STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 recommended a gradual dose reduction, however, at the time of this review the physician has not responded to the recommendation. There was no evidence in the clinical record that the physician attempted a dose reduction for the use of Fluoxetine 20 mg. A face-to-face interview was conducted with Employee #6 on September 2, 2011 at 6:45 PM. He/she acknowledged that there was no evidence that an attempted dose reduction had been attempted. The record was reviewed on September 2, 2011.	F 329	Continued From page 27 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY Ftag 371 1. The staff member was educated upon learning of this matter after the survey regarding the use of gloves and handwashing.	09/03/11
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on one (1) of five dining observations, it was determined that facility staff failed to maintain sanitary conditions while serving lunch. The findings include:	F 371	2. A random review/observation of the dining process and infection control practices has been completed by the educators. 3. Staff training and education regarding the use of gloves and handwashing has been completed by the educators. 4. Random audits of infection control and handwashing practices during the dining experience will be completed by the educators daily. Corrective actions will be implemented as needed.	10/21/11 10/21/11 10/21/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 28 A dining observation of the lunch meal service in the main dining room on the first floor on August 29, 2011, revealed facility staff failed to utilize proper hand hygiene during meal service. At approximately 12:25 PM, Employee #20 was observed wheeling Resident #167 into the dining room while wearing gloves. The employee picked up an object from the floor and placed it into a trash receptacle. (Still wearing the gloves) The employee then walked over to the beverage cart, removed a can of soda from the cart, took a plate from a dietary attendant and served the resident without washing and/or sanitizing his/her hands. The employee failed to remove used disposable gloves and wash and/or sanitize his/her hands prior to serving food and providing meal set up. A face-to-face interview was conducted with Employee #20 at approximately 3:00 PM on September 1, 2011. The employee acknowledged the finding and stated, " I was moving so fast, I was just trying to get everything done. Next time I ' ll slow down and pay attention to what I am doing. "	F 371	Continued From page 28	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations made during the survey,	F 372	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY Ftag 372	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 29 it was determined that the facility failed to maintain the garbage refuse area clean and free of debris. The findings include: On September 2, 2011 at approximately 5:00 PM the loading dock / garbage refuse area was observed to be soiled with debris such as: two (2) large trash bags on the ground next to the trash compactor. These observations were made in the presence of Employee # 7 who acknowledged the findings.	F 372	Continued From page 29 1. The garbage and refuse area was cleaned and free of debris upon awareness of this finding during the survey. 2. After the garbage refuse pick-up the Environmental Services Manager/ Designee will check the garbage refuse area to ensure that it is clean and free of debris. 3. Staff assigned to clean this area has been educated by the Director/ Manager of Environmental Services regarding the proper disposal of trash in the refuse area and this regulatory requirement. 4. Random audits of the refuse area will be completed by the Director of Environmental Services/Designee daily. Corrective actions will be implemented as needed.	09/02/11 10/21/11 10/21/11 10/21/11
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of four (4) sampled End Stage Renal Disease residents, it was determined that the attending physician failed to review the residents fluid volume needs in his/her total plan of care for Resident #69.	F 386	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS Ftag 386	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 30 The findings include: A review of Resident #69's record revealed that he/she had diagnoses which included, Chronic Renal Failure - Stage IV [Stage 4 chronic renal disease is defined as a GFR [Glomerular filtration rate] of 15 to 29 milliliters per minute. A normal GFR is 90 to 120 milliliters per minute. When the GFR falls below 15 milliliters per minute, kidney replacement therapy (dialysis) or transplantation becomes necessary] and Hemodialysis. The August 2011 physician's orders signed and dated August 3, 2011 directed, " Diet: Renal ...snacks 2 times a day for additional kcalories [kilocalories] " . " Treatments: Dialysis on Tues, Thurs and Sat; Check graft site every shift; Check pre/post weight on dialysis days; Check every shift for emergency dialysis kit at head of bed. " Although the attending physician signed the aforementioned monthly orders, there was no order to direct the amount of fluid Resident # 69 is to have within 24 hours. A review of the attending physician ' s progress from July and August 2011 lacked documented evidence that the physician addressed Resident #69 ' s fluid volume needs in his/her total plan of care. A face-to-face interview was conducted on September 2, 2011 at approximately 4:45 PM	F 386	Continued From page 30 1. A fluid restriction order was written for Resident #69 of 2000cc/day. 2.An audit of physician's progress note and orders for residents with diagnosis End Stage Renal Disease (ESRD) has been completed by the unit managers. Physicians were notified as needed for corrective actions. 3. The medical director has discussed this finding with the attending physicians as the physician's meeting. 4. An audit of physicians documentation and orders for residents with ESRD will be completed by the medical director quarterly and report provided to the QI committee of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	9/02/11 9/30/11 9/22/11 10/21/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 31 with Employee #6. He/she acknowledged that Resident #69 ' s fluid volume needs was not addressed in the attending physician ' s total plan of care. The record was reviewed on September 2, 2011	F 386	Continued From page 31 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON Ftag 428	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 38 sampled residents, it was determined that facility staff failed to act upon the pharmacy recommendations for Resident #69. The findings include: Facility staff failed to act upon the pharmacy recommendations for Resident #69. A review of the pharmacist ' s reports revealed that irregularities were reported and	F 428	1. The psychiatrist evaluated Resident #69 and declined to reduce her medications due to the presence of depressive symptoms at both evaluations. 2. An audit of pharmacy reviews for physician response has been completed by the unit managers. Corrective actions have been implemented as indicated. 3. A new protocol has been implemented regarding the completion pharmacy review recommendations. The charge nurse and unit managers have been educated on this process. 4.A random audit of pharmacy review completions will be completed by the ADON quarterly. A report will be provided to QI Committee quarterly by the ADON of problems identified and corrective actions implemented. The QI committee will determine the need for further actions.	9/26/11 10/03/11 10/21/11 10/21/11 10/21/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 32 recommendations were made to the physician on March 21, April 26, May 31, June 27 [repeated recommendation from 3/21/2011] and July 18, 2011 [repeated recommendation from 4/26/2011]. There was no evidence that action was taken in response to the irregularities identified by the pharmacist. A face-to-face interview was conducted on September 2, 2011 at 6:45 PM with Employee #6. He/she acknowledged that there was no action taken by the physician to respond to the pharmacist ' s recommendations. The record was reviewed on September 2, 2011.	F 428	Continued From page 32	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations made on the first day of the survey at approximately 9:00 AM, it was determined that the facility failed to maintain a safe and sanitary environment as evidenced by two (2) of four (4) drain pipes from the dishwahing machine and one (1) of one (1) drain pipe from the three-compartment sink with insufficient air gap. The findings include: Drain pipes from the dishwashing machine and the three-compartment sink did not provide sufficient air gap from the drain.	F 441	Continued From page 33 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Ftag 441 1. The air gaps in the three compartment sink and the drain pipes have been corrective. 08/30/11 2. All drains were assessed and where applicable air gaps have been corrected. 8/30/11 3. The maintenance manager and Food Service Director all both aware of this requirement. 8/30/11 4. Upon the repair or replacement of the drain pipes by maintenance. A random audit of the air gaps in the kitchen will be completed by Maintenance Manager monthly and corrections made as indicated. A report will be made to the QI committee quarterly. 10/21/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/02/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 These observations were made in the presence of Employee #7 who acknowledged the findings.	F 441		