

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

PRINTED: 10/07/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/02/2011
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A Quality Indicator Survey (QIS) was conducted on August 29 through September 2, 2011. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 38 residents.	F 000	Carolyn Boone Lewis Health Care Center, "CBL" is filing this Plan of Correction in accordance with the compliance requirements for federal and state regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However submission of this Plan of Correction does not constitute admission of facts or conclusions cited.		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for two (2) of 38 sampled residents, it was determined that facility staff failed to ensure that a prompt effort was made to resolve grievances for Residents #57 and #69.  The findings include:  1. Facility failed to resolve Resident #57's grievance concerning a missing necklace.  A progress note dated Feburary 14, 2011 revealed that the resident's [responsible party] reported to the charge nurse that [Resident #57's] necklace, in the shape of a heart, had been removed from his/her neck by a nurse who was about to give him/her a bath and it was never returned.  The "Concerns and Comments" form dated and	F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  F166 #1 1. Resident #57's grievance concern of a missing necklace was resolved satisfactorily. Reimbursement based on the verbal value provided by the resident's son for the missing necklace has been processed.  2. A review of complaints and grievances has been completed to identify outstanding unresolved	10/21/11	10/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Denise Chadwick Wright*

*NMA*

*10/21/11*

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.

Continued From page 1

complaints and grievances.  
Corrective actions were  
implemented as required.

3. The grievance and complaint policy 10/21/11  
has been reviewed with the CBL  
Administrative and Nursing  
Leadership team members to ensure  
that they are knowledgeable of and  
adhering to this regulation in an effort  
to ensure that supportive  
documentation of resolutions,  
including an unresolved status) has  
been identified and documented.
4. An audit of the grievance and complaint 10/21/11  
log will be completed by the administrator  
monthly for 3 months; then quarterly  
thereafter. A report will be provided to  
the QI committee of the problems identified  
and corrective actions implemented upon  
completion. The QI committee will  
determine the need for further actions.

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F 166	<p>Continued From page 1</p> <p>signed by the facility on Feburary 14, 2011 revealed, "came to visit my [Resident #57] today and he/she told me that a nurse took off his/her necklace giving him/her a bath and didn't put it back on him/her. Also reported to security."</p> <p>There was no evidence that facility staff ensured that a prompt effort was made to resolve the grievance for Resident #57 for seven (7) months.</p> <p>A face-to-face interview was conducted with Employee #4 on the last day of the survey at approximately 11:00 AM and he/she revealed that an incident report addressing the missing necklace could not be located and acknowledged that there has been no follow up to reslove the grievance.</p> <p>2. Facility failed to resolve Resident #69's grievance concerning a missing Radio-Am/Fm with cassette.</p> <p>The " Concerns and Comments " form, signed by facility staff on June 29, 2011 and initiated on June 10, 2011 by the facility staff on behalf of Resident #69 revealed: " What is your concern or comment? Radio-Am/Fm with cassette was missing (3 weeks ago). During time at dialysis (Tues or Thurs) radio was noticed removed from night stand. "</p> <p>The " Write your suggestion Recommendations Below ... and Facility Response " sections of the form were not addressed by the facility until September 2, 2011.</p> <p>There was no evidence that facility staff ensured that a prompt effort was made to resolve the</p>	F 166	<p>Continued From page 1a</p> <ol style="list-style-type: none"> <li>1. Resident #69 was satisfied with the resolution to his/her grievance concern of a missing Radio-AM/FM. The facility resolved this concern by purchasing a new Radio -AM/FM.</li> <li>2. A review of 2011 complaints and grievances has been completed to identify outstanding unresolved complaints and grievances. Corrective actions were implemented as needed.</li> <li>3. The grievance and complaint Policy has been reviewed with the CBL Administrative and Nursing Leadership team members to ensure that they are knowledgeable of and adhering to this regulation in an effort to ensure that supportive documentation of resolutions, including an unresolved (status) has been identified and documented.</li> <li>4. An audit of the grievance and complaint log will be completed by the administrator monthly for 3 months; then quarterly thereafter.</li> </ol>	09/02/11	10/21/11
				10/21/11	





