ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COMPLETED		
	095034	B. WING		01/29/2021		
AME OF PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLÉTION		
conducted on Janua 29, 2021. Survey ad nine (9) sampled res the facility is not in or requirements of 42 C Requirements for Lo includes the facility's §483.80 infection co census was 146. The following is a di acronyms that may b Abbreviations AMS - Altered Ma ARD - Assessme AV- Arteriovenous BID - Twice- a-C B/P - Blood Pre cm - Centimete CMS - Centers f Services CNA- Certified N CRF - Commun D.C District of Regulations D/C Discontinue DI - deciliter DMH - Departme EKG - 12 lead E EMS - Emerger	ed Infection Control Survey was ary 27, 2021 through January ctivities consisted of a review of sidents. It was determined that compliance with the CFR Part 483, Subpart B, and ong Term Care Facilities. This is non compliance with 42 CFR ontrol regulations. The resident rectory of abbreviations and/or be utilized in the report: ental Status ent Reference Date day essure rs or Medicare and Medicaid	FOC	Carroll Manor makes its best e operate in substantial complian Federal and State laws. Subm (POC) does not constitute an a agreement by any party, its off directors, employees or agents of the facts alleged or the valio conditions set forth on the stat deficiencies. This plan of corrr is prepared and/ or executed b required by State and Federal	nce with both ission of this admission or ficers, s as the truth dity of the ement of ection (POC) because it is		
ARATORY DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		 xecutive Director	(X6) DATE 3-12-2021		

(X2) MULTIPLE CONSTRUCTION

Any deliciency 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 03/05/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

PRINTED: 03/05/2021 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO). 0938-039
				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095034	B. WING			01	/29/2021
	ROVIDER OR SUPPLIER	REHAB		72	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE 26 ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	HVAC -Heating vID -IntellectualIDT -interdiscipL -LiterLbs -Pounds (MAR -MedicatioMD -MedicatioMD -MedicatioMD -MedicatioMD -MedicatioMD -MedicatioMD -milligramsmL -milligramsmL -milligramsmg/dl -milligramsmm/Hg -milligramsMNmidnightNeuro -NeurologNP -Nurse PracologNP -Nurse PracologNP -Nurse PracologPASRR -PreadmissPeg tube -PercutanPO-by mouthPOS -physiciarPrn -As neededPt -PatientQ-EveryQIS -Quality IROMRange GRp, R/P -ResponsSCCSpecialSol-Solution	ervice Center entilation/Air conditioning al disability plinary team unit of mass) n Administration Record Doctor Data Set s (metric system unit of mass) (metric system measure of ns per deciliter ers of mercury ical actitioner sion screen and Resident neous Endoscopic Gastrostomy n's order sheet ed ndicator Survey of Motion sible party Care Center	F	000			
F 580 SS=D	Notify of Changes (I CFR(s): 483.10(g)(1	njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F	580			
	§483.10(g)(14) Notit (i) A facility must im	fication of Changes. mediately inform the resident;					

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Facility ID: CARROLLMANO If continuation sheet Page 2 of 13

PRINTED: 03/05/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	: 0938-0391 : SURVEY PLETED
	095034	B. WING			01/	29/2021
NAME OF PROVIDER OR SUPPLIER	G & REHAB	-	7	BTREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
PREFIX (EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
consistent with h representative(s) (A) An accident i in injury and has intervention; (B) A significant of mental, or psycho- deterioration in h status in either lif complications); (C) A need to alton need to discontin due to adverse of new form of treat (D) A decision to from the facility a (ii) When making (g)(14)(i) of this se all pertinent infor available and pro- physician. (iii) The facility m resident and the when there is- (A) A change in r specified in §483 (B) A change in r State law or regu (e)(10) of this set (iv) The facility m the address (mai of the resident representative(s) §483.10(g)(15)	esident's physician; and notify, s or her authority, the resident when there is- nvolving the resident which results the potential for requiring physician change in the resident's physical, osocial status (that is, a ealth, mental, or psychosocial e-threatening conditions or clinical er treatment significantly (that is, a ue an existing form of treatment onsequences, or to commence a ment); or transfer or discharge the resident s specified in §483.15(c)(1)(ii). notification under paragraph ection, the facility must ensure that mation specified in §483.15(c)(2) is vided upon request to the ust also promptly notify the resident representative, if any, oom or roommate assignment as .10(e)(6); or esident rights under Federal or lations as specified in paragraph ction. ust record and periodically update ling and email) and phone number		580	 F580 1) The Physician extender notified of resident #2 of condition on 12/4/ 2) The unit managers or reviewed the resident current change in corr who were inhouse on to ensure that the physician extenders will educate the licen on the timely notified. 3) The staff educator or will educate the licen on the timely notifica physicians/ physician of resident change of conditions. The Unit or designee will revier change of conditions week X's 3 months to that physicians/physic extenders are notified resident change of condition resident change of conditions week X's 3 months to that physicians/physic extenders are notified resident change of condition resident change of co	2's change 2020. designee ts with dition, 3/8/2021 ysician/ vere designee sed nurses tion of extenders Manager w resident 3 x's per ensure cian d of nditions in	3/20/2021

