

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 280	Continued From page 13 and/or revise the resident's plan of care for: two (2) residents with multiple falls; one (1) resident for nutrition, Diabetes Mellitus, and falls; one (1) resident for psychotropic medication; one (1) resident for discharge planning and one (1) resident for skin integrity. Residents #13, #14, #24, #149, #167 and #170. The findings include: 1. Facility staff failed to update the falls care plan with approaches/interventions after the Resident #13 had multiple falls with and without injury. A review of the Nursing Progress notes revealed the following: June 30, 2011- " resident observed on the floor in shower/bath area, md [medical doctor] and family notified, neurochecks [neurological checks] initiated " [observed-no injury] July 2, 2011-resident observed on the floor in the bathroom-no injury was sustained...md and family notified August 21, 2011-observed floor at this time in upright position-abrasion rp [responsible party] and np [nurse practitioner]. [fall with injury] August 27, 2011 -notified res [resident] observed sitting on floor in shower room-no injury A face-to-face interview was conducted with Employee #5 at 3:08 PM on August 30, 2011. He/she stated, " I did not update the care plans after the falls but on June 30, 2011 we monitored	F 280	Continued From page 13 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Ftag 280 F280#1 1. A review of resident #13's care plan has been completed by the ADON. The care plan has been updated to reflect goals, interventions, and changes that were implemented post each fall. 2. A review of care plans for residents with falls has been completed by the unit managers. Corrections have been made as indicated. 3. Staff education has been completed by the educators on care plan development and the process for review and update post incidents. 4. A review of care plans post falls will be completed by the supervisors. A report will be provided monthly to the QI committee by the ADON 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

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 280	<p>Continued From page 14</p> <p>[him/her] frequently and we don't allow him/her to go to his/her room without assistance. We make sure he/she is toilet with assistance; it [the intervention after the fall] is in my personal notes. After the fall on July 2, 2011 I told the CNA about the fall that the resident had early in the morning. Then we got a referral for psych. The psychiatrist recommended a patch [nicotine patch] and to continue to monitor him/her closely. " " I did not document in the chart the interventions, I documented in my notes and I reported in the meeting."</p> <p>The unit manager the reviewed the Fall care plan and discovered that the June 30, 2011 fall incident was embedded with care plan approaches from December 12, 2010.</p> <p>There was no evidence that facility staff updated the Fall care plan to address the residents falls after incidents on June 30, July 2, August 21 and August 27, 2011; and in one instance the fall incident was not recorded in sequence with resident ' s incidents. The record was reviewed on August 30, 2011.</p> <p>2. Facility staff failed to review and/or revise Resident #14 ' s fall care plan after resident was observed on the floor. A review of nursing documentation in the progress notes revealed the following note dated August 18, 2011 at 3:00PM, " Observed sitting on the floor by the bedside. Resident assess. No apparent injury noted. " A review of the resident ' s fall care plan revealed that it was initiated on February 25, 2011. The goal at that time was listed as " No</p>	F 280	<p>Continued From page 14</p> <p>F280 #2</p> <p>1. A review of resident #14's care plan has been completed by the unit manager. The care plan has been updated to reflect goals, approaches, interventions, and changes that have been implemented post fall. 9/06/11</p> <p>2. A review of care plans for residents with falls has been completed by the unit managers. Corrections have been made as indicated. 9/09/11</p> <p>3. Staff education has been completed by the educators on care plan development and the process for review and update post incidents. 10/21/11</p> <p>4. A review of care plans post falls will be completed by the supervisors. A report will be provided monthly to the QI committee by the ADON of problems identified and corrective actions implemented. The QI committee will determine the need for further actions. 10/21/11</p>		

