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 24 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.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 41 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches for one (1) resident receiving psychotropic medications, and for one (1) resident receiving an anxiolytic	F 279		

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 279	Continued From page 25 medication. Residents' #146, and 152. The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches and potential side effects to address the use of Buspirone (Therapeutic Class: Anxiolytic Medication) for Resident #146. According to a readmission " Physician Order Sheet and Plan of Care " signed June 19, 2014 at 11:00 AM directed, " Buspirone 10mg (milligram) - 1 po bid (twice a day) for anxiety disorder." A " Psychiatric Evaluation " dated 6/17/14 revealed, " Psychiatric Diagnosis: Anxiety, Depression. " A review of the June 2014 Medication Administration Record revealed initials in the allotted spaces indicating Buspirone was given daily at 9:00 AM and 9:00 PM. A review of the care plan section of the clinical record was last updated June 17, 2014. There was no evidence that a care plan was initiated with goals and approaches for the use of and potential side effects for Resident #146 ' s anxiolytic medication.	F 279	Continued From page 25 **# 1** 1.Care plan has been initiated for Resident #146 to address the use of Buspirone, with the goals and approaches and potential side effects. 2.Care plan has been initiated for Resident # 152 to address the use of Psychotropic medications (Prozac, Xyprexia, Klonopin) with goals and approaches and potential side effects. **#2 for 1, 2** To identify other residents that have the Potential to be affected, medical records and care plans have been reviewed for residents on anti-anxiety medications and psychotropic medications. **#3 for 1, 2** In-service on care planning to reinforce the Care planning process and need to initiate Care plans for residents on anti-anxiety and psychotropic medications. We have put a system in place for unit managers to review care plan documentation monthly and quarterly to ensure care plans are initiated.	7/31/14 7/31/14 9/8/14 9/11/14

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 279	Continued From page 26 A face-to-face interview was conducted with Employee #6 on July 31, 2014 at approximately 4:00PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on July 31, 2014. 2. Facility staff failed to initiate a care plan with goal and approaches for the use of and potential side effects of Psychotropic medications for Resident #152. A review of the resident's annual MDS revealed that it was coded for the use of Psychotropic medications. A review of the resident ' s clinical record revealed a physician ' s order which directed that the resident receive the following: Prozac 10 mg (milligrams) PO (by mouth) daily Xyprexia 2.5mg PO PRN (as needed) for Psychosis Klonopin 0.5mg PO PRN for Agitated behavior. A review of the care plan section located on the resident ' s record, revealed that there was no care plan initiated for the use of and potential side effects from the use of psychotropic medications. A face-to-face interview was conducted with	F 279	Continued From page 26 #4 for 1, 2 To monitor for compliance, Assistant Director of Nursing/designee with unit managers, and Director of Nursing will present results of care plan reviews to QAPI Committee monthly for 3 months.	Monthly & On-going Monthly x3

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 279	Continued From page 27 Employee #5 at approximately 3:00 PM on July 31, 2014. The employee acknowledged the finding during the interview. The record was reviewed on July 31, 204.	F 279	Continued From page 27	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 41 sampled residents, it was determined that facility staff failed to amend a care plan to include a cervical head pillow to prevent right cervical flexion contracture for Resident #42.	F 280		

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 280	Continued From page 28 The findings include: Resident #42 was observed on August 1, 2014 at approximately 1:30 PM. He/she was lying on his/her back with a white triangle shaped cervical neck foam pillow around his/her neck. His/her head and neck was slightly positioned towards his/her right shoulder. A history and physical dated October 20, 2013 revealed Resident #42 diagnoses included CVA (Cerebral Vascular Accident) with Left Hemiplegia. A review of an " Occupational Therapy Screen Form " dated August 4, 2014 revealed; " [Patient] was referred to OT (Occupational Therapy) for head neck positioning. Patient was seen in room supine [lying on back] be in bed with head/neck well positioned with triangular wedge, cervical pillow and regular pillow. [Patient ' s] head neck was observed to be well positioned and supported. No decline in ROM (range of motion) or change in pain noted from prior status. No new intervention needed at this time. Nursing can continue to position [patient] as per previous OT recommendation .... " A review of the care plan updated May 11, 2014 lacked evidence that the care plan was amended	F 280	Continued From page 28 # 1.The care plan for Resident #42 has been amended to include the cervical pillow as an intervention for resident's contracture. #2. To identify other residents that may be affected, all residents' clinical records and care plans have been reviewed to ensure that care plans are updated. #3. In-service on care planning to reinforce the care planning process and need to update care plans for residents. We have put a system in place for Unit Managers to review care plan Documentations monthly x3 and quarterly Ensure care plans are updated. #4. To monitor for compliance Assistant Director of Nursing, Unit Managers and Director of Nursing will present results of Care Plan review to QAPI Committee Monthly for 3 months.	9/5/14 9/11/14 9/11/14 Monthly Quarterly On-going Monthly & On-going Monthly x3

