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	095015	A. BUILDING _____ B. WING _____	12/06/2007

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L 000	Initial Comments An annual licensure survey was conducted December 3 through 6, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 27 residents based on a census of 177 residents on the first day of survey and five (5) supplemental residents.	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 appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (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: Based on record review and staff interview for three (3) of 27 sampled residents, it was	L 051	**L051** **#1** **RESIDENT #19** 1. Unit Manager updated resident #19 Care plan on 12-6-07 for Additional goals and approaches for fall prevention and rehab screen was requested on 12-6-07 and recommendations are 2. All other residents identified for falls care plans were reviewed and were updated with additional goals and approaches if needed. 3. Unit Managers were in-serviced on 12-24-07 for updating care plans for residents with falls for additional goals and approaches by the Educator. 4. Unit Managers will do random chart audits for care plan updates and will monitor in quarterly CQI.	12-28-07

Health Regulation Administration

Calanthia Green — TITLE: Administrator — (X6) DATE: 12-28-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 051	Continued From page 1 determined that the charge nurse failed to update one (1) residents care plan for falls, and obtain physician orders to monitor two (2) residents' PT/INR (Prothrombin Time)/(International Normalized Ratio) and an physician's order prior to performing a treatment for one (1) resident. Residents #4, 19 and F1. The findings include: 1. The charge nurse failed to update Resident #19's care plan for falls. A review of Resident #19's record revealed that the resident fell on June 19, 22, 30, August 22, September 4 and October 8, 2007. The resident was screened by the physical therapist on July 25, 2007. No therapy was initiated as a result of the screen. There was no evidence in the record that additional goals and approaches were initiated after the aforementioned falls. There were no injuries noted. A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 5:30 PM. He/she acknowledged that additional goals and approaches were not initiated after the aforementioned falls. The record was reviewed December 6, 2007. 2. The charge nurse failed to obtain physician's orders to obtain PT/INR laboratory (lab) tests and an order prior to performing a treatment to Resident #4's left foot. A. The charge nurse failed to obtain physician's orders to obtain PT/INR lab tests for Resident	L 051	**L051** **#2A, #3** 1. Unit Manager obtained orders for PT/INR for resident #4 and F1 on 12-5-07 and labs were drawn on 12-6-07 and labs were within normal limits. 2. All other resident identified on anticoagulants records were reviewed and corrected as needed. 3. Licensed staff was in-serviced on 12-24-07 on anticoagulant therapy policy and procedures by unit managers. 4. Random chart audits will be done by Unit Managers for residents on anticoagulant therapy to ensure lab orders have been followed per PMD orders and monitored in Quarterly CQI.	12-28-07

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L 051	Continued From page 2 #4's. According to the manufacturer's recommendations, "Acceptable intervals for PT (Prothrombin Time)/INR (International Normalized Ratio) determinations are normally within the range of 1 to 4 weeks after a stable dosage has been determined" from the web site www.bristol-myers-squib. The Physician Order Sheet [POS] and Plan Care dated August 13, 2007 and October 30, 2007 revealed, "Coumadin 5 mg po [by mouth] qd [everyday] for a blood thinner." A review of the POS for September, October and November 2007 revealed that there were no physician's orders for PT/INR. A review of the resident's record revealed that PT/INR values were obtained on August 15, 2007 and were within expected limits. There was no evidence that additional PT/INR values were drawn after August 15, 2007. A review of the September, October, November and December 2007 Medication Administration Records revealed that Warfarin (Coumadin) 5 mg was initialed [indicating that it was administered] daily. A face-to-face interview was conducted with Employee #2 on December 4, 2007 at 3:00 PM. He/she acknowledged that there was no physician order to monitor the PT/INR level since August 15, 2007. The record was reviewed December 4, 2007. B. The charge nurse failed to obtain a physician's order prior to performing a treatment	L 051	**L051** **#2B** Resident #4 1. Charge nurse obtained a treatment order for resident #4 on 12-4-07. 2. All other residents identified with wound care, records were reviewed for treatment orders and corrected as needed. 3. Licensed staff was in-serviced on 12-26-07 on obtaining treatment orders for all wounds. 4. Unit Managers will do random chart audits for treatment orders and findings will be reported in quarterly CQI.	12-28-07

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L 051	Continued From page 3 to Resident #4's left foot. At the completion of a dressing change observation conducted on December 4, 2007 at 11:15 AM, it was observed that Resident #4's left foot was wrapped in gauze that was dated December 3, 2007 and initialed [indicating that the dressing change was performed]. According to the October 2007 Treatment Administration Record, Panafil ointment was applied to the left foot from October 1 through 31, 2007. There was no documented evidence that the left foot dressing was done from November 1 through December 2, 2007. Employee #11 was asked why he/she did not do the dressing to the left foot. He/she replied, " I don't have an order to administer a treatment to the left foot." Employee #11 was asked to remove the dressing. Once the dressing was removed, a green substance was observed on the gauze. Employee #11 stated, " It's Panafil." The lateral left foot had a darkened area measuring 1 x 2 cm - unstageable. There was no odor or drainage observed. A review of the physician's orders for October, November and December 2007 lacked evidence that there was an order for a treatment to Resident #4's left foot. The record was reviewed on December 4, 2007. 3. The charge nurse failed to obtain a physician's order for PT/INR lab tests for Resident F1. The Physician Order Sheet and Plan of Care signed and dated October 22, 2007 revealed, "Coumadin 2.5 mg po [by mouth] qd [everyday] for a blood thinner." There was no order for	L 051		