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F 176	Continued From page 4 time Employee #5 was present and acknowledged that the medication was on the over-the-bed table and in the attached drawer. Employee #5 stated, "[He/she] self administers the ointment and cream to his/her throat."  An interim order dated June 12, 2011 at 4:50 PM directed, "Resident may keep treatment cream and lotion [at] the bedside."  There was no evidence that facility staff initiated a care plan reflect self-administration.  The clinical record lacked evidence that the interdisciplinary team (IDT) made a determination that it was safe for the resident to self-administer medications.  A face-to-face interview was conducted with Employee #5 on August 31, 2011 at approximately 11:15 AM who acknowledged that the medications were at the bedside and that there was no evidence that the Interdisciplinary team (IDT) had determined it was safe for Resident #149 to self administer the ointment and creams. The record was reviewed on August 31, 2011.	F 176	Continued From page 4  4. An audit will be completed by the Unit Managers quarterly of resident's that self-administer. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	10/21/11	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:	F 241			

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F 241	<p>Continued From page 5</p> <p>Based on a dinning observations and staff interview, it was determined that facility staff failed to maintain residents dignity and respect by: one (1) resident sat idle as others dined in his/her presence and facility staff stood over three (3) residents while assisting them to eat, Residents' #62, #87, #88 and #95.</p> <p>The findings include:</p> <p>1. Facility staff failed to promote dignity during dining as evidenced by the observation of Resident #62 that sat idle as others dined in his/her presence.</p> <p>The observation of the lunch meal on August 29, 2011 at 12:40 PM revealed Resident #62 shared a table with three (3) residents who began their meals at 12:40 PM. Resident #62 sat idle at the table with other residents who were served and dined in his/her presence. At 12:53 PM [13 minutes later], facility staff presented a lunch meal to Resident #62.</p> <p>Facility staff failed to promote dignity during dining for Resident #62, who sat idle while others dined at his/her table. The findings were discussed during an interview with Employee #5 on August 29, 2011.</p> <p>2. Facility staff failed to promote dignity during dining as evidenced by the facility staff standing over residents while feeding.</p> <p>On September 1, 2011 during a dinning observation for lunch in the third floor dining room Employees #21, #22, and #23 were observed standing over the Resident's #87, #88,</p>	F 241	<p>Continued From page 5</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>Ftag 241 #1</p> <p>1. The facility staff was unable to correct the unfavorable meal experience of Resident #62 observed. However for future meals of Resident #62 the dining services director/dining staff has coordinated with unit manager(s)/ nursing staff to ensure that meals are delivered and served for all residents eating in the dayroom in a timely manner.</p> <p>2. An assessment of the dining process has been conducted by the, Food Services Director and Unit Manager(s). Residents who have chosen to eat in the common dining areas will be noted to ensure that the dining services carts entail their meal trays at the same time of delivery. Other corrective actions have been implemented as needed.</p> <p>3. Staff have been re-educated on resident dignity and provided with an overview of the dining experience to be provided to the residents at the facility.</p>	<p>10/21/11</p> <p>10/21/11</p> <p>10/20/11</p>

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F 241	Continued From page 6 and #95 as they assisted them to eat.  The findings were discussed during an interview with Employee #6 on September 1, 2011 at approximately 1:30 PM.	F 241	Continued From page 6	10/21/11	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by:  Based on observations, record review and staff interview, for six (6) of 38 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches to address: chewing and denture problems for one (1) resident; one (1) resident's	F 279	4. An audit of the dining process will be completed by the Administrative staff weekly x 4 and monthly thereafter. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions		

