STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	A. BUILDING: _____ B. WING _____	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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) COMPLETE DATE
L 000	Initial Comments A Licensure Survey was conducted on September 24, 2013. The deficiencies are based on observations, record review, resident and staff interviews for 40 sampled residents.	L 000	Carolyn Boone Lewis Health Care Center, "CBL", is filing this Plan of Correction in accordance with the compliance requirements for federal and state regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observations, record reviews, and staff interviews for six (6) of 40 sampled residents, it was determined that the charge nurse failed to initiate care plans with goals and	L 051		

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L 051	Continued From page 1 approaches to address: one (1) resident whose behaviors included public sexual acts; functional maintenance needs of one (1) resident referred for restorative care; one (1) resident for a medication allergy; one (1) resident who engaged in unauthorized alcohol consumption; impaired vision for one (1) resident and resistance of care for one (1) resident. Residents #14 , #85, #104, #153, # 171 and #173. The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches to address Resident #14 ' s behaviors that included public sexual acts. On September 19, 2013 at approximately 10:00AM, while a face-to-face interview was being conducted in the Day Room, Resident #14 unzipped his/her pant and fondled his/her genitalia. Facility staff intervened and redirected the resident. On September 20, 2013 the resident was observed seated in a wheel chair on the second floor hallway masturbating and again on September 23, 2013 at approximately 5:00 PM in the dining room on the first floor. A face-to-face interview was conducted with Employee #9 at approximately 4:00PM on September 20, 2013. The employee was queried whether he/she was aware of the resident ' s behavior and whether approaches were in place to address the behavior. The employee acknowledged awareness of the behavior, however; responded, " No " [regarding approaches] and stated whenever we [staff] see [him/her] displaying the behavior we usually put	L 051	**#1, #2, #3, #5, #6, & #7** 1. Resident # 14's care plan was updated to include behaviors and sexual acts conducted in public. The resident was also evaluated by the psychiatrist	9/26/13
			Resident # 85's care plan was updated to Include Restorative strengthening of muscle.	11/29/13
			Resident # 104's care plan was updated to include approaches for allergy to Clonidine	9/23/13
			Resident # 153's care plan was updated to include approaches for diagnosis of Astigmatism when diagnosis was received.	10/26/13
			Resident # 171's care plan was updates to include alcohol consumption with potential for falls and injury due to intoxication.	11/25/13
			Resident # 194's care plan was updated to include behaviors for refusal of care.	9/25/13
			2. A 100% review of residents' care plans was conducted to ensure the care plan includes contains goals and approaches that reflect the resident's current and potential care needs.	11/29/13
			3. A class/in-service on care planning resident care issues will be conducted by the MDS Director. All MDS staff will conduct monthly reviews of care plans and report the findings to the Director of Nursing & Assistant Director of Nursing or Designee.	10/10/13

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CAROLYN BOONE LEWIS HEALTH CARE Performance Improvement (QAPI) Ongoing	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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L 051	Continued From page 2 [him/her] in [his/her] room. " A review of the demographic information in the clinical record revealed that the resident resides in a semi-private room with another resident. The resident ' s roommate was not available to be interviewed. Facility staff failed to initiate a care plan with goals and approaches to address Resident #14 ' s behavior of public sexual acts. The record was reviewed on September 19, 2013. 2. Facility staff failed to initiate a care plan with goals and approaches for Restorative Care for Resident #85. On September 23, 2013 at approximately 10:30 AM Resident #85 was observed seated in a chair in his/her room. The resident was queried why he/she was still in the room. The resident responded, "I am waiting for someone to take me to therapy." A review of Resident #85's clinical record revealed that the resident was referred to Restorative Care in July, 2013. A review of the care plan section of the record revealed a care plan in place for physical therapy, however; there was no evidence of a functional maintenance plan to address the restorative care needs of the resident. A face-to-face interview was conducted with Employee #8 on September 23, 2013 at approximately 11:00 AM. After reviewing the resident's record he/she acknowledged that the record lacked a care plan for restorative care.	L 051	4 The Director of Nursing or Designee will report to the Quality Assessment and Committee the findings, and problems identified and interventions based on the results of the audit. The QAPI Committee will determine the need for further interventions, continued monitoring and follow up.	Monthly & Ongoing

