

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

FEB 16 2007

PRINTED: 02/09/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095015	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED  R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 SOUTHERN AVE SE WASHINGTON, DC 20032
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(K4) 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)	(K5) COMPLETION DATE
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(F 000)	INITIAL COMMENTS	(F 000)		
(F 253) SS-E	<p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled wheelchairs, HVAC (Heating Ventilation and Air Conditioning) panels, ceiling lights and exhaust vents. These findings were observed in the presence of maintenance, housekeeping and nursing staff. All observations were made on February 6, 2007.</p> <p>The findings include:</p> <p>1 Wheelchairs were soiled with dust on the spoke and frame surfaces.</p> <p>1st floor day room in two (2) of three (3) wheelchairs observed at 10:10 AM.</p> <p>2nd floor day room in four (4) of six (6)</p>	(F 253)	<p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <ol style="list-style-type: none"> <li>Wheelchairs that were soiled with dust on the spoke and frame surfaces in the 1<sup>st</sup> floor day room and 2<sup>nd</sup> floor day room were cleaned immediately by housekeeping during the survey period. The top panels under HVAC louvers soiled with dust and debris in rooms 119, 122, 126, 139, 142, 143, 207, 218, 234, 244, 310, 311, 341 and 345 were cleaned on 2/16/07. Ceiling lamps in bathrooms, hallways and resident rooms found soiled with dust and dead insects in rooms 139, hallway lamp near rooms 128 and 126 and dayroom, room 226 and room 335 were cleaned on February 7, 2007. Interior surface of exhaust vents in residents' Bathrooms soiled with accumulated dust and debris in rooms 142, 212, 218, 244, 310 and 325 were cleaned on 2/8/07.</li> <li>All wheelchairs were cleaned as needed. Top panels under HVAC louvers were inspected by maintenance staff throughout the facility and cleaned as needed. Rounds have been conducted by housekeeping staff and ceiling lamps have been cleaned of dust and dead bugs and exhaust vents have been cleaned in all residents' bathrooms that was found with accumulated dirt and debris.</li> <li>The Director of Environmental Services in-serviced staff on 2/15/07 on cleaning of lamps and cleaning of wheelchairs. Director of Environmental Services or designee will conduct bi-weekly inspections to monitor the effectiveness of cleaning and make necessary corrections as needed.</li> <li>Monitoring of corrective actions will be done in quarterly CQI.</li> </ol>	2/19/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Calanthia Green</i>	TITLE <i>Administrator</i>	(K6) DATE <i>2-16-07</i>
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  090015	(X2) MAIL TITLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/08/2007
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 SOUTHERN AVE NE WASHINGTON, DC 20032	
OSD IDENTIFICATION TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID NUMBER TAG	PROVIDER'S PLAN OF CORRECTION (WHEN CORRECTIVE ACTION SHOULD BE TAKEN, REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETION DATE
(F 253)	Continued From page 1 wheelchairs observed at 12:05 PM  2. The top panels under HVAC covers were soiled with dust and debris  1st floor rooms 118, 122, 126, 130, 142 and 143 in six (6) of 11 panels observed between 10:20 AM and 10:30 AM  2nd floor rooms 207, 218, 234 and 244 in four (4) of seven (7) panels observed between 10:30 AM and 11:05 AM  3rd floor rooms 310, 311, 341 and 345 in four (4) of eight (8) panels observed between 11:35 AM and 12:20 PM  3. Ceiling lamps in bathrooms, hallways and residents' rooms were soiled on the inside with dust and dead insects.  1st floor room 129, hallway lamp near rooms 128 and 129, and dayroom in three (3) of 11 lamps observed between 10:20 AM and 10:30 AM  2nd floor room 226 in one (1) of seven (7) lamps observed between 10:30 AM and 11:05 AM  3rd floor room 335 in one (1) of eight (8) lamps observed at 11:50 AM  4. Interior surfaces of exhaust vents in residents' bathrooms were soiled with accumulated dust and debris  1st floor room 142 in one (1) of 11 vents observed between 10:20 AM and 10:30 AM  2nd floor rooms 212, 218 and 244 in three (3) of	(F 253)		

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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 253}	Continued From page 2	{F 253}			
{F 279}	<p>eight (8) vents observed between 10:30 AM and 11:05 AM.</p> <p>3rd floor rooms 310 and 325 in two (2) of eight (8) observations between 11:35 AM and 12:20 PM.</p> <p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on the review of one (1) of 17 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches for the use of Lovenox and nine (9) or more medications. Resident #9.</p> <p>The findings include:</p>	{F 279}			

