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	095015	A. BUILDING _____ B. WING _____	08/05/2014

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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
F 000	INITIAL COMMENTS A recertification Quality Indicator Survey was conducted on July 28 through August 5, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 41 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C- Discontinue Dl - Deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency medical services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - Interdisciplinary team INR - International Normalised Ratio L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set	F 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 deficiencies cited. However submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Nora J. Wesson | Interim Administrator | 9/11/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of urvey 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 ocuments 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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F 000	Continued From page 1 Mg - Milligrams (metric system unit of mass) mL - Milliliters (metric system measure of volume) mg/dl - Milligrams per deciliter mm/Hg - Millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- By mouth POS - Physician's order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews for one (1) of 41 sampled	F 176		

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F 176	Continued From page 2 residents, it was determined that the interdisciplinary team failed to assess one (1) resident's ability to self-administer medications in a safe manner. Resident #37. The findings include: During a resident interview on July 29, 2014 at approximately 11:21 AM, Resident #37 was observed removing four (4) patches from under a red cloth mat located on his/her over bed table. Resident #37 then applied the patches to his/her left thumb area, right ankle, left ankle, and right knee. The patches were dated "7/28/14 "[with a nurse's initial]. The resident stated, "These patches are for pain. I take the pain pill for my neck. "Two (2) 30 ml clear plastic cups were observed with crushed medication(s) sitting on top of the red mat on the over-the-bed table. The resident stated, "In one of the cups it is Extra Strength Tylenol (pointing to the cup with the crushed white medication) and the other is for my heart. I don't know the name of the medication." The resident picked up an oxygen mask with a clear liquid fluid in the chamber and stated, "This is for my breathing. " The resident then picked up a cup of apple sauce [that was also located on the over-the-bed table] and began mixing the applesauce with [his/her] " heart medication " that he/she stated was in the clear plastic cup and self-administered the medication with orange juice. The resident proceeded to mix applesauce with [his/her] "Extra Strength Tylenol "that he/she stated was in the plastic cup. During [his/her] preparation of the medication, Employee #37 returned to the resident's room and asked, "Are you ready to take your medicine?" The resident responded, "I have already started	F 176	Continued From page 2 #1. The interdisciplinary Care Team has met and addressed and assessed resident #37's medication management to determine that it is safe for resident to self-administer his/her medications. The IDT has concluded that it is safe for resident #37 to self-administer medication with supervision, and that supervision will be provided. Also the "Medication Administration (ALL) Policy has been revised and updated to reflect self-administration of medication. #2. To identify other residents that have the potential to be affected by this, we have reviewed and assessed residents who self-administer their medications, and other residents who may have the potential to self- administer medications at this time. #3. We have presented an in-service on Resident Rights with focus on Resident Self-Administration of for Registered Nurses, Licensed Practical Nurses and Social Workers and other members of the IDT. This presentation will be available to the IDT and licensed nurses twice a year.	8/5/14 9/9/14 9/11/14

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F 176	Continued From page 3 taking my medicine, " and proceeded to prepare the Extra Strength Tylenol in the plastic cup and self-administered it at approximately 11:47 AM. Review of the facility's policy titled "Medication Administration (ALL), " Revised date: 07/29/10, lacked any evidence that indicated that the Interdisciplinary team must determine that it is safe for the resident to self-administer medications before the resident may exercise that right. The July 2014 Physician's Order Form signed by the physician on July 5, 2014 directed, "(Miscellaneous Orders) - Resident may self admin meds (self administer medications) including po (by mouth), eye drops, nasal spray, po puffs (metered dose inhalers) and nebulizer treatment with nurses supervision, Resident wishes to administer own meds. " A review of the July 2014 Medication Administration Records revealed the following: Resident may self admin medication including PO Medications, Eye Drops, Nasal spray, PO puffs and nebulizer treatment with nurses' supervision', and Atrovent 0.2mg via inhalation, Tylenol Extra Strength two (2) tablets po, Lactulose 30ml po, Lisinopril 10mg po, Amlodipine 5mg, one (1) Alphagan 0.15% eye drops, Dorzolamide 2% eye drops and Losartan Potassium 50mg po. The aforementioned medications were administered daily at 9:00 AM.	F 176	Continued From page 3 A process that has been put in place of evaluating the resident(s) who may want to self-administer medication and present this information to the interdisciplinary care team. The IDT will meet to address the resident's need. Recommendations will be made to the physician(s) as the need arises to ensure the process is followed. #4. To monitor for compliance, the Unit Manager or designee will monitor quarterly for safety of self-administration and report to the QAPI Committee quarterly. The Social Worker will monitor monthly 3x for compliance of the process to ensure the interdisciplinary team follows the process. The results of the monitoring will be reported to the QAPI monthly.	9/12/14 & Monthly x3