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L 051	Continued From page 3 Facility staff failed to initiate a care plan with goals and initiatives for Restorative Care. The record was reviewed September 23, 2013. 3. Facility staff failed to initiate a care plan with goals and approaches for allergy to Clonidine for Resident #104. An annual physician ' s " Admitting Evaluation History " dated August 28, 2013 revealed the following: " Allergies: Clonidine causes excessive drowsiness and bradycardia. " The resident ' s care plan which was updated July 13, 2013 lacked evidence that a care plan with goals and approaches was developed to address the resident ' s adverse response to Clonidine. A face-to-face interview was conducted with Employees #10 and #15 on September 23, 2013 at approximately 10:30 AM. After reviewing the clinical record, both employees acknowledged the aforementioned findings. Facility staff failed to initiate a care plan with goals and approaches to address the resident ' s allergy and/or adverse response to Clonidine. The clinical record was reviewed on September 23, 2013. 5 Facility staff failed to develop a care plan with goals and approaches to address the visual needs of Resident #153 who was assessed with visual impairment. A review of admission Minimum Data Set [MDS] Assessment Reference Date (ADR) December	L 051		

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L 051	Continued From page 4 19, 2012 revealed that Resident #153 was coded as " 1 " visually impaired under section B [Hearing, Speech, and Vision] B1000. A review of the quarterly [MDS] with (ADR) August 23, 2013 revealed that under section B [Hearing, Speech, and Vision] B1000 Resident #153 was coded as " 1 " indicating the resident was "visually impaired" . Observations of the resident during the survey period lacked evidence that the resident utilized corrective lenses or other visual aids to manage the visual impairment. A review of the comprehensive care plan dated August 30, 2013 lacked evidence of goals and approaches to manage the resident ' s visual impairment. There was no evidence that a care plan was initiated to address the resident ' s visual impairment. A face-to-face interview was conducted with Employee #8 on September 20, 2013 at approximately 3:00 PM. He/she acknowledged the findings. The record was reviewed on September 20, 2013. 6. Facility staff failed to develop a care plan with goals and approaches to address Resident #171 ' s behavior of unauthorized alcohol consumption. A review of the medical record revealed that Resident #171 was admitted to the facility on February 1, 2013 with diagnoses which included Anemia, Hyperlipedemia, Pancreatic Disease, Hypertension (HTN) and Adjustment Disorder.	L 051		

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L 051	Continued From page 5 A review of the physician ' s order dated August 26, 2013 at 2:15AM directed " Transfer resident to ER [emergency room] for evaluation of frequent falls, unsteady gait, changes in mental status secondary to possible alcohol consumption. " A review of an area hospital's Medical Center Emergency Department Discharge instructions record dated August 26, 2013 at 9:37AM revealed a discharge diagnoses of falling, alcohol intoxication and left hand scratch. During a face-to-face interview conducted with Employee #2 on September 20, 2013 at approximately 2:00PM, he/she stated that" ... [Resident #171] attends every outing plus goes out with family members and takes those opportunities to buy alcohol. On one trip [resident name] was observed by staff leaving the function they were attending at a department store. The staff followed the resident who was found in a nearby liquor store and observed purchasing alcohol . Staff advised the resident return the alcohol. Housekeeping also reported finding rum flasks in the resident's trash can and between the resident's head board and bed. [Resident name] was questioned concerning the liquor bottles found in the room [resident name] denied it. Moving forward [resident name] now has staff escort at every outing, to the doctor and all appointments." A review of the Social Worker's note dated July 25, 2013 revealed the following: " Recently resident was found to have a bottle of alcohol in [his/her] room. [He/she] was sent out to the ER [emergency room] due to a fall on July 20, 2013 and the bottle was discovered afterwards.	L 051		

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L 051	Continued From page 6 Resident stated that [he/she] had the bottle for several weeks and had been sipping out of it from time to time. [Resident name] goes out of facility with [his/her] spouse on occasion. Counseling was provided on July 23, 2013 during a visit to SW ' s [social worker ' s] office." The Social Worker's progress note dated August 11, 2013 stated " This writer learned of an incident that occurred on a recent outing resident made while being out with Therapeutic Recreation. Apparently [resident name] left the group from [facility's name] (they had gone to a name of store) and had gone next door to purchase some liquor. [Employee name] happened to follow him/her and witnessed this. [He/she] was asked to return the bottle and got [his/her] money back." Social Worker's Progress note dated September 6, 2013 stated " On August 26, 2013 was made aware that resident had an incident in which [he/she] fell or tripped over [his/her] shoes in [his/her] room and cut [his/her] fingers. The Nurse Manager explained that another bottle of alcohol (vodka) was found in the resident ' s room. [Resident/s name] went out to the hospital on the 25th of August regarding the fall. It was found that [resident's name] alcohol level was high. Resident, the nurse manager and SW [social worker] met in social worker ' s office. Resident stated that the alcohol does not make [him/her] unsteady on [his/her] feet and got very upset that we had to discuss this with [him/her] again " . Social Worker Progress note dated September 9 2013 stated " Social worker located a phone number for the private organization of Alcohol	L 051		