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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 SOUTHERN AVE SE WASHINGTON, DC 20032
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[F 279]	<p>Continued From page 3</p> <p>A. Facility staff failed to initiate a care plan for the use of Lovenox for anticoagulant therapy.</p> <p>The review of the resident's clinical record included a physician's order signed and dated January 10, 2007 directed, "Lovenox inject 0.4m (40)mg subcutaneously every day for prophylaxis.</p> <p>The interdisciplinary care plan dated January 31, 2007 lacked a problem with goals and approaches for anticoagulant therapy due to the use and administration of Lovenox.</p> <p>B. Facility staff failed to initiate a care plan to include appropriate goals and approaches for the potential adverse drug interactions involving nine (9) or more medications.</p> <p>The review of the the resident's clinical record included a physician's orders signed and dated January 10, 2007 included medication orders for Lasix, Welbutin, Atarax, Lamopri, Prandin, Multivitamin, Trental, Nitrodur patch, Potassium, Risperdal, Lovenox and insulin.</p> <p>The review of the interdisciplinary care plan dated January 31, 2007 lacked a problem with goals and approaches for the potential adverse drug interactions involving the use of nine (9) of more medications.</p> <p>A face-to-face interview was conducted with the Minimal Data Set Coordinator (MDS) On February 6, 2007 at approximately 11:00 AM who acknowledged that the resident's care plan lacked goals and approaches for the use of Lovenox and nine (9) or more medications. The record was</p>	[F 279]	<p><b>F279 483.20(d) 483.20(k)(1) Comprehensive Assessment</b></p> <ol style="list-style-type: none"> <li>1. Resident #9 care plan was reviewed and updated on 2/7/07 to include goals and approaches for Lovenox. Care Plan was also updated to include approaches for the potential adverse drug interactions involving 9 or more medications.</li> <li>2. All other residents on Lovenox and 9 or more meds have been identified and care plans reviewed and updated as necessary on 2/9/07.</li> <li>3. Unit Manager were given an in-service by DON to include approach, goal and interactions for these residents on 9 or more meds on 2/15/07.</li> <li>4. Unit Manager to do weekly audits of care plan for compliance. Report findings to QA Committee Quarterly.</li> </ol>	2/19/07
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065015	(K2) MULTIPLE CONSTRUCTION A. (BUILDING) _____ B. (WING) _____	(K3) DATE SURVEY COMPLETED  R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER  ROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032
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(X4) IS PREP 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)	DOE COMPLETION DATE
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(F 279) (F 280) SS-D	<p>Continued From page 4 reviewed on February 8, 2007.</p> <p><b>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</b></p> <p>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.</p> <p>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.</p> <p>The REQUIREMENT is met as evidenced by:</p> <p>Based on observations, staff interview and record review for one (1) of 17 sampled residents, it was determined that facility staff failed to update the care plan with appropriate goals and interventions for Resident #13 after each fall. This was a repeat deficiency.</p> <p>The findings include:</p> <p>A review of Resident #13's record revealed the following nurses' notes:</p> <p>January 13, 2007 at 8:00 AM Resident observed</p>	(F 279) (F 280)	<p><b>F280 483.20(d) 483.10(k)(2) Comprehensive Care Plans</b></p> <ol style="list-style-type: none"> <li>Resident #13 care plan has been updated to include additional goal and interventions related to falls as 2/7/07</li> <li>All other residents who have been identified as frequent fallers care plans have been updated to include additional goals and interventions as needed.</li> <li>Unit Manager will do weekly audits for care plan compliance. Unit Managers were given an in-service by the OON to review care plans and update as needed on 2/15/07. Findings will be reported to CQI meeting quarterly.</li> </ol>	2/14/07
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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION		QTY PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  088015	Q2. MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WARD: _____	Q3. DATE SURVEY COMPLETED  R 02/09/2007
NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
Q4. ID# (N/A) TAG	ELIMINATE STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Q5. PREPARE TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	Q6. COMPLETE DATE
(F-280)	<p>Continued From page 5</p> <p>on floor beside. Resident denied any discomfort ROM (range of motion) tolerated in all extremities, no swelling, bruises, or open areas observed. (Physician) called no new orders.</p> <p>January 18, 2007 at 7:30 AM: Resident observed sitting on floor in room on buttocks. ROM WNL (within normal limits), N/C (no complaint) of pain or discomfort... at this time. Since this is the 2nd fall in the past week, MD will be notified for new orders. Ambulating without difficulty.</p> <p>January 22, 2007 at 2:00 PM: Resident climbed over side rails @ foot of bed, got out and went to bathroom. Resident observed sitting on floor in bathroom @ 930-A, no injuries noted. (Physician) called.</p> <p>February 2, 2007 at 4:50 AM: Resident observed sitting on the floor in front of (his/her) bathroom; alert, responsive moving all extremities.</p> <p>A review of the "Fall Prevention" care plan revealed:          *1/22/07 low bed, Lapse UA C&amp;S (urinalysis with culture and sensitivity) Chem 7 (Chemistry) Done-normal.          *1/24/07 Low bed &amp; mat obtained.          *2/2/07-found on floor.</p> <p>There was no evidence that additional goals and interventions were developed to prevent further falls after the resident fell on January 12 and 18 and February 2, 2007.</p> <p>A face-to-face interview was conducted with the unit manager on February 8, 2007 at 3:00 PM. He/She acknowledged that the care plan was not</p>	(F-280)		