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L 051	Continued From page 4 PT/INR laboratory studies included in the October, November and December 2007 Physician's Order Forms. A review of the October, November and December 2007 Medication Administration Records revealed that Warfarin (Coumadin) 2.5 mg was initialed [indicating that it was administered] daily. A review of the record revealed that there were no PT/INR laboratory values since the resident's return from the hospital on October 22, 2007. A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 10:45 AM. He/she acknowledged that there was no physician order to monitor Warfarin therapy. The record was reviewed December 6, 2007.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (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; (d) Protection from accident, injury, and infection;	L 052		

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L 052	Continued From page 5 (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (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; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. Based on observations, staff interviews and record review for two (2) of 27 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to: monitor behaviors for two (2) resident, obtain laboratory tests for two (2) residents, and administer oxygen for one (1) resident. Residents #3, 16, 21, F2 and F3. The findings include:	L 052		

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L 052	Continued From page 6 1. Facility staff failed to monitor Resident #3's behavior as per physician's orders. A review of Resident #3's record revealed a physician's order initially dated November 13, 2006 and renewed on the physician's order forms (monthly orders) August 30, September 22 and October 25, 2007 that directed, "Monitor behavior q shift for kicking and abusive language." There was no evidence in the record that the resident's behavior had been monitored for kicking and abusive language for September and October, 2007. According to the November 2007 Treatment Administration Record (TAR) the resident's behavior was monitored every shift from November 1 through 20, 2007. Hand written on the November 2007 TAR next to the behavior monitoring order was " D/C " (discontinue). There was no physician's order to discontinue the behavior monitoring. A face-to-face interview was conducted with Employee #1 on December 4, 2007 at 3:30 PM. He/she acknowledged that there was no behavior monitoring for August, September and October 2007 and that there was no physician's order to discontinue the behavior monitoring in November 2007. The record was reviewed December 4, 2007. 2. Facility staff failed to document Resident #16's behavior who was receiving a psychotropic medication. The November 2007 "Physician's Order Form" signed November 15, 2007 revealed, "Clonazepam 0.5 mg one tab by mouth twice daily for agitation behavior."	L 052	L 052 NURSING FACILITY #1, #2 Resident #3, #16 1. Unit Manager obtained a behavior Monitoring order for resident #3 on 12-20-07 and obtained A behavior monitoring record/ sheet for Resident #16 on 12-05-07. 2. All other residents identified on psycho tropic's therapy records were reviewed for behavior monitor Orders and records were updated as Needed. 3. Licensed staff was in-serviced on On psychotic orders and accuracy Of behavior monitoring process. By Unit Managers on 12-27-07. 4. Random MAR audits will be done By unit managers and findings will Monitored in quarterly CQI.	12-28-07

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L 052	Continued From page 7 A review of the November and December 2007 Medication Administration Record revealed that Clonazepam 0.5 mg was initialed [indicating that it was given] daily. A review of the record lacked evidence that Resident #16's behavior was being monitored for November and December 2007. A review of the nursing notes lacked evidence that the resident had any documented episodes of agitation. A face-to-face interview was conducted with Employee #3 December 4, 2007 at 3:50 PM. He/she acknowledged that the resident's behavior was not monitored. The record was reviewed December 4, 2007. 3. Facility staff failed to obtain a PT/PTT for Resident #21 as per physician's orders. A review of Resident #21's record revealed a physician's telephone order dated October 27, 2007 and signed by the physician on October 30, 2007, that directed, "Lovenox 80 mg subcutaneous daily x 4 days and Coumadin (anticoagulant) 10 mg orally at bedtime for 2 days then Coumadin 5 mg orally at bedtime. PT (Prothrombin Time) and PTT (Partial Thromboplastin Time) on Monday, Tuesday, Wednesday, Thursday and Friday, then PT weekly x 4 weeks then PT monthly." Facility staff identified the following dates for drawing the PT/PTT: October 29, 30 and 31, 2007 and November 1, 2, 5 and November 12, 2007. The PT/PTT was drawn as follows: October 29,	L 052	**L052** #3 & #4 Resident 21 and F2 1. Unit Manager obtained next Scheduled blood draw for PT/INR On resident #21 on 11-12-07 and PT/PTT on resident #F2 on 12-5-07. 2. All other residents identified with lab test orders for PT/INR and PT/PTT records have been reviewed and test completed as ordered. 3 Licensed staff was in-serviced on 12-24-07 by DON on the importance of obtaining lab draws and informing the Unit Managers if test is not done. 4. Residents receiving anticoagulant therapy records will be audited for compliance and findings reported in quarterly CQI.	12-28-07

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L 052	Continued From page 8 30, and 31 and November 1, 2 and 12, 2007. There was no evidence that the PT/PTT was drawn on November 5, 2007. PT/PTT values were within the expected ranges for October 29, 30, 31 and November 1 and 2, 2007. The PT/PTT for November 12, 2007 was approximately 10 times the expected value. The resident was sent to the hospital for further evaluation of the elevated PT and concurrently cellulitis to both lower extremities. A face-to-face interview was conducted with Employee #1 on December 5, 2007 at 4:00 PM. He/she acknowledged that the November 5, 2007 PT/PTT was not done. The record was reviewed December 5, 2007. 4. Facility staff failed to obtain a PT/PTT (Partial Thromboplastin Time) lab tests for Resident F2 as ordered by the physician. AA review of a physician's order dated November 21 and signed November 24, 2007 directed, "PT/PTT on November 23, 2007 and q [every] month " . A review of a lab order form dated November 26, 2007 revealed, " ...test requested- PT, PTT ... " Both tests requested were marked done [indicating that labs were drawn]. A review of lab results dated December 6, 2007 lacked evidence of PT/PTT results. A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 1:50 PM. He/she stated, "The labs were drawn [pointing to the lab order form], but we did not get the results. I called the lab and they don't have results."	L 052		