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F 279	<p>Continued From page 7</p> <p>refusal to wear shoes; refusal of therapy services for one (1) resident; Activities of Daily Living (ADL) for one (1) resident; self administration of medication for one (1) resident and allergies, anticoagulant therapy, psychotropic medication, mouth care and the use of nine (9) or more medications for one (1) resident. Residents # 75, #111, #115, #132, #149, and #165.</p> <p>The findings include:</p> <p>1. Facility staff failed to develop a care plan with appropriate goals and approaches for chewing and denture problems for Resident #75.</p> <p>A review of the resident's care plan dated January 5, 2011 identified a problem of "Alteration in Nutrition (less than body requirements) related to chewing problem, does not wear dentures," however the care plan lacked evidence of appropriate goals and approaches to address the chewing and denture problems.</p> <p>A review of the medical record revealed a "Dental" exam was conducted on June 10, 2011. The consult indicated that the resident had poor "Periodontal Health", previous "Periodontal Health" unknown, "General Condition" (edentulous), esthetics (poor).</p> <p>A face-to-face interview was conducted on September 1, 2011 at approximately 10:30 AM with the Employee #5. He/she acknowledged that the care plan lacked evidence of goals and approaches for the chewing and dental problem.</p>	F 279	<p>Continued From page 7</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>Ftag 279 #1</p> <p>1. Resident #75 was seen by dentist. The care plan for resident #75 has been updated to reflect approaches and goals for the resident's chewing and dental problems due to the resident's wish to await to the receipt of dentistry services until he/she returns to home. Her appointment was made for 11/14/11.</p> <p>2. The unit managers have reviewed care plans for residents that have the potential to be affected by this practice and corrective actions have been implemented as needed.</p> <p>3. Staff education has been completed by the educators on the care plan development.</p> <p>4. A review of care plans will be completed by the ADON monthly x3 and quarterly thereafter. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions</p>	9/01/11 10/03/11    10/21/11  10/21/11

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F 279	<p>Continued From page 8</p> <p>A face-to-face interview was conducted with Resident #75 on September 1, 2011 at 3:20 PM, he/she indicated that he/she will see his/her own dentist and will get dentures from him/her when he/she leaves the facility and that he/she has chewing problems because his/her teeth are out. The resident also indicated that he/she did not want dentures from the facility.</p> <p>Facility staff failed to develop a care plan with appropriate goals and approaches for Resident #75 with chewing and denture problems. The record was reviewed on September 1, 2011.</p> <p>2. Facility staff failed to develop a care plan with goals and approaches to address Resident # 111's refusal to wear shoes.</p> <p>According to the podiatry visit conducted on July 11, 2011 the resident had a diagnosis of Hallux Valgus [A bunion] to both feet.</p> <p>On August 29 and 30, 2011 and on September 1, 2011 (at various times) Resident #111 was observed wearing non-skid socks while continuously ambulating (without assistant) on the 3rd floor nursing unit.</p> <p>An observation on the resident 's room was conducted on September 1, 2011 at approximately 4:15 PM in the presence of Employee # 6. It was observed that Resident #111 had seven (7) pairs of shoes in the closet.</p> <p>A face-to-face interview was conducted with Employee # 6 on September 1, 2011 at 4:30 PM. He/she stated, we put the non-skid socks on because of his/her bunions and he/she doesn ' t</p>	F 279	<p>Continued From page 8</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>Ftag 279 #2</p> <p>1. The care plan for resident # 111 has been updated to reflect approaches and goals for the resident's refusal to wear shoes.</p> <p>2. The unit managers have reviewed care plans for residents that have the potential to be affected by this practice and corrective actions implemented needed.</p> <p>3. Staff education has been completed by the educators on the care plan development.</p> <p>4. A review of care plans will be completed by the ADON monthly x3 and quarterly thereafter. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions</p>	<p>9/16/11</p> <p>10/21/11</p> <p>10/21/11</p> <p>10/21/11</p>	

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F 279	Continued From page 9 keep his/her shoes on long.  A review of the residents clinical record lacked evidence of a care plan to address the resident ' s refusal to wear shoes on his/her feet.  A face-to-face interview was conducted with Employee # 6 on September 1, 2011 at 4:30 PM. He/she acknowledged that there was no care plan initiated to address Resident #111 ' s refusal to wear shoes. The record was review on September 1, 2011.  3. Facility staff failed to develop a comprehensive care plan with measurable goals and objectives to address Resident #132' s Activities of Daily Living (ADL).  On August 30, 2011 at approximately 10:00 AM Resident #132 ' s oral cavity was observed to be malodorous with white creamy substance around the teeth and gums. A face-to-face interview was conducted with the resident at approximately 3:00PM on September 1, 2011. He/she stated, " They don ' t really help me to brush my teeth. I usually do it myself and when my son/daughter comes he/she helps me. About once a week one (1) of the nurses will help me to brush my teeth. " Review of the Minimum Data Set with a completion date of May 21, 2011 revealed that the resident was classified under Section G (Activities of Daily Living Assistance) as being totally dependent on staff for toileting and personal hygiene needs. Review of the comprehensive care plans which	F 279	Continued From page 9     Ftag 279 #3  1. The care plan for resident # 132 has been updated to reflect approaches and goals to assist resident #132 with activities for daily living.  2. The unit managers have reviewed care plans for residents that have the potential to be affected by this practice.  3. Staff education has been completed by the educators on the care plan development.  4. A review of care plans will be completed by the ADON monthly x3 and quarterly thereafter. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions and corrective actions implemented as needed.	9/02/11     10/21/11  10/12/11  10/21/11	

