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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 25 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. 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.	L 052	Continued From page 25 **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. . 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. 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. #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. #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	8/29/14 8/29/14 8/29/14 9/10/14 9/10/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 26 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. " 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	L 052	Continued From page 26 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 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.	9/10/14 Weekly, Monthly & On-going 9/9/14 9/10/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 27 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 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 "	L 052	Continued From page 27 #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. #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	9/10/14 & Bi-weekly 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
	HFD02-0011	A. BUILDING: _____ B. WING _____	08/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 28 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: " [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	L 052	Continued From page 28 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
	HFD02-0011	A. BUILDING: _____ B. WING _____	08/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 29 351-400 = 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. 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	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 30 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." 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	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 31 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: " 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	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 32 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 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, "	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 33 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 (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. "	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 34 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. 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. B.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	L 052	Continued From page 34 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.	8/1/14 9/9/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 35 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 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.	L 052	Continued From page 35 Also resident has been placed on toileting program.	9/8/14
			In addition resident has been scheduled scheduled for more frequent special care meetings.	9/10/14
			#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.	9/9/14
			#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.	9/9/14 & On-going
			Residents who refuse care will be referred to the attending physician for follow up and clinical intervention as required.	9/8/14
			Residents who refuse care will also be referred to the restorative nursing aide for further evaluation on a routine basis.	Weekly & On-going

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 36 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 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. C. Based on record review and staff interviews for two (2) of 41 sampled residents, it was determined that facility staff failed to keep the residents free from unnecessary drugs as evidenced by two (2) residents receiving excessive doses of insulin. Residents' #143, and 187. The findings include: 1.Facility staff failed to keep the resident free from unnecessary drugs as evidenced by Resident #143 receiving excessive doses of insulin. A review of the phyician's order revealed, [Humalog KwikPen] Insulin Lispro (Human) [fast-acting insulin in injectable pen form] 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;	L 052	Continued From page 36 #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 analysis and review. The Director of Nursing and Assistant Director of Nursing will monitor for compliance **1, 2** #1 Due to the type deficiency we cannot retroactively and correct the deficiency for Residents' # 143 and 187. The staff however has been counseled and a one to one competency has been provided for the staff. #2 To identify other residents that may have the potential to be affected, we have reviewed all Medication Administration Records, to ensure that residents do not receive unnecessary drugs, and that all insulin based on sliding scale ordered are given as ordered.	