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L 052	Continued From page 9 Employee #8 further acknowledged that there was no follow up to obtain PT/PTT labs before today [December 6, 2007]. The record was reviewed December 6, 2007. 5. Facility staff failed to administer Resident F3's oxygen as per the physician's order. On December 6, 2007 at approximately 9:30 AM it was observed that Resident F3 was lying in bed with a nasal cannula in his/her nose. The O2 [oxygen] concentrator was not plugged into the wall. Employee #3 in the room at the time of the observation immediately plugged the oxygen concentrator into the wall. Resident F3 suffered no untoward effects. A review of the November 2007 physician's order signed November 15, 2007 revealed, "O2 at 4L/min via nasal cannula." A face-to-face interview was conducted on December 3, 2007 at approximately 9:30 AM with Employee #3. He/she acknowledged that the O2 concentrator was unplugged and not delivering the oxygen per the physician's order.	L 052	**L052** #5 Resident #F3 1. Unit Manager plugged the 02 concentrator into the wall outlet on 12-6-07. 2. All other residents' identified on 02 therapy units were checked for proper operation and corrected as needed. 3. All staff was in-serviced on the importance of proper function of 02 concentrators and 02 therapy on 12-24-07 and 12-26-07 by the DON. 4. Random and frequent checks for 02 concentrators function will be done by nursing staff and findings will be reported in quarterly CQI.	12-28-07
L 054	3211.3 Nursing Facilities To meet the requirements of subsection 3211.2, facilities of thirty (30) licensed occupied beds or more shall not include the Director of Nursing Services or any other nursing supervisor employee who is not providing direct resident care. This Statute is not met as evidenced by: Based on a review of the "Nursing Daily Staffing" sheets and staff interview for three (3) of five (5) days reviewed, it was determined that facility staff failed to maintain nurse staffing at 3.5 nursing	L 054		

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L 054	Continued From page 10 hours per resident per day. This is a repeat deficiency. The findings include: According to 22 DCMR 3211.3, "Beginning no later that January 1, 2005, each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day." The "Nursing Daily Staffing" sheets were reviewed with Employee #8 for December 1, 2, 3, 4 and 5, 2007 and revealed inadequate nurse staffing on the following days: Date Nursing Hours December 1, 2007 3.46 December 2, 2007 3.36 December 3, 2007 3.40 On December 6, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Employee #8 who acknowledged that the staffing was below 3.5 nursing hours per resident per day due to staff not reporting to work. Employee #8 stated, "The agencies are supposed to replace staff. Sometimes the agency person does not report and the agency does not have any one to replace the person who called in."	L 054	**L 054** **NURSING FACILITIES** 1. A tickler sheet has been developed and given to DON, Staffing Coordinator and Supervisors to staff facility Based on census and staff Have been instructed to Utilized agency and overtime When call-ins have occurred. 2. Staffing sheets will be reviewed daily by DON, staffing coordinator and supervisors to ensure compliance and facility will overstaff to allow for call ins. 3. In-service was given to staffing coordinator and supervisors on 12-07-07 of staffing facility appropriately by DON. 4. Daily monitoring will be done by DON, Staffing Coordinator and Supervisors and findings reported in quarterly CQI.	12-28-07
L 083	3216.4 Nursing Facilities Physical restraints shall not be applied unless: (a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful:	L 083		

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L 083	Continued From page 11 (b)The restraint has been ordered by a physician for a specified period of time; (c)The resident is released, exercised and toileted at least every two (2) hours,except when a resident's rest would be unnecessary disturbed. (d)The use of the restraint doe not result in a decline in the resident's physical, mental psychological or functional status; and (e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition. This Statute is not met as evidenced by: Based on observations, record review and staff interviews for a sample of 27 residents, one (1) of four (4) residents identified with restraints, it was determined that the clinical record lacked evidence that a vest restraint was the least restrictive device for Resident #2. The findings include: During the review of the clinical record, physician's orders signed and dated November 16, 2007 with an original order date of May 15, 2007, indicated "Vest Posey jacket to protect pt. (patient) release every two (2) hours for mobility and circulation in bed/wheelchair." Resident #2 has a history of falls. On December 3, 2007 at approximately 9:30 AM, Resident #2 was observed sitting in the day room in a wheelchair in a Vest Posey jacket with the Velcro fasteners in the back, the straps attached to the jacket were wrapped around the lower rims of the wheelchair. The resident was pulling on the vest in an attempt to remove it saying that	L 083	**L 083** **NURSING FACILITIES** 1. Unit Manager referred resident #2 for rehab screen on 12-07-07. Rehab recommended a self release seat belt which is the least restrictive. Seat belt was placed on residents' wheelchair on 12-14-07. 2. All other residents identified with restraints has been assessed for the least restrictive device and referred to rehab for screens as needed. 3. Licensed staff were in-serviced on 12-07-07 on the use of restraints by Unit Manager and the referral process for rehab screens. 4. Random audits will be conducted to ensure the process is being followed and monitored in quarterly CQI.	12-28-07

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L 083	Continued From page 12 he/she was hot. On December 3, 2007 at approximately 5:15 PM, the resident was observed in his/her wheelchair in the hallway across from the first floor nurse's station. He/she was pulling the vest up in an attempt to remove it; the vest was observed anchored at the resident's neck beneath his/her chin. Review of the clinical record revealed a consent form for vest restraint use signed and dated by the resident's responsible party on May 15, 2007. The resident's care plan for restraint use for safety was updated on October 24, 2007. A "Rehabilitation Screening" form in the record signed and dated October 29, 2007 by the physical therapist indicated, "Pt. using Posey Vest which [he/she] is able to remove on occasion allowing nursing to prevent a fall. ...[She/he] is on the least restrictive device at this time." The record lacked evidence that other devices and/or interventions had been tried. On December 5, 2007 at approximately 12:30 PM, a face-to-face interview was conducted with Employee #12. The employee stated, "This type of vest is the most restrictive; that type of restraint is not frequently used at the present time." During observation, the resident was unable to remove the restraint on both attempts. The record was reviewed on December 3, 2007.	L 083		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure	L 091		