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F 176	Continued From page 4 There was no evidence in the clinical record that the Interdisciplinary Care Team (IDT) determined that it was safe for Resident #37 to self-administer medications. Additionally, it was observed that there was no direct supervision provided to Resident #37 when he/she self-administered medications on July 29, 2014 at approximately 11:21 AM. A face-to-face interview was conducted on July 29, 2014 at approximately 12:00 PM with Employees #6 and #37. Both employees stated, "[Resident #37] self-administers his/her medications. We observe him/her take the medications. Employee #37 further stated, "[Resident #37 will call when he/she is ready to take the medications." The record was reviewed July 29, 2014. There was no evidence that the interdisciplinary team assessed Resident #37's ability to self-administer medications in a safe manner.	F 176	Continued From page 4	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for three (3) of 41 sampled residents, it was	F 241		

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F 241	Continued From page 5 determined that the facility staff failed to promote care in a manner and an environment that maintained and enhanced dignity and respect as evidenced by: signage was observed on the bathroom door of one (1) resident's room; to request permission prior to entering the room of one (1) resident; and staff was observed to be standing while feeding one (1) resident. Residents ' # 94, 102, and 124. The findings include: 1.Facility staff failed to promote one resident's dignity and respect by allowing the resident's roommate to post signage that relayed to staff and visitors aspects about the resident ' s health status symptom. On July 28, 2014 at approximately 10:30 AM a tour of Resident 94 ' s room was conducted. A sign with the writing " Stop P___ [urine]on floor [Resident # 94 ' s name]" was observed taped on the inside of the bathroom door in the resident's room. On July 29, 2014 at approximately 10:25 AM, a face-to-face interview was conducted with Resident #102 (roommate of Resident # 94) regarding the posted sign on the inside door of the bathroom. The resident explained that he/she posted the sign to alert anyone entering the bathroom to check the floor before using the toilet because his/her roommate urinated on the floor, all the time. On July 29, 2014 at approximately 10:30AM, a face-to-face interview was conducted with Employee #30 regarding the aforementioned observations. The employee acknowledged the	F 241	Continued From page 5 1. The sign posted on the inside of the door of the bathroom was removed and no posted signs will be allowed to be placed in residents' bathroom door. The Unit Manager had a meeting and discussion with resident #102 to address residents' rights and dignity of all residents. Resident acknowledged understanding of discussion. 2. To identify other residents that Have the potential to be affected by this, a walk through of the facility has been accomplished to ensure that there are no posted signs that may infringe on the rights of others. 4. We have presented an in-service to staff on Resident Rights with focus on Resident Dignity for all residents. In addition observation of resident to resident interaction and observation of signs posted will be added as a line item on our weekly "Environment of Care Rounds" throughout the facility.	7/30/14 7/30/14 8/11/14 9/10/14 & On-going

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F 241	Continued From page 6 sign, but stated that he/she was unaware of it being posted on the door. He/she stated that Resident #102 had brought the matter to their attention and they were addressing it. The employee did not remove the sign from the door, and stated that the staff did not put the sign on the door. On July 31, 2014 at approximately 10:00 AM, a face-to- face interview was conducted with Resident #94 regarding the sign that was posted on the bathroom door. The resident acknowledged that he/she was aware of the sign and stated he/she would like it [the sign] to be removed, but his/her roommate wanted it up because he/she [Resident #94] sometimes accidentally urinated on the floor. On July 29, 2014 at approximately 10:35, July 30, 2014 at approximately 3:00 PM, and on July 31, 2014 at approximately 10:10 AM, observations were made of the resident's bathroom. There was no urine observed on the floor at those times. Additionally, on July 31, 2014 at approximately 3:00 PM, the sign was no longer observed on the bathroom door in the resident's room. On July 31, 2014 at approximately 5:00 PM, a face-to-face interview was conducted with Employee #4 regarding the aforementioned findings. He/she acknowledged the findings and explained that measures were in place to address the situation. Facility staff failed to promote one resident's dignity and respect by allowing the resident's roommate to post the signage regarding the resident health status symptom on the door of	F 241	Continued From page 6 4. To monitor for compliance the results of the Environment of Care Rounds will be compiled and reported Monthly x3 to QAPI for review and assessment for corrective measures as required. **#2** 1. Staffs have been instructed to knock and wait for acknowledgement before entering resident #102 and other residents' rooms. Staffs have also been instructed that if a resident is unable to respond to the knock, that they (staffs) must stand and wait briefly before entering residents' room. 2. To identify other residents that have the potential to be affected by this, department directors and managers conducted a walk through observing staff when they enter residents rooms. 3. System that have been put in place is to include the line item in our Environment of Care Rounds Monitoring Tool to include "Knock and wait for response or wait briefly before entering resident's room". In addition an in-service on Resident Rights with emphasis on "waiting for acknowledgement or waiting briefly for those residents who may not be able to acknowledge" has been presented.	Monthly & On-going Monthly x3 8/22/14 9/10/14 & Weekly & Monthly x3