Monthly & On-going Monthly x3 8/29/14 9/9/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 37 151-200 = 2 units; 201-250 = 4 units; 251-300 =6 units; 301-350 = 8 units; 351-400 = 10 units; <60 or >400 please call MD " On July 31, 2014 at approximately 3:40 PM, a Medication Administration Record [MAR] review revealed an order for Resident #143 directed the following: " [Humalog KwikPen] Insulin Lispro (Human) [fast-acting insulin in injectable pen form] 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 review of the July 2014 MAR revealed that on July 6, 2014 at 5:00 PM the resident's blood sugar result of "150" was recorded. The insulin dose administered was " 2u[units], " to " LA " [Left Arm] as documented on the MAR. According to the physician's order the resident should not have received 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 July 31, 2014 at approximately 3:40 PM. He/she acknowledged the aforementioned findings. The record was reviewed on July 31, 2014. There was no evidence that facility staff kept the resident free from unnecessary drugs.	L 052	Continued From page 37 #3 We have put a system in place for the Education Director to conduct one to one Identified during the survey competency for nurses identified by their managers as needing further teaching on insulin administration, and sliding scale orders. Our Education Department has also increased the frequency of clinical competencies for nurses from annual to semi-annual in the area of medication administration, particularly insulin and sliding scale orders. In additional we will have a list of residents with diagnosis of Diabetes per unit location in the facility. The list will be utilized by the charge nurses to review per shift for and observed return demonstration for accuracy of insulin administration ordered by the physician. The charge nurses will report to the Unit Manager, the findings of the shift review. #4 The Unit Managers will compile the results of the reports to the Director of Nursing weekly for further review. This will be presented to the QAPI Committee meetings monthly for analysis of compliance for 3 months.	9/10/14 9/10/14 9/10/14 & On-going Monthly x3 9/11/14, 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
	HFD02-0011	A. BUILDING: _____ B. WING _____	08/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 38 2. Facility staff failed to keep Resident #187 free from unnecessary drugs as evidenced by the resident recieving an excessive dose of insulin. A review of the physician's order revealed, " Sliding scale finger stick with Aspart [fast- acting insulin] Insulin sub-Q [subcutaneous] AC [before meals] and HS [at night] as follows 6:30 AM 11:00 4:30 PM 9:00 PM; 201-250 = 2 units; 251-300 =4 units; 301-350 = 6 units; 351-400 = 8 units; <60 or >400 = call MD/NP " A review of the July 2014 Medication Administration Record [MAR] for Resident #187 revealed the following: " Sliding scale finger stick with Aspart [fast- acting insulin] Insulin sub-Q [subcutaneous] AC [before meals] and HS [at night] as follows 6:30 AM 11:00 4:30 PM 9:00 PM 201-250 = 2 units 251-300 =4 units 301-350 = 6 units 351-400 = 8 units <60 or >400 = call MD/NP " A further review of the MAR revealed that on July 30, 2014 at 6:30 AM, the resident's blood sugar result was recorded as " 190 ". The Insulin dose administered was " 2u[units], " to " LLQ " [Left Lower Quadrant] as documented on the MAR. According to the physician's order the resident should not have received 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 July 31, 2014 at approximately	L 052		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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	Continued From page 39 3:40 PM. He/she acknowledged the aforementioned findings. The record was reviewed on July 31, 2014. There was no evidence that facility staff kept the resident free from unnecessary drugs. D.	L 052	Continued From page 39	
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenths] hour for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on eight (8) of the eight (8) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on August 5, 2014 at approximately 2:30 PM. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6)	L 056	1. No residents were affected by this alleged deficiency. 2. Residents of CBL have not been affected by this alleged deficiency. 3. Facility has increased recruiting efforts for RN and nursing personnel in order to achieve mandated staffing pattern. 4. Administrative staff will monitor and audit efficacy of recruitment efforts for RNs weekly until mandated staffing pattern is achieved. Changes to recruitment will be completed as needed based on results of recruiting. Results of audits and efficacy of recruitment efforts will be reviewed via QAPI meetings with recommendations made as needed.	8/15/14 Weekly Monthly x3 Months