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	095015	A. BUILDING _____ B. WING _____	12/06/2007

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L 091	Continued From page 13 that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to maintain an effective infection control program as evidenced by: soiled oxygen concentrator filters, medications located at a resident's bed side and a soiled chair. A review of the facility's infection control program failed to utilize collected data to initiate preventive measures. The findings include: 1. Soiled oxygen concentrator filters were observed in rooms 128 and 136. Residents in both rooms were using the device. 2. Panafil ointment and Calmoseptin ointment were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #7 and the Calmoseptine was prescribed for Resident #16. 3. The seat, back and arms of an arm chair in the 3rd floor B hallway were soiled and stained. This prompted a review of the facility's infection control program. A review of the Infection Control Program was conducted on December 5, 2007 at 1:40 PM with Employee #10. Employee #10 explained that he/she had been the Infection Control Program coordinator for about three (3) years. Employee #10 stated, "I started tracking	L 091	**L 091** **NURSING FACILITIES** **#1, #2, #3** 1. Charge nurse removed concentrator Filter on 12-03-07 from rooms 128 and 126. Medicarion was removed from bedside at the time of observation for resident #20 a new supply of ointment was ordered for resident #20. The chair cited on the 3rd floor back hall that was stained and soiled was discarded on 12-5-07. 2. All other concentrators through Out the facility was inspected And filters were cleaned as needed And bedside were checked for Medication and removed as needed And a new supply ordered. All Furniture was checked for soiled/ Stains and was cleaned as needed. The infection control policy and Unit based infection control work Sheets were reviewed by the Administrator, Director of Quality Assurance, DON and Unit Managers On 12-20-07 to ensure policy Control compliance.	review received 1/7/08

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L 091	Continued From page 14 infections in September 2007. There was really nothing else in place that I knew of prior to when I started this program. Because of HIPPA (Health Insurance Portability and Accountability Act), I didn't write down all the information like organisms, antibiotics used, and dates. I did identify the infections that were acquired in house and those that came from the hospital. " Employee #10 presented a monitoring tool summarizing infections monthly and quarterly. A quarterly monitoring tool listing infections for July, August and September 2007 was reviewed. The number of infections described in the "Statuses of concerns for this quarter" were not consistent with the number of infections described in the unit totals. The quarterly summary listed the following number of infections: Clostridium Difficile (C-Diff) - 1 Methicillin resistant staphylococcus Aureus (MRSA) -4 Urinary Tract infections (UTI) - 8 Skin infections - 8 Respiratory infections - 5 There was a listing of each infection type for each unit. A summary of the total number of infections listed included: C. diff - not identified for any unit MRSA - 5 UTI - 5 Skin infections - 9 Respiratory infections - 5 There was no explanation for the difference in the number of infections listed on the quarterly summary and the number of infections listed by unit.	L 091	3. Nursing staff was in-serviced by Unit Managers on cleaning the Concentrators filters on 12-3-07, On medication at the bedside ad on not using other resident's medication 12-7-07 and housekeeping staff was in-serviced on 12-21-07 on procedures for cleaning chairs by Director of Environmental Services. On 12-27-07 Director of Nursing In-serviced Educator on proper Use of the infection control work Sheets. 4. Random rounds will be done to Ensure concentrators filters are Clean, no interexchange of other Residents' medication for usage, No medication at the bed side and There are no furniture soiled/stainded And DON will monitor usage of The infection control worksheet And findings will be reported to. Quarterly CQI.	Revised report 1/7/08 12-28-07

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L 091	Continued From page 15 Employee #10 stated that there is an infection control in-service conducted monthly. There was no evidence that the data collected monthly regarding infections was utilized to initiate measures to prevent the spread of infection. Listed on the quarterly report under " Statuses of Corrections " were the statements: " preventing the spread of infection and inadequate infection control program. " Based on documents presented, facility staff failed to accurately track the number of facility infections, dates of onset of infection, organisms when available, antibiotic use, reconcile differences between the July, August and September 2007 quarterly report with individual unit reports of types and numbers of infections, and utilize collected data to initiate preventive measures. Additionally, there was no evidence of identified interventions to improve the infection control program.	L 091		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations of a test tray conducted at the lunch meal on December 5, 2007, it was determined that hot food was served below 140 degrees Fahrenheit (F) and cold foods were served above 45 degrees F in the presence of Employee #13.	L 108	**L 108** **3220.2 NURSING FACILITIES** 1. The hot foods were pulled from the Line, reheated and cold foods were Placed back in the walk in refrigator Immediately during survey period 2. Daily checks will be done by director/ Supervisor to ensure that all temperatures are taken at each meal and the temperatures exceed the recommended Requirements. Test trays will be increased. 3. All dietary staff was in-serviced on 12-26-07 by Director of Dietary on temperature requirements and the placement of the HACCP logs. 4. Temperatures will be checked at all Meals by the supervisor and findings Will be reported in quarterly CQI.	12-28-07

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L 108	Continued From page 16 The findings include: A test tray observations was conducted on December 5, 2007 at the lunch meal. The tray left dietary services at 1:10 PM and arrived on unit 3 at 1:17 PM. The last tray was passed and all residents were eating by 1:20 PM. Temperatures of the test tray food were as follows: Baked chicken 123.6 F Pureed Vegetable 132.9 F Pureed Meat 133.0 F Noodles 126.0 F Coffee 129.9 F 2% Low Fat Milk 47.0 F Employee #13 acknowledged the findings at the time of the observation.	L 108		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;	L 128		