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 280	Continued From page 15 injury " and the Goal Time was documented as " Two weeks. " The care plan lacked documentation to indicate that it was reviewed and/or updated with new goals and/or approaches after the resident sustained a fall on August 18, 2011. A face-to-face injury was conducted with Employee #4 at approximately 4:45 PM on September 1, 2011. He/she had no response for why the care plan was not updated. The record was reviewed on September 1, 2011. 3. Facility staff failed to review and revise care plan for nutrition, Diabetes Mellitus and falls for Resident #24. Review of Resident #24's care plan revealed that the interdisciplinary team (IDT) identified Potential for decreased nutritional intake, falls and Diabetes Mellitus as problems on February 2, 2011. A review of the updated care plan dated June 9, 2011 lacked evidence that the IDT identified a goal time and evaluation for these problems. A face-to-face interview was conducted on September 2, 2011 with Employee #5 at approximately 11:30 AM. After review of the care plans he/she acknowledged the findings and indicated that he/she updated the notes, but had not placed the entries in the computer. The observation was made on September 1, 2011. 4. Facility staff failed to revise the care plan for psychotropic medication for Resident #149. A review of the clinical record for Resident #149	F 280	Continued From page 15 F280 #3 1. A review of resident #24's care plan has been completed by the IDT. The care plan has been updated to reflect goal times and evaluation for diabetes, potential for decreased nutritional intake, and falls. 2. A review of care plans has been completed by the IDT to assure goal times and evaluation periods are identified. Corrections have been made as indicated. 3. Staff education has been completed by the educators on the care planning process. 4. A random audit of care plans will be completed by the ADON monthly. A report will be provided to the QI committee quarterly by the ADON of problems identified and corrective actions implemented. The QI committee will determine the need for further actions. F280 #4 1. A review of resident #149 care plan has been completed by the unit manager and revised to reflect the use of the psychotropic medication. 2. A review of care plans for resident receiving psychotropic medications has been completed by the unit managers. Corrections have been made as indicated. 3. Staff education has been completed by the educators on the care planning process.	10/10/11 10/21/11 9/02/11 9/19/11 10/21/11	

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 280	Continued From page 16 revealed facility staff developed a care plan for psychoactive drug use. Last updated November 10, 2010. The problem statement identified was " Resident is at risk for side effects related to psychoactive drugs ordered for antipsychotics. Approaches/interventions: Review for possible reduction or elimination of medication and behavioral interventions ...Administer medication as ordered ... " According to physician ' s orders dated August 5, 2011, directed " Haldol Inj [Injectable] 5mg/ml...Inject 0.4 ml (2mg) intramuscularly every 12 hours as needed for psychosis (If delusional behavior interferes with daily activities). " According to a psychiatric consult note dated June 27, 2011 revealed, " Psychiatric Diagnosis: Psychosis. Psychotropic Medication: Haldol for psychosis. Recommendations/Plan: No changes in treatment, Follow up in 1-2 months. " Facility staff failed to revise the care plan to include the psychotropic medication Haldol for the diagnosis of psychosis. A face-to-face interview was conducted with Employee #5 on August 31, 2011 at approximately 2:30 PM. He/she acknowledged the findings and proceeded to revise the care plan. The record was reviewed August 31, 2011. 5. Facility staff failed to review and revise plan of care for Discharge planning for Resident #167. A review of the " Social Worker Progress Note "	F 280	Continued From page 16 4. An audit of the care plans for resident's receiving psychotropic medication will be completed by the unit managers monthly. A report will be provided to QI Committee quarterly by the DON of problems identified and corrective actions implemented. The QI committee will determine the need for further actions. F280 #5 1. A review and revision of the discharge care plan for resident #167 has been completed by the social worker. 2. A review of care plans for residents with discharge plans has been completed by the social workers and correction made as needed. 3. Staff education has been completed by the educators on the care planning process 4. An audit of care plans for residents with discharge plans will be completed by the Social Service Director monthly x3 then quarterly thereafter. A report will be provided to QI Committee monthly x3 then quarterly by the Social Service Director of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	10/21/11	