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 056	Continued From page 40 hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] for eight of eight days reviewed as outlined below. July 25, 2014 RN 0.5 July 26, 2014: RN 0.2 July 27, 2014: RN 0.3 July 28, 2014: RN 0.45 July 29, 2014: RN 0.57 July 30, 2014: RN 0.57 July 31, 2014: RN 0.55 Aug 01, 2014: RN 0.55 The facility also failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day for eight of eight days reviewed as outlined below. July 25, 2014: 3.6 July 26, 2014: 3.36 July 27, 2014: 3.48 July 28, 2014: 3.63 July 29, 2014: 3.53 July 30, 2014: 3.58 July 31, 2014: 3.48 Aug 01, 2014: 3.43 The review was made in the presence of	L 056		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 056	Continued From page 41 Employee #36 who acknowledged the findings.	L 056	Continued From page 41	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on July 28, 2014 between 9:00 AM and 3:00 PM , it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by two (2) of three (3) open bags of pasta that were stored in the dry food storage area undated, one (1) of one (1) steamer that was covered with spilled grease, one (1) of one (1) soiled deep fryer, two (2) of two (2) convection units that were covered with dust and sticky particles, damaged lids from one (1) of one (1) ice cream freezer, one (1) of two (2) soiled convection units and torn air curtains from the walk-in freezer. The findings include: 1. Two (2) of three (3) bags of pasta were stored in the dry food storage area open and undated. 2. The top of one (1) of one (1) steamer unit was soiled with liquid grease. 3. One (1) of one (1) deep fryer was soiled with a week old grease and fried food particles. 4. The top of two (2) of two (2) convection oven units was soiled with dust and sticky particles.	L 099	**1, 2, 3, 4, 5, 6, 7, 8** #1 The pasta bags were dated. All labeling and dating were completed The top of the steamer unit has been cleaned, and liquid grease removed. The deep fryer was cleaned and sanitized, grease particles removed, and the grease was replaced. The tops of the two convection oven units have been cleaned. The ice cream freezer lid has been replaced The convection unit soiled on the inside was cleaned The Air Curtains to the walk-in freezer has been replaced Due to the type of deficiency, we cannot correct the deficiency of the staff failing to sanitize the thermometer as oppose to wiping the thermometer with napkins. #2 To identify other equipments that may have the potential to be affected, a walkthrough was conducted in the kitchen to make sure all equipments are clean, and in order.	7/28/14 7/28/14 7/28/14 7/28/14 8/28/14 7/28/14 9/11/14 8/15/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 099	Continued From page 42 5. One (1) of two (2) lids to the ice cream freezer was falling apart and needed to be repaired or replaced. 6. One (1) of two (2) convection units was soiled internally with burnt food particles. 7. Air curtains to the walk-in freezer were torn in several areas. 8. One (1) of one (1) food service employee failed to sanitize the food thermometer in between uses during food temperature testing at lunch time on the second floor dining room. on July 28, 2014. The food service employee used a napkin to wipe the thermometer between uses. These observations were mede in the presence of Employee #29 who confirmed the findings.	L 099	Continued From page 42 #3 We have put a system in place to increase the frequency of environment of care rounds in the kitchen from weekly to three times a week for one month. A special monitoring tool will be used that identifies areas that usually need cleaning. The monitoring tool will be completed based on compliance with cleanliness of the equipments, etc. The results of the monitoring will be assessed by the Director Food Service and corrective measures taken. #4 The Environment of care rounds, team will present the compilation and analysis of the results of the kitchen rounds at the QAPI Committee meeting monthly. The Food Services Director and Administrator will monitor for compliance.	9/11/14 Monthly Monthly x3
L 157	3227.8 Nursing Facilities Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition. This Statute is not met as evidenced by: Based on record review, and staff interview during the evaluation of medication storage, it was determined that facility staff failed to consistently document the monitoring of temperature of the Medication refrigerator	L 157	#1 Due to the type of deficiency we cannot retroactively correct this deficiency. Employees/nurses however have been instructed to ensure that the Refrigerator Monitoring Log" is maintained daily per shift with the refrigerator temperature, and signed/initialed by the nurse who observe the temperature. #2 To identify other dates that may have the potential for this deficiency, the refrigerator monitoring log has been reviewed to ensure temperatures are recorded going forward.	8/15/14 8/28/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 157	Continued From page 43 located in the nurse ' s station medication room in one (1) of one (1) refrigerator used to store medications. The findings include: A review of the " Refrigerator Monitoring Log " for July 2014 revealed that there were no temperature recordings on the following days: July 1, 5, 8, 9, 12,13,14,15, 16 17, 18, 19, 20, 30, 31, 2014 There was no documented evidence that facility staff consistently monitored of temperature of the Medication refrigerator located in the nurse ' s station medication room. A face-to-face interview was conducted with Employee #3 at the time of the observation and he/she acknowledged the findings.	