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L 128	Continued From page 17 (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents, it was determined that the pharmacist failed to identify the lack of monitoring for Resident #4 who was receiving Warfarin. (Coumadin). The findings include: A review of Resident #4's record revealed a physician's order dated August 13, 2007 and renewed November 2007 directing, "Warfarin Sodium 5 mg tablet, one (1) tab by mouth every day for blood thinner." A review of Resident #4's record revealed that laboratory studies were not completed to monitor the use of Warfarin. According to the manufacturer's recommendations, "Acceptable intervals for PT/INR determinations are normally within the range of 1 to 4 weeks after a stable dosage has been determined" from the web site www.bristol-myers-squib. A review of the "Medication Regimen Review" revealed that the pharmacist reviewed the resident's medications September, October, November and December, 2007. There were no irregularities identified on the aforementioned reviews. The record lacked evidence that the	L 128	**L128** **NURSING FACILITIES** 1. DON obtained orders for PT/INR for resident #4 on 12-5-07 and was drawn on 12-6-07. Pharmacy was called on 12-6-07 by the DON and informed of the missing pharmacy monitoring. 2. All other residents' identified on anticoagulant therapy records were reviewed and corrected as needed by DON, Unit Manager/ Charge Nurses. 3. All licensed staff was in-serviced on 12-21-07 by the DON on the policy and procedure for residents on anticoagulants and pharmacy was sent a copy of the facility policy on 12-6-07. 4. Random chart audits for anti-coagulant lab orders by unit manager and pharmacy will provide the consultant pharmacist with a list of resident of residents anticoagulants for monitoring every 30 days and finding will be reported in quarterly CQI.	12-28-07

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L 128	Continued From page 18 pharmacist identified that there was no monitoring for the use on Warfarin. A face-to-face interview was conducted with Employee #2 on December 4, 2007 at 3:00 PM. He/she acknowledged that the pharmacist failed to identify the lack of monitoring for the use of Warfarin. The record was reviewed December 4, 2007.	L 128	**L161** **NURSING FACILITIES** **#1, #2** 1. Director on Nursing called pharmacy to inform them of expire medication in the emergency box and medication cart on 12-5-07. 12-06-07 pharmacy came in to exchange the boxes. The expired medication was removed from medication on 12-5-07 by charge nurses. 2. All other emergency boxes and medication carts were checked for expired medications and were removed as needed. 3. All licensed staff was in-serviced on 12-24-07 by the Educator and DON on monitoring expired dates on the emergency boxes and medication carts. 4. Emergency medication boxes and medication carts will be monitored by pharmacy monthly and unit managers/team leaders weekly and findings will be reported to Quarterly CQI.	12-28-07
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interview, for three (3) of three (3) nursing units, it was determined that facility staff failed to remove expired medication from an emergency box and medi cation carts. The findings include: The facility failed to remove expired medications from the emergency box and medication carts. 1. On Monday, December 5, 2007, between 11:00 AM and 4:00 PM, during the inspection of the facility's emergency boxes, the Emergency Box # 946 in the first floor medication room contained the following expired drugs: Two (2) vials of Furosemide 40mg/ml (4ml), expired December 1, 2007 and November 1, 2007. One vial of Lidocaine 2% 30 ml, expired December 1, 2007.	L 161		

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L 161	Continued From page 19 Two (2) vials of Diazepam 10mg/2ml, expired December 1, 2007 The expiration date on the emergency box was October 2007. During a face-to-face interview with Employee #8, he/she stated that the pharmacist checked the nursing units two (2) weeks ago. The pharmacist did not mention any expired medications. 2. On Monday, December 5, 2007, between 11:00 AM and 4:00 PM, during the inspection of the facility's medication carts, the following drugs were expired: 2nd Floor Unit, Cart 2 -Team 1 One (1)- Ceftriaxone 1gm reconstituted vial, expired May 2007 Employee #16 acknowledged that the medication was expired at the time of the observation. 3rd Floor Unit, Cart 3-Team 1 Eight (8)- Promethazine Injection 25mg/ml - 1ml vial, expired April 2007 One (1) -Acetylcysteine 20 % 30 ml vial, expired Employee #17 acknowledged that the medications were expired at the time of the observation.	L 161	**L168** **NURSING FACILITIES** 1. Multi-dose medication and vials that lacked date and initials when first opened were discarded and Reordered on 12-5-07. 2. All other medication carts and medication refrigerators were checked for compliance and corrected as needed. 3. Licensed staff was in-serviced on 12-24-07 on dating and initialing Multi-dose medication vials when first open by Nurse Manager 4. Charge nurse and night shift will monitor daily open vials for dates and report findings to quarterly CQI.	12-28-07
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by:	L 168		

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L 168	Continued From page 20 Based on observations and staff interview, for three (3) of three (3) nursing units, it was determined that the facility staff failed to date and initial multi-dose medication vials when first opened. The findings include: On December 5, 2007, between 11:00 AM and 4:00 PM, the medication carts and refrigerators were inspected on each unit. 1st Floor Unit Xalatan ophthalmic drops - two (2) vials Employee #1 acknowledged that the vials of Xalantan listed above were not dated and/or initialed at the time of the observations. 2nd Floor Unit Xalatan ophthalmic drops - three (3) vials Bacteriostatic water 30 ml - one (1) vial Employee #16 acknowledged that the vials listed above were not dated and/or initialed at the time of the observations. 3rd Floor Unit PPD 5 TU/0.1ml - one (1) vial Xalatan ophthalmic drops - one (1) vial Sterile Water 30 ml - one(1) vial Employee #17 acknowledged that the vials listed above were not dated and/or initialed at the time of the observations.	L 168		

