STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

(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 463	Continued From page 79 observation #4 was made on 5 east, in the presence of Employee #22. They both acknowledged the findings.	F 463		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 33 sampled residents, it was determined that facility staff failed to document: weight assessments post dialysis treatments for one (1) one resident; an alteration in skin integrity for one (1) resident and episodes of suicidal ideations verbalized by one (1) resident. Residents #151, 153 and 376. The findings include: 1. Facility staff failed to document Resident #151's post dialysis weights in the electronic	F 514		

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F 514	Continued From page 80 medical record. A review of the medical record revealed that Resident #151 ' s dialysis treatments scheduled at the Dialysis facility was on Monday, Wednesday and Fridays, morning shift. A review of the resident ' s dialysis electronic medical record on September 21, 2012 revealed that facility staff did not ensure that the post dialysis weights were consistently documented on Resident #151 ' s electronic medical record dated from March 28, 2012 to September 19, 2012. According to your facility ' s policy entitled " Protocol for Preparing a Resident for Dialysis and Receiving a Resident from Dialysis " , date not indicated; stipulated under " Post Dialysis- Weigh resident and document in OPTIMUS [facility ' s electronic medical record]. " A face-to-face interview was conducted with Employees #9 and #10 on September 21, 2012 at approximately 1:54 PM. Both acknowledged that the post dialysis weights were not consistently documented in the electronic medical record. Stated, " Although, staff obtain the weight from the dialysis record; the staff is still suppose to obtain a post dialysis weight and vital signs and document in Optimus Electronic Medical Record. " The clinical record was reviewed on September 21, 2012. 2. Facility staff failed to document an alteration in the integrity of the skin on Resident #153 ' s left leg/shin.	F 514	F514 483.75(i)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE 1. 1. Resident #151 post dialysis weight was documented on the next dialysis visit. 2. All residents requiring post dialysis weights have been identified and weight has been recorded. 3. All nursing staff have been in-serviced on the new process for obtaining pre and post dialysis weights. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	9/21/12 11/9/12 11/9/12 Ongoing

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F 514	Continued From page 81 A bandage was observed on Resident #154 ' s left leg/shin. Upon removal of the bandage [by facility staff], an alteration in skin integrity on was observed. A review of the nurses ' notes, physician ' s orders, progress notes and the resident ' s Treatment Administration Records lacked evidence of any documentation related to the presence of the altered skin. A face-to-face interview was conducted with employee #11 at approximately 11:30 AM on September 24, 2012. The employee reviewed the record and acknowledged that the resident ' s record lacked any documentation about the altered skin on the resident ' s left leg. The employee also added the following statement, " We have been putting the dressing there to prevent the skin from breaking down. " The employee further acknowledged that they have been dressing the affected area daily. Employee #26 was observed cleansing the area with Normal Saline Solution (NSS), applying Moisture Barrier Cream and covering with 4x4 gauze and tape. The record was reviewed on September 24, 2012. Facility staff failed to document an alteration in skin integrity for Resident #153. 3. Facility staff failed to document episodes of suicidal ideation verbalized by Resident #376. A face-to-face interview was conducted on September 21, 2012 at 4:45 PM with Employee # 23 (Social Worker). He/she stated, " I documented the incident the first time not the	F 514	2. 1. Resident #153's left/shin area was healed at the time of this observation. 2. All residents with alteration in skin integrity have been identified and there is documentation reflecting this finding. 3. All licensed staff have been in-serviced on facility alteration in skin protocol. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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F 514	Continued From page 82 second time. I went in to talk to him/her and assess him/her again and he/she denied being suicidal. He/she said, " Suicide is a sin. " There was no evidence that Employee # 23 documented the reported incident/clinical visit in the progress notes. The record was reviewed on September 21, 2012.	F 514	3. 1. Resident #376 was visited by social worker and incident was documented. 2. All residents who verbalized suicidal ideation have been identified and there is documentation reflecting such verbalizations. 3. All social workers have been in-serviced on documenting episodes of suicidal ideation verbalizations immediately. 4. Random audits will be conducted by Social Services Manager. Results will be presented at the quarterly QA/QI meeting.	10/1/12 11/9/12 11/9/12 Ongoing