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 280	Continued From page 29 to include the use of a cervical pillow as a specific intervention for Resident #42 ' s right cervical flexion contracture. A face-to-face interview was conducted with Employee #4 on August 1, 2014 at approximately 2:00 PM. He/she acknowledged that the cervical pillow was not included in the interventions for the resident ' s contracture care plan. The record was reviewed August 1, 2014. Facility staff failed to amend a care plan to include specific interventions for Resident #42 ' s right cervical flexion contracture.	F 280	Continued From page 29	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews for 10 of 41 sampled residents, it was determined that the facility staff failed to provide care and services to attain the residents ' highest practicable physical, mental, and psychosocial well-being as	F 309		

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 309	Continued From page 30 evidenced by failure: to ensure that one (1) resident was seen by the psychiatrist for a recommended three month follow-up evaluation; failed to administer medications in accordance with the physician ' s order for nine (9) residents; and failed to perform blood glucose checks as ordered for one (1) residents. Residents' # 11, 24, 34, 37, 90, 143, 152, 154, 157, and 166. The findings include: 1. Facility staff failed to follow the physician 's order for administration of the appropriate dose of Insulin, based on the blood glucose level (sliding scale) for Resident # 11. Insulin coverage was not administered according to the sliding scale on July 28, 2014 at 6:30 AM. The nurse administered 3 units, instead of 4 units of Humalog Insulin coverage. A review of Residents #11 ' s clinical record on August 1, 2014, revealed that he/she was admitted to the facility on April 3, 14 with diagnoses which included Diabetes Mellitus, Right Foot Abscess, Peripheral Vascular Disease, Right Below Knee Amputation, Left Second Toe Amputation, Hypertension (HTN), and Dementia. A physician ' s order dated July 23, 2014 directed, " ...Sliding Scale: Humalog Insulin coverage as follows: 6:30 AM and 4:30 PM; Blood Sugar of 150-200= 2 Units, 201- 250= 3 Units, of 251- 300= 4 Units, 301- 350= 5 Units, > [greater than] 351 units = 6 Units, < [less than] 60 and > 400	F 309	Continued From page 30 **#1 for 1, 2,** Based on the type of the deficiency for Resident #11 and the deficiency for Resident #24 we cannot retroactively make corrections to these deficiencies. Employees have been counseled and one on one competency was conducted for the nurses involved. **#2 for 1, 2** To identify other residents that may have the potential to be affected by this, medication administration records have been reviewed to ensure that the correct insulin route and dosages have been given to residents as ordered by the physician. **#3 for 1, 2** We have put a system in place to conduct one to one competency for nurses identified by their managers as needing teaching. Also our Education Department has increased the frequency of competency for nurses from annual to semi-annual in the area of medication administration. In addition we will have a list of residents with diagnosis of Diabetes per unit location in the facility. This list will be utilized by the charge nurses to review per shift for to observe return demonstration for those nurses identified during the survey for accuracy of administration of the insulin ordered. The charge nurse will report to the Unit Manager the findings of the shift review.	8/18/14 8/29/14 8/18/14 8/18/14 & Semi-Annual 9/11/14 & Daily