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L 051	Continued From page 7 Anonymous [phone number]. The contact person informed this writer that anyone can walk into their meeting places, all over the city, as long as they have transportation " A face-to-face interview was conducted with Employee # 2 and Employee #9 on September 20, 2013 at approximately 2:45 PM. Both employees acknowledged the findings. The record was reviewed September 20, 2013. The facility failed to develop a care plan with goals and approaches to address Resident #171 ' s behavior of unauthorized alcohol consumption. 7. Facility staff failed to initiate a care plan to address behaviors of resistance of care for Resident #194. Resident #194 was observed on September 20, 2013 at approximately 2:45 PM sitting in a wheelchair proximal to the nursing station. Exposed wounds were observed on his/her right arm. The dressing bandage was observed loosely hanging around his/her right wrist and drainage was noted on the resident ' s clothing. A face-to-face interview was conducted with Employee#8 on September 20, 2013 at approximately 3PM, he/she was asked why the resident did not have a dressing on his/her wounds, he /she stated "[Resident #194] refused to have his/her dressing changed this morning as scheduled by the wound care nurse and that he/she is often resistant to care ...the charge nurse and responsible party were made aware." A review of the physician ' s order sheet dated September 10, 2013 revealed the resident ' s	L 051		

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L 051	Continued From page 8 diagnoses included Disquamative skin disorder and hemorrhagic blisters of the skin. The Medication and treatment administration record for September 2013 revealed wound treatments to the affected area(s) [right arm] were scheduled at twice daily at 10AM and 6PM. A review of Resident #194 ' s comprehensive care plan lacked evidence of goals and approaches to manage behaviors of resistance of care. Employee #8 acknowledged the findings on September 20, 2013 at approximately 4:30 PM. The record was reviewed on September 20, 2013. B. Based on record review and staff interview for four (4) of 40 sampled residents, it was determined that the charge nurse failed to review and revise care plans: for one (1) resident with an indwelling catheter; one (1) resident who required PROM [Passive Range of Motion] prior to application of splint devices and one (1) resident who required the use a gel cushion for pressure redistribution. Resident's #93, #121, and #182. The findings include: 1. Facility staff failed to review and revise a care plan with goals and approaches for Resident #93 who had an indwelling catheter A review of the resident ' s admission record dated March 7, 2013 revealed that he /she was	L 051	**B** (1). Resident #93 care plan was updated to indicate use of a Foley on 9/20/13. (2). Resident #121 was updated to include PROM before the splint application on. (3.) Resident #182 care plan is unable to be amended due to the resident no longer resides at this facility. 2. A 100% review of all resident's assessments and care plans were conducted to ensure each care plan contains goals and approaches that reflect the resident's current and potential care needs. 3. The MDS staff will conduct monthly review of care plan completion and report the findings to the DON/ADON. 4. The DON/designee will report to the Quality Assessment and Performance Improvement Committee (QAPI) the findings, problems identified and interventions based on the results of the audit. The QAPI Committee will determine the need for additional audits and frequency of further monitoring and follow up.	9/20/13 9/23/13 10/10/13 Monthly Monthly & Ongoing

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L 051	Continued From page 9 readmitted to facility `with diagnosis of Seizure Disorder, DVT [Deep Vein Thrombosis], CVA [Cerebral Vascular Accident], Psychosis, Pressure Ulcer, Anemia, Diabetes Mellitus and Senile Dementia A review of the Physician's order sheet dated May 21, 2013 revealed an order that directed "Change indwelling foley catheter now with18FR [french] secondary to foley catheter leaking." A review of the comprehensive care plan for Resident #93 revealed a care plan, " Problem: Functional Incontinence, [secondary to] decreased bladder capacity. " The care plan was last updated September 12, 2012. The facility staff failed to update [since September 2012] the care plan related to the use of the indwelling catheter. A face-to-face interview was conducted on September 19, 2013 with Employee #9 at approximately 10:50AM. He/she acknowledged the findings after reviewing the care plan. The record was reviewed September 19, 2013. 2. Facility staff failed to review and revise a care plan for Resident #121 who was to receive PROM [passive range of motion] prior to the application of splints. A review of the residents care plan indicated a problem " Requires Supportive Devices " right ankle boot. The care plan was last updated July 6, 2013. Review of the medical record revealed an	L 051		