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L 214	Continued From page 21	L 214		
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 during the survey period, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: ointments located at a resident's bedside, broken prong on a resident's electric bed plug, missing wheel on a resident's bed, window that failed to completely close in a resident's room, pest strips hanging in residents' rooms, lack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the laundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. The findings include: 1. Panafil ointment and Calmoseptin were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #7 and the Calmoseptine was prescribed for Resident #16. 2. The prong of a resident's electric bed plug in 312A was observed missing. The resident was in the bed at the time of the observation. 3. The wheel of a resident's bed was observed missing in room 223A. The resident was in the bed at the time of the observation. 4. The curtain in room 323 was observed briskly moving as the wind blew into the resident's room.	L 214	1. Medication was removed From bedside at time of Observation for resident #20 and a new supply of ointment was ordered for resident #20. 2. All other residents' bedside Were checked for medication Inappropriately placed and Medication was removed as Needed and a new supply Ordered.. 3. In-service was given by Unite Manager to licensed Staff on 12-7-07 for proper Procedure of administration. 4. Random audits will be performed By Educator and finding will be Reported in quarterly CQI.	12-28-07

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L 214	Continued From page 21	L 214		
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 during the survey period, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: ointments located at a resident's bedside, broken prong on a resident's electric bed plug, missing wheel on a resident's bed, window that failed to completely close in a resident's room, pest strips hanging in residents' rooms, lack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the laundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. The findings include: 1. Panafil ointment and Calmoseptin were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #7 and the Calmoseptine was prescribed for Resident #16. 2. The prong of a resident's electric bed plug in 312A was observed missing. The resident was in the bed at the time of the observation. 3. The wheel of a resident's bed was observed missing in room 223A. The resident was in the bed at the time of the observation. 4. The curtain in room 323 was observed briskly moving as the wind blew into the resident's room.	L 214	#2, #3, #4 1. The bed with the prong missing in room 312A was immediately removed and replaced. The missing wheel on bed 223A was placed on bed the day of the survey. The window was repaired on the same day of observation. 2. All other residents' rooms were checked to ensure beds were compliant and windows were opening and closing properly. 3. Maintenance staff was in-serviced on 12-25-07 on procedure for monitoring maintenance of beds by the Director of maintenance. 4. Monitoring of Preventive maintenance of beds will be done monthly and findings will be reported in quarterly CQI.	12-28-07

revised received 1/7/08

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L 214	Continued From page 22 The window was unable to completely close. The Resident F4 did not complain of being cold, however complained of the wind. 5. Pest strips were observed hanging from the ceiling above residents' beds in rooms 313 and 337. 6. There was no eye wash station observed in the laundry. Employee #5 stated that the sink had an eye wash faucet, but was repaired a few weeks ago and the eye wash faucet was not replaced. 7. One (1) side of the door between the washing area and the drying area in the laundry was unable to be opened. The other side of the door in the washing area was blocked by a large floor mat, bins and other debris. Employees #1, 2, 3, 4, 5, 6, 7, and 11 acknowledged the above findings at the time of the observations.	L 214	#5 1. The pest strips that were cited in rooms 313 and 337 were removed immediately. 2. All other residents' rooms were checked for pest strips and were removed as needed. 3. Staff were in-serviced on 12-21-07 on placing unauthorized articles/products in the facility and following the regulations by the Unit Manager. 4. Unit Managers will make random rounds To ensure units are free of pest strips and findings will be reported in quarterly CQI. #6 1. The eyewash station in the laundry room Was repaired on 12-21-07. 2. All other eyewash stations were inspected by maintenance staff to ensure compliance And were repaired or replaced as needed. 3. Maintenance staff was in-serviced on 12-24-07 by the Director of Maintenance on monitoring of the eyewash stations to ensure compliance. 4. Monthly rounds will be done by the maintenance staff to monitor compliance of all eyewash stations and findings will be reported to quarterly CQI.	12-28-07 12-28-07
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 during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled baseboards, ceiling tiles, corners, bed frames, ice machine, window tracts, front window of facility washing machines, damaged/marred walls, furniture, doors, dusty overbed lights, missing	L 410		

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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 22 The window was unable to completely close. The Resident F4 did not complain of being cold, however complained of the wind. 5. Pest strips were observed hanging from the ceiling above residents' beds in rooms 313 and 337. 6. There was no eye wash station observed in the laundry. Employee #5 stated that the sink had an eye wash faucet, but was repaired a few weeks ago and the eye wash faucet was not replaced. 7. One (1) side of the door between the washing area and the drying area in the laundry was unable to be opened. The other side of the door in the washing area was blocked by a large floor mat, bins and other debris. Employees #1, 2, 3, 4, 5, 6, 7, and 11 acknowledged the above findings at the time of the observations.	L 214	#7 1. The laundry room door that was cited during survey as not being open because it was blocked by a large floor mat, bins and other debris were immediately corrected. 2. All other doors in the laundry were checked to ensure compliance and corrections were made as needed. 3. Staff was in-serviced on 12-21-07 on removal of bins from door that is preventing from opening and cleaning of laundry room by the Director of Environmental Services. 4. Monitoring of the laundry for cleanliness and blocked doors will be conducted daily and findings will be reported in quarterly CQI.	12-28-07
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 during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled baseboards, ceiling tiles, corners, bed frames, ice machine, window tracts, front window of facility washing machines, damaged/marred walls, furniture, doors, dusty overbed lights, missing	L 410		