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 309	Continued From page 31 call MD ... " There was no evidence that the route of administration was included in the physician ' s order. A review of the Medication Administration Record for July 2014 revealed that on July 28, 2014 the nurse documented his/ her initials, a blood sugar level of 252 milligrams per deciliter (mg/dL), the site were the medication was administered, and " 3U [Units]. According to the sliding scale the resident should have received 4 Units of Humalog Insulin coverage. There was no evidence that facility staff administered insulin in accordance with the physician's order for Resident # 11. A face-to-face interview was conducted with Employee #6 on August 5, 2014 at approximately 12:50 PM. He/she acknowledged the findings. The record was reviewed on August 5, 2014. 2. Facility staff failed to administer insulin in accordance with the physician's order for Resident #24. On July 31, 2014 at approximately 3:30 PM, a Medication Administration Record [MAR] review revealed an order for Resident #24 as follows: " Novolog [fast acting insulin] 100units/ml [milliliter] sub-Q[subcutaneous] inject per sliding scale:	F 309	Continued From page 31 **#4 for 1, 2** The Unit Managers will compile the charge nurses' reports and present to the Director of Nursing for further review. This will be presented at monthly QAPI Committee meetings for review and analysis for compliance. The Assistant Director of Nursing and Director of Nursing will monitor for compliance. **3, 8** #1 The eye drops were administered to resident 7/29/14. The inhaler was administered to Resident #154 #2 To identify other residents that have the potential to be affected, all Medication Administration Records have been reviewed to ensure residents receive their eye drops; also to ensure that residents receive their inhalers. #3 We have put a system in place to generate and utilize the "exception report" per shift to review and account for accuracy of medications administered as ordered. The charge nurses will review the exception report and report to the Unit Manager and/or off Shift Supervisors the results of the review of the exception reports. We have also put a system in place to have the charge nurse record on the 24-Hour Report any medications that are not delivered by Pharmacy as required. After faxing of the orders this information	Monthly & On-going 8/29/14 9/10/14 9/10/14 & On-going

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 309	Continued From page 32 Check blood sugar 6:30 AM 9:30 PM 0-200=0 units 201-250 = 1unit 251-300 = 2 units 301-350 = 3 units 351-400 = 4 units 401 and above = 5 units Call MD if less than 60 or greater than 400 " The MAR revealed on July 14, 2014 at 9:30 PM the blood sugar result of " 222 " , the insulin dose administered " 0 " , and the site " 0. " According to the physician's order the resident should have received one unit of insulin. There was no evidence that facility staff administered insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 who acknowledged the aforementioned findings. He/she stated he/she would address the findings with the appropriate staff member. 3. Facility staff failed to administer eye drops as ordered by the physician for Resident #34. During a medication administration observation on July 31, 2014 at approximately 10:00 AM, Employee #15 stated that the resident's eye drops were not present or available. A review of the Medication Administration Record (MAR) for Resident #34, revealed the eye drops had been documented as " held " on July 30, 2014. When queried why the medication was not administered, Employee # 15 stated " pharmacy was probably faxed a requisition to replace the medication and it has not been delivered " .	F 309	Continued From page 32 will also be included on the 24-Hour report for effective follow up and follow through if the medication is not received during the shift; to make sure the incoming shift and the supervisor contact pharmacy. This will ensure that medications are followed up on with the Pharmacy if not delivered. #4 Results of the exception reports will be presented and analyzed at the monthly QAPI meetings. Unit Managers and Supervisors will also report the results of analysis Director of Nursing and Assistant Director of Nursing. Follow through with pharmacy will also be presented at the monthly QAPI meetings. Compliance will be determined for corrective action as required. **4A; 4B** #1 Due to the nature of the deficiencies, we cannot correct the deficiencies for Resident # 37. The employees/staff have been counseled to ensure that physician's orders are transcribed accurately, and also to ensure that medications are not missed when resident goes on medical appointments. #2 To identify other residents that may have the potential to be affected, we have reviewed Medication Administration Records, to ensure that the medications are not missed.	Monthly & On-going Monthly x3 8/29/14 9/10/14