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L 051	Continued From page 10 Interim Order Form dated and signed August 26, 2013 at 3:00 PM, which indicated: apply Left elbow splint, Left hand splint, Left ankle boot and bilateral knee splints, perform gentle PROM [Passive Range of Motion] to BUE [Bilateral Upper Extremities] and BLE [Bilateral Lower Extremities before application of splints. Review of the " Restorative Charting Review " revealed the resident received PROM for the months of August and September 2013. The supportive devices care plan lacked evidence of approaches that included passive range of motion prior to the implementation of splints as prescribed. A face-to-face interview was conducted on September 20, 2013 at approximately 2:30 PM with Employee #10. After review of the care plans he/she acknowledged the care plan was not updated to include PROM to be performed prior to application of the splints. 3. Facility staff failed to review and revise Resident #182' s care plan to include a prescribed pressure redistribution strategy for the use of a gel cushion while seated in a geriatric chair. Physician ' s orders signed and dated August 8, 2013 at 3:05 PM indicated " Resident to use gel cushion when out of bed to geri-chair for pressure relief for sacral ulcer. " A review of the medical record wound assessment sheets dated September 18, 2013 revealed that the resident had a left buttock	L 051		

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L 051	Continued From page 11 shear skin impairment measuring 3.1x1.2x0.2cm. A review of Resident #182 ' s care plan last revised on September 18, 2013 lacked evidence of revisions to the altered skin integrity care plan include the use of a gel cushion when out of bed to geri chair for pressure relief of the sacral ulcer. " A face-to-face interview was conducted with Employees #10 and #19, on September 19, 2013 at approximately 3:05 PM. After review of the care plans, both acknowledged that the care plan was not revised to include goals and interventions to use the gel cushion. The record was reviewed September 19, 2013.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and	L 052		

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L 052	Continued From page 12 infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that sufficient nursing time was not given to ensure that residents received 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 as evidenced by a failure to follow physician's	L 052		

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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) COMPLETE DATE
L 052	Continued From page 13 orders for the utilization of a pressure redistribution device while seated in a chair for Resident #182. The findings include: 1. Facility staff failed to follow physician's orders to utilize a pressure redistribution device, a gel cushion, while Resident #182 was seated in a geriatric [recliner] chair. A review of Resident #182 ' s medical record revealed physician ' s orders signed and dated August 8, 2013 at 3:05 PM that directed, " Resident to use gel cushion when out of bed to geriatric chair for pressure relief of sacral ulcer. " Review of the medical record wound assessment sheet dated September 18, 2013 identified that the resident had a left buttock shear skin impairment measuring 3.1x1.2x0.2cm. An observation was made on September 19, 2013 at approximately 3:05 PM. The resident was in the dining area engaged in an activity, resting in a semi-fowlers [45 degree angle] position in a geriatric chair. There was no evidence that a gel cushion was applied to the geriatric chair as ordered. The observation was made in the presence of Employees #10, #19, #20. Employee #20 acknowledged that the resident should have been on a gel cushion. A face-to-face interview was conducted with Employees #10 and 19. A query was made regarding the use of a gel cushion for Resident #182. Employees #10 and 19 acknowledged that the resident was not on the gel cushion. Employee #10 then stated that "[the resident's	L 052	1. Resident #182 gel cushion was corrected immediately. 2. A 100% review of all residents with positioning devices was conducted. 3. The restorative aide will be given a listing of all residents with assistive devices. The RN Charge Nurse/Team Leader will conduct a random daily audit check to ensure proper placement of these devices. The audit tool result will be collected daily. A monthly report will be provided to DON. 4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	9/19/13 10/29/13 Daily & Monthly Monthly & Ongoing

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	HFD02-0011	A. BUILDING: _____ B. WING _____	09/24/2013