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 280	<p>Continued From page 17</p> <p>dated April 18, 2011 revealed a note that read " Follow up needed to determine/ resolved issues presented in social work assessment for MDS. (Minimum Data Set) Housing application (District of Columbia Housing Authority) to be given "</p> <p>A review of the " Social Discharge Plan Form " dated April 18, 2011 revealed a checked mark in the box next to " working toward discharged " and a note in the comment section that read, " Resident will need to establish housing at discharge " .</p> <p>A review of care plan initiated May 6, 2011, under problem " Strength: need to evaluate resident ' s potential to be discharged to less restrictive environment " with a scheduled goal time July 6, 2011. The section under "evaluation" was left blank.</p> <p>There was no evidence that the care plan for " Discharge Planning " was revised or updated to include interventions that had occurred subsequent to its initiation.</p> <p>A face-to-face interview was conducted on September 2, 2011 approximately 12:00 PM with Employees #6. After review of the clinical record he/she acknowledged the record. The record was reviewed on September 2, 2011.</p> <p>6. Facility staff failed to revise the skin integrity plan of care for Resident #170.</p> <p>On June 15, 2011 Impairment of skin integrity related to urine and or bowel incontinence, immobility and diabetes was initiated as a</p>	F 280	<p>Continued From page 17</p> <p>Ftag 280 #6</p> <ol style="list-style-type: none"> 1. Resident #170 pressure ulcer was restaged. The skin integrity plan of care was revised to include weekly skin assessments. 2. A review of all skin sheets has been completed and corrections made. 3. Staff education was conducted on wound documentation by the educators. 	9/02/11	9/30/11	10/21/11

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 280	Continued From page 18 problem for Resident #170. A review of the clinical record revealed a healing stage II pressure sore on the sacrum that was identified and treated on June 15, 2011. A review of the clinical record revealed a nurses admission note dated August 29, 2011at 7:30PM that reads, " Head to toe assessment done with nurse and supervisor [revealed a] stage II wound on the left outer gluteal A review of Physician order sheet and plan of care dated August 29, 2011 revealed a treatment that directs, " Calmoseptine ointment every shift and as needed on sacral area and left outer gluteal stage 2 wound " . The plan of care for " Impairment of skin integrity ", most recently reviewed September 2, 2011 lacked evidence of revisions to update sacral stage II pressure ulcer and to include left outer gluteal stage II pressure sore identified on August 29, 2011. A face-to-face interview was conducted on September 2, 2011 approximately 12:00 PM with Employees #5. After review of the clinical record he/she acknowledged the record. The record was reviewed on September 2, 2011.	F 280	Continued From page 18 4. An audit will be completed by wound nurse monthly x3. A report will be provided to QI Committee quarterly by the DON of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	10/21/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST	

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 309	Continued From page 19 and plan of care. 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 address one (1) resident's fluid volume needs and for one (1) resident, staff failed to follow physician 's orders for calorie count weight assessment. Residents #69 and #165. The findings include: 1. Facility staff failed to address Resident #69's fluid volume needs. A review of Resident #69's record revealed that he/she had diagnoses which included, Chronic Renal Failure, Stage IV Chronic Renal Disease [defined as a Glomerular filtration rate [GFR] of 15 to 29 milliliters per minute. A normal GFR is 90 to 120 milliliters per minute. When the GFR falls below 15 milliliters per minute, kidney replacement therapy (dialysis) or transplantation becomes necessary] and Hemodialysis. The " Nutrition Progress Assessment " completed August 26, 2011 revealed, " Fluid: Per MD orders " A face-to-face interview was conducted with the Dietitian on September 2, 2011 at approximately 4:00 PM. He/she stated, " I don ' t calculate the fluid needs for dialysis patients. I go by the	F 309	Continued From page 19 Ftag 309 #1 1. The fluid volume needs for resident #69 have been addressed by the dietician and the plan of care has been revised an updated. 2. A review of fluid volume needs for dialysis residents has been complete by the dieticians and the plans of care have been updated and revised as needed. 3. Staff education has been completed by the educators on the care planning process. 4. An audit of the plans of care for dialysis residents will be completed by the dietary manager quarterly. A report will be provided to QI Committee quarterly by the dietary manager of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	9/02/11 10/01/11 10/21/11 10/21/11	