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F 241	Continued From page 7 their bathroom. 2. Facility staff failed to promote dignity and respect for Resident #102 when he/she knocked on the door and entered the resident ' s room without first obtaining permission. During an interview with Resident #102 on July 29, 2014 at approximately 10:00 AM, Employee #30 was observed entering the resident's room without first requesting and/or obtaining permission. Resident #102 stated, "They [the staff] do that all the time. They knock but then barge right on in." A face-to-face interview was conducted with Employee #30 on July 29, 2014 at approximately 10:30AM. The employee acknowledged the aforementioned findings. Facility staff failed to promote dignity and respect for Resident #102 when he/she knocked on the door and entered the resident ' s room without first obtaining permission. 3. Facility staff failed to enhance/promote Resident #124's dignity by standing while feeding the resident. During the initial tour on July 28, 2014 at approximately 10:00 AM, Employee #33 was observed standing while feeding Resident #124. A face-to-face interview was conducted with Employee #30 at the time of the observation and he/she acknowledged the findings. Facility staff failed to enhance/promote Resident #124's dignity by standing while feeding the	F 241	Continued From page 7 4. Directors/managers will present the results of the Environment of Care rounds at the Monthly QAPI meetings of assessment for compliance. Corrective measures will be taken as required or as needed. **#3** 1. The employee have been instructed to never stand while feeding Resident #124. 2. To identify other residents that have the potential to be affected, observations of meal times were conducted in the facility. 3. In-service to reinforce the aspect of resident meal time experience and Resident Rights was presented to staff. We have put a system in place of increased accountability by all for compliance with resident meal time experience. A system of counseling and disciplinary process will be followed to ensure compliance. Also Directors and Managers will observe resident meal time experience and record their findings regarding compliance on this. 4.Directors and Managers will present the results of their meal time observations to the QAPI Committee monthly x3 for assessment and review of compliance.	Monthly & On-going Monthly x3 8/11/14 9/10/14 & Semi-Annual 9/11/14 & On-going 9/11/14 & On-going 9/11/14 & On-going Monthly x3

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F 241	Continued From page 8 resident.	F 241	Continued From page 8	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 29, 2014 between 10:00 AM and 1:00 PM, it was determined that the facility failed to provide effective maintenance services in residents' areas as evidenced by: marred walls in three (3) of 33 residents's rooms, a stained ceiling tile in one (1) of 33 resident 's room, a torn bedspread in one (1) of 33 resident's room, a malfunctioning wall clock in one (1) of 33 resident's room, a non-operational shower in one (1) of 33 resident's room, a lack of suction from the air vent in the bathroom of two (2) of 33 residents' rooms, and a malfunctioning toilet in (1) of 33 resident's rooms. The findings include: 1. Walls were marred in rooms # 109, and #145, two (2) of 33 residents' rooms surveyed. 2. A ceiling tile was stained in room #226, one (1) of 33 resident's room. 3. The bedspread in resident's room #143 was torn, one (1) of 33 resident's room. 4. The clock in resident room #310 was not operational, one (1) of 33 resident's room. 5. The shower in resident room #222 was not functioning, one (1) of 33 resident's rooms.	F 253	1. Walls in rooms # 109, and #145 have been painted. 8/11/14 2. Stained ceiling tile in resident's room #226 has been replaced. 7/29/14 3. Torn bedspread in resident's room #143 has been removed and replaced. 7/29/14 4. The clock in resident's room # 310 is now operational as the battery has been replaced. 8/5/14 5. Concerning non-functioning shower in resident # 222, the resident was informed that the shower was made non-functioning by facility for resident safety purpose. Resident acknowledge understanding of the reason and understanding of the availability of other shower area on the unit. 9/4/14 6. Air vent suction in residents rooms # 141 and # 245 have been repaired. 7/29/14 7. Malfunctioning toilets was corrected and the bathroom wall was painted. 7/29/14	