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L 052	Continued From page 14 name] usually is, and that the CNA [Certified Nursing Assistant] must have just changed [him/her] and forgot to replace the cushion." Facility staff failed to follow the physician ' s order to place the resident on a gel cushion when up in a geriatric chair secondary to a stage 2 sacral ulcer. The record lacked evidence of worsening of the skin impairment. The record was reviewed September 19, 2013. B. Based on an observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that sufficient nursing time was not given to provide the necessary care and services to maintain good grooming and personal hygiene for Resident #P1. The findings include: On September 19, 2013 at approximately 4:00 PM Resident #P1 was observed lying in bed with lengthy nails that were soiled beneath the nail beds. A review of Resident #P1's Minimum Data Set (MDS) dated June 26, 2013 revealed that the resident was coded as cognitively impaired under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. Employee #8 that was present in the resident ' s room was asked to observed the resident ' s nails. The employee observed the nails and stated, " We will take care of them [the resident's finger nails]. "	L 052	1. Resident #P1 nails were cleaned immediately. 2. A random check of 30 residents was conducted through out the facility weekly for grooming. 3. All staff was re-educated on providing ADL care and personal hygiene. 3B. The Nurse Supervisor will conduct random audits of resident care such as grooming, clean attire, hair care daily. These results will be reported to the DON/designee. 4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	9/19/13 Daily 12/5/13 Daily Monthly & Ongoing

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L 052	Continued From page 15 The facility staff failed to carry out activities of daily living to maintain good grooming for Resident #P1. C. Based on clinical record review and staff interview for one (1) of 40 sampled residents, it was determined that sufficient nursing time was not given to ensure Resident #160's pulse oximetry was monitored according to physician's orders. The findings include: A physician ' s order dated August 15, 2013 at 3:00 PM directed " Continue oxygen 3-4 liters/minute via trach mask at 28 % to keep oxygen level greater than 95%. " The quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) dated July 26, 2013 was coded under Section O (Special Treatments and Programs) as requiring oxygen therapy and tracheostomy care. A review of the Medication/Treatment Administration Record (MAR/TAR) for the months of June through September 2013 revealed that Resident #160 was scheduled to receive oxygen saturation assessments via pulse oximetry every shift. The spaces allotted on the MAR/TAR for pulse oximetry testing were labeled " N, D, E " [night, day and evening]. The MAR/TAR records for the months of June through September 2013 lacked evidence that pulse oximetry assessments were conducted on the following dates, as evidenced by blank spaces in the allotted spaces for pulse oximetry testing:	L 052	1. The dates observed for missing pulse oximetry values for resident #160 cannot be corrected at this time. All values for resident #160 has been entered since 9/14/13. 2. A 100% review of residents on oxygen therapy has been conducted. 3. All licensed nursing staff have been re-educated on the documentation process for pulse oximetry; and completed the O2 competency skills evaluation and documentation review. 4. The Unit Manager/designee will monitor weekly and report findings to the Director of Nursing and Assistant Director of Nursing who will report monthly to the QAPI Committee the findings and problems identified with a corrective action plan for three months. The QAPI Committee will determine the need for further follow up.	9/14/13 12/2/13 11/25/13 Monthly & Ongoing

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L 052	Continued From page 16 June 11, 2013 - night shift July 7, 2013 - night shift July 8, 2013 - night shift July 9, 2013 - night shift July 10, 2013 - night shift September 14, 2013- night shift A review of the clinical record lacked evidence that Resident #160 ' s pulse oximetry was monitored as prescribed. A face-to-face interview was conducted with Employees #10 and #26 on September 20, 2013 at approximately 3:30 PM. After reviewing the clinical record; both acknowledged the aforementioned findings. The clinical record was reviewed on September 20, 2013. D. Based on observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that sufficient nursing time was not given to ensure that Resident #153 received assistive devices when it was determined the resident ' s vision was impaired. The findings include: A review of admission Minimum Data Set [MDS] Assessment Reference Date (ADR) December 19, 2012 revealed that Resident #153 was coded as " 1 " visually impaired .under section B [Hearing, Speech, and Vision] B1000. A review of the quarterly [MDS] with (ADR) August 23, 2013 revealed that under section B [Hearing, Speech, and Vision] B1000 Resident #153 was coded as " 1 " indicating the resident was "visually impaired."	L 052	1. Resident # 153 was evaluated by the eye doctor on 10/26/13. 2. A 100% review of residents' charts was conducted to ensure that all residents received their annual eye exams. 3. The Unit Manager/Unit Clerk will continue to audit monthly the clinical records to ensure compliance with annual eye exams. These results will be reported to the Director of Nursing/ADON. 4. The Director of Nursing/ADON will report to the QAPI Committee the findings, problems, interventions and corrective plans monthly x3. The QAPI Committee will review the results and determine the need for further review or new process development.	10/26/13 11/6/13 Monthly Monthly & Ongoing

