STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/04/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 01300 On August 5, 2010 a Life Safety Code Survey was completed at your Facility. The following findings were observed during a tour of your facility on August 5, 2010.	K 000	Carolyn Boone Lewis Health Care Center, "CBL", is filing this Plan of Correction in accordance with the compliance requirements for NFPA 101 Life Safety Code Standards. 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 the facts or conclusions cited.	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Surveyor: 01300 Based on observations during the Life Safety Code Inspection it was determined that penetrations were observed in wall surfaces above ceiling tiles in smoke barrier walls, on the first floor in one (1) one (1) observations, in wall surfaces above the Activity Room Ground Floor Level in two (2) of two (2) observations, in wall	K 017	**K 017 NFPA 101 Life Safety Code Standard** **1 a). Corrective Actions** No resident(s) was (were) negatively impacted. The 12x12 inch opening above ceiling tiles in the residents first floor dining room was corrected immediately. **b). Identification of Deficient Practices & Corrective Actions** The Maintenance staff checked facility-wide above ceiling tile areas and have corrected upon discovery penetrations found. **c). Measures/Systematic Changes** • Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of penetrations/openings above ceiling tiles as part of the monthly Preventative Maintenance Program to ensure compliance. • Above ceiling tile checks have been added to maintenance inspection form to be checked during monthly rounds. **d). Monitoring** The findings and corrections of the penetrations/openings above ceiling tiles will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. **2a). Corrective Actions** No resident(s) was (were) negatively impacted. Two penetrations above wall surfaces in the activity ground floor level	08/04/10 10/26/10 08/20/10 10/28/10 08/04/10

Denise Chadwick Wright LNHA 10/26/10

TITLE (X6) DATE

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

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K 017	Continued From page 1 surfaces above tiles near room 246 in one (1) of eight (8) observations, above the entrance door to room 243 in one (1) of eight (8) observations. The findings include: 1. A 12 x 12 inch opening was observed in wall surfaces above ceiling tiles in the residents Dining Room on the first floor in one (1) one (1) observations at 11:45 AM on August 7, 2010. 2. Two penetrations, approximately 1-2 inches were observed in wall surfaces above the Activity Room Ground Floor Level in two (2) of two (2) observations at 11:45 AM on August 7, 2010. 3. A 12 X 14 inch penetration was observed in wall surfaces above tiles near room 246 in one (1) of eight (8) observations at 11:55 AM on August 7, 2010. 4. A 2-3 inch penetration was observed above the entrance door to room 243 in one (1) of eight (8) observations at 12:10 PM on August 7, 2010. The findings were observed in the presence of employees # 1, 13, 14 and 31.	K 017	Continued from page 1 were immediately corrected. **b). Identification of Deficient Practices & Corrective Actions** The Maintenance staff checked facility-wide above ceiling tile areas and have corrected Upon discovery penetrations found. **c). Measures/Systematic Changes** • Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of penetrations/openings above ceiling tiles as part of the monthly Preventative Maintenance Program to ensure compliance. • Above ceiling tile checks have been added to maintenance inspection form to be checked during monthly rounds. **d). Monitoring** The findings and corrections of the penetrations/openings above ceiling tiles will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. **3 a). Corrective Actions** No resident(s) was (were) negatively impacted. The 12x14 inch opening above ceiling tiles near room 246 was corrected.	10/26/10 8/20/10 10/28/10 08/09/10
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6	K 018	**b). Identification of Deficient Practices & Corrective Actions** The Maintenance staff checked facility-wide above ceiling tile areas and have corrected Upon discovery penetrations found. **c). Measures/Systematic Changes** • Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of penetrations/openings above ceiling tiles as part of the monthly Preventative Maintenance Program to ensure compliance.	10/26/10 08/20/10