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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032
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(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 6 updated to reflect additional interventions in response to the above cited falls. The record was reviewed on February 6, 2007	{F 280}		
{F 309}	<p>483.25 QUALITY OF CARE</p> <p>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 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation, staff interviews and record review for two (2) of 17 sampled residents, facility staff failed to administer insulin and perform fingersticks as per physician's orders for one (1) resident and notify the physician when a laboratory test was not completed for one (1) resident. Residents #12 and 16.</p> <p>The findings include:</p> <p>1. Facility staff failed to administer insulin and perform fingersticks as per the physician's order for Resident #12.</p> <p>A review of Resident #12's record revealed a physician's order signed and dated December 28, 2006, that included three (3) insulin orders:</p> <p>(1) "Humalog vial - Ins (insulin) inject 3 units subcutaneously for fingerstick greater than 300 Mg/dl. Finger sticks were done at 7:00 AM, 12:00 PM and 4:30 PM daily.</p>	{F 309}	<p><b>F309 483.25</b> <b>Quality of Care</b> <b>#1</b></p> <ol style="list-style-type: none"> <li>1. Resident #12 Physician was notified on 2/13/07 of resident receiving 3 units of Insulin when fingerstick was 280 on January 9, 2007 at 4:30pm, no new orders was given.</li> <li>2. All residents on Fingerstick have been identified and MAR's have been reviewed and corrected when needed.</li> <li>3. Charge Nurses to do weekly audits of MAR's for compliance. Charge Nurses were in-serviced on the "Importance of Following Physicians Orders, Administering of Insulin &amp; Nurse Signatures" on 2/8/07.</li> <li>4. Findings for compliance will be reported to CQI Quarterly.</li> </ol>	2/19/07

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

TYPE OF PROVIDER TYPE OF FACILITY	ONLINE PROGRESS/PLEASURES IDENTIFICATION NUMBER	PROG/ACTIVITY CONSTRUCTION A BUILDING _____ B WING _____	ONLINE SURVEY COMPLETED R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1388 SOUTHERN AVE SE WASHINGTON, DC 20032
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OSR ID REF ID DATE	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)	OSR COMPLETION DATE
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(F 288)	Continued From page 6 Updated to reflect additional interventions in response to the above cited falls. The record was reviewed on February 6, 2007	(F 290)		
(F 309) 33-0	402.25:QUALITY OF CARE  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 and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interviews and record review of two (2) of 17 sampled residents, facility staff failed to administer insulin and perform finger sticks as per physician's orders for one (1) resident and notify the physician when a laboratory test was not completed for one (1) resident. Residents #12 and 13.  The findings include:  1. Facility staff failed to administer insulin and perform fingersticks as per the physician's order for Resident #12.  A review of Resident #12's record revealed a physician's order signed and dated December 28, 2006, that included three (3) insulin orders:  (1) "Humalog val - Ins (insulin) inject 3 units subcutaneous for fingerstick greater than 300 Mg/dl" Finger sticks were done at 7:00 AM, 12:00 PM and 4:30 PM daily.	(F 309)	<b>F309 Quality of Care #1</b>  1. License Nurse was re-educate on 2/7/07 regarding the "Importance of Administering Humalog Insulin sliding scale per Physician Orders" as outlined #11.  2. All incidents where nurses Humalog insulin sliding scale have been identified and MAR's reviewed for compliance and corrected as needed.  3. Charge Nurses to review MAR's weekly for compliance. Charge Nurses were re-serviced on 2/8/07 regarding the "Importance of Following Physician Orders, Administering of Insulin & Nurse Signatures"  4. Findings for compliance will be reported to CQI Quarterly.	2/19/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER

CAROLYN BOONE LEWIS HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1380 SOUTHERN AVE SE  
WASHINGTON, DC 20032

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(F 280)	Continued From page 6 updated to reflect additional interventions in response to the above cited falls. The record was reviewed on February 6, 2007	(F 280)		
(F 309) SS=D	483.25 QUALITY OF CARE  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 and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interviews and record review for two (2) of 17 sampled residents, facility staff failed to administer insulin and perform fingersticks as per physician's orders for one (1) resident and notify the physician when a laboratory test was not completed for one (1) resident. Residents #12 and 16  The findings include:  1. Facility staff failed to administer insulin and perform fingersticks as per the physician's order for Resident #12.  A review of Resident #12's record revealed a physician's order signed and dated December 28, 2006, that included three (3) insulin orders:  (1) "Humalog vial - Ins (insulin) inject 3 units subcutaneously for fingerstick greater than 300 Mg/dl." Finger sticks were done at 7:00 AM, 12:00 PM and 4:30 PM daily.	(F 309)	<b>F309 Quality of Care #1</b>  1. License Nurses were re-educated 2/7/07 regarding the "Importance of administering Humalog insulin sliding scale per physician Orders" on resident #12.  2. All residents who receive Humalog Insulin sliding scale have been identified and MAR's reviewed for compliance and corrected as needed.  3. Charge Nurses to review MAR's daily for compliance. Charge Nurses were re-serviced on 2/8/07 regarding the "Importance of Following Physicians Orders, Administering of Insulin & Nurse Signatures".  5. Findings for compliance will be reported to CQI Quarterly.	2/19/07

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(F 280)	Continued From page 6 updated to reflect additional interventions in response to the above cited falls. The record was reviewed on February 6, 2007	(F 280)		
(F 309) SS=D	<p>483.25 QUALITY OF CARE</p> <p>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 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation, staff interviews and record review for two (2) of 17 sampled residents, facility staff failed to administer insulin and perform fingersticks as per physician's orders for one (1) resident and notify the physician when a laboratory test was not completed for one (1) resident. Residents #12 and 16</p> <p>The findings include:</p> <p>1. Facility staff failed to administer insulin and perform fingersticks as per the physician's order for Resident #12.</p> <p>A review of Resident #12's record revealed a physician's order signed and dated December 28, 2006, that included three (3) insulin orders:</p> <p>(1) "Humalog vial - Ins (insulin) inject 3 units subcutaneously for fingerstick greater than 300 Mg/dl." Finger sticks were done at 7:00 AM, 12:00 PM and 4:30 PM daily</p>	(F 309)	<p><b>F309 483.25 Quality of Care #1</b></p> <ol style="list-style-type: none"> <li>1. Resident #12 Physician was notified on 2/13/07 of resident receiving 3 units of Insulin when fingerstick was 280 on January 9, 2007 at 4:30pm, no new orders was given.</li> <li>2. All residents on Fingerstick have been identified and MAR's have been reviewed and corrected when needed.</li> <li>3. Charge Nurses to do daily audits of MAR's for compliance. Charge Nurses were in-serviced on the "Importance of Following Physicians Orders, Administering of Insulin &amp; Nurse Signatures" on 2/8/07.</li> <li>4. Findings for compliance will be reported to CQI Quarterly.</li> </ol>	2/19/07

