DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/01/2010 FORM APPROVED

CENTER	S FUN MILUICANE	N PE	EDICAID OLIVITORO				CIND INC	. 0330-038		
		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED				
			095015	B. WIN	IG		08/0	4/2010		
NAME OF PR	OVIDER OR SUPPLIER				STR	EET ADDRESS, CITY, STATE, ZIP CODE				
CAROLYN BOONE LEWIS HEALTH CARE CENTER					1380 SOUTHERN AVE SE WASHINGTON, DC 20032					
(X4) ID	SUMMARY ST	ATE	MENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ON	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST	BE	PRECEDED BY FULL REGULATORY FYING INFORMATION)	PRET		(EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	COMPLETION		
K 000	INITIAL COMMENT	S		К	000	Carolyn Boone Lewis Health Care Center, "CBL", is filing this Plan of	<u>.</u> 6			
	completed at your F	aci	ife Safety Code Survey was lity. The following findings a tour of your facility on			Correction in accordance with the compliance requirements for NFPA 101 Life Safety Code Standar Plan of Correction constitutes the				
	August 5, 2010.	•				facility's written allegation of complia the deficiencies cited. However, sub	ince for mission			
K 017 SS=D	NFPA 101 LIFE SA	-E	TY CODE STANDARD	K	017	of this Plan of Correction does not constitute admission of the facts or				
	constructed with at I	ea	d from use areas by walls at ½ hour fire resistance	х		conclusions cited. K 017 NFPA 101 Life Safety Code 1 a). Corrective Actions	Standard			
	required to resist the	eq e	uildings, partitions are only assage of smoke. In non- valls properly extend above			No resident(s) was (were) negative impacted. The 12x12 inch opening	above	08/04/10		
	the ceiling. (Comido	T W	valls may terminate at the here specifically permitted by			ceiling tiles in the residents first floor room was corrected immediately.	_			
	Code. Charting and	cl	erical stations, waiting areas, rity spaces may be open to			b). Identification of Deficient Prac Corrective Actions The Maintenance staff checked facilities		10/26/10		
	the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors					above ceiling tile areas and have co upon discovery penetrations found.		10/20/10		
	by non-fire rated wa	lis i	f the gift shop is fully 1, 19.3.6.2.1, 19.3.6.5			c). Measures/Systematic Changes Maintenance staff were in-service		08/20/10		
	epinidered.) 13.3	.0.	1, 18.0.0.2.1, 18.0.0.0			the Director of Maintenance rega NFPA requirements in regard to the	rding			
						monitoring of penetrations/opening above ceiling tiles as part of the manual control of	gs			
						Preventative Maintenance Progra ensure compliance.				
9	9					 Above ceiling tile checks have bee maintenance inspection form to be 				
	This STANDARD is	nai	met as evidenced by:			during monthly rounds. d). Monitoring				
	Surveyor: 01300		*			The findings and corrections of the penetrations/openings above ceiling		10/28/10		
	Based on observations during the Life Safety Code				tiles will be reported to the monthly committee until it has been determine	-				
	Inspection it was determined that penetrations were observed in wall surfaces above ceiling tiles in					by the committee that a quarterly rep is effective.				
	smoke barrier walls, or the first floor in one (1) one (1) observations, in wall surfaces above the Activity					2a). Corrective Actions No resident(s) was (were) negatively		08/04/10		
Room Ground Floor Level in two (2) of two (2)					impacted. Two penetrations above	wall	55,54,10			
	observations, in wall				-	surfaces in the activity ground floor l				
	. []		() ()			TITLE		(X8) 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 095015 08/04/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE CAROLYN BOONE LEWIS HEALTH CARE CENTER WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG K 017 Continued From page 1 K 017 Continued from page 1 surfaces above tiles near room 246 in one (1) of eight (8) observations, above the entrance door to were immediately corrected. room 243 in one (1) of eight (8) observations. b). Identification of Deficient Practices & **Corrective Actions** The Maintenance staff checked facility-wide 10/26/10 The findings include: above ceiling tile areas and have corrected Upon discovery penetrations found. 1. A 12 x 12 inch opening was observed in wall c). Measures/Systematic Changes 8/20/10 surfaces above ceiling tiles in the residents Dining Maintenance staff were in-serviced by Room on the first floor in one (1) one (1) the Director of Maintenance regarding observations at 11:45 AM on August 7, 2010. NFPA requirements in regard to the monitoring of penetrations/openings above ceiling tiles as part of the monthly 2. Two penetrations, approximately 1-2 inches were Preventative Maintenance Program to observed in wall surfaces above the Activity Room ensure compliance. Ground Floor Level in two (2) of two (2) Above ceiling tile checks have been added to observations at 11:45 AM on August 7, 2010. maintenance inspection form to be checked during monthly rounds. 3. A 12 X 14 inch penetration was observed in wall d). Monitoring surfaces above tiles hear room 246 in one (1) of The findings and corrections of the eight (8) observations at 11:55 AM on August 7. penetrations/openings above ceiling 10/28/10 2010. tiles will be reported to the monthly CQI committee until it has been determined by the committee that a quarterly report 4. A 2-3 inch penetration was observed above the is effective. entrance door to room 243 in one (1) of eight (8) 3 a). Corrective Actions observations at 12:10 PM on August 7, 2010. 08/09/10 No resident(s) was (were) negatively impacted. The 12x14 inch opening above The findings were observed in the presence of ceiling tiles near room 246 was corrected. amnlovees # 1 12 11 and 31 b). Identification of Deficient Practices & NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018 **Corrective Actions** SS=D The Maintenance staff checked facility-wide 10/26/10 Doors protecting corridor openings in other than above ceiling tile areas and have corrected required enclosures of vertical openings, exits, or Upon discovery penetrations found. hazardous areas are substantial doors, such as c). Measures/Systematic Changes 08/20/10 those constructed of 134 inch solid-bonded core · Maintenance staff were in-serviced by the Director of Maintenance regarding wood, or capable of resisting fire for at least 20 NFPA requirements in regard to the minutes. Doors in sprinklered buildings are only monitoring of penetrations/openings required to resist the passage of smoke. There is above ceiling tiles as part of the monthly no impediment to the closing of the doors. Doors Preventative Maintenance Program to are provided with a means suitable for keeping the ensure compliance. door closed. Dutch doors meeting 19.3.6.3.6