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 309	Continued From page 33 A review of the Physician's Order Form dated and signed July 28, 2014 under routine medications revealed, " Lumigan 0.01% drops instill 1drop in each eye every day for glaucoma " . A review of the unit's record of faxes to the pharmacy for the dates July 24 through July 29 2014 requesting medications revealed no evidence of a fax requesting Resident #34 ' s eye drops. A face-to-face interview was conducted with Employee #5 on July 31, 2014 at approximately 10:30 AM. When queried regarding the process for obtaining medications for residents the employee stated, "The request for medications are faxed to the pharmacy and the medications are delivered during the next delivery of routine medications." There was no evidence that facility staff followed through with the physician ' s order for administering the eye drops. Facility staff failed to administer eye drops or follow through on a physician ' s order for eye drops to be administered daily for treatment of glaucoma for two days July 30 2014 and July 31, 2014.The findings were acknowledged by Employee #5 on July 31, 2014 at approximately 10:45 AM. The medical record was reviewed on July 31, 2014. 4A. Facility staff failed to administer Resident #37 ' s medications in accordance to the physician ' s orders.	F 309	Continued From page 33 #3 We have put a system in place for the night shift charge nurses to audit physicians' orders daily to ensure that physicians orders are transcribed accurately. We have also put a system in place to generate residents appointment list weekly of residents going on appointments for the week. This list will be used by the charge nurse in order to contact the physician for change in the medication time if medical appointment will impact on the time of medication administration. The Unit Manager or designee has responsibility to ensure this process/system is followed. Also the Medication Administration (ALL) policy has been updated to include the procedure for administration pre or post resident medical appointment. #4 The above procedures will be monitored and reported by the Unit Managers to the QAPI Committee monthly for compliance. Reports will also be presented to Assistant Director of Nursing and Director of Nursing for monitoring. **5, 6, 9, 9B & 10** #1 Due to the type of the deficiency Resident #90, we cannot correct retroactively this specific, but the staff have been counseled to ensure that physician's orders for insulin are carried out as ordered.	9/10/14 Daily & On-going 9/10/14 Monthly & On-going Monthly x3 8/29/14

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 309	Continued From page 34 An annual history and physical dated July 28, 2013 revealed Resident #37 ' s diagnoses included Osteoarthritis, COPD (Chronic Obstructive Pulmonary Disease), Hypertensive Cardiovascular Disease and Peripheral Artery Disease. An " Interim Physician's Order " dated May 19, 2014 at 2:00 PM directed, " Salon Pas patch one (1) to [left] ankle, [right] knee, [left hand], [left] neck daily x 30 days for pain. A review of the May 2014 and June 2014 Medication Administration Records revealed that nurses ' initialed in the allotted spaces, indicating the medication was administered daily from May 20, 2014 to June 16, 2014. The record revealed that the resident received the medication for 26 days rather than 30 days as prescribed by the physician. A face-to-face interview was conducted with Employee #6 on July 31, 2014 at approximately 11:30 AM. He/she stated, " The nurse transcribed the order to end on June 16, 2014 instead of June 20, 2014. " The clinical record was reviewed on July 31, 2014. Facility staff failed to administer Resident #37 ' s pain medication in accordance to the physician ' s orders for four days. There were no untoward effects on the resident.	F 309	Continued From page 34 Also we cannot correct this specific deficiency for Resident #143. The staff also has been counseled for orders going forward to make sure insulin orders are administered as ordered.	8/29/14
			Also we cannot correct this specific deficiency for Resident #157 regarding glucose check. The staff has been counseled to ensure that blood glucose check is done and insulin is administered as ordered by physician. Also we cannot correct specific deficiency for Resident #166.	8/29/14
			#2 To identify other residents that may have the potential to be affected, Medication Administration Records have been reviewed to ensure that residents receive the blood glucose checks and insulin as ordered.	9/10/14
			#3 We have put a system in place to conduct one to one competency for nurses identified by their managers as needing further teaching on insulin administration.	9/10/14
			Our Education Department has also increased the frequency of clinical competencies for nurses from annual to semi-annual in the area of medication administration for the next year. In addition we will have a list of residents with diagnosis of Diabetes per unit location in the facility. This list will be utilized by the	9/10/14