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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:  095015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  R 02/08/2007
NAME OF PROVIDER OR SUPPLIER  TROTLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1340 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID NUMBER: SAC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID NUMBER 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 7</p> <p>According to the January 2007 Medication Administration Record (MAR) on January 9, 2007 at 4:30 PM, the resident's finger stick was 280 and 3 units of insulin were administered. No insulin should have been administered.</p> <p>There was no evidence that the resident's finger stick was completed on January 14 and 15, 2007 at 12:00 PM as evidenced by the lack of the nurse's initials and blood sugar values in the designated boxes.</p> <p>(2) "Humalog vial - Ins inject 2 units subcutaneously three times daily at 7AM, 12PM, and 4:30PM"</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered on January 5 and 6, 2007 at 12:00 PM and on January 14, 2007 at 7:00 AM as evidenced by the lack of the nurse's initials in the designated box.</p> <p>(3) "Insulin Lantus (Glargine) U-100 vials - Ins - inject 43 units subcutaneously every evening for Diabetes Mellitus." Facility staff scheduled this insulin at 9:00 PM every evening.</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered January 1, 2007 as evidenced by the lack of the nurse's initials in the designated box.</p> <p>A review of the resident's record revealed that there was no documentation for the above cited dates to explain the omission of insulin.</p> <p>A face-to-face interview with the unit manager was conducted on February 9, 2007 at 3:00PM. He/she acknowledged that insulin was not</p>	(F 309)	<p>#2</p> <ol style="list-style-type: none"> <li>1. License Nurses were re-educated on 2/7/07 regarding the "Importance of Administering Humalog Insulin per Physician Orders" for resident #12.</li> <li>2. All residents who receive Humalog Insulin have been identified and MAR's reviewed and corrected as needed.</li> <li>3. Charge Nurses to review MAR's weekly for compliance. Charge Nurse was re-serviced on 2/8/07 regarding the "Importance of Following Physicians Orders, Administering of Insulin &amp; Nurse Signatures"</li> <li>4. Findings for compliance will be reported to CQI Quarterly.</li> </ol>	2/16/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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  R 02/06/2007
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)	(X6) COMPLETION DATE	
{F 309}	<p>Continued From page 7</p> <p>According to the January 2007 Medication Administration Record (MAR) on January 9, 2007 at 4:30 PM, the resident's finger stick was 280 and 3 units of insulin were administered. No insulin should have been administered.</p> <p>There was no evidence that the resident's finger stick was completed on January 14 and 15, 2007 at 12:00 PM as evidenced by the lack of the nurse's initials and blood sugar values in the designated boxes.</p> <p>(2) "Humalog vial - ins inject 7 units subcutaneously three times daily at 7AM, 12PM, and 4:30PM."</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered on January 5 and 9, 2007 at 12:00 PM and on January 14, 2007 at 7:00 AM as evidenced by the lack of the nurse's initials in the designated box.</p> <p>(3) "Insulin Lantus (Glargine) U-100 vials - ins - inject 43 units subcutaneously every evening for Diabetes Mellitus." Facility staff scheduled this insulin at 9:00 PM every evening</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered January 1, 2007 as evidenced by the lack of the nurse's initials in the designated box.</p> <p>A review of the resident's record revealed that there was no documentation for the above cited dates to explain the omission of insulin.</p> <p>A face-to-face interview with the unit manager was conducted on February 6, 2007 at 3:00PM. He/she acknowledged that insulin was not</p>	{F 309}	<p>#2</p> <ol style="list-style-type: none"> <li>1. License Nurses were re-educated on 2/7/07 regarding the: "Importance of Administering Humalog Insulin per Physician Orders" for resident #12.</li> <li>2. All residents who receive Humalog Insulin have been identified and MAR's reviewed and corrected as needed.</li> <li>3. Charge Nurses to review MAR's daily for compliance. Charge Nurses were in-serviced on 2/8/07 regarding the "Importance of Following Physicians Orders, Administering of Insulin &amp; Nurse Signatures".</li> <li>4. Findings for compliance will be reported to CQI Quarterly.</li> </ol>	2/19/07	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(R) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095015	(S) MULTIPLE COMPLETION A. BUILDING _____ B. WING _____	(Y) DATE SURVEY COMPLETED  02/06/2007	
NAME OF PROVIDER OR SUPPLIER  CARDLYN BOONE LEWIS HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1482 SOUTHERN AVE SE WASHINGTON, DC 20032		
CMS ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(Y) COMPLETION DATE
(P) 309	<p>Continued from page 7</p> <p>According to the January 2007 Medication Administration Record (MAR) on January 8, 2007 at 4:30 PM, the resident's finger stick was 280, and 3 units of insulin were administered. No insulin should have been administered.</p> <p>There was no evidence that the resident's finger stick was completed on January 14 and 15, 2007 at 12:00 PM as evidenced by the lack of the nurse's initials and blood sugar values in the designated boxes.</p> <p>(2) "Humalog vial - ins inject 7 units subcutaneously three times daily at 7AM, 12PM, and 4:30PM"</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered on January 5 and 9, 2007 at 12:00 PM and on January 14, 2007 at 7:00 AM as evidenced by the lack of the nurse's initials in the designated box.</p> <p>(3) "Insulin Lantus (Glargine) U-100 vials - ins - inject 42 units subcutaneously every evening for Diabetes Mellitus." Facility staff scheduled this insulin at 8:00 PM every evening.</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered January 1, 2007 as evidenced by the lack of the nurse's initials in the designated box.</p> <p>A review of the resident's record revealed that there was no documentation for the above cited cases to explain the omission of insulin.</p> <p>A face-to-face interview with the unit manager was conducted on February 8, 2007 at 3:00PM. He/she acknowledged that insulin was not</p>	(P) 309	<p>#3</p> <ol style="list-style-type: none"> <li>1. License Nurses were re-educated on 2/7/07 regarding the "Importance of Administering Lantus Insulin per Physicians orders for resident #12.</li> <li>2. All residents on Lantus Insulin have been identified and MAR's reviewed and updated as needed.</li> <li>3. Charge Nurses were in-serviced on 2/8/07 regarding the "Importance of Following Physicians Orders, Administering of Insulin &amp; Nurse Signatures"</li> <li>4. Findings will be reported to CQI Quarterly.</li> </ol>	2/8/07