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L 052	Continued From page 17 The clinical record revealed an authorization Form for " Senior Vision Services "signed and dated by Resident #153 on May 22, 2013. A review of current physician ' s orders dated August 31, 2013 directed " Ophthalmology [consult] prn. " The original date of the order was December 19, 2012. A telephone interview was conducted with Employee #23 on September 20, 2013 at approximately 3:00 PM, when questioned regarding the prescribed ophthalmology evaluation for Resident #153; he/she stated "the resident signed the consent in May 2013. The appointment was scheduled in August 2013, but was cancelled by Senior Vision Services to be rescheduled, date undetermined." There was no evidence that facility staff followed through with the physician's order for Ophthalmology consultation. Approximately nine (9) months lapsed from the time the resident was assessed with visual impairment in the absence of corrective visual aids and/or appliances (December 2012) and this review of the clinical record. Observations of the resident during the survey period lacked evidence that the resident utilized corrective lenses or other visual aids. There was no evidence that facility staff progressively implemented measures to ensure Resident #153 received assistive devices to manage impaired vision. A face-to-face interview was conducted with	L 052		

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L 052	Continued From page 18 Employee #8 on September 20, 2013 at approximately 3:00 PM. He/she acknowledged the findings. The record was reviewed on September 20, 2013	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made during a tour of the dietary services on September 18, 2013 at approximately 12:30 PM, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced by soiled lids from one (1) of one (1) ice machine, a bowl of puree brownies that fell on the floor and returned to the tray line to be served and improper handling of food service equipment such as warming tray covers and tongs by staff. The findings include: 1. The lid to the ice machine in the main kitchen was soiled from the inside and needed to be disinfected. 2. A bowl of puree brownies that accidently fell on the floor was not discarded and instead, was placed back on the tray line to be served. 3. A staff member was observed handling food service equipment such as warming tray covers	L 099	1. The ice machine lid was cleaned and sanitized on the day of the survey, September 18, 2013. A cleaning schedule was developed to maintain the cleanliness of the utensils. Future incident of puree brownies will not be picked up and placed near tray line, it will be discarded immediately. Staff was instructed not to place warming covers on the floors. Staff have been instructed also how to properly handle food services equipment. 2. The dietary supervisor has conducted a thorough walk-through of the kitchen to observe cleanliness of the ice machine lids, and other kitchen utensils, and also observation of staff practices. 3. All staff was educated on the principles of Infection Control practice, standard precautions and the prevention of infection transmission; handling food serving utensils, clean and dirty services line areas. The dietary staff/designee will conduct random observations audits of the meal service process. This will be reported to the QAPI Committee monthly x3.	9/18/13 9/30/13 12/2/13

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L 099	Continued From page 19 and tongs with bare hands. These observations were made in the presence of Employee # 12 and/or Employee #13 who confirmed the findings.	L 099	4. The QAPI Committee will determine based on the results of the monthly audits the need and pattern of further monitoring .	Ongoing
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 18, 2013 at approximately 12:30 PM, it was determined that the facility failed to ensure that call bells were functioning properly as evidenced by a non-functioning call bell in one (1) of 40 resident's room. The findings include: 1. The call bell in room #238 (A side) did not	L 306	1 The call bell in room #238A was fixed and corrected on the day of the survey. 2. All call lights were checked to identify any call light that may be affected, and not working properly. 3. Random checks of call bells will be incorporated in the daily Environment of Care Rounds by Directors and Managers. Report of the daily rounds will be provided to the Administrator, Director of Nursing and Nurse Managers, and Building Services/Maintenance Manager. 4. Results and analysis of the Environment of Care rounds will be presented at the QAPI Committee monthly meetings. The committee will make a determination on the pattern of continuous monitoring.	9/18/13 9/30/13 12/2/13 & Daily Monthly & Ongoing