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 309	<p>Continued From page 20 physician ' s order. "</p> <p>The August 2011 physician's orders signed and dated August 3, 2011 directed, " Diet: Renal ...snacks 2 times a day for additional kcalories [kilocalories]" . " Treatments: Dialysis on Tues, Thurs and Sat; Check graft site every shift; Check pre/post weight on dialysis days; Check every shift for emergency dialysis kit at head of bed. "</p> <p>The physician ' s orders lacked evidence of an order to direct the amount of fluid Resident # 69 is to have within 24 hours.</p> <p>A review of the " Renal Disease " care plan initiated and last updated on June 9, 2011 included the following approaches: 3. Monitor resident ' s fluid balance10. Maintain fluid restriction as ordered ___cc per 24 hours: shifts- nursing total___, nursing per hour___ and dietary total___ to be recorded on 7am -3pm, 3 pm - 11 pm and 11 pm - 7 am shifts. The care plan was left blank for the fluid restriction, total nursing and dietary and the nursing [amount to be given] per hour.</p> <p>A face-to-face interview was conducted on September 2, 2011 at approximately 4:45 PM with the Dietitian. He/she acknowledged that Resident #69 ' s fluid volume needs was not addressed in his/her plan of care.</p> <p>There was no evidence that facility staff addressed the fluid volume needs for Resident #69. The record was reviewed on September 2,</p>	F 309	Continued From page 20		

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 309	Continued From page 21 2011. 2 (a). Facility staff failed to follow physician's orders to obtain a weight 72 hours after admission for Resident #165. According to the admission MDS [Minimum Data Set] completed on June 23, 2011, Resident #165 was admitted on June 10, 2011 from an acute hospital. Physician's orders signed June 10, 2011 directed, "Weight on admission then (in) 72 hours" According to an initial "nutrition assessment" dated June 16, 2011, "Resident admitted [history of] dehydration, altered mental status , hypoglycemia at [hospital]...Appears to have weight loss in the past. Resident cachectic, inconsistent eater." A review of the " Weekly Weight Documentation Log " and " Medication Administration Record " revealed the following weights. June 10, 2011 (Admission) - 115.2 lbs June 12, 2011 - 115 lbs June 13, 2011 - No weight documented June 20, 2011 - 92 lbs. (" weight scale error?) (no re-weigh) June 27, 2011 - 105 lbs The weight log lacked evidence that facility staff acted on the physician's order to obtain the resident's weight 72 hours after admission [due on or around June 13, 2011].	F 309	Continued From page 21 F309 #2(a) 1. Resident #165 was weighed and results placed in clinical record. 2. A review of weights post admission for new admissions has been completed by the unit managers. Corrective actions have been implemented as indicated. 3. Staff education and review of the facility weight policy has been completed by the educators. 4. An audit of new admission and re-admission weights will be completed by the dieticians monthly. A report will be provided to QI Committee monthly by the dietary manager of problems identified and corrective actions implemented. The QI committed will determine the need for further actions.	9/02/11 10/21/11 10/21/11 10/21/11

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 309	Continued From page 22 A face-to-face interview was conducted with Employees #2 and #5 on August 30, 2011 at approximately 1:30 PM. Both acknowledged that the weight due 72 hours after admission was not performed in accordance with the physician 's orders. The clinical record was reviewed on August 30, 2011. 2(b). Facility staff failed to follow physician 's orders to obtain a prescribed calorie count for for Resident #165. Physician's orders dated and signed July 14, 2011 at 4:45 PM directed, " Initiate [calorie count times] 3 days. Start July 15, 2011-July 17, 2011. A review of " Weekly Nutrition Minutes " dated July 14, 2011 revealed, " Oral intake is 75-100%, takes most of all supplements per nursing today. Sleeping mode issue causes resident to eat poorly (family aware). Plan: Calorie Count times 3. " A review of the resident's meal consumption as documented on the facility's "Resident Intake Record" revealed that there was no intake data recorded [record was blank] for breakfast and lunch intake on July 14, 15 and 16, 2011. Additionally, there was no intake data recorded on July 15, 2011 for the AM, PM and bedtime [HS] snacks. A face-to-face interview was conducted with	F 309	F309 #2(b) 1. The calorie count for Resident #165 can not be completed at this time. 2.. A review of orders for residents with calorie counts will be completed by the dietician and unit managers. Corrections will be implemented as needed. 3. A review of the facility policy on obtaining calorie counts will be completed by the Staff educators with nursing staff. 4. A random of audit of residents with orders for calorie counts will be completed by the Dietary Manager monthly x3 and quarterly thereafter. A report will be provided to QI Committee quarterly by the dietary manager of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	9/02/11 9/02/11 10/21/11 10/21/11