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 095015 08/04/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE CAROLYN BOONE LEWIS HEALTH CARE CENTER WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX **PREFIX** DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) OR LSC IDENTIFYING INFORMATION) TAG TAG K 018 Continued From page 2 K 018 Continued From page 2 are permitted. 19.3.6.3 Above ceiling tile checks have been added to maintenance inspection form to be checked during monthly rounds. Roller latches are prohibited by CMS regulations in d). Monitoring all health care facilities. The findings and corrections of the penetrations/openings above ceiling 10/28/10 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 08/09/10 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** Surveyor: 01300 The Maintenance staff checked facility-wide 10/26/10 above ceiling tile areas and have corrected upon Based on observations during the Life Safety Code discovery penetrations found. Inspection it was determined that single and double c). Measures/Systematic Changes 08/20/10 swinging fire doors were not able to close without Maintenance staff were in-serviced by assistance when tested at the entrance to the first the Director of Maintenance regarding NFPA requirements in regard to the floor Dining Room and failed to latch when tested in monitoring of penetrations/openings one (1) of three (3) observation, entrance door to above ceiling tiles as part of the monthly the Shower Room on the first floor failed to close Preventative Maintenance Program to without assistance when tested in one (1) of six (6) ensure compliance. observations, entrance doors to rooms 212 and 246 · Above ceiling tile checks have been added to were difficult to open and close by staff when the maintenance inspection form to be checked door was tested in one (1) of five (5) observations during monthly rounds. and closet doors located near the entrances doors d). Monitoring to resident rooms impeded the entrance doors from The findings and corrections of the fully closing in six (6) of 13 observation. penetrations/openings above ceiling 10/28/10 tiles will be reported to the monthly CQI The findings include: committee until it has been determined by the committee that a quarterly report is effective. 1. The entrance door to the first floor Dining Room failed to latch when tested in one (1) of three (3) K 018 NFPA 101 Life Safety Code Standard observations at 12:25 PM on August 5, 2010. 1 a). Corrective Actions No resident(s) was (were) negatively 08/09/10 impacted. The first floor dining room entrance door latch was corrected.