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F 253	Continued From page 9 6. There was no suction from the air vent in the bathroom of residents' rooms #141 and #245, two (2) of 33 residents' rooms. These observations were made in the presence of Employee 28 who acknowledged the findings. 7. On July 28, 2014 at approximately 10:30 AM during a tour of the resident's room, the following observations were made: The bathroom wall was marred and the toilet was malfunctioning and making a constant noise in one (1) of 33 resident's rooms observed. These observations were made in the presence of Employee #30, who acknowledged the aforementioned findings.	F 253	Continued From page 9 2. To identify other residents rooms that may be affected, we did a walk-through of all residents rooms. 3. We have put a system in place of weekly Environment of Care Rounds and system of immediate corrections by Building Services or areas not in compliance. 4.Results of the Environment of Care Rounds will be presented to the QAPI Committee monthly for review and assessment for compliance with corrective measures taken as required. The Building Service Manager, the Environmental Services Director and Administrator will monitor for compliance for 3 months.	8/11/14 9/11/14 & On-going Monthly & On-going Monthly x3
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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F 272	Continued From page 10 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 15 of 41 sampled residents, it was determined that facility staff failed to identify the location and date of the Care Area Assessment (CAA) information on the admission, annual or significant change Minimum Data Sets (MDS) under Section V0200A. Residents' #11, #34, #37, #42, #66, #70, # 88, #94, #113, #120, #146, #154, #157, #166, and #187. The findings include: According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, indicate the date and location of the CAA documentation...CAA documentation should	F 272	Continued From page 10 **#1** 1. Our electronic medical record software does not show on the CAA Summary the location of where the clinical record information could be found for areas triggered for Resident # 11's admissions MDS. Going forward staff have been instructed to ensure that he/she have the location and date on care areas triggered in the CAA worksheet.	9/10/14
			2. Our electronic medical record software does not currently to show on the CAA Summary the location of where the clinical record information could be found for care areas triggered for Resident #34's comprehensive. Going forward staff have been instructed to ensure that he/she have the date and location on care areas triggered on the CAA worksheet.	9/10/14
			3. Our electronic medical record software does not currently show on the CAA Summary, the location of where the clinical record information could be found for the care areas triggered for Resident #37's annual MDS. Going forward staff have been instructed to ensure that he/she have the date and location on care areas triggered on the CAA worksheet.	9/10/14

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F 272	Continued From page 11 include information on the complicating factors, risks and any referrals for the resident for this care area ... " 1. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission Minimum Data Set [MDS] for Resident #11. A review of Resident #11 ' s admission MDS with an Assessment Reference Date (ARD) of April 11, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence / Catheter, #11 Falls, #12 Nutrition, #15 Dental Care, #16 Pressure Ulcers, #17 Psychotropic Medication Use, #19 Pain, and #20 Return to Community Referral. The record reflects that the location and date of CAA information for care areas [# 5, 6, 11, 12, 15, 16, 17, 19, and 20] were recorded as " CAA 3.0 04/09/14. " There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found. In addition, there were no " CAA worksheets " available for review. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 10:20 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5,	F 272	Continued From page 11 4. Our electronic medical software does not show on the CAA Summary, the location of where the clinical record information could be found for the care areas triggered for Resident #42's annual MDS. Going forward staff have been instructed to have the location and date on care areas triggered on the CAA worksheet.	9/10/14
			5. Our electronic medical record software does not currently show on the CAA Summary, the location of where the clinical record information could be found for the care areas triggered for Resident #66's comprehensive MDS. Going forward staff have been instructed to have the date and location for care areas triggered on the CAA worksheet.	9/10/14
			6. Our electronic medical record software does not currently have the capability to show on the CAA Summary, the location of where the clinical record information could be found for the care areas triggered for Resident #70's comprehensive MDS. Going forward staff have been instructed to ensure that the date and location for care areas triggered are recorded on the CAA worksheet.	9/10/14