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L 306	Continued From page 20 activate when tested in one (1) of 40 resident's room. This observation was made in the presence of Employee #13 who acknowledged the finding.	L 306		
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations made on September 16, 2013 at approximately 9:00 AM and on September 18, 2013 at approximately 10:15 AM, it was determined that the facility failed to serve and store food under sanitary conditions as evidenced by two (2) of four (4) open packs of lunch meat, an open box of donuts and an open pack of breadsticks that were not labeled to indicate the initial date of use, two (2) of two (2) soiled air curtains from the dishwashing machine, a soiled kitchen floor and freezer floor, dust from the Ansul fire system located above the tilt skillet, one (1) of three (3) leaking detergent holder from the dishwashing machine, missing lids from the ice scoop holder, eight (8) of eight (8) six-inch dented and soiled steam table pans, two (2) of two (2) dry food scoops (sugar and flour) that were not clearly identified or labeled for their specific use, a bowl of puree brownies that fell on the floor and returned to the tray line to be served and improper handling of food service equipment such as warming tray covers and tongs by staff. The findings include:	L 359	**#1, #2, #3, #4, #5, #6, #7, #8, #9 & #10** The packs of lunch meat, the box of donuts and the open bags of breadsticks that were unlabeled were discarded The two air curtains from the dishwashing machines has been.replaced. The kitchen floor and freezer floor were cleaned. The area around the Ansul fire system above the tilt skillet have been cleaned. The one detergent holder from the side of the dishwashing machine has been replaced. The lids to the ice scoop holder have been replaced. The eight six-inch 1/6 steam table pans have been replaced.	9/18/13 9/18/13 9/18/13 9/18/13 9/18/13 9/18/13 9/24/13

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L 359	Continued From page 21 1. Two (2) of four (4) open packs of lunch meat in the walk-in refrigerator were not labeled to indicate when they were initially used, a box of donuts and an open bag of breadsticks stored in the freezer were also open but not labeled. 2. Two (2) of two (2) air curtains from the dishwashing machine were soiled and needed to be replaced. 3. The kitchen floor and the freezer floor were soiled. 4. The area around the Ansul fire system located above the tilt skillet was soiled with dust. 5. One (1) of three (3) detergent holders from the dishwashing machine was leaking. 6. The lids to the ice scoop holder were missing. 7. Eight (8) of eight (8) six-inch 1/6 steam table pans were dented and soiled and needed to be replaced. 8. Two (2) of two (2) scoops used for dry food use (sugar and flour) were not clearly identified or labeled for their exact use. 9. A bowl of puree brownies that accidently fell on the floor was not discarded and instead, was placed back on the tray line to be served. 10. A staff member was observed handling food service equipment such as warming tray covers and tongs with bare hands. These observations were made in the presence	L 359	The scoops for the sugar and flour have been labeled and identified. The bowl of puree brownies was discarded when informed. 2. A thorough walk through was done in the Food Services Department to ascertain that any areas with the potential for this deficiency for corrective action. 3.The staff was re-educated on Infection Control practice, standard precautions, the prevention of infection transmission; handling food serving utensils, handling of food items and identification of clean and dirty service line areas. The dietary supervisor will monitor all areas in the kitchen, observe the kitchen floor daily and report weekly to the Food Services Director. 4. The Food Service Director will report the findings, and problems identified with the corrective actions to the QAPI Committee, and the Infection Control Committee monthly for three (3) consecutive months. The QAPI Committee will determine the need and pattern for further audits and continuous monitoring.	9/18/13 9/18/13 9/30/13 12/2/13 Monthly & Ongoing

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L 359	Continued From page 22 of Employee #13 who confirmed the findings.	L 359		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 18, 2013, between 11:40 AM and 2:15 PM, it was determined that the housekeeping and maintenance department failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by privacy curtains that were detached from hooks in four (4) of 40 resident ' s rooms surveyed, A stained ceiling tile in one (1) of 40 resident ' s rooms, clutter in two (2) of 40 resident ' s rooms and marred furniture in five (5) of 40 resident ' s rooms. The findings include: 1. Privacy curtains were hanging off their hooks in rooms #242, #329, #338 and #341, four (4) of 40 resident ' s rooms surveyed. 2. A ceiling tile was fully stained in one (1) of 40 resident ' s rooms (#145). 3. Rooms #146 (A side) and room #238 (A side) were cluttered with clothing, newspapers and boxes piled up on top of each other. 4. The baseboard was marred in room #141,	L 410	1. Privacy curtains in rooms #242, #329, and #341were corrected and hung properly. 2. A review was completed of other resident's rooms and corrections were made as indicated. 3. Environmental Services staff were in-services by Director on partially detached privacy curtain hooks. 4. Weekly rounds will be completed by the EVS Department Director/supervisor using monitoring tool. Results of rounds will be reported monthly to the QAPI Committee The QAPI Committee will determine the need for further audits. **#2.** 1. Stained ceiling tile was removed and replaced with new tile. 2. Maintenance staff will check resident's rooms for stained ceiling tiles and correct or replace tiles. 3. Maintenance staff were in-serviced b y Director of Maintenance, monitor resident room ceiling monthly to ensure compliance.. 4. Finding and corrections of the ceiling tiles will be reported to the monthly QAPI Committee, following monthly monitoring by the Maintenance Manager utilizing monitoring tool.	9/18/13 9/18/13 11/25/13 9/18/13 Ongoing 9/30/13 11/29/13 11/29/13 On going 11/29/13