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F 279	Continued From page 10 were last updated on June 2, 2011 failed to reveal a care plan to address the resident 's total dependence on staff for all toileting and personal care needs. A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on September 1, 2011. He/she stated, "[Resident #132] needs gum treatments and extractions. He/she was seen by the dentist on June 1 and August 5, 2011. I think he/she is scheduled to have extractions and cleaning this month. I thought there was a care plan to address the resident 's total dependence for personal care needs on the chart. I will place one on the chart."  4. Facility staff failed to initiate a care plan with appropriate goals and approaches for self administration of medication for Resident #149.  An " Interim Order Form " dated and signed by the physician on June 12, 2011 at 4:55 PM, directed " resident may keep treatment cream and lotion [at] the bedside. "  A review of the plan of care for Resident #149 lacked problem identification, objectives and approaches for self administration of cream and lotion.  A face-to-face interview was conducted with Employee #5 on August 31, 2011 at approximately 11:30 AM. He/she acknowledged that the record lacked a care plan for self administration of cream/lotion. The record was reviewed on August 31, 2011.	F 279	Continued From page 10  F279 #4 1. The care plan for resident # 149 has been updated to reflect approaches and goals to assist resident #149 with self-administration of medication.  2. The unit managers have reviewed care plans for residents that have the potential to be affected by this practice and corrective actions implemented as needed.  3. Staff education has been completed by the educators on the care plan development.  4. A review of care plans will be completed by the ADON monthly x3 and quarterly thereafter. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions	9/02/11  10/21/11  10/21/11  10/21/11	

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F 279	Continued From page 11 5. Facility staff failed to develop a care plan for potential drug interactions secondary to the use of nine (9) or more medications for Resident #165. Additionally, there was no care plan to address the resident's allergy history, anticoagulant therapy, psychotropic medication and mouth care.  A review of the clinical record for Resident #165 revealed physician 's orders dated and signed August 5, 2011 included the following medications: Tylenol 325 mg 2 tablets 30 minutes prior to wound care sacral area, Aspirin chewable 81 mg 1 tablet every day for blood thinner, Colace 100 mg 1 capsule twice daily, Pepcid 20 mg 1 tablet every day, Hydralazine 25 mg 1 tablet 3 times a day, Metoprolol 25 mg 1 tablet every 12 hours, Multivitamins with Iron 1 tablet every day, Seroquel 25 mg 1 tablet at bedtime for agitated behavior, and Zocor 40 mg 1 tablet at bedtime.  The physician's order sheet and plan of care dated June 10, 2011 indicated the resident was allergic to " Lisinporil causes Angiodema. " The history and physical dated June 19, 2011 indicated the resident was allergic to Lisinopril.  A review of care plans last updated on June 23, 2011 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications, anticoagulant therapy, allergies, psychotropic medication or mouth care.	F 279	Continued From page 11 F279 #5 1. The care plans for resident #165 has been updated to reflect goals and approached to manage the resident's allergies, anticoagulant therapy, the potential for interaction of nine or more medication, mouth care and the use of and the use of psychotropic medications.  2. The unit managers have reviewed care plans for residents that have the potential to be affected by this practice and corrective actions implemented as needed.  3. Staff education has been completed by the educators on the care plan development.  4. A review of care plans will be completed by the ADON monthly x3 and quarterly thereafter. A report will be provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	9/02/11  10/10/11  10/21/11  10/21/11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/02/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLYN BOONE LEWIS HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1380 SOUTHERN AVE SE WASHINGTON, DC 20032</b>	
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F 279	Continued From page 12 A face-to-face interview was conducted with Employee #5 on August 31, 2011 at approximately 3:00 PM. He/she acknowledged that the record lacked care plans for the potential adverse drug interaction for the use of nine (9) or more medication, allergies, anticoagulant and psychotropic drug. The record was reviewed on August 31, 2011.	F 279	Continued From page 12	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for six (6) of 38 sampled residents, it was determined that facility staff failed to review	F 280		