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F 272	Continued From page 12 2014. 2. Facility staff failed to identify the location and date of CAA information under Section V [V0200A], " Care Area Assessment Summary " of the comprehensive MDS for Resident #34. A review of Resident #34 ' s comprehensive MDS dated April 16, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #2 Cognitive Loss, #3 Visual Function, #4 Communication, #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, #15 Dental Care, #16 Pressure Ulcer, and #17 Psychotropic Medication Use. The record reflects that the location and date of CAA information for care areas [#2,3,4, 5, 6, 11, 12,14,15 ,16 and 17] were recorded as "CAA 3.0 04/17/2014 " . There was no evidence that facility staff documented where in the clinical record information related to the triggered areas could be found. In addition, there were no " CAA worksheets " available for review. A face-to-face interview was conducted with Employee # 2 on August 1, 2014 at 3:30 PM. He/she acknowledged that the date and location where information related to the CAA ' s could be found was not documented in the CAA Summary. The medical record was reviewed on August 1, 2014.	F 272	Continued From page 12 7. Our electronic medical record software does not currently have the capability to show on the CAA Summary, the location of where the clinical record information could be found for care areas triggered for Resident #88'comprehensive MDS . Going forward staff have been instructed to ensure that the date and location for care areas triggered are recorded on the CAA worksheet. 8. Our electronic medical record software does not currently show on the CAA Summary, the location of where the clinical record information could be found for care areas triggered for Resident #94's admission MDS. Going forward staffs have been instructed to ensure that the location and date for care areas triggered are recorded in the CAA worksheet. 9. Our electronic medical record software does not currently show on the CAA Summary, the location of where the clinical record information could be found for care areas triggered for Resident #113's annual MDS. Going forward staff have been instructed to ensure that the location and date for care areas triggered are recorded in the CAA worksheet.	9/10/14 9/10/14 9/10/14

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F 272	Continued From page 13 3.Facility staff failed to identify the location and date of CAA information under Section V [V0200A], " Care Area Assessment Summary " of the annual MDS for Resident #37. A review of Resident #37' s annual MDS dated March 25, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected triggered for #3 Visual Function. #5 ADL Functional Status, #11 Falls, #12 Nutrition, #14 Dehydration/ Fluid Maintenance, #16 Pressure Ulcers, and #17 Psychotropic Medication Use. The record reflects that the location and date of CAA information for care areas [#3, 5, 11, 12, 14, 16, and 17] were recorded as " CAA 3.0 03/25/2014. " There was no evidence that facility staff documented where in the clinical record information related to the triggered areas could be found. In addition, there were no " CAA worksheets " available for review. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 12:05 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 4.Facility staff failed to identify the location and date of CAA information under Section V [V0200A], " Care Area Assessment Summary " of the annual MDS for Resident #42.	F 272	Continued From page 13 10. Our electronic medical record software does not currently show on the CAA Summary, the location of where the clinical record information could be found for care areas triggered for Resident #120's admission MDS. Going forward staff have been instructed to ensure that the location and date for care areas triggered are recorded in the CAA worksheet.	9/10/14
			11. Our electronic medical records software does not currently show on the CAA Summary the location of where the clinical record information could be found for care areas triggered for Resident #146's admission MDS. Going forward staff have been instructed to ensure that the location and date for care areas triggered are recorded in the CAA worksheet.	9/10/14
			12. Our electronic medical record software does not currently show on the CAA Summary the location of where the clinical record information could be found for care areas triggered for Resident #154 annual MDS. Going forward staff have been instructed to ensure that the location and date for care areas triggered are recorded in the CAA worksheet.	9/10/14