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K 018	Continued From page 2 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Surveyor: 01300 Based on observations during the Life Safety Code Inspection it was determined that single and double swinging fire doors were not able to close without assistance when tested at the entrance to the first floor Dining Room and failed to latch when tested in one (1) of three (3) observation, entrance door to the Shower Room on the first floor failed to close without assistance when tested in one (1) of six (6) observations, entrance doors to rooms 212 and 246 were difficult to open and close by staff when the door was tested in one (1) of five (5) observations and closet doors located near the entrances doors to resident rooms impeded the entrance doors from fully closing in six (6) of 13 observation. The findings include: 1. The entrance door to the first floor Dining Room failed to latch when tested in one (1) of three (3) observations at 12:25 PM on August 5, 2010.	K 018	Continued From page 2 • Above ceiling tile checks have been added to maintenance inspection form to be checked during monthly rounds. **d). Monitoring** The findings and corrections of the penetrations/openings above ceiling tiles will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. **4 a). Corrective Actions** No resident(s) was (were) negatively impacted. 2-3 penetration above the entrance door to room 243 corrected. **b). Identification of Deficient Practices & Corrective Actions** The Maintenance staff checked facility-wide above ceiling tile areas and have corrected upon discovery penetrations found. **c). Measures/Systematic Changes** • Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of penetrations/openings above ceiling tiles as part of the monthly Preventative Maintenance Program to ensure compliance. • Above ceiling tile checks have been added to maintenance inspection form to be checked during monthly rounds. **d). Monitoring** The findings and corrections of the penetrations/openings above ceiling tiles will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. **K 018 NFPA 101 Life Safety Code Standard** **1 a). Corrective Actions** No resident(s) was (were) negatively impacted. The first floor dining room entrance door latch was corrected.	10/28/10 08/09/10 10/26/10 08/20/10 10/28/10 08/09/10

Continued From Page 3 of 6

b). Identification of Deficient Practices & Corrective Actions

The Maintenance staff checked facility-wide door closures and latching. Corrections have been made on discovery . 09/26/10

c). Measures/Systematic Changes 08/20/10

- Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of door latching/closure as part of the monthly Preventative Maintenance Program to ensure compliance.
- Door latch/closure checks have been added to maintenance inspection form to be checked during monthly rounds.

d). Monitoring

The findings and corrections of the Door latching/closures will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. 10/28/10

2 a). Corrective Actions

a). No resident(s) was (were) negatively impacted. The entrance door to the Shower Room has been corrected. 08/06/10

b). Identification of Deficient Practices & Corrective Actions

The Maintenance staff checked facility-wide door closures and latching. Corrections have been made on discovery . 09/26/10

c). Measures/Systematic Changes 08/20/10

- Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of door latching/closure as part of the monthly Preventative Maintenance Program to ensure compliance.
- Door latch/closure checks have been added to maintenance inspection form to be checked during monthly rounds.

d). Monitoring

The findings and corrections of the Door latching/closures will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. 10/28/10

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Continued From Page3b of 6

3a). Corrective Actions
No resident(s) was (were) negatively impacted.
The entrance doors to rooms 212 and 246 have been adjusted to close properly. 10/12/10

b). Identification of Deficient Practices & Corrective Actions
The Maintenance staff checked facility-wide door closures and latching. Corrections have been made on discovery . 09/26/10

c). Measures/Systematic Changes 08/20/10

- Maintenance staff were in-serviced by the Director of Maintenance regarding NFPA requirements in regard to the monitoring of door latching/closure as part of the monthly Preventative Maintenance Program to ensure compliance.
- Door latch/closure checks have been added to maintenance inspection form to be checked during monthly rounds.

d). Monitoring
The findings and corrections of the Door latching/closures will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report is effective. 10/28/10

4 a). Corrective Actions
The closet doors to rooms 212, 304, 309, 322, 314 and 346 were replaced to prevent impediment with the entrance door. 10/13/10

b). Identification of Deficient Practices & Corrective Actions
Maintenance staff have performed a facility wide inspection to ensure all closet doors with the potential to impede the entrance doors from full closure when opened are replaced. Closet doors have been ordered. 10/25/10

c). Measures/Systematic Changes
Maintenance staff were in-serviced by the Director of Maintenance regarding the NFPA requirement in regard to the monitoring of door closing impediment as part of the monthly Preventative Maintenance Program to ensure compliance. 10/18/10

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K 018	Continued From page 3 2. The entrance door to the Shower Room on the First Floor failed to close without assistance when tested in one (1) of six (6) observations at 12:20 PM on August 5, 2010. 3. During the Life Safety Code tour of the facility it was determined that the entrance doors to rooms 212 and 246 was difficult to open and close by staff when the door was tested in one (1) of five (5) observations at 1:30 PM on August 5, 2010. 4. Closet doors located near the entrances doors to resident rooms, impeded the entrance doors from full closing when closet doors were in the open position in rooms 212, 304, 309, 322, 314 and 346 in six (6) of 13 observations betwee11:00 AM and 2:45 PM on August 5, 2010. These observations were made in the presence of employees #1, 13, 14, and 31.	K 018		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 01300 Based on observations during the survey period it was determined that wall lamps in stairwells failed to provide illumination in the event of a fire as means to provide access to exits to assist residents and staff in the event of a fire in two (2)	K 045		

