUPPLIER	EALTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP COD 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
F 279	A face-to-face into Employee #7 on A 4:35 PM. After a resident 's clinical	ches for hypertension and erview was conducted with August 4, 2010 at approximately review of the care plans in the all record. He/she acknowledged cked evidence that care plans	F 27	Continued From page 57		
were initiated hypertens The record was reviewe 6. Facility staff failed to potential adverse interac or more medications for A review of the clinical re-		ertension, and communication. eviewed on August 4, 2010. led to develop a care plan for the interaction for the use of nine (9) ons for Resident #12.		 F tag 279 #6 Resident #12 Resident #12 is no longer the facility and no further commade. A random audit of reside over the past ninety days we to ascertain the accuracies 	er a resident in corrections can be ent's assessments vil be completed	10/19/10
	2, 2010 included the Acetaminophen (Taspirin, Carvedilo (Certagen), Docus Fentanyl (Durages	ian 's order dated and signed July the following medications: Tylenol), Ascorbic Acid (vitamin C), I (Coreg), Certavite-Lutein sate Sodium (Colace), Enulose, sic), Isosorbide Dinitrate (Isordil), (Reglan), Omeprazole and		assessment. Any care plan of the resident's status hav 3. Care Area Triggers ident completion of the comprehe will be care planned within MDS Coordinator will ensur documentation is available	n lacking evidence re been corrected. tifled through ensive assessmen seven days. The re supporting	10/19/10 ts
	2010 revealed that developed with appropriate for potential adversuse of nine (9) or A face-to-face interest.	are plan last updated on July 28, at there was no care plan oppropriate goals and approaches rse drug interactions involving the more medications.		planning decisions. The da the supporting documentati on the CAT summary and s Coordinator indicating com will be reviewed and revise established timetable that r and approaches set forth in triggered area.	ion will be entered signed by the MDS pletion. Care plans d according to an neets the objective	s
	3, 2010. He/she a lacked a care plar medications. The 3, 2010.	pproximately 10:00 AM on August acknowledged that the record in for the use of nine (9) or more record was reviewed on August		A random review of the completed monthly evaluat of goals and approaches as assisting the residents to at	ing the inclusion speciated with	10/28/10
	i. Facility start fall	led to develop a care plan				

Continued from page 58

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	N BOONE LEWIS HEA	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE	
F 279	for Anemia for Resident An admission Minimassessment compleresident in Section I diseases that included According to a histor May 29, 2010, the reincluded anemia. A further review of revealed that care post 2010 for his/her actions for anemia. A face-to-face interved for anemia. Section of the clinical revealed for anemia. Oversight. I will compressed for anemia. A review of the clinical revealed physician for more medications heel ulcer for Resided A review of the clinical revealed physician for the clinical forms. A review of the clinical forms for the clinical forms for the clinical forms for the clinical forms. A review of the clinical forms for the clinical for the clini	dent #15. from Data Set (MDS) sted on June 8, 2010 coded the (Disease Diagnoses) for ed anemia. ry and physical completed on esident 's active problem the resident 's clinical record clans initiated on June 2 and 18, experience was conducted with gust 4, 2010 at approximately experience the care plans in the ecord. He/she acknowledged ed evidence that care plan was he/she stated, "That was an plete one right away." The d on August 4, 2010. If to develop a care plan for the teraction for the use of nine (9) s, allergy to Levaquin and left	F	279	Continued From page 58 F tag 279 #7 Resident #15 1. The care plan for Resident updated to include goals and care associated with a diagn. The resident has been asses associated complications are Resident #15 is receiving me for this diagnosis. 2. A random audit of resident over the past ninety days will to ascertain the accuracies of assessment. Any care plant of the resident's status have. 3. Care Area Triggers identific completion of the compreher will be care planned within some MDS Coordinator will ensure documentation is available to planning decisions. The date the supporting documentation the CAT summary and sign Coordinator indicating completed in the care established timetable that me and approaches set forth in a triggered area. 4. A random review of the care completed monthly evaluating of goals and approaches assassisting the residents to attach.	d approaches for losis of anemia. It is a seed and no evident. It is assessments as a seed and location of the care plan acking evidence been corrected. It is assessment it is assessment is acking evidence been corrected. It is assessment is a supporting to support care even days. The example is support care in will be entered in will be entered in will be entered in according to an according to an according to an eets the objective each individualizate plans will be the inclusion sociated with	10/19/10 10/19/10 nts es ed	
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Continued from page 59

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.

F tag 279 # 8 Resident #16

- 1. The care plans for Resident #16 has been updated to reflect goals and approaches associated with multiple medication usage and allergy to Levaquin, and right heel ulcer. The resident has been assessed and no associated contraindications or adverse reactions have been noted for multiple medication usage or allergy to Levaquin. Resident #16 is currently receiving treatment to the right heel ulcer.
- 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 acking 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

10/28/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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_	OVIDER OR SUPPLIER 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	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD B	E CROSS-	(X5) COMPLETION DATE
F 279	A review of the med Resident #16 had ar front of the chart. The plan of care dated A resident was allergic physical dated April was allergic to Leval A review of the facilit Documentation Formacquired in house, width 2 cm, depth 0.2010 revealed, "wowound 2x2 cm in size procedure well." A review of care plan revealed that there was no care plan develop approaches for pote involving the use of allergies or left heel. A face-to-face interved Employee #5 at app 4, 2010. He/she ack lacked care plans for interaction for the us medications, allergier record was reviewed.	ical record revealed that in allergy to Levaquin on the physician order sheet and april 27, 2010 indicated the cook to Levaquin. The history and 28, 2010 indicated the resident quin. Ity 's "Pressure Area in "revealed, "July 16, 2010, [left] heel ulcer, length 2cm x in Nursing notes dated July 16, 2010, pund rounds per [MD]. Left heel ite, scab, no drainage. Tolerated in last updated on June 9, 2010 was no problem identified and ped with appropriate goals and intial adverse drug interactions nine (9) or more medications, ulcer. In was conducted with roximately 4:00 PM on August nowledged that the record in the potential adverse drug se of nine (9) or more es, and left heel ulcer. The did August 4, 2010.	F	279	Continued From page 59 the resident's highest practic mental, and psychosocial was Results of the audit will be so CQI committee monthly. A problems identified and committee will determine the interventions and need and further audits. F tag 279 #9 Resident #19	ell-be ubmiti report ective ed. T	ing. ted to the t of actions he CQI I for other	
	for Resident #19. According to the pre signed by the physic	I to initiate a care plan for Plavix printed "Physician's Orders" sian on July 2, 2010, directed " blet by mouth every day."			1. An updated care plan for present reflecting goals and care associated with the use anticoagulant. The resident assessed and no evidence obeen identified.	appro of an	eaches for een	10/19/10

Continued from page 60

2. A 100% audit of resident's assessments 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.

10/19/10

- 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 F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		095015	B. WING _		08/1 ⁻	1/2010
	ROVIDER OR SUPPLIER	EALTH CARE CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 279	A review of the resthere was no care goals and approach A face-to-face interployee #5 on A 3:30 PM. He/she acare plan for the unreviewed on Augur 10. Facility staff faincontinence for RA review of an annindicates that the review of an annindicates that the review of the clincontinence care Quarterly MDS concoded for incontinent Coursely. A review of the clincontinence care Quarterly MDS concoded for incontinent for the clincontinence care Quarterly MDS concoded for incontinent for the clincontinent of the clincontinent of the clincontinent for	page 60 sident's care plans revealed that e plan initiated with appropriate ches for the use of Plavix. erview was conducted with August 7, 2010 at approximately acknowledged that there was no use of Plavix. The record was ust 7, 2010. ailed to develop a care plan for Resident #21. nual MDS dated April 5, 2010 resident was coded as incontinent awel Sections H1a and H1b, RAP summery triggered for an aplan and was coded yes. The ampleted July 28, 20110 is also dence under sections H1a and inical record failed to reveal a care plan with appropriate goals or incontinence. erview was conducted on August loyee #49, who stated " [Resident during the day, but uses briefs at s not like to get up at night. The wed on August 5, 2010. ailed to initiate discharge planning	F 279	Continued From page 60 F tag 279 # 10 Resident #21 1. The care plans for Resider updated to include goals and addressing incontinent care a Resident #21 continues to us briefs at night. 2. A random audit of resident over the past ninety days will to ascertain the accuracies of assessment. Any care plan to find the resident's status have a sees a see	nt #21 is I approaches and brief usage. Se incontinent It's assessments I be completed If the care plan acking evidence been corrected. Ided through asive assessment even days. The supporting o support care and location of in will be entered igned by the MDS etion. Care plans according to an eets the objective each individualize iter plans will be g the inclusion	es s
	Resident #23 at ap 6, 2010. During that he/she has be	erview was conducted with pproximately 11:00AM on August he interview the resident stated een approved for public housing am trying to find an		of goals and approaches assisting the residents to atta resident's highest practical phrental, and psychosocial we Results of the audit will be su CQI committee monthly. A reproblems identified and corre	ain and maintain t hysical, ell-being. ubmitted to the report of	ihe

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER N BOONE LEWIS HEA	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032		1,2010	
(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 APPROPR A	ULD BE CROSS-	(X5) COMPLETION DATE	
F 279	apartment that is where resident added, "The assist me in finding and/or pending disclar appropriate goals ar Discharge planning A face-to-face intervent Employee #21 at ap 6, 2010. He/she act the resident's applichas been approved. acknowledged that he resident is a second to the resident in the res	neel chair accessible. The neel social worker has agreed to	F 2	79	Continued From page 61 implemented will be presente committee will determine the interventions and need and fr further audits.	need for other		
	status and/or his/her	r pending discharge and added, day." The record was reviewed			F tag 279 #12 Resident #CBL 1. Resident #CBL 13 is no lor resident in the facility and no	nger a	10/19/10	
		ed to develop care plans for patitis C for Resident CBL13.			corrections can be made.			
	assessment compleresident in Section I	ted on June 30, 2009 coded the (3) (Other current Diagnoses or diseases that included CD-9 code VO2.62.			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 have the	be completed the care plan cking evidence	10/19/10	
	s clinical record date s diagnostic impress	ry and physical in the resident 'ed March 17, 2010, the resident 'sion included right upper lobe tuberculosis and hepatitis C			3. Care Area Triggers identific completion of the comprehens will be care planned within se MDS Coordinator will ensure documentation is available to planning decisions. The date the supporting documentation	sive assessmen ven days. The supporting support care and location of	10/19/10 ts	
		al Progress Notes dated March nt 's care plan update	•		on the CAT summary and sig Coordinator indicating comple will be reviewed and revised a	ned by the MDS ction. 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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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD B	E CROSS-	(X5) COMPLETION DATE
F 279		ge 62 se he/she was hospitalized.	F 2	279	Continued From page 62			
	3:30 stated "Re-ad	s Notes " of March 30, 2010 at mitted to this facilitywas in received treatment for			established timetable that rand approaches set forth in triggered area.			
	A further review of the lacked documented initiated care plan wanderess the resident A face-to-face interved Employee #5 on Aug 10:30 AM. After a reresident 's clinical reacknowledged that the care plan was initiated. After a review of the she acknowledged.	ne resident 's clinical record evidence that facility staff ith goals and approaches to t's pneumonia and Hepatitis C. iew was conducted with gust 10, 2010 at approximately view of the care plans in the			4. A random review of the completed monthly evaluat of goals and approaches a assisting the residents to a resident's highest practical mental, and psychosocial Results of the audit will be CQI committee monthly. A problems identified and cor implemented will be preser committee will determine the interventions and need and further audits.	ing the special train ar physical well-be submitted rective need. The need of the special training the special training the special training training the special training tra	inclusion ed with ad maintain al, ing. ted to the t of actions he CQI I for other	10/28/10 the
F 280 SS=E	The resident has the incompetent or other under the laws of the planning care and tretreatment. A comprehensive ca within 7 days after the comprehensive asset interdisciplinary team physician, a register.	e right, unless adjudged rwise found to be incapacitated e State, to participate in eatment or changes in care and are plan must be developed the completion of the essment; prepared by an in, that includes the attending ed nurse with responsibility for	F 2	280				
	comprehensive asset interdisciplinary team physician, a register the resident, and other than the resident in	essment; prepared by an n, that includes the attending						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY			(EACH CORRECTIVE ACTION SI	OULD B	E CROSS-	(X5) COMPLETION DATE
and, to the extent pr the resident, the res legal representative;	acticable, the participation of ident's family or the resident's and periodically reviewed and	F:	280				
Based on observation for six (6) of 26 sam supplemental reside facility staff failed to mode of transfer for needs for one (1) resident, smoking resident, falls for one integrity for one (1) reside for one (1) reside conditions for two (29, 10, 20 and CBL3.	ons, record review and interview pled residents and one (1) nt, it was determined that review and revise care plans for one (1) resident, nutritional sident, diabetes mellitus for one grelated incidents for one (1) e (1) resident, altered skin esident, management of graft ent and management of chronic) residents. Residents #1, 5, 6,			483.20(d)(3), 483.10(k)(2) I PARTICIPATE PLANNING Ftag 280 # 1 Resident #1	RIGHT CARE	TO :-REVISE (P
1. Facility staff failed interventions of Resi Pulmonary disease [Failure [CHF] care pulmonary disease [Failure [CHF] care pulmonary disease [CHF] care pulmonary disease [CHF] care was June 16, 2010. Apport the management of Check pulse oximetrial A review of the Trease pulmonary disease [CHF] care pulmon	to update the approaches and dent #1 's Chronic Obstructive COPD] and Congestive Heart lan. evealed that the COPD and is most recently updated on oaches and interventions for these conditions included "y every shift and as needed."			from the plan of care for Re Resident #1 has been asse currently stable and do not monitoring. 2. A random audit of reside over the past ninety days w to ascertain the accuracies assessment. Any care plan	sident ssed a this lev of sass lil be co of the clacking	#1. nd is rel of sessments completed care plan g evidence	10/19/10 10/19/10
	SUMMARY STA (EACH DEFICIENCY MUST OR LSC IDE Continued From page and, to the extent provided the resident, the resident, the resident provided in the resident provided interventions of Resident provided interventions of Resident plan of care was June 16, 2010. Approved the review of the Treat on Resident provided provided interventions of Check pulse oximetr A review of the Treat interventions o	DENTIFICATION NUMBER: 095015 ROVIDER 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 63 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for six (6) of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to review and revise care plans for mode of transfer for one (1) resident, nutritional needs for one (1) resident, diabetes mellitus for one (1) resident, site for one (1) resident, aftered skin integrity for one (1) resident, and management of graft site for one (1) resident and management of chronic conditions for two (2) residents. Residents #1, 5, 6, 9, 10, 20 and CBL3. The findings include: 1. Facility staff failed to update the approaches and interventions of Resident #1 's Chronic Obstructive Pulmonary disease [COPD] and Congestive Heart Failure [CHF] care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of these conditions included "Check pulse oximetry every shift and as needed." A review of the Treatment Administration Record [TAR] lacked evidence of the assessment of pulse	OPSO15 IDENTIFICATION NUMBER: OPSO15 A. BUIL OPSO15 ROUNDER 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 63 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for six (6) of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to review and revise care plans for mode of transfer for one (1) resident, nutritional needs for one (1) resident, diabetes mellitus for one (1) resident, smoking related incidents for one (1) resident, falls for one (1) resident, altered skin integrity for one (1) resident, management of graft site for one (1) resident and management of chronic conditions for two (2) residents. Residents #1, 5, 6, 9, 10, 20 and CBL3. The findings include: 1. Facility staff failed to update the approaches and interventions of Resident #1 's Chronic Obstructive Pulmonary disease [COPD] and Congestive Heart Failure [CHF] care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of these conditions included "Check pulse oximetry every shift and as needed." A. BUIL A. BUIL The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of these conditions included." Check pulse oximetry every shift and as needed. "A review of the Treatment Administration Record [TAR] lacked evidence of the assessment of pulse	DENTIFICATION NUMBER: A. BUILDING B. WING D95015 STR 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 63 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for six (6) of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to review and revise care plans for mode of transfer for one (1) resident, nutritional needs for one (1) resident, diabetes mellitus for one (1) resident, smoking related incidents for one (1) resident, falls for one (1) resident, altered skin integrity for one (1) resident, management of graft site for one (1) resident and management of chronic conditions for two (2) residents. Residents #1, 5, 6, 9, 10, 20 and CBL3. The findings include: 1. Facility staff failed to update the approaches and interventions of Resident #1's Chronic Obstructive Pulmonary disease [COPD] and Congestive Heart Failure [CHF] care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of these conditions included "Check pulse oximetry every shift and as needed." A review of the Treatment Administration Record [TAR] lacked evidence of the assessment of pulse	This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview facility staff failed to review and revise care plans for mode of transfer for one (1) resident, diabetes mellitus for one (1) resident, diabetes mellitus for one (1) resident, and management of praftistie for one (1) resident, and management of graft site for one (1) resident, and management of graft site for one (1) resident and management of conditions for two (2) residents #1, 5, 6, 9, 10, 20 and CBL3. The findings include: 1. Facility staff failed to update the approaches and interventions of Resident #1 's Chronic Obstructive Pulmonary disease [COPD] and Congestive Heart Failure [CHF] care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions or fire treatment Administration Record [TAR] lacked evidence of the assessment of pulse assessment.	This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for six (6) of 28 sampled residents and one (1) resident, falls for one (1) resident, diabetes mellitus for one (1) resident, diabetes mellitus for one (1) resident, falls for one (1) resident, and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of chronic conditions for two (2) resident and management of the failure (CHF) care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of the assessment of pulse oximetry every shift and as needed." A review of the Treatment Administration Record [TAR] lacked evidence of the assessment of pulse assessment.	OSPICE TO RESTRICT ON NUMBER: OBSO15 DESCRIPTION NUMBER: OSPICE OF SUPPLIER NOONE LEWIS HEALTH CARE CENTER SUMMARY STATELEARY OF DEPICIENCES SUMMARY STATELEARY OF DEPICIENCES (EACH DEPICION MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) (CONTINUED From page 63 and, to the extent practicable, the participation of the resident, family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for six (8) of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to review and revise care plans for mode of transfer for one (1) resident, diabetes mellitus for one (1) resident, management of graft site for one (1) resident, management of chronic conditions for two (2) residents. Residents #1, 5, 6, 9, 10, 20 and CBL3. The findings include: 1. Facility staff failed to update the approaches and interventions of Resident #1 's Chronic Obstructive Pulmonary disease (COPD) and Congestive Heart Failure (CHF) care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of these conditions included "Check pulse oximetry every shift and as needed." A review of the Treatment Administration Record (TAR) lacked evidence of the assessment of pulse oximetry varger plan lacking evidence of the resident's current status have been assessment.