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F 272	Continued From page 14 A review of Resident #42' s annual Minimum Data Set dated July 30, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #2 Cognitive Loss, #3 Visual Function, #4 Communication, #6 Urinary Incontinence / Catheter, #12 Nutrition, #13 Feeding Tube (s), #14 Dehydration/ Fluid Maintenance, #15 Dental Care and #16 Pressure Ulcers. The record reflects that the location and date of the Care Area Assessment for care areas [#3, 4, 6, 12, 13, 14, 15, and16] were recorded as " CAA 3.0 03/25/2014. " There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 12:10 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 5.Facility staff failed to identify the location and date of CAA information under Section V [V0200A], " Care Area Assessment Summary " of the comprehensive MDS for Resident #66. A review of Resident #66 ' s comprehensive MDS dated December 23, 2013 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #3 Visual Function, #4 Communication, #6 Urinary Incontinence / Catheter, #15 Dental Care, and #16 Pressure Ulcers.	F 272	Continued From page 14 13. Our electronic medical record software does not currently show on the CAA Summary the location of where the clinical record information could be found for care areas triggered for Resident #157's admission MDS. Going forward staff have been instructed to ensure that the location and date for care areas triggered are recorded in the CAA worksheet. 14. Our electronic medical record software does not currently show on the CAA Summary the location of where the clinical record information could be found for care areas triggered for Resident #166 admission MDS. Going forward staff have been instructed to ensure that the location and date of care areas triggered are recorded in the CAA worksheet. 15. Our electronic medical record software does not currently show on the CAA Summary the location of where the clinical record information could be found for care areas triggered for Resident #187's admission MDS. Going forward staff have been instructed to ensure that the location and date of care areas triggered are recorded in the CAA worksheet.	9/10/14 9/10/14 9/10/14

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F 272	Continued From page 15 The record reflects that the location and date of the Care Area Assessment for care areas [#3, 4, 6, 15, and16] were recorded as " CAA 3.0 03/25/2013." There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 12:15 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 6.Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the comprehensive MDS for Resident #70. A review of Resident #70' s comprehensive MDS dated June 4, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #3 Visual Function, #4 Communication, #5 ADL Functional Status, #6 Urinary Incontinence / Catheter, #11 Falls, #12 Nutrition, #15 Dental Care, #16 Pressure Ulcers and #17 Psychotropic Medication Use. The record reflects that the location and date of CAA information for care areas [#3, 4, 5, 6, 12, 15,16, and 17] were recorded as " CAA 3.0 06/11/2014. " There was no evidence that facility staff	F 272	Continued From page 15 #2 for 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 MDS's have been reviewed for residents' admissions, annual, and comprehensive MDS's within the last year to identify those residents that have the potential to be affected. #3 for 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 A required in-service for members of the interdisciplinary care team has been developed and presented to reinforce the MDS requirement for identifying the location and having the date for clinical record information for care areas triggered for the admissions, annual, comprehensive, significant change MDS's. An audit system has been put in place for the MDS Director will do continuous times 3 months monitoring for of the MDS's for compliance. #4 for 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 Results of the monitoring will be compiled monthly to assess the rate of compliance and this will be presented to the QAPI Committee at the monthly QAPI meetings x3 months.	9/11/14 9/11/14 Monthly & On-going Monthly x3 Monthly & On-going Monthly x3

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documented where in the clinical record information related to the CAA ' s could be found.

A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 12:30 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014.

7. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the comprehensive MDS for Resident #88.
A review of Resident #88's comprehensive MDS dated April 16, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #2 Cognitive Loss, #3 Visual Function, #4 Communication, #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, #15 Dental Care #16 Pressure Ulcer #and #17 Psychotropic Medication Use.

The record revealed that the location and date of CAA information for care areas [#2, 3, 4, 5, 6, 11, 12,14,15 ,16 and 17] were recorded as "CAA 3.0 04/17/2014 " .

There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review.

A face-to-face interview was conducted with

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Employee #2 on August 1, 2014 at 3:30 PM. He/she acknowledged that the date and location where information related to the CAA ' s could be found was not documented in the CAA Summary. The medical record was reviewed on August 1, 2014.

8.Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission MDS for Resident #94.

A review of Resident #94's admission MDS dated May 19, 2014 revealed that Care Area Triggered [and] the Care Planning Decision Area" were selected for #3 Visual Function, 4 Communication, #5 ADL Functional Status, #6 Urinary Incontinence/ Catheter, #11 Falls, #12 Nutrition, #15 Dental Care, #16 Pressure Ulcers, and #17 Psychotropic Medication Use.

The record reflects that the location and date of the Care Area Assessment information for care areas [#3, 4, 5, 6, 11, 12, 15, 16, and 17] were recorded as " CAA 3.0 05/28/2014."

There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found.

A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 10:03 AM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014.