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L 410	Continued From page 23 the bedside tables were marred in room #143 and #145, two (2) of two (2) night tables were marred in room #137 and one (1) of two (2) closets and the walls were marred in room #222, five (5) of 40 resident ' s rooms surveyed. These observations were made in the presence of Employee #13 who confirmed the findings. Based on observations made during a tour of the dietary services on September 18, 2013 at approximately 12:30 PM facility, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by water temperatures above 120 degrees Fahrenheit from the eyewash sink in the main kitchen. The findings include: 1. Water temperature from the eyewash sink in the main kitchen was as high as 155 degrees Fahrenheit (F). A face-to-face interview with Employee #14 was conducted on September 18, 2013 at approximately 1:30 PM. He/she revealed that the hot water from the eyewash sink is coming straight from the boiler room and is usually as high as 155 degrees F. He/she suggested that the hot water supply to the eyewash sink be temporarily turned off. Employee #14 shut off the hot water supply to the eyewash sink and the water temperature dropped to approximately 75 degrees F. No residents or employees were affected by the elevated water temperatures from the eyewash sink.	L 410	**# 3** 1. Room # 146 (A side) and Room # 238 (A side) have been de-cluttered. We have had discussion with the residents and families and the excess clothing, newspaper, and boxes have been removed from both rooms. 2. Environmental Services Director, Maintenance /Building Service Manager have conducted observations of all residents' rooms to identify rooms that are cluttered and they have been corrected. 3. Department Directors and managers will incorporate observations of cluttered resident rooms in their Daily Environment of Care Rounds. Results of the daily rounds will be provided to the Nurse Managers and Environmental Services Director for corrective action. Reports also will be provided to Director of Social Services for communication with families. 4. Results of the EOC rounds will also be presented to the QAPI Committee monthly for analysis. Based on the results of the monthly reports, the committee will make a decision on the pattern and frequency of continuous monitoring. **#4.** 1. Marred baseboard was removed and replaced with new baseboard and the area was corrected. 2. Maintenance department will monitor resident room(s) baseboard as directed by	11/6/13 12/2/13 12/2/13 & Ongoing Monthly & Ongoing 11/25/13 11/29/13

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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) COMPLETE DATE
L 410	Continued From page 24 The observation was made in the presence of Employee #12 who confirmed the findings.	L 410	Maintenance Director to identify resident room(s) that may be affected. 3. Baseboards to be included as a part o f the Monthly Preventative Maintenance Program to ensure compliance. 4. Finding and corrective actions will be reported to QAPI Committee following monthly monitoring by manager utilizing monitoring tool. 1. The water supply for eyewash was disconnected on the day of the survey. The eyewash in the main kitchen has been replaced with a brand new eyewash bowl that has cold water only. 2. All areas have been reviewed to identify those areas that may be affected, needing eyewash stations. 3. Maintenance staff will check the eyewash stations weekly and report results to the Director. This process of checking eyewash stations also will be incorporated in the Daily Environment of Care Rounds by Department Directors and Managers. Results of the rounds will be provided to the Food Service Director, Administrator, and Nurse Managers and others directors. 4. The Director(s) will present the results of the daily and weekly checks to the QAPI Committee monthly. The committee will make a determination based on the analysis of the results of the process, as to the pattern of continuous monitoring.	11/29/13 11/29/13 & Monthly 9/18/13 11/22/13 11/24/13 12/2/13 & Daily & Weekly Monthly & Ongoing