Continued from page 64.

- 3. Care Area Triggers identified through 10/19/10 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 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. of the audit will be submitted to the 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.

Results

CQI

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095015	B. WING	G			08/1	1/2010
l	ROVIDER 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 PREFIX TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	OULD E	BE CROSS-	(X5) COMPLETION DATE
F 286	This REQUIREMEN Based on record rev (1) of 18 sampled re facility staff failed to completed Minimum in Resident #12's ac The findings include A review of the clinic revealed the followir were not on the activ this review: January 17, 2010, May 5, 20: 2010. A review of the clinic revealed the followir not on the active clinic review: April 29, 2010, May A face-to-face interv Employee #4 at appr approximately 4:00 fi the discharge and re active clinical record August 9, 2010. 483.20(f) ENCODINA ASSESSMENT Within 7 days after a assessment, a facilit	iew and staff interview for one sidents, it was determined that maintain 15 months of Data Set (MDS) assessments tive record. all record for Resident #24 and discharge tracking forms we clinical record at the time of 27, 2010, March 11, 2010, April 10, June 16, 2010 and July 7, and record at the time of this discharge tracking forms were discal record for Resident #24 and Reentry tracking forms were discal record at the time of this discal record at the time of the discal record at the time	F2	286	2. A 100% audit of resident' returned over the past ninet completed to ensure tracking evident in the clinical record record lacking evidence of the and re-entry tracking will be a submitted to the Discharge and Re-entry the tracking forms according required schedule. The Admit Department will provide a list to the Medical Records Departments discharged and refacility. 4. The Medical Records Coordinater the clinical records must be presidents discharged and refacility evaluated to the facility evaluated to the facility evaluated to the facility evaluated to the completed monthly expresence of 15months of As present on the clinical recording audit will be submitted to the monthly. A report of problem corrective actions implement presented. The CQI commit determine the need for other and need and frequency of the submitted to the submitted to the submitted and need and frequency of the submitted to the submitted	y days g form Any ne dis correcting e artme admi ordina ordina charge ating f A ran valuat sessn d. Re CQI ns ide ted wi ttee w r inter	s will be as are clinical charge cted. even days I complete e OBRA as aach month of tted to the tor will y utilizing a sed and for the adom audit sing for the committee entified and ill be ill ventions	10/19/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		095015	B. WING	G	08/	11/2010		
	ROVIDER OR SUPPLIER	ALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 1380 SOUTHERN AVE SE WASHINGTON, DC 20032				
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F 287	Significant change Quarterly review as A subset of items u discharge, and dea Background (face-sadmission assessment, a facilitransmitting to the Stresident contained conforms to standadictionanes, and the defined by CMS and A facility must elect monthly, encoded, the State for all assprevious month, incompatible of the Significant corrections assessment Significant correction Significant corrections assessment Significant corrections assessment Significant corrections assessment Significant correction Significant corrections assessment Significant correction Significant Co	in status assessments. Issessments. Issessments. Ispon a resident's transfer, reentry, th. Isheet) information, if there is no tent. It a facility completes a resident's ity must be capable of State information for each in the MDS in a format that red record layouts and data at passes standardized edits detailed the State. It is transmit, at least accurate, complete MDS data to essments conducted during the cluding the following: In status assessment. In of prior full assessment. In of prior quarterly assessment. It is a	F 2	87				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095015	B. WING			08/1	1/2010
	OVIDER OR SUPPLIER	ALTH CARE CENTER		TREET ADDRESS, CITY, ST. 1380 SOUTHERN AVE S WASHINGTON, DC	SE		
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F 287	This REQUIREMEN Based on observation interviews for one (it was determined the appropriate transport of the appropriate transport in the appropriate transport in the appropriate transport of the appropriate transport in the appropriate transport i	ge 72 NT is not met as evidenced by: ons, record reviews and staff 1) of 30 supplemental residents, nat facility staff failed to complete sfer, re-entry and discharge (MDS) for Resident CBL 13.	F 28	1. Resident #CBI from the facility. A 3/17/2010 and Re 3//30/2010 for Re added to the clini 2. A 100% audit of	A discharge track e-entry tracking the esident# CBL 13 ical record	king form for form for will be	
	The findings include			returned over the completed to ens evident in the clir record lacking ev re-entry tracking	past ninety day sure tracking form nical record. Any ridence of the dis	s will be ns are clinical scharge and	
	A nursing note date indicated that the re to the hospital by th	d March 17 2010 at 3:00PM that sident was ordered transferred		3. The MDS Cool of the Discharge the tracking form: required schedule Department will p to the Medical Reresidents dischargacility.	and Re-entry will saccording to the Endingstone the Endingstone to the Endingstone the Ending Secords Departments	Il complete le OBRA ins each month ent of	10/19/10
	the facility. The last nursing not dated May 17, 2010 resident was ordered the physician. The resident has be 84days, and accord the resident's will be as a single room be Further review of the lacked documented.	te in the resident's clinical record at 4:00PM indicated that the ad transferred to the hospital by eing out of the facility now for ing to Employees #2, 3, and 5 a returned to the facility as soon		4. The Medical R review the clinical listing provided by Department of returned to the fapresence of track will be completed presence of 15mpresent on the clinical audit will be submitted.	on the Admission of the Admission of Assessing forms. A rare on this of Assessinical record. Research on the Assessinical record. Research of Assessinical record.	y utilizing a sed and for the andom audit ting for the ments esults of the	10/19/10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
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F 287 F 309 SS=H	discharge MDS for the A face-to-face intervent of the resident's clinical the above findings. August 9, 2010. 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessal maintain the highest and psychosocial were resident with the resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest and psychosocial were resident must provide the necessal maintain the highest provide the necessal maintain the necessal maintai	riew was conducted with agust 9, 2010. After reviewing al record, he/she acknowledged The record was reviewed		309	committee monthly. A report identified and corrective action will be presented. The CQI determine the need for other and need and frequency of full forms.	ons implemented committee will interventions	
	Based on observation interviews for eight (six (6) supplemental that facility staff failed physician orders for specialty consultation administer oxygen the (3) residents, discorrorder for adaptive exclarify orders for typeresident, fully asses (1) resident, administer prescribed for two (2) resident that sustain a sudden change in condition, failed to he	ons, record reviews and (8) of 26 sampled residents and residents, it was determined to to: manage a graft site per one (1) resident, obtain one for two (2) residents, herapy as prescribed for three attinue eye drops and obtain an equipment for one (1) resident, e of isolation for one (1) an eye injury sustained by one ster pain medications as (2) residents and for one (1) led undue pain, failed to assess one (1) resident's respiratory lave medication available for 3 days, failed to administer					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
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F 309	escalated in the abs blood pressure per residents and considevice for one (1) re 13, 16, 18, 25, CBI CBL14. The findings include 1. Facility staff faile according to physic resulting in escalation Resident #2. A review of the MAR Record) for Resident	(1) resident whose behaviors sence of the medication, assess physician 's orders for three (3) stently monitor a venous access esident. Residents #2, 4, 5, 10, _3, CBL8, CBL10, CBL11, and	F 309	483.25 PROVIDE CARE/SE HIGHEST WELL BEING Ftag 309 #1 - Resident#2 1. A review of Resident #2's medication regimen has bee All medications are being adordered and the resident's beunder control. 2. A review of new physician past 30 days has been compunit managers to assure medications made as needed.	current n completed. ministered as chaviors are orders for the leted by the dications have nner.	10/19/10
	22, 2010. Further rethe medication was 26th, as evidenced doses being circled dose was also circled A review of the MAI administered reason following:	ehavior, original order date July eview of the MAR revealed that not given on July 24th, 25th, by the 6:00 AM and 6:00 PM and that July 27th 6:00 AM ed. R's " medication not not section identified the DOAM, not yet received by		3. A review of the process of medications has been completed pharmacy consultant and the physician. Supervisors have by the Director of Nursing, to physician orders each shift, where the process is a supervisor of the physician orders and to implement the process of the proce	eted with the attending been educated check vith each nurse ations have ent corrective	10/19/10
	pharmacy; July 24, 6:00 PM K not given; July 25, 2010 6:00 [Pharmacy calle July 25th 6:00 PM K (delivery); not given July 26th 6:00 AM K complete and faxed	Ionopin 0.25 mg awaiting supply ino AM or PM time identified], and awaiting del. Clonopin 0.25mg awaiting supply its clonopin 0.25 mg C-2 form to be		4. An audit of this process wi monthly by the Director of Nu. The results of the above audit to the CQI committee monthly months, then quarterly. A rejidentified and corrective action will be presented. The CQI of determine the need for other and the frequency of further as	rsing/designee. It will be reported y for three port of problems ins implemented ommittee will interventions	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	ALTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032				
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F 309	as given] anxiety cheffective. According to the Number of Series	Interest and signed July 26, narmacy called for Klonopin 0.25 " Has not received since 2010." The dated and signed July 26, narmacy called for Klonopin 0.25 " Has not received since 2010." The dated and signed July 27,[Resident #2] OOB (out of bed) throughout the night he/she was the carts and infection control oing through trash " and signed July 27, 2010 at 4:00riding [wheelchair] up and	F	309					
	Nurses Progress No	ote dated and signed July 30,		•					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	ROVIDER OR SUPPLIER N BOONE LEWIS HEA	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
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F 309	2010 9:30 PM " resi (medications). "	dent received all evening meds	F	309	Continued From page 76 Ftag 309 #2a – Resident#4 1. The eye drops were discontinued From page 76	tinued for	10/19/10
	Employee #6 on Aug 3:40 PM. He/she ac of the escalating beh Klonopin C-2 form w	iew was conducted with gust 2, 2010 at approximately knowledged the above findings naviors and indicated that the " as faxed to the MD (Medical ility and that the MD faxed to			Resident #4 on 7/2/10. 2. An audit was completed on orders over the past 30 days. implemented as needed.	physician	10/19/10
	pharmacy. Pharmac delay. The medication at night. The record 2010.	cy did not give a cause for the ons were sent on July 27, 2010 was reviewed on August 5,			3. New orders will be reviewe unit managers/supervisors to a have been transcribed correct records will have a 24-hour chorders written for the day by the team leader. All new orders were recorded to the day by the sear leader.	assure that they y. All medical art review of all e night shift	10/19/10
	discontinuation of ey adaptive equipment a.) The physician 's	orders dated and signed July 2,			for accuracy, start/stop dates, MAR/TAR. The night shift sup with each team leader on each that the process is completed sent to pharmacy.	transcription on ervisor will check unit to ensure	
	instill one (1) drop glaucoma. An interim telephone	oto Homatropine 5% drops in each eye every day for corder dated July 21, 2010 nue] isopto homatropine 5%			4. Problems identified in the al will be reported to the CQI con for three months, then quarter designee. A report of problem corrective actions implemented presented. The CQI committee the need for other intervention	nmittee monthly y by the DON or s identified and d will be e will determine	10/28/10
	Record (MAR) revea	2010 Medication Administration led that Isopto Homatropine being given daily at 9:00 AM on			need for frequency of further a		
	There was no evider discontinued the Isop July 21, 2010.	nce that facility staff oto Homatropine eye drops on					
		iew was conducted on August ly 1:00 PM with Employee #5. ed that the					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETED (X3) DATE SURV COMPLETED					
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	N BOONE LEWIS HEA	LTH CARE CENTER		REET 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 SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 309	Isopto Homatropine as directed by the precord was reviewed Resident #4 was observed approximately 12 Not A review of the resit that the facility staff administer an arm so A face-to-face interved Employee #45 and E 2010 at approximate the resident 's recorresident, he/she ack clinical record lacked obtained a physiciar	eye drops was not discontinued hysician on July 21, 2010. The d on August 3, 2010. Discreved on August 3, 2010 at bon wearing a splint on left arm. Discreved on August 3, 2010 at bon wearing a splint on left arm.	F 309	Ftag 309 #1a 1. The order for a splint was on 8/4/10 for Resident #4. 2. Rehab staff will assure that splints are obtained prior to lead equipment at the bedside. Introduced in the communication form will be us and nursing to assure orders at 3. New orders will be reviewed unit managers/supervisors to a have been transcribed correct records will have a 24-hour chorders written for the day by the team leader. All new orders we for accuracy, start/stop dates, MAR/TAR. The night shift sup with each team leader on each that the process is completed sent to pharmacy.	orders for aving adaptive er-depart ed by therapy are in place. In daily by the assure that they y. All medical art review of all e night shift ill be reviewed transcription on ervisor will check unit to ensure	8/4/10 10/19/10 10/19/10
	s gastrostomy tube is as it related to pater gastrostomy tube researched. According to physici 2010 directed, "Entiproper placement primedication administifullimeters] of water tube with 30ml water needed and 5ml water.	o properly manage Resident #4 'n accordance to facility policy acy, subsequently resident had placed. an 's orders signed July 2, reral Protocol Check tube for ior to each feeding, flush or ration Flush tube with 250ml revery 4 [four] hours Flush refore and after medication as er between each medication July 3, 2020 at 8:00 AM		4. Quarterly Rehab will audit s results of the audit will be reported to actions implemented will be proceeded actions implemented will be proceeded actions implemented will determine to other interventions and need for	rted to the CQI nab coordinator. and corrective esented. The the need for or frequency of the hospital at tube to assure y procedure.	10/28/10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
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	ROVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT 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 BE CROSS-	(X5) COMPLETION DATE
F 309	revealed, "GT [Gas due to breakage whi [Percutaneous Endo need to go out to be	strostomy Tube] is very short hile milking it. It is a PEG oscopic Gastrostomy] GT and e replaced. "	F	309	Continued From page 78 3. Staff have been educated to for liquid medications for resid A G-tube skills competency has completed by the educator and	ents with G-tubes as been	10/19/10
	Dictionary ", 20th ed 1367 defined " milki contents of a tubular tube with the fingers course of the tube a maneuver forces ma not otherwise be see	er's Cyclopedic Medical edition, copyright 2005, page sing as removal of the ir structure by compressing the s and moving them along the and away from the origin This aterial out of the tube that might en. "			4. Random audit of medication G-tubes will be completed by The results of this audit will be CQI committee monthly for the quarterly by the Educator/Destof problems identified and committee will be presented committee will determine the relative to the committee will determine the committee will be completed by the committee will be presented by the committee will be committeed by the committeed by the committee will be committeed by the committee will	the Educator. reported to the ree months then ignee. A report rective actions d. The CQI need for other	10/28/10
	Tube Feeding, "Eff 08/03/07", directed Gravity Feeding Tub air into the feeding to stethoscope over the gurgling sound. (If n feeding and report to Pump Feeding Flu	fective: 02/2005, Revised: d the following: "Procedures, be #7 [seven] Insert 30cc of tube while holding the le epigastrium to listen for hone is heard, do not start o supervisor or charge nurse), lush feeding tube with prescribed of an eccentric or catheter tip			practice. An aud Resident#5 1. Resident #5 venous access device was assessed and flus of survey. There were no reductionage observed 2. All residents with Venous A have the potential to be affect Venous Access Devices.	thed at the time less and/or Access Devices	of residents 8/2/10 10/19/10
	A review of the "EC [Esophagogastroduc on July 20, 2010 rev Malfunctioning GT].	GD oenoscopy] Report " completed vealed, " Indications: Other findings: S/P [Status ent. GT was replaced with a #20			Systematic changes/meas implemented to correct this prostaff education, which has bee assessment and documentation access devices.	actice include en provided on on of venous	10/19/10
	Employees #4 and at 5:59 PM. Both sta	view was conducted with Employee #5 on August 5, 2010 ated " we do not milk the tubing. eviewed on August 5, 2010.			4. Unit Managers will complet which will be provided to the problems identified and correct implemented.	OON/designee of	10/28/10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SUR COMPLETI	
		095015	B. WING	3	08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	<u>.</u>	
(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 CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE CROSS-	(X5) COMPLETION DATE
F 309	3. Upon review of th #5, it was determine assess a venous ac pressure, obtain an specialty consultation that were labeled ar According to the His dated August 23, 20 included hypertension disease, degeneration stasis wounds and a a.) Facility staff failed Porta-cath [VAD] per Physician's orders assess Porta-cath ir redness, warmth, sware A review of the mon Administration Record the Porta-cath assess on the TAR by a darinitialed inside the best performed. The box following dates, reflewere not performed and 25th 2010. Licensed staff failed resident's Porta-cath accordance with phywas reviewed August	the clinical record for Resident ed that facility staff failed to coess device [VAD], blood a Ear, Nose and Throat [ENT] on and administer medications and dispensed for the resident. Story and Physical Examination 209, Resident #5 's diagnoses fon, anemia, peripheral vascular ive joint disease, chronic venous angioedema. Ed to assess Resident #5 's er physician orders. Ed dated July 7, 2010 directed "insertion site every 3 days for welling and drainage." Inthly Treatment and Medication fords [TAR/MAR] revealed that resiment schedule was annotated resiment schedule.	F 30	Continued From page 80 Resident #5b 1. The corrective action ach Resident #5 includes the revelocity Resident #5's blood pressure revealed that no others were 2. All residents have the potaffected by this practice. Rehypertensive medications hat their MAR. 3. The systematic change/me correct this practice entails: stathe importance of documenta MAR/TAR and revised shift rincludes the review of MARs. 4. Unit Managers will complete and a report will be provided to results of this audit will be reported in the results of the provided to the results of the provided to results of the provided to the results of the provided to the review of MARs. 4. Unit Managers will complete and a report will be provided to results of this audit will be reported to mittee monthly for three m	view of monitoring missed. ential to be sidents receiving d a review of asures taken to aff education on the eport, which TTARs. e audits monthly the DON. The orted to the CQI onths then e. A report of tive actions I. The CQI eed for other	10/19/10 10/19/10 10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		LE CONSTRUCTION	(X3) DATE SUP COMPLET	
		095015	B. WIN	G		08/1	1/2010
	ROVIDER 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 PREFI; TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 309	blood pressure in accorders.	ge 80 scordance with physician 's ication regimen included	F3	309	Continued From page 80 Resident#5 C 1. The corrective action achine Resident #5, is that an ENT of was completed on 8/24/10.	consultation	8/24/10
	Norvasc 5mg daily a times daily by mouth Physician's orders	and Hydralazine 50mg three of for hypertension. dated July 7, 2010 [originated ted blood pressure assessments]			 All residents with consultathe potential to be affected by An audit has been completed secretary of appointments for days to assure completion of identified have been corrected. 	y this practice. I by the unit the past 30 problems d.	
	A review of the mon Administration Reco the blood pressure a annotated on the TA staff documented the	thly Treatment and Medication rds [TAR/MAR] revealed that assessment schedule was IR by a darkened box. Licensed blood pressure reading inside sessment was performed. The			 Systematic changes/measthis practice from reoccurring education has been complete regarding the process for appscheduling and follow-up. The will complete weekly audits of and provide a report to the Do 	entails: staff ed by the DON pointment e unit secretaries f appointments	10/19/10
	reflecting that blood missing: April 1st, M 9th, 16th, 23rd, 30th 2010.	nk on the following dates, pressure assessments were ay 6th, 20th, 27th, June 2nd, July 7th, 14th, 21st, and 28th, consistently assess Resident		ļ	4. The results of the above a reported to the CQI committee for three months then quarter designee for three months the report of problems identified actions implemented will be CQI committee will determine	e monthly ly by DON/ en quarterly. A and corrective presented. The	10/28/10
	#5 's blood pressure	e on three (3) occasions weekly obysician 's orders. The record			further interventions and nee of further audits.		
	c.) Facility staff failed consultation per phy	d to obtain an ENT specialty sician orders.					
	Physician 's order d directed "ENT appt	ated February 16, 2010 in 3 months "					
	ENT appointment so	2010 TAR revealed that an cheduled for May 11, 2010 was cal record lacked evidence of a cellation and		-	4WTJ11		

