

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	<p>Initial Comments</p> <p>A Licensure Survey was conducted on August 5, 2014. The deficiencies are based on observations, record review, resident and staff interviews for 41 sampled residents.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p>Abbreviations</p> <p>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 DI - 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 Mg - Milligrams (metric system unit of mass) mL - Milliliters (metric system measure of</p>	L 000	<p>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.</p>	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Nava J. Wejler

TITLE

Interim Administrator 9/10/14

(X6) DATE

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 1 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	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 2</p> <p>appropriate goals and approaches, and revising them as needed;</p> <p>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;</p> <p>(e)Supervising and evaluating each nursing employee on the unit; and</p> <p>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:</p> <p>A. 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.</p> <p>The findings include:</p> <p>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 include information on the complicating factors, risks and any referrals for the resident for this care area ... "</p> <p>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.</p>	L 051	<p>Continued From page 2</p> <p>#1</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>9/10/14</p> <p>9/10/14</p> <p>9/10/14</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 3</p> <p>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.</p> <p>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. "</p> <p>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.</p> <p>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, 2014.</p> <p>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.</p> <p>A review of Resident #34's comprehensive MDS dated April 16, 2014 revealed that "Care Area</p>	L 051	<p>Continued From page 3</p> <p>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.</p> <p>9/10/14</p> <p>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.</p> <p>9/10/14</p> <p>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.</p> <p>9/10/14</p>	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 4</p> <p>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.</p> <p>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 " .</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	L 051	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>9/10/14</p> <p>9/10/14</p> <p>9/10/14</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 5</p> <p>Pressure Ulcers, and #17 Psychotropic Medication Use.</p> <p>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. "</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	L 051	<p>Continued From page 5</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>9/10/14</p> <p>9/10/14</p> <p>9/10/14</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 6</p> <p>3.0 03/25/2014. "</p> <p>There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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."</p> <p>There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found.</p> <p>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</p>	L 051	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>9/10/14</p> <p>9/10/14</p> <p>9/10/14</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 7</p> <p>triggered care areas could be found was not recorded. The record was reviewed August 5, 2014.</p> <p>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.</p> <p>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.</p> <p>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. "</p> <p>There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found.</p> <p>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.</p> <p>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</p>	L 051	<p>Continued From page 7</p> <p>#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.</p> <p>#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.</p> <p>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.</p> <p>#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.</p>	<p>9/11/14</p> <p>9/11/14</p> <p>Monthly & On-going Monthly x3</p> <p>Monthly & On-going Monthly x3</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 051	<p>Continued From page 8</p> <p>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.</p> <p>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 " .</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A review of Resident #94's admission MDS dated May 19, 2014 revealed that Care Area Triggered [and] the Care Planning Decision Area" were</p>	L 051		
-------	---	-------	--	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 9</p> <p>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.</p> <p>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."</p> <p>There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The record revealed that the location and date of</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 10</p> <p>CAA information for care areas [#5, 6, 8, 11, 12, and 16] were recorded as "CAA 3.0 03/10/2014 " .</p> <p>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.</p> <p>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.</p> <p>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 for Resident #120.</p> <p>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,</p> <p>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."</p> <p>There was no evidence that facility staff documented where in the clinical record</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 11</p> <p>information related to the CAA's could be found.</p> <p>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.</p> <p>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.</p> <p>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, #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,</p> <p>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."</p> <p>There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found.</p> <p>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</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 12</p> <p>triggered care areas could be found was not recorded. The record was reviewed August 5, 2014.</p> <p>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.</p> <p>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.</p> <p>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."</p> <p>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.</p> <p>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.</p> <p>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.</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 13</p> <p>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.</p> <p>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."</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A review of Resident #166' s admission MDS</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 14</p> <p>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.</p> <p>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. "</p> <p>There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found.</p> <p>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.</p> <p>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.</p> <p>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</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 15</p> <p>Urinary Incontinence / Catheter, #11 Falls, and #16 Pressure Ulcers.</p> <p>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."</p> <p>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.</p> <p>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.</p> <p>B. 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 medication. Residents' #146, and 152.