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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  R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1280 SOUTHERN AVE SE WASHINGTON, DC 20032
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(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 7</p> <p>According to the January 2007 Medication Administration Record (MAR) on January 9, 2007 at 4:30 PM, the resident's finger stick was 280 and 3 units of insulin were administered. No insulin should have been administered.</p> <p>There was no evidence that the resident's finger stick was completed on January 14 and 15, 2007 at 12:00 PM as evidenced by the lack of the nurse's initials and blood sugar values in the designated boxes.</p> <p>(2) "Humalog vial - ins inject 7 units subcutaneously three times daily at 7AM, 12PM, and 4:30PM."</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered on January 5 and 9, 2007 at 12:00 PM and on January 14, 2007 at 7:00 AM as evidenced by the lack of the nurse's initials in the designated box</p> <p>(3) "Insulin Lantus (Glargine) U-100 vials - ins - inject 43 units subcutaneously every evening for Diabetes Mellitus." Facility staff scheduled this insulin at 8:00 PM every evening.</p> <p>According to the January 2007 MAR, there was no evidence that insulin was administered January 1, 2007 as evidenced by the lack of the nurse's initials in the designated box</p> <p>A review of the resident's record revealed that there was no documentation for the above cited dates to explain the omission of insulin.</p> <p>A face-to-face interview with the unit manager was conducted on February 6, 2007 at 3:00PM. He/she acknowledged that insulin was not</p>	(F 309)	<p>#3</p> <ol style="list-style-type: none"> <li>Lic:ncse Nurses were re-od:dated on 2/07/07 regarding the "Importance of Administering Lantus Insulin per Physicians orders for resident #12</li> <li>All residents on Lantus Insulin have been identified and MAR's reviewed and updated as needed.</li> <li>Charge Nurses were in-serviced on 2/8/07 regarding the "Importance of Following Physicians Orders, Administering of Insulin &amp; Nurse Signatures", and Charge Nurses will review MAR's daily for compliance.</li> <li>Findings will be reported to OJI Quarterly.</li> </ol>	2/19/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095013	(K2) MULTIPLE CONSTRUCTION # BUILDING _____ # WING _____	(K3) DATE SURVEY COMPLETED  02/06/2007
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1995 20th STREET AVE SE WASHINGTON, DC 20032
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(L1) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL KEY INDICATOR OR LSC IDENTIFYING INFORMATION)	(M) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(N) COMPLETION DATE
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# 308	<p>Continued From page 8</p> <p>administered as ordered by the physician on the above cited dates. The record was reviewed on February 6, 2007.</p> <p>2. Facility staff failed to notify the physician when a stool test for clostridium difficile (c-diff) was not done per physician's orders for Resident #16.</p> <p>A review of Resident #16's record revealed a physician's telephone order dated January 24, 2007, signed by the physician on January 30, 2007. "Repeat stool specimen for c-diff on January 26, 2007."</p> <p>There was no evidence in the record that the stool sample was collected and the laboratory test was completed.</p> <p>According to the nurses' notes, attempts were made to collect the stool on January 31, 2007 and February 4, 2007. There was no evidence in the record that the physician was notified of the delay in collecting the stool specimen.</p> <p>A face-to-face interview was conducted with the unit manager on February 6, 2007 at 10:30 AM. He/she acknowledged that the physician should have been notified.</p>	# 308	<p>#2</p> <ol style="list-style-type: none"> <li>1. The Physician was notified on 2/6/07 that the repeat stool specimen for January 26, 2007 was not collected on resident #16, stool specimen collected on 2/7/07</li> <li>2. All residents with order for stool specimen for C-DIFF records will be reviewed for test completion and Physician will be notified if unable to obtain</li> <li>3. Charge Nurses to review MAR's weekly for compliance. In-service given on 2/8/07 to Charge Nurses on "Collection of Stool Specimen" in a timely manner and follow-up with physician if unable to obtain.</li> <li>4. Findings will be reported to CCL.</li> </ol>	2/16/07
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# 323 55-0	<p>463.25(c)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on an observation during the initial tour, it was determined that the facility failed to ensure</p>	# 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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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  R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1360 SOUTHERN AVE SE WASHINGTON, DC 20032
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X) 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 8</p> <p>administered as ordered by the physician on the above cited dates. The record was reviewed on February 6, 2007.</p> <p>2. Facility staff failed to notify the physician when a stool test for clostridium difficile (c-diff) was not done per physician's orders for Resident #16.</p> <p>A review of Resident #16's record revealed a physician's telephone order dated January 24, 2007, signed by the physician on January 30, 2007, "Repeat stool specimen for c-diff on January 26, 2007."</p> <p>There was no evidence in the record that the stool sample was collected and the laboratory test was completed.</p> <p>According to the nurses' notes, attempts were made to collect the stool on January 31, 2007 and February 4, 2007. There was no evidence in the record that the physician was notified of the delay in collecting the stool specimen.</p> <p>A face-to-face interview was conducted with the unit manager on February 6, 2007 at 10:30 AM. He/she acknowledged that the physician should have been notified.</p>	{F 309}	<p>#2</p> <ol style="list-style-type: none"> <li>1. The Physician was notified on 2/6/07 that the repeat stool specimen for January 26, 2007 was not collected on resident #16, stool specimen collected on 2/7/07.</li> <li>2. All residents with order for stool specimen/lab test records will be reviewed daily for test completion and Physician will be notified if unable to obtain.</li> <li>3. Charge Nurses to review M/R's daily for compliance. In-service given on 2/8/07 to Charge Nurses on "Collection of Stool Specimen" in a timely manner and follow-up with physician if unable to obtain.</li> <li>4. Findings will be reported to CCL.</li> </ol>	2/19/07
{F 323} SS=D	<p>483.25(h)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on an observation during the initial tour, it was determined that the facility failed to ensure</p>	{F 323}		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 02/06/2007
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 9 that the environment was free from accident hazards as evidenced by the lack of eye guards on residents' television sets. These observations were made in the presence of the Directors of Maintenance and Housekeeping and nursing staff. This was a repeat deficiency.  The findings include: The eye guards on residents' television sets were missing, exposing the sharp tips of the antennas in the following areas:  1st floor rooms: 113, 139 and 147 in three (3) of 11 television sets observed between 10:20 AM and 10:30 AM on February 2, 2007.	{F 323}	F323 483.25 (h)(1) Accidents  1. The eye guards that were cited on resident's televisions missing, exposing the sharp tips of the antennas in rooms 113, 139, and 147 were replaced on 12/15/07. 2. All other residents rooms have been inspected by maintenance staff to ensure all residents television antennas are safe and were repaired or replaced as needed. 3. Maintenance staff will make monthly rounds to ensure safety and compliance of television antennas in residents rooms. 4. Monitoring will be conducted in quarterly CQI.	2/19/07
F 372 SS=D	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that the garbage and refuse container was not in good condition and trash was not properly contained in the trash dumpster. These findings were observed in the presence of the Food Service Director and Supervisor.  The findings include:  The trash dumpster located outside the kitchen was rusty on the bottom surface and bags of trash were piled on top of and outside of the dumpster in one (1) of one (1) dumpster observation between 11:35 AM and 12:20 PM on February 6, 2007	F 372	F372 483.35 Sanitary Conditions-Garbage Disposal  1. Trash dumpster located outside the kitchen with rust on surface and bags of trash piled on top of and outside of the dumpster was emptied immediately by contracted company and hosed down by housekeeping staff to remove rust. 2. Arrangements have been made with contractor to change pick up from 2 times per week to 3 times per week. 3. Director or supervisor of Environmental Services will make daily rounds to monitor the effectiveness of trash removal and make necessary adjustments as needed. 4. Monitoring of cited deficiency will be done in quarterly CQI.	2/19/07