L 157	Continued From page 43 #3 We have put a system in place that requires the incoming shift nurse to check the "Refrigerator Monitoring Log" as part of the hand-off inter-shift communication, to ensure that the outgoing shift nurse checked the refrigerator and recorded the temperature. Also we have put in place a system of daily check by the Unit Manager or designee and the Night Shift Supervisor who will review the monitoring log to double-check that the log has the temperatures per shift. #4 The Assistant Director of Nursing, will review the " Refrigerator Monitoring Log" bi-weekly and report to the Director of Nursing. The Assistant Director of Nursing and the Director of Nursing will monitor for compliance. The report and findings will be presented monthly to the QAPI Committee meeting to assess for compliance.	8/28/14 9/10/14 9/11/14
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute 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.	L 214	3234.1 Nursing Facilities **#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.	7/29/14 7/29/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 214	Continued From page 44 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. These observations were reported to Employee #1 who acknowledged the findings and proceeded to have the carts locked and secured.	L 214	Continued From page 44 #3 We have put a system in place that requires the incoming shift nurse to check the "Refrigerator Monitoring Log" as part of the hand-off inter-shift communication, to ensure that the outgoing shift nurse checked the refrigerator and recorded the temperature. Also we have put in place a system of daily check by the Unit Manager or designee and the Night Shift Supervisor who will review the monitoring log to double-check that the log has the temperatures per shift.	9/10/14 9/11/14
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on an observation made on July 29, 2014 at approximately 10:30 AM, it was determined that the facility failed to maintain the resident call/communication system (call bell) in good, functional condition as evidenced by the failure of	L 306	#4 The Assistant Director of Nursing, will review the " Refrigerator Monitoring Log" bi-weekly and report to the Director of Nursing. The Assistant Director of Nursing and the Director of Nursing will monitor for compliance. The report and findings will be presented monthly to the QAPI Committee meeting to assess for compliance. #1. The call bell in Room 143(a) and the call bell in the bathroom of Room 246 have been repaired. Both call bells are now working. #2. In order to identify other residents who may be affected, we did a walkthrough and tested call bells in the facility to make sure they are working properly. #3. We have put a system in place for the Environmental of Care Rounds team to Increase rounds to three rounds a week	9/11/14 & Monthly x3 7/29/14 8/29/14 9/11/14 & Weekly

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 306	Continued From page 45 the call bell system failed to operate correctly in one (1) of 32 resident rooms and one (1) of 32 resident bathrooms. The findings include: On July 29, 2014 at approximately 10:30 AM, the call bell, when activated did not sound an audible alarm in resident room #143 (A side); and in the resident bathroom #246. However the visual indicator illuminated in room #143 and #246 when the call bell was activated. According to facility staff the when the call bells are activated the visual indicator and the audible alarm should be seen and heard by staff. These observations were made in the presence of Employee #28 who acknowledged the finding. There was no evidence that facility staff ensured that all aspects of the call system was functioning as intended when the call bell system was activated.	L 306	Continued From page 45 for testing of the call bells for a month and observations. Also we have put a system in place of Have the Unit Secretaries checking call bells in resident's room once a week for one month and record. The results of the check will be recorded in the monitoring log. #4. Results of the Environmental of Care Rounds will be reported to the QAPI Committee monthly meeting. Results of The Unit Secretaries monitoring will be reported to the Assistant Director of Nursing and the Director of Nursing, then to the QAPI Committee meeting. The Assistant Director of Nursing and Director of Nursing will monitor for compliance for one month to determine compliance.	Weekly x1 month
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 29, 2014 between 10:00 AM and 1:00 PM, it was determined that the facility failed to provide effective maintenance services in residents' areas as evidenced by: marred walls in three (3) of 33 residents's rooms, a stained ceiling tile in one (1)	L 410	1. Walls in rooms # 109, and #145 have been painted. 2. Stained ceiling tile in resident's room #226 has been replaced 3. Walls in rooms # 109, and #145 have been painted. 4. Stained ceiling tile in resident's room #226 has been replaced 5. Torn bedspread in resident's room #143 has been removed and replaced 6. The clock in resident's room # 310 is now operational as the battery has been replaced. 7. Torn bedspread in resident's room #143 has been removed and replaced	8/11/14 7/29/14 8/11/14 7/29/14 7/29/14 8/5/14 7/29/14