</p> <p>The findings include:</p> <p>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.</p>	L 051	<p>Continued From page 15</p> <p># 1</p> <p>1. Care plan has been initiated for Resident #146 to address the use of Buspirone, with the goals and approaches and potential side effects. 7/31/14</p> <p>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. 7/31/14</p> <p>#2 for 1, 2</p> <p>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. 9/8/14</p> <p>#3 for 1, 2</p> <p>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. 9/11/14</p>	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 16</p> <p>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."</p> <p>A " Psychiatric Evaluation " dated 6/17/14 revealed, " Psychiatric Diagnosis: Anxiety, Depression. "</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>2. Facility staff failed to initiate a care plan with</p>	L 051	<p>Continued From page 16</p> <p>#4 for 1, 2</p> <p>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 three months..</p>	<p>Monthly & On-going Monthly x3</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 17</p> <p>goal and approaches for the use of and potential side effects of Psychotropic medications for Resident #152.</p> <p>A review of the resident's annual MDS revealed that it was coded for the use of Psychotropic medications.</p> <p>A review of the resident ' s clinical record revealed a physician ' s order which directed that the resident receive the following:</p> <p>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.</p> <p>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.</p> <p>A face-to-face interview was conducted with 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, 2014.</p> <p>C. 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</p>	L 051		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 18</p> <p>prevent right cervical flexion contracture for Resident #42.</p> <p>The findings include:</p> <p>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.</p> <p>A history and physical dated October 20, 2013 revealed Resident #42 diagnoses included CVA (Cerebral Vascular Accident) with Left Hemiplegia.</p> <p>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 "</p>	L 051	<p>Continued From page 18</p> <p># 1.The care plan for Resident #42 has been amended to include the cervical pillow as an intervention for resident's contracture.</p> <p>#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.</p> <p>#3. In-service on care planning to reinforce the care planning process and need to update care plans for residents.</p> <p>We have put a system in place for Unit Managers to review care plan Documentations monthly x3 and quarterly Ensure care plans are updated.</p> <p>#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.</p>	<p>9/5/14</p> <p>9/11/14</p> <p>9/11/14</p> <p>Monthly Quarterly On-going</p> <p>Monthly & On-going Monthly x3</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	<p>Continued From page 19</p> <p>A review of the care plan updated May 11, 2014 lacked evidence that the care plan was amended to include the use of a cervical pillow as a specific intervention for Resident #42 ' s right cervical flexion contracture.</p> <p>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.</p> <p>Facility staff failed to amend a care plan to include specific interventions for Resident #42 ' s right cervical flexion contracture.</p>	L 051		
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:</p> <p>(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p>	L 052		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 20</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>j) Prompt response to an activated call bell or call for help.</p> <p>This Statute is not met as evidenced by:</p> <p>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 evidenced by failure: to ensure that one (1) resident was seen by the psychiatrist for a recommended three month follow-up evaluation;</p>	L 052		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 052	<p>Continued From page 21</p> <p>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.</p> <p>The findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 call MD ... "</p> <p>There was no evidence that the route of administration was included in the physician ' s</p>	L 052	<p>Continued From page 21</p> <p>#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.</p> <p>#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 dosages have been given to residents as ordered by the physician.</p> <p>#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.</p> <p>Also our Education Department has increased the frequency of competency for nurses from annual to semi-annual in the area of medication administration.</p> <p>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.</p>	<p>8/18/14</p> <p>8/29/14</p> <p>8/18/14</p> <p>8/18/14 & Semi-Annual</p> <p>9/11/14 & Daily</p>
-------	--	-------	---	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 22 order.</p> <p>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].</p> <p>According to the sliding scale the resident should have received 4 Units of Humalog Insulin coverage.</p> <p>There was no evidence that facility staff administered insulin in accordance with the physician's order for Resident # 11.</p> <p>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.</p> <p>2. Facility staff failed to administer insulin in accordance with the physician's order for Resident #24.</p> <p>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: Check blood sugar 6:30 AM 9:30 PM</p> <p>0-200=0 units 201-250 = 1unit 251-300 = 2 units</p>	L 052	<p>Continued From page 22</p> <p>ordered. The charge nurse will report to the Unit Manager the findings of the shift review.</p> <p>#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.</p> <p>3, 8 #1 The eye drops were administered to resident 7/29/14. The inhaler was administered to Resident #154</p> <p>#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.</p> <p>#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</p>	<p>Monthly & On-going</p> <p>8/29/14</p> <p>9/10/14</p> <p>9/10/14 & On-going</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 23</p> <p>301-350 = 3 units 351-400 = 4 units 401 and above = 5 units Call MD if less than 60 or greater than 400 "</p> <p>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. "</p> <p>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.</p> <p>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.</p> <p>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 " . 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 " .</p>	L 052	<p>Continued From page 23</p> <p>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 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.</p> <p>#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.</p> <p>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.</p>	<p>Monthly & On-going Monthly x3</p> <p>8/29/14</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2014
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 24</p> <p>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.</p> <p>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."</p> <p>There was no evidence that facility staff followed through with the physician ' s order for administering the eye drops.</p> <p>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.</p> <p>4A. Facility staff failed to administer Resident #37 ' s medications in accordance to the physician ' s orders.</p> <p>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.</p>	L 052	<p>Continued From page 24</p> <p>#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.</p> <p>#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.</p> <p>Also the Medication Administration (ALL) policy has been updated to include the procedure for administration pre or post resident medical appointment.</p> <p>#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.</p>	<p>9/10/14</p> <p>9/10/14 Daily & On-going</p> <p>9/10/14</p> <p>Monthly & On-going Monthly x3</p>