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 309	Continued From page 35 B. Facility staff failed to administer Resident #37 ' s medication in accordance to physician ' s orders as evidenced by medication not administered prior or post an ophthalmology appointment. An annual history and physical dated July 28, 2013 revealed Resident #37 ' s diagnoses included Osteoarthritis, COPD (Chronic Obstructive Pulmonary Disease), Hypertensive Cardiovascular Disease and Peripheral Artery Disease. According to a consultation evaluation report, Resident #37 had an ophthalmology appointment on July 1, 2014 at 8:00 AM. The "Physician's Order Form" signed July 5, 2014, directed that the resident was to receive the following medications at 9:00 AM: Tylenol Extra Strength- 500mg - 2 caplets po (by mouth), Norvasc 5mg- 1 tablet po, Lisinorpil 10mg- 1 tablet po, Cozaar 50mg- 1 tablet po and Atrovent- one vial via nebulizer at 12:00 PM. A review of the July 2014 MAR revealed that on July 1, 2014 circled initials were in the allotted spaces for the 9AM and 12 Noon meds. The MAR exception report revealed, " 9 AM and 12 Noon Meds Held. "	F 309	Continued From page 35 charge nurses to review and observe return demonstration for those nurses identified during the survey for accuracy of insulin administration ordered by physician. The charge nurse will report to the Unit Manager the findings of the shift review. #4 The Unit Managers will compile the results of the reports and report to the Director of Nursing weekly for further review. This will be presented to the QAPI Committee meetings monthly for analysis of compliance 7 #1 Resident #152 has been seen by the Psychiatrist 9/9/14 #2 To identify other residents that may have the potential to be affected, we have reviewed and audited residents' charts that have orders for psychiatrist consultation and recommendations to ensure that all those residents have been seen by their psychiatrist. #3 We have put a system in place to compile a list with names, scheduled dates to be seen (appointment dates), and name of psychiatrist to ensure residents will not miss their consultation psychiatrist appointments. The Unit Manager will review this list bi-weekly to ensure compliance.	Weekly, Monthly & On-going Monthly x3 9/9/14 9/10/14 9/10/14 & Bi-weekly Monthly x3

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 309	Continued From page 36 A nurses ' notes dated July 1, 2014 at 9:26 AM and 2:18 PM revealed, " Held [medication named], Reason: out of building. " There was no evidence that the prescribed medications were given at 9:00 AM and 12 Noon or when resident returned to the facility after scheduled appointment. In addition, there was no evidence that licensed staff explored alternative options such as querying the physician to modify the dosing schedule to accommodate the resident ' s ' ophthalmology appointment ' schedule. A face-to-face interview was conducted with Employee #6 on August 1, 2014 at approximately 3:00 PM. After reviewing the clinical record, he/she acknowledged the aforementioned findings. The clinical record was reviewed on August 1, 2014. 5. Facility staff failed to administer insulin as ordered by the physician for Resident #90. On July 31, 2014 at approximately 3:32 PM, a record review revealed an order for Resident #90 as follows: " Novolog R [short- acting insulin] 100units/ml [milliliter] sub-Q[subcutaneous] inject per sliding scale: Check blood sugar t.i.d. [three times a day] 6:00 AM 12:00 Noon 4:30 PM 0-150 = 0 units	F 309	Continued From page 36 review this list bi-weekly to ensure compliance. #4 The Unit Manager will present reports to the Director of Nursing monthly and will also present to the QAPI Committee meetings monthly to analyze and assess for compliance. The Director of Nursing and Assistant Director of Nursing will monitor for compliance.	Monthly & On-going Monthly x3

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 309	Continued From page 37 151-200 = 3 units 201-250 = 5 units 251-300 = 7 units 301-350 = 9 units 351-400 = 10 units <60 or >400 = call MD " The MAR record review revealed on July 26, 2014 at 4:30 PM, the blood sugar result of "151" , the insulin dose administered " 2u[units], " to " RLQ " [Right Lower Quadrant]. According to the physician's order the resident should have received three units of insulin. There was no evidence that facility staff administered insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 on August 5, 2014 at approximately 10:00 AM who acknowledged the aforementioned findings. He/she stated he/she would address the findings with the appropriate staff member. There was no evidence that facility staff administered insulin as ordered by the physician for Resident #90. The record was reviewed on 6. Facility staff failed to administer insulin in accordance with the physician's order for Resident #143. On July 31, 2014 at approximately 3:40 PM, a review of the MAR revealed an order for Resident #143 directed the following:	F 309		