Continued From page 81

Ftag 309 #5d

1. Medications were ordered for Resident #5 8/11/10 and received.

Poving of MAPs has been completed to 40/40/40

2. Review of MARs has been completed to assure that medications have been received as ordered.

3. Staff has been educated by the harmacist on the ordering and receiving of medications.

4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported 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 interventions and the frequency of further audits.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095015	B. WIN			08/1	1/2010
	ROVIDER OR SUPPLIER			13	REET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
F 309	there krasled entitled been rescheduled. 4. Facility staff faile therefinaling are sentere since at 14 faces in the first of the first	lisquettræddheraRpesiohemte#56.had ed to follow physician 's orders edvipeverohamel\coAfheried\ctemings)a evdiahjibisEdayksydeRt&&idenAuld@st	FS	309	Continued From page 82 #4- Resident#10 1. The tape was removed at to survey for Resident #10 and to remediated.		8/3/10
	dig mendibity then filipise	hysician 's Orders dated and iodiato Judiyn 2hi 20e1 Ontbalicative otethat irisse use oteloor Reside Vits#5e. at			A review has been complet receiving dialysis by the unit r assure orders are being imple ordered by the physician.	manager to	10/19/10
1	During a wound tree #5 obsargatio6,v20s dependental that is obsargation but the control of the c	eatment observation for Resident of Chard & 10th 0 Autylust Grads 2010 at n Pilotye Retsideartr#ilf Osteared birs/inent valbetetch fair, Resideart at 15ed			The educator has provided training to the staff on care of access sites.		10/19/10
	Physician 's orders the administration of Buttidege fathe thinks the considerated in the state of the state o	the left arm AV site was noted in s dated July 7, 2010 prescribed of Ammonium Lactate 12% to stail yearnchicle action the country and cover.			Random audits of dialysis s completed weekly by the supe corrective actions made as ne Ftag 309 #5	ervisor and	10/28/10
	Erfeuleyteef#d6 iaden Ene ployeel#i7eetm%e 2nedie#tloafteentevies the#sPhelyesplondin/publig	nvirieste weeds the nonexcliculativiths during noguls to @ p.20 fl, Osates rippovo of the tely svisng of sestident n#fl Oresvies fleet Virisite peter bland the napelish o Laid to be over ere			Resident #13, we are unable the cited deficiency for pain in Staff was remediated at the tirsurvey.	nedication. ime of the	8/4/10
	ladente flooreside inter- August 3, 2010. A face-to-face inter- Entresident #163fbbb	s other valor Resident 45.0n view was conducted with colinicather cording the sacioty			2. Review of residents with somedication and those receiving pain medication prior to wound been completed.	ng scheduled	10/19/10
	Stadjulstile d201401rHisa persomip tivenskihe blood predsidation's trateres	and white state of the discription of the control o			3. An in-service for staff has be by the educator on pain mana	agement.	10/19/10
	Residerid to the first dated Sept 19, 2009 Frability date mellitus, and disease, congestive	Striptions office examination 9, Resident #13 's diagnoses invendentiistes sudativatie ease hat attherosclerotic cardiovascular e heart failure emphysema and e heart failure emphysema and			4. An audit of this process will monthly by the Director of Nur The results of the above audit reported to the CQI committee three months, then quarterly, problems identified and correct implemented will be presented.	rsing/designee. t will be e monthly for A report of ctive actions	10/28/10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095015	B. WIN	WING			08/11/2010	
	ROVIDER OR SUPPLIER 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	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	ULD E	BE CROSS-	(X5) COMPLETION DATE
F 309	resident's medicati 20mg daily for hypera. 20mg daily for June and blood pressure asserb.) Physician's order [originated Septemb Ultra regular strengt skin of right shoulder remove at 9PM for part of July 2010 medication, Bengay thru 4th, 6th and 7th a reason why the medication are soon why the medication of the province of the physician with respiral According to the physician of shortner hypertension, chronic properations of the physician of the physic	coulmonary disorder. The on regimen included Lisinopnil ritension. ers dated July 2, 2010 2, 2006] directed, " [assess] y Tuesday. " ication Administration Records July 2010 lacked evidence of essments. ers dated July 2, 2010 per 22, 2009] directed "Bengay h 5% patch, apply one patch to revery morning at 9AM and pain. " ication Administration Record revealed the resident's pain was not administered July 1st and the record lacked evidence of edication was omitted. eviewed and confirmed during a w with Employee #7 on August ately 12:30 PM. The record was 2010. It to administer oxygen dent #16 according to physician attly resident was transferred to	F	309	committee will determine the interventions and the frequer audits. Ftag 309 #6 1. Resident #16 was transfe hospital at the time of survey remediated at the time of survey remediated at the time of sur 2. An audit has been compler receiving oxygen therapy by managers. Corrective action implemented as needed. 3. Staff education has been or respiratory assessment and oxygen by the educator. 4. A monthly audit of respiral services will be completed by manager/ designee monthly then quarterly and a report ple DON. The results of the aboreported to the CQI committee three months then quarterly the designee. A report of problemand corrective actions implemented. The CQI committee the need for other interventions frequency of further audits.	erred . Sta vey. led o the use have the use the correction of the	to ff was n residents init we been leted on use of care and unit ree months ed to the udit will be onthly for e DON/ lentified ed will be determine	8/3/10 10/19/10 10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	E CONSTRUCTION	(X3) DATE SUI COMPLET	
		095015	B. WIN	NG		08/1	1/2010
	N BOONE LEWIS HEA	LTH CARE CENTER		13	ET 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 PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOT REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 309	and cardiomyopathy According to resident was admitted on Apir Resident was admitted 2010 with chief combreath and lethargy/was discharged back May 11, 2010. On Madmitted with chief cough and chest tight the facility on May 20 Physician's orders and dated April 27, 2 liters via [nasal cannibreath. Physician's orders May 26, 2010, direct cannula every shift for According to the adr [MDS] dated June 8, Diagnoses included Congestive Heart Fay Vascular Disease, a Obstructive Lung Disresident required oxy April 26, 2010 and uresident oxygen defined to the side of the cough and the cough	at 's clinical record, resident ril 27, 2010 to the facility. Ted to [hospital] on April 28, plaint of worsening shortness of altered mental status. Resident k to skilled nursing facility on May 15, 2010, resident was complaint of shortness of breath, atness and discharged back to 6, 2010. Sheet and plan of care signed 2010, directed [Oxygen at 2 atla] continuous for shortness of the and plan of care signed ated oxygen- 2 liters via nasal or shortness of breath. Inission Minimum data Sets and Emphysema/Chronic sease. Section I, Disease Arteriosclerotic Heart Disease, allure, Hypertension, Penpheral and Emphysema/Chronic sease. Section P revealed the year therapy. In gen nursing care plan initiated podated June 9, 2010 revealed, spendent 2L [oxygen] via nasal by Saturation 95% on oxygen.	F	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	G		08/1	1/2010
	ROVIDER OR SUPPLIER N BOONE LEWIS HEA	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS'	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ILD BE CROSS-	(X5) COMPLETION DATE
F 309	[Oxygen] at 2L/min Resident observed of dayroom at approximately 5:15 transport were, Block Pulse 63, Respiration of the continuously to ensistant order; subsequently	signed July 2, 2010 prescribed via nasal cannula every shift. on August 3, 2010 in the mately 1:20 PM sitting in he window. Resident was not gen. A face-to-face interview Employee #5 regarding status. He/she stated, "he/she times three, however, he/she times three, however, he/she hen he/she is not on his oxygen, "Informed Employee #5 he/she ygen. Employee #5 proceeded isted resident back to his/her ise ox. Resident's oxygen the dayroom by the door to the trator was taken to resident's was unable to obtain a pulse when placed on index finger of a was initiated. Employee #5 of 70% to 78% when placed on oxygen titrated from 2-4L by lent's vital signs were: Pulse 63, Respirations 28, and 70. Gerred to the hospital at PM. Vital signs at the time of od Pressure 130/70-130/78, ons 18, Pulse Ox-99% on 12 oreathing mask.	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		095015	B. WING	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	FIX (EACH CORRECTIVE ACTION SHO			BE CROSS-	(X5) COMPLETION DATE	
F 309	staff failed to consis blood pressure prior antihypertensive me pre-treatment pain r wound care. According to the his dated October 8, 20 included psychotic of failure, atherosclero schizophrenia and sa.) Physician 's orde [originated October	clinical record revealed facility tently assess the resident's to the administration of an edication and failed to administer nedication prior to performing tory and physical examination 09, Resident #18's diagnoses disorder, diabetes mellitus, heart tic cardiovascular disease,	F 30	09	1. Resident #18's Blood prebeing monitored as ordered. 2. All residents have the potaffected by this practice. Rehypertension medications hat their MAR. 3. The systematic change/me correct this practice entails: stathe importance of documenta MAR/TAR and revised shift rincludes the review of MARs. 4. Unit Managers will complete and a report will be provided to results of this audit will be reported.	entia sider d a r asur aff ec attion (TAF e auce o the	Il to be ints receiving review of es taken to ducation on on the t, which its. dits monthly DON. The to the CQI	10/19/10 10/19/10 10/19/10	
	systolic blood press A review of the Med [MAR] for May and resident 's blood pressed. Paramete systolic less than 11 absence of blood pressed. Physician 's order [originated October]	ication Administration Records June, 2010 revealed the essure was inconsistently ers of administration [hold for 0] were not followed in the essure assessments. ers dated July 2, 2010 5, 2009] directed "Tylenol 650 day 30 minutes before dressing			Ftag 309 7a – Resident#18 1. Resident #18, we are unat the cited deficiency for pain r Staff was remediated at the t survey. 2. Review of residents with a medication and those receiving pain medication prior to wour been completed. 3. An in-service for staff has by the educator on pain man	ole to nedici ime schee ng so nd ca	o correct cation. of the duled pain cheduled are has	8/6/10 10/19/10 10/19/10	
	A review of the Medication Administration Record [MAR] for May and June, 2010 revealed Resident #18's pre-treatment pain medication, was inconsistently administered in synchronization with wound care. The record lacked evidence of reasons why the medication was omitted.				4. An audit of this process w monthly by the Director of Nt The results of the above aud reported to the CQI committee three months, then quarterly.	ill be irsing t will e me	conducted g/designee. l be onthly for	10/28/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION		(X3) DATE SUF COMPLETI		
		095015	B. WIN	G			08/11	1/2010	
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER				13	TREET 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 COI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE	CROSS-	(X5) COMPLETION DATE	
F 309	face-to-face intervie 6, 2010 at approxim reviewed August 6,	eviewed and confirmed during a w with Employee #5 on August ately 4:30 PM. The record was 2010.	F	309	continued from page 87 problems identified and corre implemented will be presente committee will determine the interventions and the frequent audits.	ed. Th	e CQI for other		
	The Interim Order F directed, "Dental Co A review of the curre there was no eviden	ailed to follow up on a dental consult cians order for Resident #25. er Form dated July 22, 2010 al Consult for cleaning teeth ." current clinical was conducted and idence that Resident #25 was seen ng his/her stay at the facility.		,	1. Resident #25 no longer refacility. 2. An audit of appointments has been conducted by the uncorrective actions and physical have been completed as need 30 days.	and fo unit sec cian no	llow-up cretaries otifications	10/19/10	