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F 272	Continued From page 18 9. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set for Resident #113. A review of Resident #113's annual Minimum Data Set dated March 4, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" were selected for #5 ADL Functional Status, unction, #6 Urinary incontinence and Indwelling Catheter, #8 Mood State, #11 Falls, #12 Nutritional, and #16 Pressure Ulcer. The record revealed that the location and date of CAA information for care areas [#5, 6, 8, 11, 12, and 16] were recorded as "CAA 3.0 03/10/2014 " . There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. There were no " CAA worksheets " available for review. A face-to-face interview was conducted with Employee #2 on August 1, 2014 at 3:30 PM. He/she acknowledged that the date and location where information related to the CAA's could be found was not documented in the CAA Summary. The medical record was reviewed on August 1, 2014. 10. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission MDS	F 272		

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F 272	Continued From page 19 for Resident #120. A review of Resident #120's admission MDS dated July 18, 2014 revealed that Care Area Triggered [and] the Care Planning Decision Area" were selected for #3 Visual Function, #5 ADL Functional Status, #6 Urinary Incontinence / Catheter, #11 Falls, #12 Nutrition, #14 Dehydration/ Fluid Maintenance, and #16 Pressure Ulcers, The record reflects that the location and date of the Care Area Assessment information for care areas [#3, 5, 6, 11, 12, 14 and 16] were recorded as "CAA 3.0 07/18/2014." There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 12:00 PM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 11. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission MDS for Resident #146. A review of Resident #146's admission MDS dated June 8, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" triggered for: #2 Cognitive Loss,	F 272		

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F 272	Continued From page 20 #5 ADL Functional Status, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutrition, #14 Dehydration/ Fluid Maintenance, #16 Pressure Ulcers, #17 Psychotropic Medication Use and #20 Return to Community Referral, There was no evidence that the location and date of CAA information for care areas [#3, 5, 6, 11, 12, 14 and 16] were recorded as "CAA 3.0 06/12/2014." There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 11:10 AM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 12. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual MDS for Resident #154. A review of Resident #154's annual MDS dated January 28, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" triggered for, #5 ADL Function Status, #11 Falls, #15 Dental care, and #16 Pressure Ulcers. The record revealed that the location and date of CAA information for care areas [#5, 11, 15, and 16] were recorded as " CAA 3.0 02/03/2014."	F 272		

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F 272	Continued From page 21 There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets" available for review. A face-to-face interview was conducted with Employee #2 on August 1, 2014 at 3:30 PM. He/she acknowledged that the date and location where information related to the CAA's could be found was not documented in the CAA Summary. The medical record was reviewed on August 1, 2014. 13.Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission MDS for Resident #157. A review of Resident #157's admission MDS dated July 15, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" triggered for #2 Cognitive Loss, #3 Visual Function, #5 ADL, #6 Urinary Incontinence / Catheter, #7 Psychosocial Well-being, #9 Behavioral Symptoms, #11 Falls, #12 Nutrition, and #16 Pressure Ulcers. The record reflects that the location and date of the Care Area Assessment information for care areas [# 2,3 5, 6, 7, 9, 11, 12, and 16] were recorded as "CAA 3.0 07/16/2014." There was no evidence that facility staff documented the location in the clinical record	F 272		

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F 272	Continued From page 22 where the information related to the CAA's could be found. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 10:03 AM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 14. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission MDS for Resident # 166. A review of Resident #166' s admission MDS dated January 17, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" triggered for: #2 Cognitive Loss, #3 Visual Function, #4 Communication, #5 ADLs, #6 Urinary Incontinence /Catheter, #7 Psychosocial Well-Being, #10 Activities, #11 Falls, #13 Feeding Tube (s), #14 Dehydration/ Fluid Maintenance, #15 Dental Care, #16 Pressure Ulcers, #18 Physical Restraints, and #19 Pain. The record reflects that the location and date of the Care Area Assessment for care areas [# 2, 3, 4, 5, 6, 7, 10, 11, 13, 14, 15,16, 18, and 19] were recorded as "CAA 3.0 02/03/2014. " There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	08/05/2014

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
F 272	Continued From page 23 A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately 11: 50 AM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 5, 2014. 15. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission MDS for Resident #187. A review of Resident #187's admission MDS dated 07/01/2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" triggered for #5 ADL/ Functional Status, #6 Urinary Incontinence / Catheter, #11 Falls, and #16 Pressure Ulcers. The record reflects that the location and date of the Care Area Assessment information for care areas [#5, 6, 11, and 16] were recorded as "CAA 3.0 07/1/2014." There was no evidence that facility staff documented the location in the clinical record where the information related to the CAA's could be found. A face-to-face interview was conducted with Employee #9 on August 5, 2014 at approximately	F 272		