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 410	Continued From page 46 of 33 resident 's room, a torn bedspread in one (1) of 33 resident's room, a malfunctioning wall clock in one (1) of 33 resident's room, a non-operational shower in one (1) of 33 resident's room, a lack of suction from the air vent in the bathroom of two (2) of 33 residents' rooms, and a malfunctioning toilet in (1) of 33 resident's rooms. The findings include: 1. Walls were marred in rooms # 109, and #145, two (2) of 33 residents' rooms surveyed. 2. A ceiling tile was stained in room #226, one (1) of 33 resident's room. 3. The bedspread in resident's room #143 was torn, one (1) of 33 resident's room. 4. The clock in resident room #310 was not operational, one (1) of 33 resident's room. 5. The shower in resident room #222 was not functioning, one (1) of 33 resident's rooms. 6. There was no suction from the air vent in the bathroom of residents' rooms #141 and #245, two (2) of 33 residents' rooms. These observations were made in the presence of Employee 28 who acknowledged the findings. 7. On July 28, 2014 at approximately 10:30 AM during a tour of the resident's room, the following observations were made: The bathroom wall was marred and the toilet was malfunctioning and making a constant noise in one (1) of 33 resident's rooms observed. These observations were made in the presence of Employee #30, who acknowledged the aforementioned findings.	L 410	Continued From page 46 8. The clock in resident's room # 310 is now operational as the battery has been replaced. 9. Concerning non-functioning shower in resident # 222, the resident was informed that the shower was made non-functioning by facility for resident safety purpose. Resident acknowledge understanding of the reason and understanding of the availability of other shower area on the unit. 10. Air vent suction in residents rooms # 141 and # 245 have been repaired. 11. Malfunctioning toilets was corrected and the bathroom wall was painted. 2. To identify other residents rooms that may be affected, we did a walk-through of all residents rooms. 3. We have put a system in place of weekly Environment of Care Rounds and system of immediate corrections by Building Services or areas not in compliance. 4.Results of the Environment of Care Rounds will be presented to the QAPI Committee monthly for review and assessment for compliance with corrective measures taken as required. The Building Service Manager, the Environmental Services Director and Administrator will monitor for compliance for 3 months.	8/5/14 9/4/14 7/29/14 7/29/14 8/11/14 9/11/14 & 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
	HFD02-0011	A. BUILDING: _____ B. WING _____	08/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE	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 442	Continued From page 47	L 442	**1, 2**	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made on July 28, 2014 at approximately 9:30 AM and on July 29, 2014 at approximately 9:15 AM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by one (1) of one (1) reach-in refrigerator that failed to maintain an internal temperature of 41 degrees F or less, a convection oven from one (1) of two (2) convection units that was out of service and a feeding pump that did not alarm during an alarm condition. The findings include: 1. The internal temperature of one (1) of one (1) reach-in refrigerator used to store grape and orange juice was as high as 52 degrees Fahrenheit, well above the recommended temperature of 41 degrees F. 2. The top convection oven from one (1) of two (2) convection units was no longer functional. 3. A feeding pump in use in room #115 did not produce an audible alarm when a flow error occurred. The pump was checked by staff in material management. These observations were made in the presence of Employee #29 who acknowledged the findings.	L 442	#1 The internal temperature of the reach-in refrigerator used to store grapes and orange juice has been corrected. The refrigerator has been repaired by a refrigerator company and the temperature is maintained at 40 degrees and below. #2 The top convection oven is no longer functional, in spite of repairs which have been done by outside contractor, so the oven has been placed out of service. We have placed "Out of Order Out of Service, No longer in use" sign on the top convention oven. This oven is a double unit oven with the bottom oven functional. There are three (3) functional convention ovens in use in the kitchen. To identify other equipments that have the potential to be affected, we did a walk-through and inspected the ovens. #3 We have put a system in place to increase the frequency of our "Environment of Care Rounds" to include observations of the kitchen equipments and report observations of the rounds to the Food Service Director and Administrator. #4 The team leader of the Environment of Care Rounds will report the findings to the QAPI Committee meetings monthly to assess Food Service Director and Administrator will monitor for compliance. monitor for compliance	8/6/14 9/10/14 9/10/14 9/11/14 Monthly & On-going Monthly x3