DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2011 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0			(X3) DATE SURVEY COMPLETED			
		095015	B. WIN	IG		09/	20/2011
	ROVIDER OR SUPPLIER N BOONE LEWIS HEA	LTH CARE CENTER	•	1	EET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032	007	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 000	A recertification Life conducted on Septe deficiencies are base	Safety Code survey was mber 20, 2011. The following ed on observations, review of	K	000	Carolyn Boone Lewis Health Ca Center, "CBL" is filing this Plan	n of	
K 017 SS=C	Corridors are separal constructed with at larating. In sprinklered required to resist the non-sprinklered build above the ceiling. (Of the underside of ceil permitted by Code, waiting areas, dining may be open to the of specified in the Code from corridors by nor	views. EETY CODE STANDARD Ited from use areas by walls east ½ hour fire resistance described buildings, partitions are only passage of smoke. In dings, walls properly extend corridor walls may terminate at lings where specifically Charting and clerical stations, rooms, and activity spaces corridor under certain conditions as Gift shops may be separated in-fire rated walls if the gift shop 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K(017	Correction in accordance with the compliance requirements for feed and state regulations. This Plan correction constitutes the facility written allegation of compliance deficiencies cited. However submission of this Plan of Corredoes not constitute admission of or conclusions cited.	leral of y's for the	
	Based on observation Inspection it was detwalls were not in good	ons during the Life Safety Code ermined that smoke barrier and condition to prevent the the event of a fire in two (2) of			NFPA 101 LIFE SAFETY COL STANDARD K017	DE	
	The findings include: Smoke barrier walls we penetrations which we can be seen that the same of the s	were observed to have rould not prevent the	-				
BORATORY D	IRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		095015	B. WING		09/2	0/2011		
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER			09/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032					
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	penetration in walls 1 to 2 inch openings rear of the clothes do These observations Employee #F1 at 1:0	as evidenced by a 2 inch near the Cosmetology area and around gas supply lines in the yers in the Laundry Room. were made in the presence of 00 PM on September 21, 2011.	K 01	1. Corrective Actions a). The 2 inch penetration in wa the Cosmetology area and 1 to 2 openings around the gas supply 1 rear of the clothes dryers in the I Room were corrected.	inch ines in the	09/20/11		
K 018 SS=D	Doors protecting cor required enclosures hazardous areas are those constructed of wood, or capable of minutes. Doors in sprequired to resist the no impediment to the are provided with an door closed. Dutch of permitted. 19.3.6.3	phibited by CMS regulations in	K 01	b). The Maintenance staff will p quarterly inspections to identify a upon discovery penetrations in w c). The Maintenance staff were in-serviced by the Director of Maregarding NFPA requirements in the monitoring of penetrations/op d). The findings and corrections penetrations/openings in the wall reported to the monthly CQI comuntil it has been determined by the committee that a quarterly report effective.	and correct valls. aintenance regard to benings. of the s will be smittee ae	11/4/11 11/4/11 11/4/11		
	Based on observation	on and interview it was ble doors filed to latch into ix (6) observations and						

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K 018	closing in one (1) of The findings include Double doors failed the entrance to the Management of the entrance to the Management of the entrance to the Management of Management of Management of Management of Management of the Management of Mana	eded residents room doors from seven (7) observations.	K 018	NFPA 101 LIFE SAFETY CONSTANDARD K 018 1. Corrective Actions a). The double doors located at the entrance to the Main Dining Root located on the Ground floor; First Dining room; room 242 have been to ensure that they close and later frames. b). The Maintenance staff will promonthly inspections to identify a if applicable doors that do not close (latch into frames). c). The Maintenance staff were by the Director of Maintenance rowspars of the monthly Preventation Maintenance Program. d). The findings and corrections door latches will be reported to mother CQI committee until it has been determined by the committee that quarterly report is effective.	the om st Floor en repaired ch into the erform and correct ose in-service egarding the or latches we of the nonthly to sen	11/4/11	
	Based on observation	ns during the Life Safety			TO STATE OF THE ST		

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K 052	Continued From page 3 Code Inspection it was determined that fire alarm devices were not tested on a quarterly basis as required. The findings include: Fire alarm devices were not tested and maintained in the facility on a quarterly basis as required as evidence by the lack of documentation for testing during the first, third and fourth quarters. The facility had available documentation that a test was conducted on April 31, 2011 during the review of three (3) of four (4) records between 3:00 PM and 5:00 PM on September 20, 2011. These observations were made in the presence of Employee #F1 between 3:00 PM to 5:00 PM on September 20, 2011.		K 052		Continued From page 3 NFPA 101 LIFE SAFETY CO STANDARD K 052 1. Corrective Actions	DE		
					a). Semi-annual fire alarm device testir was maintained at the facility, which ha been corrected to be scheduled on a qua basis. Quarterly fire alarm device testir was conducted by BFPE.		10/6/11 ly	
K 130 SS=D	NFPA 101 MISCELL OTHER LSC DEFICI	ANEOUS ENCY NOT ON 2786	K	130	b). The Maintenance staff will schedule quarterly fire alarm devand maintain on a quarterly basisc). The Director of Maintenance maintenance staff have been educed on this requirement.	·. /	10/6/11	
	Based on observation in the findings include: Pull station fire alarm the first and third floods:55 PM. Staff failed hallway. The following after the fire alarm sy	not met as evidenced by: ons during the Life Safety Code ermined that staff failed to opputer work stations from the itial fire drill exercise, when pull lly activated. s were manually activated on rs on September 20, 2011 at to remove equipment from the g items were left in the hallway stem was activated: a gerri chair and a computer			d). The quarterly fire alarm device records will be reported to the CC committee.		11/4/11	

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K 130	interfered with the m hallway to the stairw floor. This was obse observations at 3:55 These observations	ge 4 leans of egress from the ell on the east end of the third rved in one (1) of three (3) PM on September 20, 2011. were made in the presence of extime of the third floor	K 130	NFPA 101 MISCELLANEO OTHER LSC DEFICIENCY ON 2786 K 130 a). All staff are oriented at the ti	YNOT		
	inspection.	s time of the time noon		and ongoing at a minimum of mothe expectations of adhering to the requirements of this life safety of The staff working on 09/20/11 dobservation will be provided with education.	onthly on ne ode (K130). luring this		
				b). The Maintenance staff will contain and on the spot testing with a to ensure that they can articulate actions are required during a fire. This is in addition to the monthly (unannounced).	employees what drill.		
				c). The Director of Facilities Ma or Designee conducts monthly fin and will conduct at minimum a so fire and safety educational sessio the requirements during a fire dri	e drills emi-annual n to review		
				d). The findings and corrections staff's knowledge of actions to ta a fire drill will be reported to more the CQI committee until it has be determined by the committee that quarterly report is effective.	ke during nthly to en		