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L 410	Continued From page 23 2nd floor shower room tiles, broken front panels on overbed lights, odors detected in residents' rooms and maintain laundry equipment in safe operating condition. The environmental tour was conducted on December 3, 2007 from 8:30 AM through 11:30 AM in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. A tour of the laundry was conducted on December 3, 2007 at 2:15 PM in the presence of Employee #5. The findings include: 1. Soiled, marred/damaged baseboards were observed in the following rooms: 119, 123, 128, 130, 136, 137, 139, 141, 144, 145, 147, 2nd and 3rd floor shower rooms in 13 of 36 rooms observed. 2. Stained ceiling tiles were observed in rooms 130 and 137 in two (2) of 12 rooms observed on the 1st floor. 3. Wax and dirt build-up in corners was observed in the following rooms: 128, 130, 135, 136, 142, 144, 145, and 147 in eight (8) of 12 rooms observed on the first floor. 4. Bed frames with accumulated dust were observed in the following rooms: 246, 237, 318, 321, and 337 in five (5) of 24 resident rooms observed on the 2nd and 3rd floors. 5. The 3rd floor pantry ice machine dispensing spout was observed soiled with an accumulation of dust and debris in one (1) of one (1) ice machine observed on the 3rd floor. 6. Soiled window tracts were observed in the following rooms: 126, 128, 130, 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324, 334,	L 410	**L410** **NURSING FACILITIES** **#1, #2, #3, #4, # 5, #6** 1. The soiled, marred/damaged baseboards in rooms 119, 123, 128.130, 136, 137, 139, 141, 144, 145, 147, 2nd and 3rd floor shower rooms were cleaned on 12-26-07, the stained tile in room 130 and 137 were removed and replaced immediate during survey period, the wax and dirt build up in rooms 128, 130, 135, 136, 142, 144, 145 and 147 were cleaned on 12-27-07. Bed frames sited with accumulated dust in rooms 246, 237, 318, 321 and 337 were cleaned immediately. The 3rd floor panty ice machine dispensing spout soiled with dust and debris was cleaned on the day it was sited. The soiled window tracks in rooms 126, 128, 130 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324 334 and	7 1/7/08

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L 410	Continued From page 23 2nd floor shower room tiles, broken front panels on overbed lights, odors detected in residents' rooms and maintain laundry equipment in safe operating condition. The environmental tour was conducted on December 3, 2007 from 8:30 AM through 11:30 AM in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. A tour of the laundry was conducted on December 3, 2007 at 2:15 PM in the presence of Employee #5. The findings include: 1. Soiled, marred/damaged baseboards were observed in the following rooms: 119, 123, 128, 130, 136, 137, 139, 141, 144, 145, 147, 2nd and 3rd floor shower rooms in 13 of 36 rooms observed. 2. Stained ceiling tiles were observed in rooms 130 and 137 in two (2) of 12 rooms observed on the 1st floor. 3. Wax and dirt build-up in corners was observed in the following rooms: 128, 130, 135, 136, 142, 144, 145, and 147 in eight (8) of 12 rooms observed on the first floor. 4. Bed frames with accumulated dust were observed in the following rooms: 246, 237, 318, 321, and 337 in five (5) of 24 resident rooms observed on the 2nd and 3rd floors. 5. The 3rd floor pantry ice machine dispensing spout was observed soiled with an accumulation of dust and debris in one (1) of one (1) ice machine observed on the 3rd floor. 6. Soiled window tracts were observed in the following rooms: 126, 128, 130, 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324, 334,	L 410	346 were cleaned immediately. 2. All other residents rooms and Areas That could be affected were inspected by Director of Environmental Services to ensure that baseboards are clean, tiles are free of stains, there is No wax builds up in corners, bed Frames are free from dust and debris, Ice machine on 3rd floor is free from dust and debris and window tracks in residents rooms and throughout the facility are not soiled. 3. In-services were given on 12-20-07 on cleaning of baseboards, reporting soiled ceiling tile to maintenance dept. cleaning wax and dirt build up in corners cleaning of bed frames, the cleaning of the ice machine and the cleaning of window tracks by the Director Of Environmental Services. 4. Director of Environmental Services will make monthly rounds to ensure baseboards are clean tiles are free of stains, there is no wax build up in corners bed frames are free from dust and debris, ice machine on 3rd floor is free from dust and debris and window tracks in residents rooms and throughout the facility are not soiled and report findings in Quarterly CQI.	12-28-07

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L 410	Continued From page 24 and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower room observed on the 2nd floor. 13. The front panel of the over bed light was observed broken in rooms 126 and 142 in two (2) of 12 resident rooms observed on the 1st floor. 14. Strong urine and fecal odors were detected in the following areas: rooms 113 and 114 on	L 410	#7 1. Cited black substance on inner part of front window on washer was cleaned on 12-4-07 2. All other washers were inspected by laundry staff and washers were cleaned as needed. 3. Staff was in-serviced on 12-21-07 by Director of Environmental Services on Cleaning and maintenance of washers. 4. Monitoring will be done by laundry staff weekly and finding will be reported in quarterly CQI.	12-28-07

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L 410	Continued From page 24 and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower room observed on the 2nd floor. 13. The front panel of the over bed light was observed broken in rooms 126 and 142 in two (2) of 12 resident rooms observed on the 1st floor. 14. Strong urine and fecal odors were detected in the following areas: rooms 113 and 114 on	L 410	#9 1. The broken chairs sited during the survey in the 3rd floor smoking room 3rd floor dining room and the 2nd floor dining room were removed immediately. 2. All other areas that could be affected Were inspected by Director of Environmental Services and chairs were removed or repaired as needed. 3. Housekeeping staff were in-serviced on 12-20-07 on inspecting chairs throughout The facility on their assigned units daily to ensure compliance. 4. Findings will be reported in quarterly CQI. **#10, #12 #13** 1. Damaged doors on 2nd floor smoking room and 1st floor day room citied during survey period was repaired on 12-24-07. The broken tile in the 2nd floor shower room will be repaired by 1-28-08. The broken front panel of the over bed light in rooms 126 and 142 were repaired the same day cited.	12-28-07 Reviewed 1/11/08