Continued From Page 3 of 6

b). <u>Identification of Deficient Practices & Corrective Actions</u>

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

08/20/10

09/26/10

c). Measures/Systematic Changes

- 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). <u>Identification of Deficient Practices & Corrective Actions</u>

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

09/26/10

08/20/10

c). Measures/Systematic Changes

 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

Continued From Page3b of 6

3a). Corrective Actions

No resident(s) was (were) negatively impacted. The entrance doors to rooms 212 and 246

10/12/10

have been adjusted to close properly.

b). Identification of Deficient Practices &

Corrective Actions
The Maintenance staff checked facility-wide door closures and latching. Corrections have

09/26/10

been made on discovery .
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

10/28/10

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.

4 a). Corrective Actions

The closet doors to rooms 212, 304, 309, 322, 314 and 346 were replaced to prevent impediment with the entrance

10/13/10

door.
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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING 01 - MAIN BUILDING 01 B. WING				
		095015	B. WIIN				08/04/2010	
	ROVIDER OR SUPPLIER N BOONE LEWIS HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032			2 1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	51.51	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE	
K 018	2. The entrance doo First Floor failed to dested in one (1) of son August 5, 2010. 3. During the Life Sa	r to the Shower Room on the lose without assistance when six (6) observations at 12:20 PM rety Code tour of the facility it the entrance doors to rooms	K	018				
	212 and 246 was diffused when the door was to observations at 1:30 4. Closet doors located resident rooms, imperfull closing when closed position in rooms 212	ricult to open and close by staff ested in one (1) of five (5) PM on August 5, 2010. ed near the entrances doors to eded the entrance doors from set doors were in the open 2, 304, 309, 322, 314 and 346 vations betwee11:00 AM and						
K 045 SS=D	employees #1, 13, 14 NFPA 101 LIFE SAF Illumination of means discharge, is arrange lighting fixture (bulb)	ETY CODE STANDARD s of egress, including exit ed so that failure of any single will not leave the area in s not refer to emergency	K)45				
	Surveyor: 01300 Based on observation was determined that to provide illumination	not met as evidenced by: ms during the survey period it wall lamps in stairwells failed in the event of a fire as cess to exits to assist residents of a fire in two (2)						

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 095015 08/04/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE CAROLYN BOONE LEWIS HEALTH CARE CENTER WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE CROSS-PRÉFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG Continued From page 5 K 048 Continued From page 5 K 048 quarterly report is effective. drawing in 11 of 11 observations between 11:00 AM and 2:45 PM on August 5, 2010. K048 NFPA 101 Life Safety Code Standard 1a). Corrective Actions 10/19/10 The evacuation routes posted in the These observations were made in the presence of hallways facility-wide will be revised to employees # 1, 13, 14, and 31. exhibit the location of resident's rooms, NFPA 101 MISCELLANEOUS K 130 K 130 specialty, common areas on each floor and SS=D each wing with floor number identification. OTHER LSC DEFICIENCY NOT ON 2786 **Identification of Deficient Practices & Corrective Actions** b). The evacuation routes posted throughout 10/19/10 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. Surveyor: 01300 c). Measures/Systematic Changes The Safety Committee and/Maintenance 10/18/10 Based on observations during the Life Safety Code staff will update the evacuation plans Inspection it was determined that housekeeping at the time of change being required services were not adequate to ensure that sanitary and will conduct semi-annual reviews conditions are maintained within the facility. to ensure that all evacuation routes are current. d). Monitoring These findings include: The findings and corrections of the evacuation 10/28/10 plans will be reported to the monthly CQI 1. Baseboard surfaces were observed to be committee on a semiannual basis until it has separated from wall surfaces in Room 137 in one been determined by the committee that (1) of one (1) observation at 9:30 AM on August 5. this area of concern has been resolved. K130 NFPA 101 Miscellaneous 2. The side and bottom surfaces of a mattress cover 1 a). Corrective Actions Baseboard surface in room 137 was in Room 137 were observed to be worn and torn in re-glued and connected to wall. one (1) of one (1) observation at 9:30 AM on August b). Identification of Deficient Practices & 5, 2010. **Corrective Actions** As part of the facility's Preventative 10/19/10 These observations were made in the presence of Maintenance Program on a monthly employees # 1, 13, 14, and 31. basis maintenance will identify and correct upon discovery base boards in need of repair.

(X2) MULTIPLE CONSTRUCTION

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