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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1382 SOUTHERN AVE SE WASHINGTON, DC 20032
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(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 372 SS-D	<p>(F 323) Continued From page 9 that the environment was free from accident hazards as evidenced by the lack of eye guards on residents' television sets. These observations were made in the presence of the Directors of Maintenance and Housekeeping and nursing staff. This was a repeat deficiency.</p> <p>The findings include: The eye guards on residents' television sets were missing, exposing the sharp tips of the antennas in the following areas:</p> <p>1st floor rooms: 113, 139 and 147 in three (3) of 11 television sets observed between 10:20 AM and 10:30 AM on February 2, 2007.</p> <p>483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that the garbage and refuse container was not in good condition and trash was not properly contained in the trash dumpster. These findings were observed in the presence of the Food Service Director and Supervisor.</p> <p>The findings include: The trash dumpster located outside the kitchen was rusty on the bottom surface and bags of trash were piled on top of and outside of the dumpster in one (1) of one (1) dumpster observation between 11:35 AM and 12:20 PM on February 6, 2007.</p>	(F 323)	<p>F323 483.25 (i)(1) Accidents</p> <ol style="list-style-type: none"> <li>The eye guards that were cited on resident's televisions missing, exposing the sharp tips of the antennas in rooms 113, 139, and 147 were replaced on 1/15/07.</li> <li>All other residents rooms have been inspected by maintenance staff to ensure all residents television antennas are safe and were repaired or replaced as needed.</li> <li>Maintenance staff will make daily rounds to ensure safety and compliance of television antennas in residents rooms.</li> <li>Monitoring will be conducted in quarterly CQI.</li> </ol> <p>F372 483.35 Sanitary Conditions-Garbage Disposal</p> <ol style="list-style-type: none"> <li>The dumpster located outside the kitchen with rust on surface and bag of trash piled on top of and outside of the dumpster was emptied immediately by contracted company and hosed down by housekeeping staff to remove rust.</li> <li>Arrangements have been made with contractor to change pick up from 2 times per week to 3 times per week.</li> <li>Director or supervisor of Environmental Services will make daily rounds to monitor the effectiveness of trash removal and make necessary adjustments as needed.</li> <li>Monitoring of cited deficiency will be done in quarterly CQI.</li> </ol>	2/19/07