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 309	Continued From page 23 Employees #5 and #14 on August 30, 2011 at approximately 2:00 PM. They agreed that the resident's meal consumption record was required to perform a calorie count. Both acknowledged that the calorie count for 3 days was not performed in accordance to physician 's orders. The chart was reviewed August 30, 2011.	F 309	Continued From page 23		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on an observation for one (1) of 38 sampled residents, it was determined that facility staff failed to provide the necessary services to maintain good oral hygiene for Resident #132. The findings include: During an observation on August 30, 2011 at approximately 10:00 AM Resident #132 's oral cavity was noted to be malodorous with white creamy substance around the teeth and gums. When the resident was queried about his/her oral care, 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. " A review of the Minimum Data Set with an	F 312	Ftag 312 1. Mouth Care for resident #132 was provided at the time of survey. 2. A review of residents requiring assistance with ADL'S and mouth care has been completed by the unit managers and corrections made to the CNA Plan of Care as needed. 3. Review of CNAs plans of care for resident's requiring assistance with ADL's and mouth care has been completed by the unit managers with the CNAs. 4. A random audit of ADL care will be completed daily by the charge nurses, unit managers and supervisors during rounds and corrective actions implemented as needed.	9/02/11 10/21/11 10/21/11 10/21/11	

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 312	Continued From page 24 Assessment Reference Date (ARD) 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. A face-to-face interview was conducted with Employee #5 at approximately 4:00 PM on September 1, 2011. He/she acknowledged the findings and 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 have spoken to the staff and the resident is now receiving oral care three times each day."	F 312	Continued From page 24	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that the resident environment remained free of accident hazards as evidenced by: three (3) of three (3) oxygen tanks that were improperly stored; ashes and remnants of smoked cigarettes observed in one (1) resident room and the key to a biohazard room was left engaged in the lock,	F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Ftag 323 #1 1. Oxygen tanks were secured at the time of survey. 2. An audit of resident rooms and other facility areas has been completed by the facility safety officer for safety hazards in the resident's environment. Corrections have been made as indicated. 3. The safety officer will provide staff training on securing oxygen tanks and other safety hazards in the resident environment. 4. A random audit of oxygen tanks and safety hazards in the resident environment will be completed monthly x3 and quarterly there after by the facility safety officer.	9/02/11 9/30/11 9/16/11 10/21/11

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 323	Continued From page 25 unattended. The findings include: 1. Three (3) of three (3) oxygen tanks were stored upright, directly on the floor and unsecured in room #347 on the third floor. 2. Ashes were visible on the meal tray atop the bedside table and remnants of smoked cigarettes (butts) were observed in a cup on the meal tray in resident room #322. 3. The key to the biohazard room on the second floor was observed engaged in the lock and unattended. These observations were made in the presence of employee # 6 on who was present at the time.	F 323	Continued From page 25 A report will be provided to QI Committee monthly x3 and quarterly thereafter by the safety officer of problems identified and corrective actions implemented. The QI committee will determine the need for further actions. F323 #2 1. The Resident in room 322 was educated regarding safe smoking and the storage of smoking paraphernalia at the time of survey. 2. An audit of other residents that have the potential to be affected by this practice was completed and corrections implemented as indicated. 3. The safety officer will provide staff training on safety hazards in the resident environment. 4. A random audit of resident rooms for smoking paraphernalia will be completed by the charge nurses, unit managers and supervisors daily during rounds and corrective actions implemented as needed.	9/02/11 10/21/11 10/21/11 10/21/11	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	smoking paraphernalia will be completed by the charge nurses, unit managers and supervisors daily during rounds and corrective actions implemented as needed. F323 #3 1. The key was removed and secured at the time of survey. 2. Secured areas in the resident's environment have been audited for safety concerns and corrective action implemented as indicated.	10/21/11 9/02/11 10/21/11	