	Employee #5 at app approximately 4:17 the dental consult w	view was conducted with proximately August 9, 2010 at PM. He/she acknowledged that as not done as ordered/directed the record was reviewed on			 Staff education has been the DON regarding the proce appointment scheduling and unit secretaries will complete of appointments and provide DON. 	ess for follow- week	-up. The ly audits	10/19/10	
	#CBL3 after sustain According to the his dated May 29, 2010 included schizophre disease and frostbite amputations. A review of the clinic revealed the resider eye on August 1, 20	to fully assess Resident ing an injury to the eye. tory and physical examination, the resident 's diagnoses inia, anemia, peripheral vascular e with bilateral lower extremity cal record for Resident #CBL3 int sustained an injury to the left into. According to documentation the incident report dated August ite name]			4. The results of the above a reported to the CQI committed DON/designee. A report of cidentified and corrective action will be presented. The CQI determine the need for further and need and frequency of fine the committee of t	ee mor probler ons imp commit er inter	othly by the ns plemented itee will ventions		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION		(X3) DATE SUP COMPLET	
		095015	B. WIN	G			08/1	1/2010
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER			1:	STREET 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 PREFI TAG		PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD E	BE CROSS-	(X5) COMPLETION DATE
F 309	had a cigarette and a [his/her] left eye, assinjury, [he/she] denie eye gone at this time. Resident #CBL3 was at approximately 5:3 adhered to the left eye observation was marks, who stated the rehis/her eye. The resident stated vision is blurred since the eye with ashes for the eye with ashes for the eye with ashes for acknowledged observation affected eye. A subsequent intervion August 9, 2010 are He/she verbalized in affected eye. A subsequent intervion August 9, 2010 are He/she stated the left and that visually, he/before the incident, keep the tape off of a made it feel better, the eye doctor. " Facility staff failed to after sustaining and applied tape to his/he	some of the ashes got in sessment done, no sign of es pain but says irritation to left es, left eye clear no redness " sobserved on August 6, 2010 on PM with medical tape yelid rendering it shut. The de in the presence of Employee esident applied the tape to "my eye is irritated and my e [employee named] hit me in rom a cigarette. " sal record on August 6, 2010, an assessment of the resident 's ugust 1, 2010. Facility staff rying the resident with tape esubsequent to the incident. The interior and blurred vision of the ew was held with the resident approximately 2:30 PM. If eye had continued irritation she couldn't 't see as well as "They [facility staff] told me to my eye, I put it there because it ney are going to let me see an fully assess Resident #CBL3 injury to the eye. The resident er eye subsequent to the	F	309	Ftag 309 #9 1. CBL #3 was examined by Opthalmologist on 8/12/10. 2. A review of the Incident R past 7 days has been completed on the record Incident Reports. been completed on assessminjury. 3. Staff education has been the educator on generalized and documentation of post in 4. The results of the above a reported to the CQI committee the DON/designee. A report identified and corrective action will be presented. The CQI condition the need for further and need and frequency of the random audit of Incident Reported to the DON.	epor epor epor ents compasse ijury. udit v ee mo of pi ons ir ons ons ir ons ons ons ons ons ons ons ons ons ons	to assure nation on audit has post post post post post post post pos	8/12/10 10/19/10 10/19/10
		ned of eye irritation and blurred evidence that the medical esident 's eye.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		ELE CONSTRUCTION	RVEY TED			
		095015	B. WIN	G		08/1	08/11/2010		
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	13	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032				
PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	ULD BE CROSS-	(X5) COMPLETION DATE		
F 309	Employee #5 on Au 4:00 PM. S/he state ophthalmology cons the appointment was reviewed August 6, 10. Facility staff fails one (1) resident's re #CBL8. On August 3, 2010 of reported to nurse the nurse immediately wonecks the resident Administration Reconstruction He/she poured resident Administration Reconstruction He/she put on isolation policy. The nurse offered the medication and wate The resident refuse take his/her bronche Nurse continue to en him/her medication of try that 's when resimedication cup pick brown and the other and followed it with of Resident was able to medication. Resider breath and very fatig his/her needs to the resident up in bed ef while leaving room to resident his/her medication resident his/her medication.	riew was conducted with gust 10, 2010 at approximately d that the physician ordered an ultation on August 8, 2010 and s pending. The record was 2010. In the date of the record was 2010. In the date of the resident was in distress. The resident was in distress. The rent to the medication cart and medication in Medication red. In the rent was a pair of gloves per resident his/her morning are to drink. In the resident stated he/she will dent reached in to the resident stated he/she will dent reached in to the resident his/her mouth drinking more water. The overbalize refusal of the rest of the was observed to be short of gued as he/she communicated nurse. The nurse pulled evate his/her head and voiced that he/she will try later to offer	F	309	Ftag 309 #10 1. CBL #8 was transferred to time of survey. Staff was rentime of survey. 2. An audit has been compler receiving oxygen therapy by managers. Corrective meast implemented as needed. 3. Staff education has been respiratory assessment and to oxygen by the educator. 4. A monthly audit of respiratives and documentation completed by the unit manages submitted to the DON/design of the above audit will be represented and corrective action will be presented. The CQI of determine the need for further and need and frequency of forms.	eted on residents the unit ures have been completed on the use of tory care and will be er and ee. The results orted to the CQI and then quarter ort of problems ons implemented committee will or interventions	10/19/10 10/19/10 10/28/10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		3) 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	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE	
F 309	Ascorbic Acid 500m Aspirin chewable 81 Calcium Carbonate supplement Digoxin 250mcg tab heart failure Diltiazem HCL 120m Hypertension Disease Furosemide 20mg talsosorbide Monoonit Cardiovascular Disease Prednisone 20mg talsosorbide Monoonit Cardiovascular Disease Cardiovascular Disease Prednisone 20mg talsosorbide Monoonit Cardiovascular Disease	edication was as followed: g twice a day for wound healing mg everyday for prophylaxis 648mg tablet twice daily for let every day for Congestive mg every day for Chronic se ablet every day for diuretic trate 30mg every day for lase ablet twice daily for prophylaxis mg tablet every day for lax Disease t every day for COPD min tablet every day for lat 10:15AM another visit to lesident was observed to be in land the nurse was observed at lisigning off medication. clinical records revealed the let and plan of care dated July gen with 3 liters continuing cannula. led July 27, 2010 at 10:15AM let OX above 90 if less than 90 4 liters per nasal canula. lat 10:20AM an interview liployee # 16 revealed that the letered to resident was the	F 309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET		
		095015	B. WING		08/11/2010		
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH 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 BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE	
F 309	that the Resident's his/her respiratory st when taken by Empl A face-to-face interv incident with Employ August 3, 2010, 10:5 that an assessment condition and interved There was no explar to assess the reside August 3, 2010. 12. The facility staff available for Resider A review of medicate conducted on August that the missed med Baclofen 10mg table (3) times daily for sp during the month of Lyrica 200mg capsus mouth three (3) times missed eight(8) time 2010 Tramadol 50mg table three (3) times daily during the month of An interview was con August 6, 2010 at 10 because he/she missed medication he/she shis/her right arm, dia finger tips and deprefor my depression; I pain I felt when I missed the pain was so bad A face-to-face interved the pain was so bad A face	was experiencing a change in atus, resident pulse Ox was 88 oyee #2. iew was conducted post ree #2 and Employee #3 on 60AM. He/she acknowledged and description of the resident's entions should have been done. nation as to why the staff failed nt. The record was reviewed failed to have medication not CBL10 for three (3) days. ion administration record was at 6, 2010 at 10:00AM revealed ication dosage was as follows: give one (1) tab by mouth three asms, was missed six (6) times July 2010 le give one (1) capsule by se daily neuropathic pain, was as during the month of April et give one (1) Tablet by mouth for pain, was missed 11 times July 2010 nducted with resident CBL10 on 0:15AM and he revealed that sed those dosages of uffered from a burning pain in rrhea, no feelings in his/her assion. "I now take cymbalta do not want to go through the sed those medications because	F 309	1. CBL #8 was transferred to time of survey. Staff was rentime of survey. 2. An audit has been complereceiving oxygen therapy by managers. Corrective meast implemented as needed. 3. Staff education has been respiratory assessment and to oxygen by the educator. 4. A monthly audit of respiral services and documentation completed by the unit manages submitted to the DON/design of the above audit will be represented to the DON/design of the poon of the poon of the presented. The CQI of determine the need for further and need and frequency of forms.	nediated at the sted on residents the unit ures have been completed on the use of the colling to the colling then quarter or to f problems implemented ommittee will r interventions	10/19/10 10/28/10	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE : COMPL	
		095015	B. WING	<u> </u>		08	/11/2010
	OVIDER OR SUPPLIER	ALTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, 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 COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 309	the resident was w was review Augus 13. The facility statisolation for Reside Physician Order S signed July 7, 2016 MRSA [methicillin in sputum."	nacy called each of the three days rithout medication. The record to 6, 2010. If failed to clarify order for type of ent #CBL 14. heet and Plan of Care dated and 0 directed, " Contact Isolation for resistant staphylococcus aureus] uly 2010 MAR [Medication cord]; MRSA of sputum was	F3		Ftag 309 #13 1. CBL #14 was seen by the the isolation order was clarificated as been conducted by the A Corrective actions implement physician notified as needed. 3. The ADON has completed education on isolation implement discontinuation. A review of on Isolation has been completed.	ed on 8/23/10. ring isolation ADON. nted and d staff nentation and the facility poli	10/19/10
	A Nurse Practition 2010 revealed, "[[resistant staphyloo wound. Plan: Contwound. Nurses note dated Continue on isolation According to the Modern Completed June 4, Section I (12a Infeinfection and Section I (12a Infeinfeition I (12a Infeinfeition I (12a Infeition I (12a Infe	lacked documented evidence ad MRSA of the sputum er progress note dated April 28, positive] MRSA [methicillin foccus aureus] of left big toe act isolation for [positive] MRSA June 1, 2010 revealed, "on for MRSA to great toe. " IDS [Minimum Data Set] 2010, resident was coded under ctions) as Antibiotic resistant on M (6b) infection of the foot. erview was conducted with Employee #5 on August 10, Both acknowledged that the contact isolation for MRSA of the			4. An audit of residents on is completed monthly and a rep the DON. The results of the be reported to the CQI comm by the ADON/designee. A reproblems identified and corre implemented will be presents committee will determine the interventions and need and further audits.	oort provided to above audit winittee monthly eport of ective actions ed. The CQI need for other	

NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER SUMMARY STAMENT OF DEPICIENCY SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER SUMMARY STAMENT OF DEPICIENCY SUPPLIER SULVATORY TAG CALCIDENTIFYING INCOMMITION) F 309 F 309 Continued From page 93 F 301 Continued From page 93 F 301 F 314 F 325 Continued From page 93 F 301 F 314 F 314 SS-D PRESSURE SORES Based on the comprehensive assessment of a resident, the facility with pressure sores does not develop pressure sores unless the Individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 supplemental residents, it was determined that the facility staff failed to: accurately document the number of pressure sores are one (1) resident on the facility's "Pressure Area Documentation Form " [a line listing of all residents in the facility had 28 residents is led on the "Pressure Area Documentation Form " [a line listing of all residents in the facility had 28 residents is led on the "Pressure Area Documentation Form, Resident # EBL17. The findings include: A review of the facility's "Pressure Area Documentation Form " [a line listing of all residents in the facility had 28 residents is led on the "Pressure Area Documentation Form, of which 17 residents were identified as having pressure uclers and 11 residents were identified as having pressure uclers and 11 residents identified with non-pressure uclers.		OF DEFICIENCIES CORRECTION	I (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION		(X3) DATE SUP COMPLET	
RAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 93 Facility staff failed to clarify Physician's order for type of isolation. The record was reviewed on August 10, 2010. F 314 SS=D RESURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enfers the facility without pressure sores does not develop pressure sores unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 supplemental residents, it was determined that the facility staff failed to; accurately document the number of pressure sores and include one (1) resident on the facility. ** "Pressure Area Documentation Form" [a line listing of all residents in the facility with pressure uclers and other areas of skin impairmently was conducted with Employee #2 on August 10, 2010 at 8:45 AM. He/she confirmed that the facility was conducted with Employee #2 on August 10, 2010 at 8:45 AM. He/she confirmed that the facility and pressure uclers and other areas of skin impairment was conducted with Employee #2 on August 10, 2010 at 8:45 AM. He/she confirmed that the facility and 28 residents listed on the "Pressure Area Documentation" form, of which 17 residents were ledertified as having pressure uclers			095015	B. WIN	IG			08/1	1/2010
F309 Continued From page 93 Facility staff failed to clarify Physician's order for type of isolation. The record was reviewed on August 10, 2010. F314 482.5(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores on developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 supplemental residents, it was determined that the facility's 'Pressure Area Documentation' form. Resident # CBL17. The findings include: A review of the facility's 'Pressure Area Documentation Form' [a line listing of all residents in the facility had 28 residents listed on the 'Pressure Area Documentation' form. Sorting the facility had 28 residents listed on the 'Pressure Area Documentation' form' for sident sited on the 'Pressure Area Documentation' form' form, of which 17 residents was properties.			LTH CARE CENTER		13	880 SOUTHERN AVE SE			
Facility staff failed to clarify Physician's order for type of isolation. The record was reviewed on August 10, 2010. F 314 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 supplemental residents, it was determined that the facility staff failed to; accurately document the number of pressure sores and include one (1) resident on the facility's "Pressure Area Documentation" form. Resident # CBL17. The findings include: A review of the facility 's "Pressure Area Documentation Form " [a line listing of all residents in the facility with pressure ulcers and other areas of skin impairment] was conducted with Employee #2 on August 10, 2010 at 8:454 AM. He/she confirmed that the facility had 28 residents listed on the "Pressure Area Documentation" form, of which 17 residents were identified as having pressure ulcers	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHO	ULD B	E CROSS-	(X5) COMPLETION DATE
	F 314	Facility staff failed to type of isolation. The August 10, 2010. 483.25(c) TREATM PRESSURE SORE Based on the compresident, the facility enters the facility widevelop pressure so clinical condition de unavoidable; and a receives necessary promote healing, presores from developing. This REQUIREMENTE Based on record results of 30 supplementation of pressure sident on the facility staff the number of pressuresident on the facility on the facility with pressure Area Documentation on August 10, 2010 that the facility had a Pressure Area Documents were identification.	co clarify Physician's order for the record was reviewed on ENT/SVCS TO PREVENT/HEAL'S rehensive assessment of a must ensure that a resident who ithout pressure sores does not bores unless the individual's monstrates that they were resident having pressure sores treatment and services to event infection and prevent newing. It is not met as evidenced by: view and staff interviews for one that residents, it was determined failed to: accurately document sure sores and include one (1) ity's "Pressure Area m. Resident # CBL17. The image of all residents ressure ulcers and other areas of as conducted with Employee #2 at 8:45 AM. He/she confirmed 28 residents listed on the "umentation" form, of which 17 tified as having pressure ulcers						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	FIPLE CONSTRUCTION	(X3) DATE SUP COMPLET	
		095015	B. WING _		08/1	1/2010
	ROVIDER OR SUPPLIER	ALTH CARE CENTER		TREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES ET BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 314	Continued From page	ge 94	F 314	4 Continued From page 94		
	conducted on Augus 4:30 PM. He/she res Documentation " fo	view with Employee #5 was ust 10, 2010 at approximately eviewed the "Pressure Area orm, and acknowledged that		The pressure area documer was corrected to reflect residence. An audit has been complete.	ent CBL#17.	10/19/10
	listed on the form. queried as to the ac	ad a pressure ulcer but was not When Employee #5 was ctual stage of the wound, he/she the stage. When Employee #5		wound care nurse of resident to assure accuracy of documents	entation.	
	was asked to define wound, he/she was	e the characteristics of a Stage II sunable to do so.		3. The wound care nurse has staff on the use of the tools us documentation of wounds. The purse will suit the wound care	sed for he wound care	10/19/10
	Documentation " fo CBL17 had two (2) of thigh, that were first June 3, 2010. The fa	ort CBL17's "Pressure Area form revealed that Resident open areas to the right outer t observed and documented on facility continued to document the right outer thigh until August		nurse will audit the wound car documentation weekly and pr to the director of nursing. 4. The results of the above au reported to the CQI committee the wound care nurse. A reported to the care nurse action	udit will be e monthly by ort of problems	10/28/10
	June and July 2010	atment Administration Record for revealed that the open areas to treated from June 4, 2010		will be presented. The CQI conditions the need for other and need and frequency of fu	ommittee will interventions	1
	right thigh area for the	ed to measure the resident 's three (3) additional weeks after at stopped on July 4, 2010.				
	form, the right thigh characteristics from Wound Measureme	Pressure Area Documentation " In area #1 had the following I July 6 through August 1, 2010: Intents 1 x 0 x 0; wound base M Itent)- was left blank; Pressure Ink				
		#2 had the following July 6 through July 26, 2010:			I	

-	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	ULTIPI LDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		095015	B. WIN	IG		08/1	1/2010		
	ROVIDER OR SUPPLIER N BOONE LEWIS HEA	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 880 SOUTHERN AVE SE VASHINGTON, 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 SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE		
F 314	Wound Measurement (moist)Tx (treatment (no) There was no evider Resident CBL17 on Documentation" form the characteristics for A face-to-face interval August 11, 2010 at a stated that Resident therefore the area con #2 acknowledge that Documentation form inaccurate. Employe #5 was inserviced on	nts 1 x 0.1 x 0; wound base Ment) Y (yes); Pressure Relief Nonce that facility staff included the facility's "Pressure Area in and accurately documented for two (2) pressure sores. Identify the included the facility's "Pressure Area in and accurately documented for two (2) pressure sores. Identify the included the facility is "Pressure sores. Identify the included		314					
SS=G	The facility must ensenvironment remains is possible; and each supervision and assi accidents. This REQUIREMEN Based on observation for two (2) of 26 sams supplemental reside staff failed to adequate	rure that the resident sas free of accident hazards as a resident receives adequate stance devices to prevent T is not met as evidenced by: ns, record review and interview in it is prevent in the resident sand 3 ints, it was determined facility intely supervise one (1) resident ture, one (1) resident that fell							

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SU COMPLE				
		095015	B. WIN	IG		08/1	1/2010			
	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	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIS	ULD BE CROSS-	(X5) COMPLETION DATE			
F 323	residents involved ir smoking and to perfi (1) resident who atte keep environment fr	altercations centered around form a risk assessment for one empted to elope, and failed to ee of accidental hazards. BL2, CBL3 and CBL6.	F	323	Continued From page 96 483.25(h) FREE OF ACCIDE HAZARDS/SUPERVISION/D Ftag 323 #1 – Resident #3 1. Resident #3 returned to the systems were put in placed to incidents of elopement.	EVICES e facility and	07/26/10			
	resident receives ad accident. A review of Resider the following:	ew of Resident #3 's clinical record revealed			2. A review has been completed admissions to assure that appassessments, safety measure and referrals for evaluations disciplines are completed by managers. The director of so has reviewed new admission discharge plans are addressess.	propriate es implemented by outside the unit ocial services s to assure				
	November 2, 2009 of Demographic Inform 23, 2009. A nursing note dated noted: "Resident le advice [AMA]. Relea All personal belongii	d January 28, 2010 at 3:00 PM ft facility [without medical ise form of responsibility signed. ngs sent [with]						wishes. 3. New admissions will be retrace mythology meeting daily new admission packet has been the Director of Nursing and steducated. The discharge planas been reviewed with the steducated planning meetings implemented. A Discharge will be completed by the Director Services monthly and a report administrator.	y. The nursing een updated by taff has been uning process social workers. have been blanning audit ctor of Social	10/19/10
	"Admission noteR via ambulance. Re of altered mental sta hypothermia" A social progress no "Initial care plan med [Interdisciplinary care	te dated March 17, 2010 noted eting was held today by IDT e committee]Goal is to and assist in stabilizing living			4. The results of the above at reported to the CQI committee the Director of Social Service report of problems identified actions implemented will be pCQI committee will determine other interventions and need of further audits.	ee monthly by es/designee. A and corrective presented. The ethe need for	10/28/10			

Facility ID: HCI

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095015	B. WING		08/1	1/2010
	OVIDER OR SUPPLIER	ALTH CARE CENTER	138	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, 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 CORE (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ILD BE CROSS-	(X5) COMPLETION DATE
F 323		ed July 24, 2010 at 2:50 PM elopement attempt at 2:50 PM	F 323			
		intervene and escort resident in				
,	Resident #3 on Au 2:00 PM. He/she s was retired from th not anymore. I can worked at Saint Eli health specialist. I rest of my life. I am If I leave again, I w attempts to stop m a jail" This social me. It is like talking and should be trea	rview was conducted with gust 2, 2010 at approximately aid "My right is being denied. I be air force. I used to go out but see if I am mentally ill, I am not. I stabeth for 24 years as a mental am not going to be here for the not going to be like this for long. This is like worker has not done anything for to brick. This is a nursing home ted like one. I used to live with the lost the lease. I need my own				
	lacked documented above concerns we resident receives a his/her attempted e	the resident's clinical record devidence that: the resident's ere addressed and that the adequate supervision to prevent elopement. The resident wheeled om to the basement floor, exited ced/unsupervised.				
	Employees #2, 5 a approximately 9:30 resident's clinical rethe resident's clinic evidence that the raddressed and tha	rview was conducted with nd 8 on August 6, 2010 at 0 AM. After reviewing the ecord he/she acknowledged that cal record lacked documented esident's concerns were the resident receives adequate the resident. Employee # 5 the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		095015	B. WING	-		08/11	/2010
	NOVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 880 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	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	ULD BE CROSS-	(X5) COMPLETION DATE
F 323	resident left the faci 2010. Employee # 8 start looking into the housing in the comr Employees # 2, 5 at the intention of leav his/her rights contin he/she threatens to	ge 98 lity AMA sometime in January added further that he/she will be resident's concerns including munity. It was emphasized to not 8 that the resident verbalized ing the facility if he/she feels used to be denied and that hurt whosoever attempts to stop was reviewed August 6, 2010.	F3	23	#2 1. Cameras are in place to mon smoking areas. A smoking mo approved for the courtyard as co. 2. A review of incident reports accidents has been completed assure that residents are received are the completed supervision post incidents. A remokers has been completed Supervisor.	of 10/25/10. of residents with by the DON to ving adequate eview of facility	10/7/10 10/19/10
	residents that engage resident altercation. A review of the facil Residents #22 and August 1, 2010. The residents were in the verbal altercation erattempted to strike I	d to adequately supervise two ged in more than one resident to ity 's incident report revealed CBL3 had an altercation on e report revealed that the e designated smoking area, a nsued and Resident #22 Resident #CBL3 with a butter			3. A review of the smoking policy the administrator and chang needed. Staff education regards smoking policy and smoking scompleted by the educator. Stregarding resident safety and sincidents has been completed An audit of the changes implementation and the administrator of the above audited by the administrator of the above audited by the above audited by the above audited by the above audited by the administrator of the above audited by the adm	res made as rding the afety has been aff education supervision post by the educator nented will be esignee monthly.	
	Employee #29 on A Telephone interview Employees #33 and approximately 2:30 incident was verbali The residents were courtyard unsupervi dining hall making re-	in the outdoor smoking sed. Employee #33 was in the ounds and was alerted by a staff			to the CQI committee monthly! Administrator/designee. A repidentified and corrective actions will be presented. The CQI condetermine the need for other in need and frequency of further and the condetermine the need and frequency of	by the ort of problems implemented mmittee will terventions and	10/20/10
	altercation in the co intervened and retri Resident #22. The r and Employee #50	ed what appeared to be an urtyard. The employee eved a butter knife from residents agreed to get along left the area and radioed for onitor the smoking area.					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095015	B. WIN	≀G _			08/1	1/2010
	OVIDER OR SUPPLIER	LTH CARE CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	ULD E	BE CROSS-	(X5) COMPLETION DATE
F 323	Continued From page	ge 99	F	323	3			
	Employee # 29 enter courtyard looking for #22 and CBL3 were altercation described each other. " Employee #34 enter Resident #22 out of On August 2, 2010 a during general observing of the survey team of CBL3 unsupervised	pproximately 10 minutes] ared the unsupervised smoking of another resident. Residents observed engaged in a second das "arguing and pushing byee #29 intervened and red the courtyard and escorted the area. The approximately 11:30 AM rivations of the facility a member observed Residents #22 and and engaged in a verbal elevators on the level of the						
1	Policy that stipulat allowed in the desig and item #9 Supervi	ity 's Policy #120 " Smoking tes, item #8 smoking is only nated outside smoking areas sed smoking is conducted in eginning at 9:00 AM and ending						
	Employees #1 and 2 approximately 5:30	ews were conducted with 2 August 9, 2010 at PM. Each confirmed that gnated courtyard must be						
	Residents #22 and 0	o adequately supervise CBL3 who engaged in three (3) altercations in a period of 48						
		d to maintain a safe ovide adequate supervision to Resident CBL2 who sustained						