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K 045	Continued From page 4 of 11 observations. The findings include: Illumination as a means to assist access to exits was not provided in stairwells to assist residents and staff in the event of a fire in the Third Floor east stairwell and First Floor east stairwell near room 143 in two (2) of 11 observations between 11:00 AM and 2:45 PM on August 5, 2010. These findings were observed in the presence of Maintenance Staff Employees # 1, 13, 14, and 31.	K 045	Continued From page 4	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Surveyor: 01300 Based on observations during the Life Safety Code Inspection it was determined that evacuation routes posted in hallways lacked information to show the locations of patient rooms, common and specialty areas and floor numbers were not identified on the drawings in 11 of 11 observations . The findings include: Evacuation routes posted in the hallways failed to show the location of resident ' s rooms, specialty areas, common areas on each floor and each wing and floor numbers were not identified on the	K 048	**K045 NFPA 101 Life Safety Code Standard** **1a). Corrective Actions** The one fluorescent light that provides illumination to the third floor east stairwell and first floor east stairwell near room 143 illumination was corrected. **b). Identification of Deficient Practices & Corrective Actions** Maintenance staff will perform monthly inspections to identify and correct upon discovery stairwells of egress without illumination in an effort to ensure compliance. **c). Measures/Systematic Changes** Maintenance staff were in-serviced by the Director of Maintenance regarding the NFPA requirement in regard to the monitoring of illumination of means of egress as part of the monthly Preventative Maintenance Program to ensure compliance. **d). Monitoring** The findings and corrections of illumination of means of egress will be reported to the monthly CQI committee until it has been determined by the committee that a	08/5/10 10/19/10 10/18/10 10/28/10

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K 048	Continued From page 5 drawing in 11 of 11 observations between 11:00 AM and 2:45 PM on August 5, 2010. These observations were made in the presence of employees # 1, 13, 14, and 31.	K 048	Continued From page 5 quarterly report is effective. **K048 NFPA 101 Life Safety Code Standard** **1a). Corrective Actions** The evacuation routes posted in the hallways facility-wide will be revised to exhibit the location of resident's rooms, specialty, common areas on each floor and each wing with floor number identification.	10/19/10
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Surveyor: 01300 Based on observations during the Life Safety Code Inspection it was determined that housekeeping services were not adequate to ensure that sanitary conditions are maintained within the facility. These findings include: 1. Baseboard surfaces were observed to be separated from wall surfaces in Room 137 in one (1) of one (1) observation at 9:30 AM on August 5, 2010. 2. The side and bottom surfaces of a mattress cover in Room 137 were observed to be worn and torn in one (1) of one (1) observation at 9:30 AM on August 5, 2010. These observations were made in the presence of employees # 1, 13, 14, and 31.	K 130	**Identification of Deficient Practices & Corrective Actions** b). The evacuation routes posted throughout the facility's hallways will be revised to exhibit the location of resident's rooms, specialty, common areas on each floor and each wing with floor number identification. **c). Measures/Systematic Changes** The Safety Committee and/Maintenance staff will update the evacuation plans at the time of change being required and will conduct semi-annual reviews to ensure that all evacuation routes are current. **d). Monitoring** The findings and corrections of the evacuation plans will be reported to the monthly CQI committee on a semiannual basis until it has been determined by the committee that this area of concern has been resolved. **K130 NFPA 101 Miscellaneous** **1 a). Corrective Actions** Baseboard surface in room 137 was re-glued and connected to wall. **b). Identification of Deficient Practices & Corrective Actions** As part of the facility's Preventative Maintenance Program on a monthly basis maintenance will identify and correct upon discovery base boards in need of repair.	10/19/10 10/18/10 10/28/10 10/19/10

Continued From Page 6

c). Measures/Systematic Changes
Maintenance staff were in-serviced by the Director of Maintenance regarding the NFPA requirement in regard to base board surfaces and the monitoring of baseboard surfaces as part of the monthly Preventative Maintenance Program to ensure compliance. 10/18/10

d). Monitoring
The findings and corrections of the base board findings will be reported to the monthly CQI committee on a monthly basis until it has been determined by the committee that this area of concern can be reported quarterly. 10/28/10

2a). Corrective Actions
The mattress in room 137 was disposed of and replaced. 8/4/10

b). Identification of Deficient Practices&
A facility-wide inventory and audit of all beds and mattresses have been conducted to identify mattresses in need of replacement. Mattress replacement has been initiated and a schedule for replacement has been initiated. 08/25/10

c). Measures/Systematic Changes
Environmental Services Staff will be in-serviced on the NFPA requirement and the monitoring of mattresses as part of the weekly Cleaning Program to ensure compliance. 10/19/10

d). Monitoring
The findings and corrections of the mattress findings will be reported to the monthly CQI committee on a monthly basis until it has been determined by the committee that this area of concern can be reported quarterly. 10/28/10

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