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 309	Continued From page 38 " [Humalog KwikPen] Flexpen [fast-acting insulin in injectable pen form] Insulin Lispro (Human) 100units/ml [milliliter] Solution Pen-injector sub-Q [subcutaneous t.i.d. [three times a day] 6:30 AM 11:30 AM 4:30 PM Less than 150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 =6 units 301-350 = 8 units 351-400 = 10 units <60 or >400 please call MD " A further review of the MAR revealed that on July 29, 2014 for 11:30 AM, the result box, dose box, site box, and initial box contained the typed letters, " EAH." There was no evidence that facility staff administered insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 on August 5, 2014 at approximately 10:00 AM who acknowledged the aforementioned findings. When asked to explain what " EAH " meant, he/she stated they were employee initials. When asked if the resident received a blood sugar check at 11:30 AM, he/she could not determine if the blood sugar had been checked. 7. Facility staff failed to ensure that one resident was seen by the psychiatrist for a recommended three month follow-up evaluation for Resident #152.	F 309		

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 309	Continued From page 39	F 309		

A review of the Physicians ' orders on the clinical record revealed a " Consultation Report " , which was written and signed by the psychiatrist on September 24, 2014. In response to the following query: " Do you need to see the resident again? " (at the end of the report) the psychiatrist responded, " Yes. "

However, a review of the record revealed that the resident has not been seen by the psychiatrist since that time. Further review of the record failed to reveal any reason why the resident was not seen as was recommended by the psychiatrist.

A face-to-face interview was conducted with Employee #5 at approximately 3:00 PM on July 31, 2014. Employee failed to respond to a query as to why the resident was not seen for the recommended follow up. The record was reviewed on July 31, 2014.

8.Facility staff failed to administer the medication in accordance with the physician ' s order for Resident #154.

During a medication administration observation on July 31, 2014 at approximately 10:00 AM, Employee #15 stated the resident's " inhaler was not present or available." A review of the MAR for Resident #154, revealed the inhaler had been documented as " held " on July 30, 2014. Employee #15 was queried as to why the medication was not administered, Employee # 15 stated, " pharmacy was probably faxed a requisition to replace the medication and it has not been delivered."

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 309	Continued From page 40 A review of the Physician's Order Form dated and signed July 28, 2014 under routine medications revealed, " Advir Diskus 250-50 MCG Disk W/DEV one puff by mouth twice daily for Chronic Obstructive Pulmonary Disease " . A review of the unit faxes to pharmacy for the dates July 24 through July 29 2014 the pharmacy requesting medications revealed no evidence of a faxes requesting Resident #34 ' s inhaler. A face-to-face interview was conducted with Employee #5 on July 31, 2014 at approximately 10:30 AM, when queried regarding the process for obtaining medications for residents he/she stated the request for medications is faxed to the pharmacy and they are delivered during the next delivery of routine medications. There was no evidence that facility staff followed through with the physician ' s order for administering the inhaler. Facility staff failed to administer the medication or follow through on a physician ' s order for the inhaler to be administered for treatment of COPD for two days July 30 2014 and July 31, 2014. The findings were acknowledged by Employee #5 on July 31, 2014 at approximately 10:45 AM. The medical record was reviewed on July 31, 2014. 9. Facility staff performed the blood glucose check or administered the insulin in accordance with the physician ' s order for Resident #157. On July 31, 2014 at approximately 3:34 PM, a record review revealed an order for Resident #157 as follows:	F 309		