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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  R 02/06/2007
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 514) SS=E	<p>483.75(1)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation and record review for two (2) of 17 sampled residents and eight (8) supplemental residents, it was determined that facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" (sign out sheet for narcotics) with the Medication Administration Record (MAR) for nine (9) residents and document the reason for omission of a medication for one (1) resident. Residents #11, 14, F1, F2, F3, S1, S2, S3, S4, and S5.</p> <p>The findings include:</p> <p>1. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" with the MAR for Resident #11</p> <p>A review of Resident 11's record revealed a physician's order dated January 10, 2007 that directed, "Percocet 5/325 (mg) one po (orally)</p>	(F 514)	<p><b>F514 Clinical Record</b></p> <ol style="list-style-type: none"> <li>License Nurses were re-educated on 2/07/07 and 2/8/07 regarding the "Importance of documenting on the MAR's after signing out the control substances for residents #11, 14, F-1, F-2, F-3, S-1, S-2, S-3, S-4 &amp; S-5 .</li> <li>All other residents identified on controlled narcotics and MAR's were reviewed for accurate documentation regarding administration of controlled substances.</li> <li>All licensed staff was in-serviced on 2/7/07 and 2/8/07 on the "Importance of Accurate Documentation and Administration of Narcotics". Weekly audits of Controlled Utilization records and MAR's for compliance will be reviewed by the Charge Nurse/Unit Manager.</li> <li>Findings will be reported in CQI Quarterly.</li> </ol>	2/19/07	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	LSC DATE SURVEY COMPLETED  R 02/09/2007
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NAME OF PROVIDER OR SUPPLIER  CARDLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1386 SOUTHERN AVE SE WASHINGTON, DC 20032
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CROSS REFERENCE 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)	DATE COMPLETION DATE
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[F 514]	<p>Continued From page 11</p> <p>every 8 hours as needed for pain "</p> <p>The February 2007 MAR was reviewed and indicated with signatures that Percocet was administered five (5) times in February (February 3, 4, 5, and 6 (two times)) as evidenced by initials entered in the allotted areas for the dates mentioned</p> <p>The "Controlled Medication Utilization Record" indicated that Percocet was signed out eight (8) times: February 3 (two times), February 4 (three times), February 5, and February 6 (two times)</p> <p>There was no evidence on the February 2007 MAR that Percocet was administered two times on February 3 (signed as administered one time) and three times on February 4 (signed as administered one time).</p> <p>The record was reviewed February 6, 2007.</p> <p>2. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" with the MAR for Resident #14</p> <p>A review of Resident 14's record revealed a physician's order dated January 22, 2007 that directed, Acetaminophen with Codeine #3, one tab po (orally) one hour before dressing change "</p> <p>The February 2007 MAR was reviewed and indicated with signatures that Acetaminophen with Codeine #3 was administered one (1) time on February 6, 2007 at 10:00 AM as evidenced by initials entered in the allotted areas for the date mentioned</p> <p>The "Controlled Medication Utilization Record"</p>	[F 514]		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095018	(R2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(R3) DATE SURVEY COMPLETED  R 02/06/2007
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) IS PREP# TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(2) PREP# TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
(F 514)	<p>Continued From page 12</p> <p>indicated that Acetaminophen with Codeine #3 was signed out on February 2, 3 and 5, 2007. Although the medication was signed out, there was no evidence on the February 2007 MAR that the Acetaminophen with Codeine #3 was administered on February 2 and 5, 2007. The record was reviewed February 6, 2007.</p> <p>3. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" with the MAR for Resident F1</p> <p>A review of Resident F1's record revealed a physician's order dated December 31, 2006 that directed: "Percocet 5/325 (mg), two tabs po (orally) every 4 hours as needed for pain"</p> <p>The February 2007 MAR was reviewed and indicated with signatures that Percocet 5/325 (mg) was administered February 5 (one time) as evidenced by initials entered in the allotted area for the date mentioned.</p> <p>The "Controlled Medication Utilization Record" indicated that Percocet 5/325 (mg) was signed out on February 5 two times. There was no evidence on the February 2007 MAR or in the nurses' notes that Percocet 5/325 (mg) was administered two times on February 5, 2007. The record was reviewed February 6, 2007.</p> <p>4. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" with the MAR for Resident F2</p> <p>A review of Resident F2's record revealed a physician's order dated December 31, 2006 that directed: "Percocet 5/325 (mg), two tabs po (orally) every 4 hours as needed for pain"</p>	(F 514)		