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L 410	Continued From page 24 and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower room observed on the 2nd floor. 13. The front panel of the over bed light was observed broken in rooms 126 and 142 in two (2) of 12 resident rooms observed on the 1st floor. 14. Strong urine and fecal odors were detected in the following areas: rooms 113 and 114 on	L 410	#14 1. Rooms 113, 114, and 219 that were cited for strong urine and fecal orders were cleaned, beds were washed and privacy curtains were replaced on 12-4-07 2. All other resident rooms were inspected for urine and fecal orders and were clean and sanitized as needed. 3. Environmental Services staff was in-serviced on 12-21-07 by Director of Environmental Services on cleaning and sanitizing of residents' rooms. 4. Rounds will be done by housekeeping staff and finding reported in quarterly CQI.	12-28-07

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L 410	Continued From page 25 December 3, 2007 at 9:10 AM and December 4, 2007 at 8:00 AM and 1:40 PM, room 140 on December 3, 2007 at 9:20 AM and room 219 at 8:55 AM on December 4, 2007. 15. Two (2) of three (3) washers were in service at the time of the observation. There was no thermometer on the middle washer to monitor water in one (1) of two (2) functioning washers observed. There was no evidence that the temperature of the water coming into the washers was measured to ensure that the water temperature was in the temperature range for the chemicals used in the wash and rinse cycles. 16. Two (2) of two (2) washers were observed leaking during the wash cycle. The above findings were acknowledged by Employees #1, 2, 3, 4, 5, 6, 7, and 11 at the time of the observations.	L 410	L410 SPACE AND EQUIPMENT #15 1. The washer that was cited in the laundry room with no thermometer to monitor water temperature during the survey period is being cleaned and sanitized by a laundry compound with water temperature below 180 degrees. 2. All other washers were inspected to proper amounts of compound are being released from dispenser appropriately to ensure proper cleaning and sanitizing of clothes. 3. In-service was given to laundry Supervisor by Director of Environmental Service on inspecting clothes for cleanliness after removing from washer on 12-21-07. 4. Monitoring will be done daily by laundry supervisor and findings will be reporter in quarterly CQI.	12-28-07
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain a pest free environment. The findings include: Flying or crawling insects were observed as follows:	L 426		

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L 410	Continued From page 25 December 3, 2007 at 9:10 AM and December 4, 2007 at 8:00 AM and 1:40 PM, room 140 on December 3, 2007 at 9:20 AM and room 219 at 8:55 AM on December 4, 2007. 15. Two (2) of three (3) washers were in service at the time of the observation. There was no thermometer on the middle washer to monitor water in one (1) of two (2) functioning washers observed. There was no evidence that the temperature of the water coming into the washers was measured to ensure that the water temperature was in the temperature range for the chemicals used in the wash and rinse cycles. 16. Two (2) of two (2) washers were observed leaking during the wash cycle. The above findings were acknowledged by Employees #1, 2, 3, 4, 5, 6, 7, and 11 at the time of the observations.	L 410	#16 1. The two washers observed leaking Leaking washer will be replaced On doors by 12-28-07. 2. Maintenance staff will conduct monthly checks on washers to ensure compliance. 3. Maintenance staff was in-serviced On 12-26-07 by maintenance supervisor on preventative maintenance of washer and dryers. 4. Monitoring for compliance of washer and dryers findings will be reported in quarterly CQI.	12-28-07
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain a pest free environment. The findings include: Flying or crawling insects were observed as follows:	L 426		

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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 426	Continued From page 26 1. On December 3, 2007, flying insects were observed in rooms 108 and 115 at 12:15 PM and 1st floor dining room at 4:30 PM. 2. On December 4, 2007, flying insects were observed in the 1st floor nursing station at 7:30 AM and 10:05 AM, 2nd floor nursing station at 10:05 AM, room 114 at 11:30 AM, room 237 at 11:30 AM and 3rd floor nursing station at 4:00 PM. A roach was observed crawling across the counter of the 2nd floor nurses' station at 8:35 AM. 3. On December 5, 2007, flying insects were observed in room 114 at 8:30 AM, 3rd floor dining room at 9:00 AM, ground floor dining room at 12:15 PM and 2nd floor dining room at 4:00 PM. 4. On December 6, 2007, flying insects were observed in the 3rd floor dining room at 10:20 AM and 2nd floor hallway by room 207 at 2:30 PM. A face-to-face interview was conducted with Employee #5 on December 6, 2007 at 9:30 AM. He/she stated, "[A pest control company] comes to spray every week. We still have some problems with flying and crawling insects and mice."	L 426	**L426** **NURSING FACILITIES** **#1, #2, #3, #4** 1. Room 108, 114, 115, 1st, 2nd and 3rdfloor nursing stations 1st, 2nd, 3rd and ground floor dining rooms were cleaned and trash removed on 12-7-07 that were cited during survey with flying insects. Pest control contractor came in on 12-7-07 and 12-18-07 to exterminate the facility. 2. All other residents' rooms were checked for insects and exterminated and cleaned as needed. Trash cans are being cleansed weekly and prn to prevent further occurrences. 3. Housekeeping staff was in-serviced on 12-21-07 for trash removal, cleaning of trash cans and proper cleaning techniques by environmental services director. 4. Weekly rounds will be conducted by Director of Environmental Services To monitor for effectiveness and Findings will be reported in Quarterly CQI.	12-28-07