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 309	Continued From page 41 " Give 6 units of Novolog Flexpen [fast-acting insulin in injectable pen form] sub-Q[subcutaneous] before meals 7:30 AM 11:30 AM 5:00 PM Hold for blood sugar of 100 or less " A review of the MAR revealed the following for 11:30 AM: On August 3, 2014 - blood sugar result box, dose box, site box, and initial box was observed to be blank. There was no evidence that facility staff performed the blood glucose check or administered the insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 who acknowledged the aforementioned findings. When asked if the resident received a blood sugar check at 11:30 AM, he/she was unable to determine if the blood sugar had been checked. He/she explained that he/she was going to address the appropriate staff members. The record was reviewed on July 31, 2014. B. Facility staff failed to administer insulin as ordered by the physician for Resident #157. On July 31, 2014 at approximately 3:34 PM, a record review revealed an order for Resident #157as follows: " Give 6 units of Novolog Flexpen Flexpen [fast-acting insulin in injectable pen form] sub-Q[subcutaneous] before meals 7:30 AM	F 309		

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 309	Continued From page 42 11:30 AM 5:00 PM Hold for blood sugar of 100 or less " A review of the MAR revealed the following for 5:00 PM: On July 28, 2014 - blood sugar result " 200, " the insulin dose administered " 0," to " RA" [Right Arm]. On July 29, 2014 - blood sugar result " 199, " the insulin dose administered " 0 " to site "0" On July 31, 2014 - blood sugar result " 145, " the insulin dose administered " 0 " to " RA" [Right Arm]. On August 2, 2014 - blood sugar result " 187, " the insulin dose administered " 0 " to "RA" [Right Arm]. On August 3, 2014 - blood sugar result " 157, " the insulin dose administered " 0 " to "LA" [Left Arm]. On August 4, 2014 - blood sugar result " 149, " the insulin dose administered " 0 " to "RA" [Right Arm]. According to the physician's order the resident should have received 6 units of insulin of the aforementioned dates. There was no evidence that facility staff administered insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 who acknowledged the aforementioned findings. He/she was unable to determine if insulin had been administered. He/she explained that he/she was going to make a phone call to the Employee to address the findings. 10. Facility staff failed to administer Nystatin	F 309		

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 309	Continued From page 43 (Therapeutic Class: Antifungal Medication) for treatment of Oral Thrush in accordance to physician ' s orders for Resident #166. During a family interview conducted with Resident #166 ' s responsible party on July 30, 2014 at approximately 12:33 PM, when asked, " Does [resident ' s name] have any tooth problems, gum problems, mouth sores or denture problems? He/she responded, " [He/she] has thrush. They have ordered medication for [his/her] mouth to be cleaned. Nurses try to clean it, but she/she can be resistant. The nurses ' do the best they can. " On July 30, 2014 at approximately 12:32 PM, Resident #116 was observed sitting in Geri chair and with a white substance on his/her tongue. An " Interim Order Form " dated July 31, 2014 directed: " Nystatin 100, 000 ml, 5 ml (millimeters) -swab in mouth tid (three times a day) for 10 days for oral thrush. A review of the MAR for July 4, 2014 revealed the allotted space was blank which indicated the Nystatin was not administered at 10:00PM. There was no evidence that facility staff administered Nystatin to Resident #166 in accordance with physician ' s orders on the above mentioned date.	F 309		

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 309	Continued From page 44 A face-to-face interview was conducted with Employee #6 on July 31, 2014 at approximately 11AM. After reviewing the clinical record, he/she acknowledged the findings. The record was reviewed on July 31, 2014.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interviews for one (1) of 41 sampled residents, it was determined that facility staff failed to carry out activities of daily living necessary to maintain adequate grooming and personal hygiene for one (1) resident as evidenced by Resident #94 ' s drooling and smelled malodorous. The findings include: During an interview with Resident #94 on July 31, 2014 at approximately 10:00 AM, the resident was observed with a white towel draped around his neck and drooling continuously. He/she was also observed to be malodorous. When asked why he/she had the towel around his/her neck, the resident stated that his/her medication made him/her drool and the towel was to wipe his/her	F 312	As noted the staff received a telephone order for Scopolamine base 1.5mg patch for 14 days for Drooling /excessive secretion. In addition the attending physician gave a telephone order for the same medication, Scopolamine Base 1.5MG Patch 72 Hour transdermal place behind ear every three days for 30 days. Also resident has been placed on toileting program. In addition resident has been scheduled for more frequent special care meetings.	8/1/14 9/9/14 9/8/14 9/10/14