F 323 Continued From page 100 a fracture of the distal 3rd of the 5th metacarpal. A review of the March 12, 2009 admission Minimum Data Set (MDS) contained in the clinical record revealed that the 97 year old female was admitted to the facility with diagnoses which included Alzheimer's Disease, Dementia, Glaucoma, Hypertonsion and Popul Failure, The lune 10	• • •	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
A review of the March 12, 2009 admission Minimum Data Set (MDS) contained in the clinical record revealed that the 97 year old female was admitted to the facility with diagnoses which included Alzheimer's Disease, Dementia, Glaucoma, UX4, ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH CORRECTION, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION, DC 20032 WASHINGTON, DC 20032 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Continued From page 100 1. Resident CBL#2 has been discharged and no further corrections can be made for this resident at this time. 1. Resident CBL#2 has been discharged and no further corrections can be made for this resident at this time. 2. All residents have the potential to be affected. An audit was completed of residents using restraints for the appropriateness of the			095015	B. WING		08/11	1/2010
F 323 Continued From page 100 A review of the March 12, 2009 admission Minimum Data Set (MDS) contained in the clinical record revealed that the 97 year old female was admitted to the facility with diagnoses which included Alzheimer's Disease, Dementia, Glaucoma, Hypertonsion and Ponel Failure. The June 10			ALTH CARE CENTER		1380 SOUTHERN AVE SE		
a fracture of the distal 3rd of the 5th metacarpal. A review of the March 12, 2009 admission Minimum Data Set (MDS) contained in the clinical record revealed that the 97 year old female was admitted to the facility with diagnoses which included Alzheimer's Disease, Dementia, Glaucoma, Hypertonsion and Popul Failure. The June 10	PREFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHO	OULD BE CROSS-	(X5) COMPLETION DATE
indicated that the resident had no problems in these areas. According to the information contained in the report of an investigation which was completed by the facility and sent to the State Agency on March 7, 2010 the resident " had a history of intermittent explosive episodes and agitation. During his/her stay at the facility he/she had displayed these bouts of irritability and agitation. What triggers these episodes has been undetermined; however he/she reevaluated and updated. Staff has been in-serviced on the policies, the use of sheets to restrain residents, the overall process of restraint use, and what constitutes abuse. Staff education has been completed for the line staff and supervisors regarding the change of shift process. A Restraint audit will be completed monthly by the unit manager/designee. A report will be provided to the Director of Nursing/ designee of problems identified.	F 323	a fracture of the dist A review of the Marc Data Set (MDS) cor revealed that the 97 to the facility with dia Alzheimer's Disease Hypertension and R 2009 MDS was code (cognitive decision r memory. A score of (Mood/Behavior and indicated that the re areas. According to the info of an investigation w facility and sent to th 2010 the resident " explosive episodes a stay at the facility he of irritability and agit episodes has been thas previously preso been discontinued." staff maintained that that the assistance of Nurse (LPN) and two (CNA) was needed. that the staff also ca According to the doo occurred on the eve 2009. Per the super staff placed the resid were afraid that he/s down loosely. " Acc " the supervisor aske	ch 12, 2009 admission Minimum ntained in the clinical record year old female was admitted agnoses which included and included agnoses which included and included agnoses agnose	F 32	1. Resident CBL#2 has been and no further corrections can this resident at this time. 2. All residents have the potent An audit was completed of residents for the appropriatener restraint by the unit managers actions were implemented as a supervised on the policies, the restrain residents, the overall prestraint use, and what constituted and supervisors regarding the process. A Restraint audit will monthly by the unit manager/d report will be provided to the D designee of problems identified to the CQI committee quarterly of Nursing/designee. A report identified and corrective actions will be presented. The CQI condetermine the need for other in	tial to be affected idents using ess of the Corrective needed. policy has been the use of sheets to process of utes abuse. Staff change of shift be completed esignee. A prirector of Nursing did. dit will be reported by the Director of problems implemented mmittee will interventions and	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SU COMPLET	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 323	and placed a sheet and tied it to the bac continued, "According the night." As documented on the day staff and the informed that the renight, but no mentio being tied down. He 1:30PM the resident chair in the day roor the CNA monitoring informed the charge noted that the reside assistance or care. That, "on Monday Sonoticed that the reside assistance or care. That, "on Monday Sonoticed that the reside assistance or care. That, "on Monday Sonoticed that the resident suffered and swoll that the X-ray revea the 5th metacarpal. Per the facility 's reand maintain a safe the supervisor failed proper care for the resident suffered and adequate care." A face-to-face intervent the proper care for the resident suffered and adequate supervision Resident CBL2 who	around the back of the resident ck of the chair. " The report ling to everyone present, the in the recliner chair for the rest suddent had been agitated all in was made of the resident owever, at approximately who was still in the recliner in complained of discomfort and noticed the tied sheet and in nurse. At this time it was also ent had not received any ADL. The report further revealed deptember 21, 2009 the day shift dent's right hand was len. " The report concluded led a fracture of the distal 3rd of cort, "The staff failed to provide environment for the resident, I to monitor and supervise esident; and as a result the injury and did not receive riew was conducted with roximately 9:35AM on August cknowledged that the facility safe environment and provide in to prevent injuries for sustained a fracture of the metacarpal. The record was	F	323			

STATEMENT OF AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETED					
		095015	B. WIN	G			08/1	1/2010
	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 PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD I	BE CROSS-	(X5) COMPLETION DATE
	being transported by resident sustained a Resident # CBL6. A review of resident 2010 at 7:00AM reviewed chair and hit hof blood about not forehead. Pressure site of injury about 5 laceration with dry gemergency room at Attempted to conduct 2010 at 11:15AM with up in wheel chair in resident was unable when questioned abon her forehead or sfalling. A review of the "Resident' completed or facility staff answered questions: 1. Does the resident' completed or facility staff answered questions: 2. Is the patient require increased sating about the acknowledged that the transported resident room to put him/her because males certains take care of [fem asked to care for Resident room to	d to provide safety for resident wheel chair, and subsequently in injury after falling from chair. nurses note dated July 22, ealed, "Resident fell from the nead on floor with small amount ofted on open laceration on has been put on forehead at the min. bleeding stop cover open auze. Resident transferred to 9:15PM." ct an interview on August 9, the resident while she was sitting day room revealed that the to respond that he/she fell out the healed laceration area say what attributed to his/her sident Risk Assessment for Fall in July 20, 2010 revealed that would infety precautions? at 3:50 PM Employee # 23 was a incident. He/she he resident fell while he/she via wheelchair back to his/her in bed. He/She stated, sified nursing assistants could inale/male] residents, I was sident CBL6. The resident was ally take care of but on July 22,	F	323	Continued From page 102 #4 1. Resident #CBL6 footrests applied to the wheelchair and has been updated to reflect the safety awareness, cognition as afety precautions during transport and the appropriate of the safety awareness and the appropriate of the safety precautions during transport and the appropriate of footrests has been considered to the safety awareness and the appropriate of the safety precaution during residuring transport and the appropriate of the safety precaution. An audit of wheelchair bound be completed quarterly by the aides. 4. The results of the above as reported to the CQI committee the DON/Designee. A report identified and corrective actions presented. The CQI committee the need for other and need and frequency of of the safety precaution of the safety precau	I the dependence of points were winter	careplan ecrease in required ort. hairs with ompleted safety ateness ted by the idents will storative will be parterly by problems vill be vill rventions	10/19/10 10/19/10 10/19/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ELE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		095015	B. WIN	G		08/1	1/2010
	OVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	iD PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 323	I pushed the wheeld crossed his/her legs forward, and fell on was bleeding from fresident's chair had responded, "at the tichair did not have a According to an "occidated July 29, 2010 "comment section," in wheel chair due to and decrease cognicaseload in Februar There was no evide staff provided safety decrease safety awas on medications precautions when rechair without foot read face-to-face intervent in the comment of t	chair is when the resident at the ankles and took a tumble floor. Resident hit forehead and orehead." When asked if a foot pedal, Employee #23 ime of the incident, resident's foot pedal." cupational therapy screen" form at 10:30 AM revealed under "resident require support when be decrease safety awareness tion as was identified when on y 2010." Ince in clinical record that facility for resident identified to have areness, decrease cognition and that required increased safety esident was transported in wheel st. Friew was conducted with regust 10, 2010 at 10:00AM. The resident chair has a foot cerstand why the resident chair vening. The record was, 2010. If to keep the resident accidental hazards by not uipment (transfer lift/assistive allway. The revealed that there were no equipment to alert facility staff	F	323	Continued From page 103 #5 1. The hallways were cleared the time of survey. 2. All residents have the pote affected by this practice. 3. Environmental safety round completed weekly by the Safi Staff has been completed by Officer regarding the disposate equipment. The results of the provided to the Administration. 4. The results of the above recept to the CQI committees the Safety Officer/designee. problems identified and the cwill be presented to CQI committees and the frequency of further and the first further and the first further and the further and the first further and the further and the first further and the further and the first further and the further	ds will be ety Team. the Safety of broken e rounds will ator bunds will be quarterly by A report of the orrective actions mittee will er intervention	10/19/10 10/19/10 10/19/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
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	ROVIDER OR SUPPLIER	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032	<u> </u>	
(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 CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	OULD BE CROSS-	(X5) COMPLETION DATE
F 323	Continued From pag	ge 104	F	323			
F 325 SS=D	with Employee #3. A he/she acknowledge equipment should ha and summoned a state observation was made 483.25(i) MAINTAIN UNLESS UNAVOID. Based on a resident the facility must ensure (1) Maintains accept status, such as body unless the resident's that this is not possil	e's comprehensive assessment, ure that a resident - table parameters of nutritional y weight and protein levels, s clinical condition demonstrates ble; and	F	325			·
	nutritional problem. This REQUIREMEN Based on observation for one (2) of 26 same determined that facilities.	IT is not met as evidenced by: ons, record review and interview appled residents, it was lity staff failed to include a					
	assessment and the for a period of six (6) dietary assessment Resident #1 and 14.						
	The findings include:	:		ļ			
		linical record revealed the clude measures to address					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095015	B. WING_		08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 1380 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 325	the resident 's subr nutrition assessmen According to the his dated March 18, 20 included hypertensic	normal albumin level in the nt. story and physical examination 10, Resident #1 ' s diagnoses on, chronic obstructive	F 32	Continued From page 105 #1 Resident #1 1. Resident albumin level wa resident #1 and the results w normal limits.		10/7/10
	joint disease. The re resident 's skin was The resident 's albu	umin level was 3.2 [normal 3.5-		A random chart audit of diassessments for the past thir been completed and correcting implemented as needed.	ty days have	10/19/10
	performed on March and lacked evidence changes.	010. Nutrition assessments were n 29, 2010 and June 21, 2010 e of any significant weight		3. Dietary staff has been edu Regional Dietician on the doc Quarterly audits dietary asse conducted by the Regional D	umentation. ssments will be	10/19/10
	acknowledged and/	evidence that the dietician or implemented measures to at's subnormal albumin level in ary assessment.		A result of the above audits we to the CQI committee quarter dietician. A report of problem and corrective actions implement	ly by the is identified nented will be	10/28/10
	form entitled " lab v nutrition related lab	facility 's nutrition assessment ralues, albumin and other values "the resident's March vel was not included.		presented. The CQI committed determine the need for further and the frequency of further and the first and	er intervention	
	assessments during through March 28, 2 Nutritional Care Poli	ord lacked evidence of dietary the period of September 2009 2010. Per the facility 's icy, " all residents are assessed at a minimum of every 90 days				
	Facility staff faile assessments per facility	d to conduct dietary cility policy. Resident #14				
	According to the "F	Resident Nutritional Care "				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095015	B. WING		08/1	1/2010
	OVIDER 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 BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 325	Nutrition Assessmer Policy reads " All re comprehensive nutri individual. Assessm nutritional concerns in the medical record According to the " P	nt - RC -3 sidents will receive a tion assessment by a qualified ent and documentation of is recorded in a timely manner d by a qualified person.	F 325	F tag 325 #2 1. A nutritional assessment h completed for resident #14. I this resident were placed on record.	Lab results for the medical	8/17/10
	minimum of every 90 depends ultimately of	ents are assessed and documented on at a num of every 90 days; however, the frequency nds ultimately on the condition of the resident ew of the "Nutrition Assessment" dated an		A random chart audit of disassessments for the past thir been completed and correctivity implemented as needed.	ty days have	10/19/10
	A review of the "Nutrition Assessment" dated and signed November 9, 2009 revealed the weight for Resident #14 was 224 pounds, no labs were documented on the form.			3. Dietary staff has been edu Regional Dietician on the doc Quarterly audits dietary asses conducted by the Regional D	sumentation. ssments will be	10/19/10
	performed was date	al Assessment " that was d and signed March 2, 2010, pounds, no labs since October		A result of the above audits we to the CQI committee quarter dietician. A report of problem and corrective actions implemented. The CQI committee	ly by the as identified nented will be	10/28/10
	Employee #47 on Aureview of the clinical	iew was conducted with ugust 4, 2010 at 3:00 PM. After record he/she indicated that Nutritionist working in the		determine the need for further and the frequency of further a	er intervention	
		conduct dietary assessments ne record was reviewed on 010				
	483.25(k) TREATME NEEDS	ENT/CARE FOR SPECIAL	F 328			
		sure that residents receive d care for the following special				

