DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE CENTER	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 000	INITIAL COMMENTS This is a 4 story building type II (222) with a partial sprinkler system. The system is limited to the basement and hazardous areas. There are smoke detectors in the corridors. A comparative Federal Monitoring Survey was conducted on 1/16/08, in accordance with 42 Code of Federal Regulations, Part 483, Requirements for Long Term Care Facilities. Carolyn Boone Lewis was found not in substantial compliance for participation in the Medicare and Medicaid. The findings that follow demonstrate non compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**K018** **1 The rooms: 337, 341, and 207 will be repaired on 3-16-08 ensure complete closure, the closet doors for rooms 341,244, and 207 doors were replaced on 2/22/08 with doors that do not impede door closure.** **2 Facility rounds will be conducted by the maintenance staff of the residents rooms to ensure proper fire door closure as well as the changing of the closet doors and will be repaired or replaced as needed.** **3 In-service as was conducted on 3/3/08 by Director of Maintenance to the maintenance staff on the Preventative Maintenance data collection** **4 Findings of the preventative maintenance will be submitted to quarterly CQI.**	3/7/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calanthia Green	Administrator	3-7-08

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

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and an interview, it was determined that the facility failed to ensure that the doors to the corridors are capable of withstanding the passage of smoke. The findings include: It was observed on 1/16/08 that 3 out of 4 doors tested when fully closed leave a gap in excess of 1/2 inch between the doors and the top of the frames. These observations were made in rooms 337, 341 and 207. Also it was observed on 1/16/08 that 3 out of 6 doors tested can not fully closed when the closet doors to these rooms are open. These observations were made in rooms 341, 244 and 207. This has the possibility to affect 85% of the occupants. The maintenance manager concurred with the findings.	K 018	K020 1 **The door of the chute located in the corridor on the 4th story near room 330 that did not close entirely was repaired on 3/3/08 to ensure proper closure** 2 **All exits access routes has been checked and repaired as needed.** 3 **In-service was conducted on 3/3/08 by Director of maintenance to maintenance staff on monthly preventative maintenance on exits /access areas to ensure proper functioning and closure.** 4 **Findings of the preventative maintenance rounds/audits will be submitted to quarterly CQI.**	3/7/08
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and an interview, it was determined that the facility failed to ensure that vertical openings are properly enclosed.	K 020		

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K 020	Continued From page 2 The findings include: It was observed on 1/16/08, that the door to the chute which is located in the corridor on the 4 th. story, near room 330, can not close entirely and is in need of repair. This has the possibility to affect 25% of the occupants. The maintenance manager concurred with the findings.	K 020		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and an interview, it was determined that the facility is using an exit enclosure for a purposed that may interfere with its use as an exit, NFPA 101, section 7.1.3.2.3. The findings include: It was observed on 1/16/08 that there were bottles of water and shelves stored at the bottom of the exit stairway off the main dining area on the basement level. This has the possibility to affect 10% of the occupants. The maintenance manager concurred with the findings.	K 038	**K038** **1 The bottled water and the shelves cited during the survey period was removed the day of the survey.** **2 All other stairwells have been checked to ensure areas are not used for storage and rounds will be conducted monthly by maintenance staff to ensure compliance.** **3 In-service was conducted on 3/3/08 by Director of maintenance with maintenance staff to ensure that staff are knowledgeable of the importance of keeping exits/access clutter free and not used as storage areas.** **4 Findings will be reported in quarterly CQI.**	3/7/08
K 053 SS=F	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement	K 053		

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K 053	Continued From page 3 program to ensure proper operation. 42 CFR 483.70(a)(7) This STANDARD is not met as evidenced by: Based on observation and an interview, it was determined that the facility failed to ensure that the resident sleeping rooms and public areas are equipped with smoke detectors. The findings include: It was observed on 1/16/08 that 8 out of 30 bedrooms were not equipped with smoke detectors. It was also observed that the activity areas on the 4 th. and 2 nd. stories were not equipped with detectors. This has the possibility to affect 90% of the occupants. The maintenance manager concurred with the findings.	K 053	**K053** **1 The eight (8) rooms that were cited during the survey as not have smoke detectors and the activity area on the 4th and 2nd stories had smoke detectors placed in those areas on 2/27/08.** **2 All other resident rooms and activity areas were inspected and smoke smoke detectors will be placed in those areas as needed.** **3 The maintenance was in-serviced on 3/8/08 by Director of Maintenance on monitoring of smoke detectors.** **4 Findings will be reported in quarterly CQI.**	
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and an interview, it was determined that the facility failed to ensure that required smoke detectors are maintained in accordance with NFPA 101 section 9.6.1.3 which requires that detectors be tested for sensitivity at least once every 4 years. The findings include: Review of maintenance records revealed that between the years 2003 and 2008 there were no	K 054		3/7/08

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K 054	Continued From page 4 sensitivity tests conducted for the smoke detectors in the facility. This has the possibility to affect all the occupants of the facility. The maintenance manager concurred with the findings.	K 054	**K054** **1 Maintenance has established and will maintain log for the monitoring of the function of the smoke detectors** **2 Smoke detectors in the facility have been checked for proper function** **3 Preventative maintenance will be conducted and documented in the log on a monthly basis** **4 Findings from the preventative maintenance rounds will be submitted to the quarterly CQI.**	3/7/08