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(I) IDENTIFY OR IDENTIFYING FACILITY OR SUPPLIER	(II) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085015	(III) MULTIPLE CORRECTION A. BUILDING: _____ B. WING: _____	(IV) DATE SURVIVAL SCANS PERIOD R 02/06/2007
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1899 SOUTHERN AVE SE WASHINGTON, DC 20032
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(V) IS THIS DEFICIENCY TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	IS THIS TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IS CORRECTION MADE
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(F-314)	<p>Continued from page 13</p> <p>The February 2007 MAR was reviewed and indicated with signatures that Percocet 5/325 (mg) was administered February 5 (one time) as evidenced by initials entered in the allotted area for the date mentioned.</p> <p>The "Controlled Medication Utilization Report" indicated that Percocet 5/325 (mg) was signed out on February 5 two times. There was no evidence on the February 2007 MAR or in the nurses' notes that Percocet 5/325 (mg) was administered two times on February 5, 2007. The record was reviewed February 9, 2007.</p> <p>3. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Report" with the MAR for Resident F3.</p> <p>A review of Resident F3's record revealed a physician's order dated January 19, 2007 that directed, "Hydrocodone (Dilaudid) 2mg, one tab po (orally) every 4 hours as needed for pain."</p> <p>The "Controlled Medication Utilization Report" indicated that the medication was signed out on February 6, 2007. There was no evidence on the February 2007 MAR or in the nurses' notes that the Dilaudid was administered on February 6, 2007. The record was reviewed February 9, 2007.</p> <p>4. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Report" with the MAR for Resident S1.</p> <p>A review of Resident S1's record revealed a physician's order dated December 25, 2006, that directed, "Acetaminophen with Codeine #3, two</p>	(F-314)		
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032
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(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)	DATE COMPLETION DATE
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(F-514)	<p>Continued From page 14</p> <p>tabe po (orally) every 8 hours as needed for pain.</p> <p>The February 2007 MAR was reviewed and indicated that the medication was not administered from February 1 through 8, 2007.</p> <p>The "Controlled Medication Utilization Record" indicated that the medication was signed out on February 5, 2007. There was no evidence in the nurses' notes that the medication was administered on February 5, 2007.</p> <p>A face-to-face interview was conducted with the interim unit manager on February 6, 2007 at 3:00 PM. He/she acknowledged that the documentation on the MAR and the "Controlled Medication Utilization Record" was inaccurate. The record was reviewed February 6, 2007.</p> <p>5. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" with the MAR for Resident 22.</p> <p>A review of Resident 22's record revealed a physician's order dated January 23, 2007 that directed "Clonazepam 0.5 mg one tab po (orally) at 8:00 AM."</p> <p>The February 2007 MAR was reviewed and indicated with signatures that the medication was given daily at 9:00 AM from February 1 through February 8, 2007.</p> <p>The "Controlled Medication Utilization Record" indicated that the medication was signed out at 5:00 PM on February 1, 2 and 5, 2007. On February 3 and 4 the medication was signed out for 9:30 AM and 5:00 PM, although only one (1)</p>	(F-514)		
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NAME OF PROVIDER OR SUPPLIER  CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032
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(F 514)	<p>Continued From page 15</p> <p>tablet was administered to the resident for each day</p> <p>A face-to-face interview was conducted with the interim unit manager on February 6, 2007 at 3:00 PM. He/she acknowledged that the documentation on the MAR and the "Controlled Medication Utilization Record" was inaccurate. The record was reviewed February 6, 2007.</p> <p>6. Facility staff failed to ensure the accuracy of documentation on the "Controlled Medication Utilization Record" with the MAR for Resident S3</p> <p>A review of Resident S3' record revealed a physician's order dated December 31, 2006 that directed, "Acetaminophen with Codeine #3, one tab po (orally) every 6 hours as needed for pain."</p> <p>The February 2007 MAR was reviewed and there were no signatures to indicate that the medication was administered from February 1 through 6, 2007.</p> <p>The "Controlled Medication Utilization Record" indicated that the medication was signed out on February 2, 2007. There was no evidence on the February 2007 MAR or the nurses' notes that the resident received the medication.</p> <p>A face-to-face interview was conducted with the interim unit manager on February 6, 2007 at 3:00 PM. He/she acknowledged that the documentation on the MAR and the "Controlled Medication Utilization Record" was inaccurate. The record was reviewed February 6, 2007.</p> <p>7. Facility staff failed to document a reason for the omission of Lorazepam administration for</p>	(F 514)		
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(F 514)	<p>Continued From page 16                  Resident S5</p> <p>According to the "Controlled Medication Utilization Record" for Resident S4, Lorazepam 1 mg was signed out on February 4, 2007 with the notation "borrowed for [Resident S5]"</p> <p>A review of Resident S5's record revealed a physician's order dated January 11, 2007, that directed, "Lorazepam 1 mg via G-tube [feeding tube] a day for anxiety."</p> <p>The February 2007 MAR for Resident S5 was reviewed and indicated with a circle around the nurse's signature that the medication was not administered on February 4, 2007. There was no explanation on the February 2007 MAR or in the nurses' notes for the omission of the medication.</p> <p>A face-to-face interview was conducted with the interim unit manager on February 6, 2007 at 3:00 PM. He/she acknowledged that the reason for omission of the medication was not on the MAR and that borrowing medications from other residents was not correct facility practice. The record was reviewed February 6, 2007.</p>	(F 514)		
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