Facility ID: HCI

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095015	B. WIN	3			08/1	1/2010
	OVIDER OR SUPPLIER	LTH CARE CENTER		1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE JASHINGTON, DC 20032	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO		IÒULD E	BE CROSS-	(X5) COMPLETION DATE
F 328	Continued From paginjections; Parenteral and ente Colostomy, ureteros Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	ral fluids; stomy, or ileostomy care;	F3	328				
	Based on observation facility, it was determined post precautionary report in use in two (2) resident to the findings included During the initial tout 2010, it was determined post precautionary resident.	nis REQUIREMENT is not met as evidenced by: ased on observations during the initial tour of the cility, it was determined that facility staff failed to ost precautionary notices that oxygen therapy was use in two (2) resident rooms. The findings include: The property of the facility on August 2, one find in the initial tour of the facility on August 2, one find in the initial tour of the facility staff failed to ost precautionary notices to alert staff, residents			1. Precautionary signs were 327 and 329 at the time of s 2. An audit of residents utiliz completed by the evening s Corrective actions implement 3. Staff education has been the educator on the use of a safety precautions necessar oxygen is in use. Audit of Obe completed weekly by the A report provided to the directions and the same series of the same series are same series.	urvey ing o upervi nted a comp xyger y whe xygen unit s	xygen was isor. s needed. eleted by a and the en in signs will secretaries.	8/11/10 10/19/10 10/19/10
	oxygen therapy in the signage to relay to on the facility had a dedoors; however, dure Employee #2 on Aug 5:00 PM, he/she stamanage their own sidevices. Precautionary signs that oxygen was in-the signage their own sidevices.	n rooms #327 and 329 received be absence of precautionary of thers that oxygen was in use. signated smoking area out-ofing a face-to-face interview with gust 10, 2010 at approximately ted that some residents moking supplies and incendiary over enot posted to alert others use.			4. The results of the above reported to the CQI commit the DON/designee. A reported and corrective act will be presented. The CQI determine the need for other and need and frequency of	tee qu t of pr ions ir comm r inter	arterly by roblems nplemented nittee will ventions	10/28/10
F 329	483.25(I) DRUG RE	GIMEN IS FREE FROM	F3	29				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					RVEY 'ED	
		095015	B. WIN	G		08/11/2010		
	OVIDER 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 BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE	
F 329 SS=E	Each resident's drug unnecessary drugs. drug when used in eduplicate therapy); owithout adequate moindications for its use consequences which reduced or disconting reasons above. Based on a comprehensident, the facility have not used antips these drugs unless a necessary to treat a and documented in who use antipsychologically and behave the control of the contro	-	F	329				
	Based on observation for Five (5) of 26 san supplements resider staff failed to monito receiving psychotropy dose reduction for omedication and iden	T is not met as evidenced by: ons, record review and interview mpled residents and 2 nts, it was determined facility r behaviors of nine (7) residents oic medication, attempt gradual ne (1) resident on antipsychotic tify indications for use for stered to four (4) residents. 7. 24.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUF	
		095015	B. WIN	G		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 MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	ΦULD BE CROSS-	(X5) COMPLETION DATE
F 329	CBL3 and CBL7. The findings included the findings included to Clonazepam, Zeror Resident #2. A review of the Reform signed and control to Clonazepam, Zeror Resident #2. A review of the Reform signed and control to Clonazepam, Zeror Signed According to the lassigned July 27, 20 ordered hold meds (illegible writing on A review of the resident part of the signed July 27, 20 ordered hold meds (illegible writing on A review of the resident part of the signed July 27, 20 ordered hold meds (illegible writing on A review of the resident part of the signed July 27, 20 ordered hold meds (illegible writing on A review of the resident part of the signed to Clonazepam, Zeror Signed and Control to Cont	de: ed to adequately monitor the use olpidem, Paroxetine and Seroquel sident #2 's Physician 's Order lated by the physician on July 7, following: Clonazepam 0.5 mg tab (0.25mg) by mouth twice agitated); Zolpidem 10 mg tablet pedtime as needed for insomnia; omg tablet 1 tab by mouth every . st Psychiatry report dated and 10: continue with medications as if falls, increased sedation last recommendation). ident's record revealed that the "g Flow Record" for July 2010	F	3329	1. The behavior monitoring is Residen#2 has been update behaviors and side effects to as outlined by the physician. 2. An audit of residents receive medications has been complemanagers. Corrective actions implemented as needed. 3. Staff education has been the educator on the use of periodications in the elderly, dof monitored side effects for behaviors and the importance with the PMD and psychiatric documentation of dose redupsychotropic medications are reductions will be completed worker monthly. The results will be reported to the Admir of behaviors and side effect be completed by the unit managers.	d to reflect the be monitored in psychotropic ted by the unit have been completed by sychotropic ocumentation resident specific e of following up st in reference to ctions. Audits of ad dose by the social of these audits nistrator. Audit monitoring will	10/25/10 10/19/10 10/19/10
	lacked consistent r from July 1st to Jul Paroxetine HCL a through July 22nd, monitored until July monitoring from July A face-to-face inter Employee #6 on A 3:40 PM. After rev Flow Sheets, he/sh	e medication side effects and monitoring of targeted behaviors by 5th for Clonazepam, Zolpidem, and no monitoring from July 6th-2010. Seroquel was consistently by 5, 2010, and no further by 6th through July 22, 2010. Twiew was conducted with august 3rd, 2010 at approximately beige of the Behavior Monitoring the acknowledged that there were be through July 22, 2010. The ed			The results of these audits wo of the director of nursing. 4. The results of the above reported to the CQI committed and quarterly thereafter by the Social Services/Designee and designee. A report of problem and corrective actions implessented. The CQI committed termine the need for other and need and frequency of feb, May, Aug., Nov.	audit will be ee monthly x3 ne Director of nd the DON/ ems identified mented will be tee will interventions	10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	_	095015	B. WIN	G			08/1	1/2010
	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 PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD E	BE CROSS-	(X5) COMPLETION DATE
F 329	Continued From pag on August 3rd, 2010		F	329	The physician was notificated reduction for resident #4 a obtained.			10/25/10
	reduction for the use for Resident #4.	I to attempt a gradual dose e of a psychotropic medication			An audit of residents reconstructions have been implement	s bee gers.	en Corrective	10/19/10
	documented the folk Consultation " under Patient has been we because she has do recently." Under the Recommendations " Resume BID (twice daily) for pressure] less than sedation and call this [ninety] days or [as a According to the Phadated February 17, 2 Recommendations "	owing on a "Report of r the heading of "Report." "eaned off lorazepam recently ne well which was not the case e heading of "the psychiatrist wrote the Ativan 0.5mg po [by mouth] agitation. Hold it if B/P [blood 80/60, falls [and] increased s writer. See resident in 90			3.Staff education has been of the educator on the use of predications in the elderly, dromonitored side effects for respectively. The period of the PMD and psychiatric documentation of dose reductions will be completed worker monthly. The results will be reported to the Admir of behaviors and side effect be completed by the unit matches the director of nursing.	sycho coum siden e of f st in r ctions d dos by the of the istrat monit	otropic entation of t specific following up eference to a. Audits of se he social ese audits or. Audit toring will rs monthly.	10/19/10
	reduction, perhaps of pm while concurrent of target and/or with to continue at the curationale describing contraindicated. " According to physici 5, and June 2, 2010	lecreasing to 0.5mg q [every] ly monitoring for re-emergence drawal symptoms. Of therapy is rrent dose, please provide a dose reduction as clinically an 's orders signed April 2, May the resident 's medication brazepam 0.5mg 1 [one] table			4. The results of the above a reported to the CQI committe and quarterly thereafter by the Social Services/Designee and designee. A report of problem and corrective actions imple presented. The CQI commit determine the need for other and need and frequency of five Feb, May, Aug., Nov.	ee mo ne Dir nd the ms io mente tee w	onthly x3 rector of DON/ lentified ed will be rill ventions	10/28/10
		e record failed to reveal any n from the psychiatrist.						l

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUF	
		095015	B. WING	G		08/1	1/2010
	ROVIDER OR SUPPLIER	LTH CARE CENTER		13	EET ADDRESS, CITY, STATE, ZIP COD 380 SOUTHERN AVE SE /ASHINGTON, DC 20032	E	
(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 C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
F 329	17, April 9, June 8, a evidence in the phys Ativan was reviewed or documentation preduction was clinical A face-to-face interview.	cian saw the resident on March and July 3, 2010. There was no sician's notes that the use of d or a dose reduction attempted resent to indicate that a dose ally contraindicated.	F3	329	1. The behavior monitoring: Resident #6 has been updated behaviors and side effects as outlined by the physiciar 2. An audit of residents recepsychotropic medications have been implementations.	ated to reflect the to be monitored n. eiving as been agers. Corrective	10/25/10
	1:00 PM. He/she ac The record was revi 3. Facility staff failed of Lorazepam and F #6. A review of the Resi Form signed and da 2010 directed the fo by mouth twice daily HCL 2mg by mouth According to the las	gust 4, 2010 at approximately knowledged the above findings. iewed August 4, 2010. If to adequately monitor the use Fluphenazine HCL for Resident ident #6 's Physician 's Order ated by the physician on July 2, ollowing: Lorazepam 1 mg tablet by for agitation; Fluphenazine twice daily for psychosis. It Psychiatry report dated and 10: continue with medications as			3. Staff education has been the educator on the use of medications in the elderly, of monitored side effects for rebehaviors and the important with the PMD and psychiatr documentation of dose redupsychotropic medications a reductions will be complete worker monthly. The results will be reported to the Admit of behaviors and side effect be completed by the unit may the results of these audits to the director of nursing.	completed by psychotropic documentation of esident specific ce of following up ist in reference to actions. Audits of hd dose d by the social of these audits nistrator. Audit monitoring will anagers monthly, will be reported	10/19/10
	ordered hold meds in A review of the residual Behavior Monitoring failed to identify the lacked consistent mon July 1, 2, 3, 4, 13 and Fluphenazine.	dent's record revealed that the "g Flow Record" for July 2010 medication side effects and onitoring of targeted behaviors 3, 21, 24, and 28 for Lorazepam view was conducted with			4. The results of the above reported to the CQI commit and quarterly thereafter by Social Services/Designee a designee. A report of problem and corrective actions implemented. The CQI commit determine the need for other and need and frequency of Feb, May, Aug., Nov.	tee monthly x3 the Director of and the DON/ ems identified emented will be ittee will er interventions	10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	COMPLETI	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 329	Behavior Monitorir acknowledged tha monitoring on the	PM. After review of the grown Sheets, he/she there was inconsistent above mentioned days. The	F:	329	The behavior monitoring s Resident #7 has been updat behaviors to be monitored a physician.	ed to reflect the	10/25/10
	Facility staff faile of Seroquel for agi	ed on August 5th, 2010. ed to adequately monitor the use tation for Resident #7.			An audit of residents recepsychotropic medications had completed by the unit managactions have been implemental.	s been gers. Corrective	10/19/10
	Form signed and of 2010 directed med mg tablet 1 tab by A review of the rest Administration Recollinical record for the 13, 2010 revealed Seroquel 25mg on and 5:00 PM daily across the entries mouth. A further review of revealed "Behavior and the service of th	sident #2 's Physician 's Order lated by the physician on July 2, lications including Seroquel 25 mouth twice daily for agitation. sident 's Medication cord [MAR] in the resident 's he months of April through July the resident was administered e (1) tablet by mouth at 9:00 AM as evidenced by the initials for Seroquel 25mg I tablet by the resident 's clinical record or Monitoring Flow Record "			3. Staff education has been the educator on the use of predications in the elderly, domonitored side effects for respendicular and the importance with the PMD and psychiatric documentation of dose reductions will be completed worker monthly. The results will be reported to the Admin of behaviors and side effect be completed by the unit mather results of these audits with the director of nursing.	sychotropic ocumentation of sident specific se of following up st in reference to ctions. Audits of ad dose I by the social of these audits histrator. Audit monitoring will magers monthly.	10/19/10
	2010 that consiste and #13 Persistent The resident 's clit lacked documenter monitored for agitat Seroquel for agitat A face-to-face interest Employee #7 on A 20 AM. After a revi	nical record including the BMFR d evidence that he/she was tion while he/she was receiving			4. The results of the above a reported to the CQI committee and quarterly thereafter by the Social Services/Designee and designee. A report of problem and corrective actions impler presented. The CQI commit determine the need for other and need and frequency of feb, May, Aug., Nov.	ne Director of and the DON/ sms identified mented will be tee will	10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 329	aforementioned find August 4, 2010. 5. Facility staff failed Resident #24 receiv According to the phy	knowledged that the ings. The record was reviewed to monitor behaviors for	F	329	1.Resident #24 no longer refacility. 2. An audit of residents recepsychotropic medications has completed by the unit mana actions have been implemental. Staff education has been	eiving as been gers. Corrective nted as needed.	10/19/10
	directed, "Ambien at bedtime for insorror The nursing notes a Administration Recobehaviors being mo A face-to-face intervely, 2010 at approxim#6. He/she acknowle monitoring for the use	5 mg one (1) tab po (by mouth) nnia "	3. Staff education has been completed the educator on the use of psychotropic medications in the elderly, documentation monitored side effects for resident specific behaviors and the importance of follow with the PMD and psychiatrist in reference documentation of dose reductions. Autopsychotropic medications and dose reductions will be completed by the soc worker monthly. The results of these autility will be reported to the Administrator. And the following be completed by the unit managers monthly the results of these audits will be reported to the director of nursing.		osychotropic documentation of desident specific ce of following up ist in reference to actions. Audits of and dose do by the social of these audits nistrator. Audit amonitoring will anagers monthly.	10/19/10	
	revealed that the resincluded psychotrop management of beh failed to implement of the psychotropic of the	inical record for Resident #CBL3 sident 's medication regimen ic medications for the avioral symptoms. Facility staff measures to monitor the efficacy medications. dated June 30, 2010 directed edaily for psychosis and Ativan as needed for agitation. acked evidence that facility staff or monitor the effectiveness of d to address behavioral			4. The results of the above a reported to the CQI committ and quarterly thereafter by the Social Services/Designee and designee. A report of problem and corrective actions imples presented. The CQI commit determine the need for other and need and frequency of the Feb, May, Aug., Nov.	tee monthly x3 the Director of and the DON/ tems identified temented will be tittee will or interventions	10/28/10

Continued from page 114.

1. The behavior monitoring sheet for Resident #CBL3 has been updated to reflect monitoring for the efficacy of the medications as outlined by the physician.

10/25/10

2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed.

10/19/10

- 3. Staff education has been completed by 10/19/10 the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits
- 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.

will be reported to the director of nursing.

10/28/10

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095015	B. WIN			08/11		1/2010
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD B	E CROSS-	(X5) COMPLETION DATE
F 329		eviewed and confirmed during a w with Employee #5 on August	F	329	1.The behavior monitoring Resident #CBL7 has been the behaviors to be monitor the physician.	update	d to reflect	10/25/10
		I to adequately monitor was receiving Zoloft.			An audit of residents recipsychotropic medications homeometric completed by the unit mana actions have been implementations.	as bee gers.	Corrective	10/19/10
	physician's order da February 23, 2010 of tablet [Zoloft], 1 table depression. " According to the Jur Flow Record" there is behavior was monitor. A review of the April "Behavior Monitoring. Drug: Sertraline HC	of to the June 2010, "Behavior Monitoring word" there was no evidence that any was monitored. of the April, May, June, and July 2010 Monitoring Flow Record " indicated, " traline HCL, Strength: 50mg ", revealed esident's behavior was not consistently			3. Staff education has been the educator on the use of medications in the elderly, of monitored side effects for rebehaviors and the important with the PMD and psychiate documentation of dose redupsychotropic medications a reductions will be complete worker monthly. The results will be reported to the Admit of behaviors and side effect completed by the unit manarathe results of these audits to the director of nursing.	sycho countersident ce of for ist in re- uctions nd dos d by the of the nistrator t monite gers m	tropic entation of specific bllowing up eference to Audits of e e social se audits or. Audit bring will be nonthly.	10/19/10
F 333 SS=D	Employee #7 on Aug 3:30 PM. He/she ad behavior was not co depression. The red 2010 483.25(m)(2) RESID MED ERRORS	iew was conducted with gust 9, 2010 at approximately sknowledged that the resident's nsistently monitored for cord was reviewed August 9, DENTS FREE OF SIGNIFICANT sure that residents are free of cation errors.	F3	333	4. The results of the above reported to the CQI commit and quarterly thereafter by Social Services/Designee a designee. A report of probl and corrective actions imple presented. The CQI comm determine the need for other and need and frequency of Feb, May, Aug., Nov.	tee mo the Dire and the ems ide emente itlee wi er interv	nthly x3 ector of DON/ entified d will be II ventions	10/25/10
	This REOLIBEMEN	T ie not mat se avidancad						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING		08/1	1/2010
	OVIDER OR SUPPLIER	ALTH CARE CENTER	1:	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
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F 371 SS=F	pass, it was determensure that one (1) medication errors. The findings include Facility staff failed to manufacturer stand On August 2, 2010 medication pass, the observed crushing and administered it is medication included According to the mashould not be chewed a face-to-face interemployee # 16 on a acknowledge that reswallowing the smallowing the	vation during the medication ined that facility staff failed to resident was free of significant Resident # CBL 19. a: o administer Klor Con per lards at 10:15AM during the morning as medication nurse was two of the resident 's medication with applesauce. The resident 'ed Klor Con 20 meq tablet. anufacturer, Klor Con tablet red or crushed. view was conducted with August 2, 2010. He/she esident had no problem aller pills. The record was review	F 371	1. The physician was notified medication error. New orders for liquid medication. 2. All residents have the poter affected by this practice. A Delist has been placed on all MA 3. Staff education was comple educator regarding medication not crush list. It was requeste pharmacy send liquid medicat resident with orders to crush regastrostomy tubes. Nurses we monthly during med pass observed to the director of nurse. 4. The results of the above autreported to the CQI committee the DON/designee. A report of identified and corrective action will be presented. The CQI conditions and need and frequency of fursides.	ntial to be to Not Crush and a	08/31/10 10/19/10 10/19/10
	Based on observati was determined that	NT is not met as evidenced by: ons during the survey period it at dietary services were not that foods are prepared and			•	