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 312	Continued From page 45 mouth. When queried about his/her bathing schedule, he/she stated that he/she took a bath in the morning but sometimes he/she accidentally leaked urine. On July 31, 2014 at approximately 5:10PM, a face-to-face interview was conducted with Employee #4 who acknowledged the aforementioned findings. The employee explained that the staff was doing the best they could to address the personal hygiene matter and malodorous smell. He/she explained that the resident had a history of Bladder Cancer, urinary incontinence, and resistance to care. The employee continued to explain that on July 24, 2014 during a leadership meeting, the plan was made to place the resident on a toileting schedule, which would be implemented by the restorative aide every two hours, after meals, and as needed. He/she further stated, " The plan was delayed secondary to the Annual Survey. " Facility staff failed to carry out activities of daily living necessary to maintain good grooming and personal hygiene for Resident #94 who was observed to be malodorous and drooling continuously. A face-to-face interview was conducted on August 1, 2014 with Employee #14 and Employee #32 regarding the resident's drooling. Both employees stated that they have always known the resident to drool. When asked how the issue is being addressed and if the physician was made aware, neither had addressed the concern. A face-to-face interview was conducted with Employee #30 who acknowledged the aforementioned findings. He/she obtained a	F 312	Continued From page 45 #2 To identify other residents that may be potential to be affected, we have done a review and of residents medical records with diagnosis of schizpohrenia and checked diagnoses, to ensure that there are no residents requiring activities of daily living assistance that may impact their grooming and personal hygiene. #3 A system has been put in place to increase the frequency of special interdisciplinary care meetings for residents who frequently refuse care, in order to try more solutions to prevent negative impact on grooming and personal hygiene. For residents that have this need, Special interdisciplinary care meetings will be held twice a week for a month to discuss with the resident and try other solutions and determine the best intervention. Residents who refuse care will be referred to the attending physician for follow up and clinical intervention as required. Residents who refuse care will also be referred to the restorative nursing aide for further evaluation on a routine basis. #4 The Unit Manager will report the results of the special care meetings weekly to the Director of Nursing. Director of Nursing will compile weekly report for review, and present monthly at the QAPI meetings for	9/9/14 9/9/14 & On-going 9/8/14 Weekly & On-going Monthly & On-going Monthly x3

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 312	Continued From page 46 telephone order from Employee #37 for a Scopolamine [anticholinergic medication used for excessive secretions]. Facility staff failed to carry out activities of daily living necessary to maintain good grooming and personal hygiene.	F 312	Continued From page 46 analysis and review. The Director of Nursing and Assistant Director of Nursing will monitor for compliance.	
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on July 29, 2014 at approximately 4:00 PM, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by five (5) of six (6) cleaning carts that were left unattended and unlocked, with cleaning chemicals accessible to residents in one (1) of two (2) hallways by the main dining room on the ground floor. The findings include: Five (5) of six (6) cleaning carts were left unattended and unlocked in one (1) of two (2) hallways next to the main dining room on the ground floor. Cleaning chemicals were stored in the carts and were accessible to residents.	F 323	**#1** The cleaning carts were locked by the Environmental Services staff at 4:05 pm, 7/29/14 **#2** All cleaning carts were checked and observed and the carts were locked with the cleaning chemicals locked inside the carts. **#3** We have put a system in place for the Environmental Service Supervisor to recheck all the cleaning carts at the end of the shift to validate that the chemicals are placed inside the carts and locked. A log will be maintained for this purpose. **#4** The Environmental service supervisor will report findings of compliance to the Director of Environmental Services and this will be presented at the monthly QAPI Committee meetings. The Environmental Services Director and the Administrator Will monitor for compliance for 3 months.	7/29/14 7/29/14 9/9/14 & On-going Monthly & On-going Monthly x3

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 323	Continued From page 47 These observations were reported to Employee #1 who acknowledged the findings and proceeded to have the carts locked and secured.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of 41 sampled residents, it was determined that facility staff failed to keep the	F 329		