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			s	TREET 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 371	by: the ice cream freseal properly in one Salisbury steak was box of pork loin and were dripping onto a one (1) observation, were stored in the wexpiration date in six outer surfaces of the machine was soiled observations, frozer unthawing above 70 of three (3) observations, cheminate with rust in one (1) of staff were observed hair net in two (2) of surface of the pot an accumulated debris cutting boards were grooves in board surfaces of the pot an accumulated debris cutting boards were grooves in board surface of the pot an accumulated debris cutting boards were grooves in board surface of the pot an accumulated debris cutting boards were grooves in board surface of the pot an accumulated debris cutting boards were grooves in board surfaces during a tessix (6) observations. The findings included 1. The ice cream freseal properly allowing freezer compartment observation at 9:05	d sanitary manner as evidenced bezer doors failed to close and (1) of one (1) observation, observed unthawing on top of a juices from the Salisbury steak a box of pork loin in one (1) of six cartons of half and half ralk in refrigerator past the (6) of six (6) observations, the ewater filter adjacent to the ice in one (1) of one (1) of chicken was observed degrees Fahrenheit in three (3) tions, open drains under sink oris in two (2) of two (2) of two (2) of two (2) of two (2) observations, the emanual can opener was soiled of one (1) observation, facility in the main kitchen without a two (2) observations, the shelf of pan track was soiled with of grease and water residue, observed to be worn with rfaces in two (2) of two (2) ment jars located in the cook 's ked an open date in 22 of 22 old foods were served above 41 st tray observation in four (4) of the cook of the co	F 37	#1. The corrective actions are: 1. A new refrigerator has be the storing of dairy products received as of 10/14/10. 2. The Salisbury steak was immediately cooked at the atemperature. 3. The half and half was remwalk in and disposed of in the disposal at the time of the sea. 4. The water filter was clean the survey finding. 5. The chicken being thawed of this deficiency was immediately cooked at the long that the survey finding. 7. The drains were cleaned on the drains have been repair look. 7. A new can opener was purinstalled to replace the old until the item was delivered on 8. The cooks and utility staff and seasonings as new one usage. 9. The administrative staff we place a hairnet on his head we kitchen during the survey prowas completed. 10. The pot and pan rack was indicated as being deficient of process. 11. The cutting boards were new cutting boards at the timprocess. 12. Test trays are conducted the Director of Food Service which is conducted from the test tray is assembled until the delivery to the resident.	en ordered for and has been removed and ppropriate roved from the regarbage urvey finding, ed at the time of diduring the time diately discarded, during the survey cked closet, and for a fresher richased and nit on 8/11/10. /10/10. will date spices are opened for as informed to while in the ocess, which as cleaned when during the survey replaced with the of the survey is Department, time that the	8/11/10 8/11/10 8/11/10 8/11/10 8/11/10	
						}	

Continued from page 117 #2. The following corrective actions have been implemented for areas that have the potential to be affected by this practice:

- 1. The new refrigerator will replace the 10/14/10 ice cream cooler. It will be maintained with a temperature log and refrigerator thermometer. It will be placed on a weekly cleaning schedule.
- 2. The staff was in-serviced on August 16th 8/16/10 about the placement of food on the shelves and competency was given to the staff.

 The staff have been instructed on the requirement and reason for the requirement of appropriate storage of refrigerated food items on the correct shelf, which entailed instruction on the top shelf contains ready to eat food, second is seafood, third is whole roast, fourth is ground beef and the last shelf is raw chicken.
- 3. The utility staff and cooks were 8/31/10 in-service on August 31st to check all dates on all perishable items.
- 4. The water filter was cleaned at the time 8/11/10 of the survey finding.
- 5. Fresh chicken does not require 8 /31/10 defrosting will be utilized, until the water temperature control is resolved.
- 6. The floor drains have been placed on 8/11/10 weekly cleaning list. The drains will be checked by the weekend supervisor after cleaning.
- 7. A new can opener was purchased and 8/11/10 installed to replace the old unit on August 11, 2010.
- 8. The cooks and the utility staff were in-serviced on the dating of spices and seasonings; on the dating of new spices and seasonings as they are opened.

Continued From Page 117B

- Hairnet stations will be placed at each 10/19/10 of the door areas entering into the main kitchen.
- 10. The pot and pan rack was placed on 8/11/10 a weekly cleaning schedule.
- 11. Back-up cutting boards will be 8/11/10 maintained in the department at all times.

 The boards will be checked bi-weekly for marring and scarring and replaced immediately.
- 12. Test trays are conducted bi-weekly by the 8/11/10 Director of Food Services department, which is conducted from the time that the test tray is assembled till the time of delivery to the resident.

#3. Measures/systematic changes are as follows:

- 1. The temperature of the refrigerator will be recorded daily and the results will be reported the to the CQI committee quarterly.
- 2. The staff was in-serviced on August 16, 8/16/10 2010 about the placement of food on the shelves and a competency was given to the staff. The staff have been instructed on the requirement and reason for the requirement of appropriate storage of refrigerated food items on the correct shelf, which entailed instruction on the top shelf contains ready to eat food, second is seafood, third is whole roast, fourth is ground beef and the last shelf is raw chicken.
- 3. The staff was in-serviced on August 16,2010about the placement of food on the shelves and a competency was given to the staff.
- 4. The outer surfaces of the water filter were 8/31/10 placed on a weekly cleaning schedule.
- 5. The cooks have been in-serviced on the 10/13/10 proper thawing of foods, which included chicken.

Continued From Page 117¢

- 6. The utility aides and the cooks were 10/13/10 in-serviced to place all chemicals in the closet. The floor drains have been placed on the weekly cleaning list. The drains will be checked by the weekend supervisor after cleaning.
- 7. An alternative can opener will be 8/23/10 available in the kitchen as a spare/back-up at all times.
- 8. A monthly audit which checks to ensure 9/30/10 that all spices and seasonings will be conducted by the Food Services Director/designee. Hairnet stations will placed at each of the door areas entering into the main kitchen.
- 9. Hairnet stations will placed at each of the 10/19/10 door areas entering into the main kitchen.
- 10. A pot and pan rack was placed on a 10/19/10 weekly cleaning schedule, which will be audited on a monthly basis by the Director of Food Services/Designee utilizing the Food Sanitation tool.
- 11. Back-up cutting board will be maintained 8/11/10 in the department at all times. The cutting boards will be checked weekly for marring and scarring and replacement will be completed upon discovery.
- 12. Test tray temperatures will be monitored 8/30/10 on a biweekly basis and will be reviewed by the Director of Food Services/Designee on a monthly basis as part of the Food Safety audit. A senior dining program was introduced on September 30, 2010 on all three floors and in the main dining room to provide the residents with a quality dining experience, which entails ensuring that meals are served at the required food temperatures.

Continued From Page 117D #4. Monitoring to assure that solutions are sustained entail:

- 1. The temperature of the refrigerator will be 10/28/10 recorded daily and the results will be reported the to the CQI committee quarterly.
- 2. The food items will be monitored each 10/28/10 morning by the supervisor and the results will be reported to the CQI committee meeting quarterly.
- 3. All food items will be monitored each morning by the opening supervisor and the results reported to the CQI committee quarterly.
- 4. The sanitation of water fillers will be checked via the opening supervisor each morning and results will be reported to the CQI committee on a quarterly basis.
- 5. The temperature log will be completed for all pulled food items on a daily basis. Findings and corrective actions implemented upon discovery will be reported to the CQI committee monthly.
- 6. The daily opening and closing list will be reviewed by the utility aides and the cooks were in-serviced to place all chemicals in the closet. The Director of Food Services. District Manager will conduct monthly food sanitation audits and these audits will be reported to the CQI committee quarterly until the committee determines that this area of concern has been resolved.
- 7. An alternative can opener will be available in the kitchen as a spare/back-up at all times.
- 8. A monthly audit which checks to ensure that all spices and seasonings will be conducted by the Food Services Director/designee and reported to the CQI committee quarterly.
- 9. All food service staff will monitor all persons walking into the department to make sure hairnets are being worn and are available at each hair net station. Signs have been posted at the entrance doors to the kitchen.

Continued From Page 117E

- 10. Pot and pan rack cleaning compliance will be monitored via the opening/closing checklist. The results will be reported by the Director of Food Services/Designee to the CQI committee quarterly.
- 11. Compliance will be monitored weekly via the weekly walk through check list. It will be reported by the Director of Food Services/Designee to the CQI committee quarterly.
- 12. Test tray temperatures will be monitored on a biweekly basis and will be reviewed by the Director of Food Services/Designee on a monthly basis as part of the Food Safety audit. The results of the audit and corrections implemented is applicable will be reported to the CQI committee monthly for three months, then quarterly.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095015		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		095015	B. WIN	IG		08/11/2010	
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER				13	ET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REGULATORY	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 371	Continued From page 117 from the Salisbury steak was observed dripping onto the box of pork loin in one (1) of one (1) observation at 9:15 AM on August 2, 2010. 3. Six cartons of half and half was observed in the walk in refrigerator and was held beyond the expiration date of July 31, 2010 in six (6) of six (6) observations at 9:20 AM on August 2, 2010. 4. The outer surface of the ice machine water filter was soiled with accumulated mineral deposits in one (1) of one (1) observations at 9:25 AM on August 2, 2010. 5. Frozen chicken (legs, thighs, and breasts) was observed unthawing under submerged water in the food preparation sink at a temperature of 80 degrees F, which is above the recommended temperature of 70 degrees F in three (3) of three (3) observations at 9:30 AM on August 2, 2010. 6. Open drains under the cold food preparation and pot wash sinks were soiled with accumulated food and debris in two (2) of two (2) observations at 9:35 AM on August 2, 2010. 7. The gear and cutting surfaces of the manual can opener was soiled with rust deposits in one (1) of one (1) observation at 9:40 AM on August 2, 2010. 8. Condiment jars located in the cook 's preparation area lacked an open date in 22 of twenty-two (22) observed at 9:40 AM on August 2, 2010. 9. Administrative staff were observed in the main kitchen without a hair net while lunch meal were being prepared in two (2) of two (2) observations at 10:00 AM on August 2, 2010. 10. The shelf surfaces of the pot and pans rack was soiled with accumulated grease and water in four (4) of four (4) rack observations at 10:05 AM		F	371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY 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			00/11/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION S TAG REFERENCED TO THE APPROP		OULD BE CROSS-	(X5) COMPLETION DATE
F 371	the post and pan w deep grooves in the (2) observations at 12. During a test tr determined that col degrees F as evide vanilla pudding (66 F), and tapioca pur of six (6) observation 2010. These observations	-	F;	371			
F 386 SS=D	CARE/NOTES/ORI The physician must program of care, income treatments, at each of this section; write at each visit; and si exception of influen polysaccharide vac administered per phafter an assessment	t review the resident's total cluding medications and visit required by paragraph (c) e, sign, and date progress notes gn and date all orders with the iza and pneumococcal cines, which may be nysician-approved facility policy at for contraindications.	F	386			
	Based on record re (1) of 26 sampled re	view and staff interview for one ecords, it was determined the eview the total plan of care for					
	The findings include	> :					
	1. The physician fai	led to address Resident #3 's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095015			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING				
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	ULD BE CROSS- COMPLÉTION	
F 386	Continued From page 119 attempted elopement.		F 38		maka	40/40/40
		#3 's clinical record revealed		The physician is unable to correction at this time. All residents have the potential.		10/19/10
	A nursing note dated October 23, 2009 at 10:00 PM noted "New admission notes: Anew admissiontransferred at 8:00 PM fromvia stretcherwith diagnosis "			affected by this practice. 3. Physicians were educated director regarding the require physician documentation. A communication log has been	ements of ohysician's implemented.	10/19/10
	November 2, 2009 (num Data Set (MDS) completed coded in Section AB 1 nation: Date of entry as October		The medical director will com audits of physician documen 4. The results of the above a reported to the CQI committee	tation. udit will be	10/28/10
	noted: "Resident le advice [AMA]. Relea All personal belongi	d January 28, 2010 at 3:00 PM off facility [without medical ase form of responsibility signed. ags sent [with] resident and even (7) days sent [with] at. "		the Medical Director/designe problems identified and corre implemented will be present committee will determine the interventions and need and further audits.	ective actions ed. The CQI need for other	
	" Admission noteI fromvia ambula	arch 10, 2010 at 2:00 PM noted: Resident admitted to room nce. Resident admitted with mental status secondary to				
	noted "Resident	d July 24, 2010 at 2:50 PM elopement attempt at 2:50 PM ntervene and escort resident in				
	Resident #3 on Aug 2:00 PM. He/she sa was retired from the not anymore. I can s	view was conducted with ust 2, 2010 at approximately id "My right is being denied. I air force. I used to go out but see if I am mentally ill, I am not. I abeth for 24 years as a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095015	B. WING			08/11/2010	
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER				1380 SC	DDRESS, CITY, STATE, ZIP CODE DUTHERN AVE SE INGTON, 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 CO X (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR		OULD BE CROSS-	(X5) COMPLETION DATE
F 386	for the rest of my lifter long. If I leave a someone attempts This is like a jail A further review of revealed physician May 20 and June 3	sialist. I am not going to be here fe. I am not going to be like this again, I will not come back. If to stop me, I'll hurt the person. " the resident's clinical record notes dated March 11, April 30, 20, 2010 that lacked evidence addressed the resident's	F3	86			
	Employees #5 on a 12:45 AM. After re record he/she acking progress notes lack concerns and atter by the physician. He resident left the fact 2010 and attempted July 24, 2010. He discuss the resident in the community wemphasized to Empresident verbalized facility if he/she feed denied and that he	August 6, 2010 at approximately viewing the resident 's clinical nowledged that the physician 's ked evidence that the resident 's inpted elopement were addressed le/she acknowledged that the cility AMA sometime in January in the design of the triangle of the physician. It was ployees # 2, 5 and 8 that the the intention of leaving the els his/her rights continued to be she threatens to hurt whosoever mither. The record was reviewed					
F 387 SS=D	PHYSICIAN VISIT The resident must once every 30 day	REQUENCY & TIMELINESS OF be seen by a physician at least s for the first 90 days after east once every 60 days	F3	87			
	alorogitor.						