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 03/05/2021 FORM APPROVED OMB NO 0938-0391

STATE MENU OF DERDIENCIES AND PLANE INTERPOLICES (CONTENTION A BUILDING Destination NUMBER) CONTENTION A BUILDING DESCRIPTION A BUILDING DESCRIPTION DESCRI		S FUR MEDICARE						. 0930-0391
MALE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE_ZIP CODE CARROLL MANOR NURSING & REHAB ZBUCHANAN ST, NE WASHINGTON, DC 20017 MULTING TAG REAL DEFINITION OF DEFINITION OR LSC IDENTIFYING INFORMATION; DR LSC IDENTIFYING INFORMATION; PD/ PROVIDER ADD CORRECTION (CROSS REFERENCED TO THE APPROPRIATE DEFINITION) COMELTING (CROSS REFERENCED TO THE APPROPRIATE DEFINITION) CROSS REFERENCED TO THE APPROPRIATE DEFINITION CROSS REFERENCED TO THE APPROPRIATE DEFINITION CROSS REFERENCED TO THE APPROPRIATE DEFINITION CROSS REFERENCED TO THE APPROPRIATE DEFINITION (CROSS REFERENCED TO								
725 BUCHANAN ST. NE WASHINGTON, DC 20017 7400 204/UD FUNCTION OF DEFICIENCIES TAG 7400 CONTROLLED INTERNATION OF LIGUIDENTERNATION INFORMATION 75 740 7400 CONTROLLED INFORMATION OF LIGUIDENTERNATION INFORMATION DEFICIENCIES TAG CONTROLLED INFORMATION CONTROLLED INFORMATION F 5400 Continued From page 3 that is a composite distinct part (as defined in sphsical configuration, including the various locations that composite distinct part, and must specify the policies that apply to room changes between its different locations under \$483.15(C)(9). This REQUIREMENT is not met as evidenced by: F 580 Based on record review and staff interview, for one (1) of nine (9) sampled residents, facility staff delayed informing the resident's physician of a change in physical and mental status. Resident #2. Findings included Review Resident #2's medical record showed the following nursing progress note: 12/3/2020: 13:10 (1:10 PM)* Resident had a change in confuse the value for white word the unit as usual, and more confused poor appetite * 12/3/2020: 13:10 (1:10 PM)* Resident had a change in confused confused poor appetite * 12/3/2020: 13:10 (1:10 PM)* Resident had a change in confused poor appetite * 12/4/2020, at 9:15 AM [Resident #2] was found on the four CRNP (Certified Registered Nurse Practitioner) notified* During a face-to-face interview conducted on 02/4/2021, at approximately 10			095034	B. WING			01/	29/2021
CARPOLI MANOR UNURSING & REHAB WASHINGTON, DC 20017 (PAU) ID PREETX TAG IEACH DEFICIENCY WILLST BE PRECIDENCES OR LSE IDENTIFYING INFORMATION PIE F 580 Continued From page 3 that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the value result ocations that comprise the composite distinct part, and must specify the policies that apply to norm ochanges between its different locations under §483.15(c)(9). F 580 Based on record review and staff interview, for one (1) of nine (9) sampled residents, facility staff delayed informing the residents physician of a change in physical and mental status. Resident #2. F Findings included Resident #2 was admitted to the facility on 02/04/2019, with diagnoses that included, Dementia, Constitution, was not able to walk around the unit as usual, and more confused poor appetite * Review Resident #2's medical record showed the following nursing progress note: 12/3/2020: 13:10 (1:10 PM)* Resident had a change in confused poor appetite * Review Resident #2's medical record showed the following nursing progress note: 12/3/2020: 13:10 (1:10 PM)* Resident had a change in confused poor appetite * 12/3/2020: 13:15 AM [Resident #2] was found on the foor CRNP (Certified Registered Nurse Practitionery notified* During a face-to-face interview conducted on 02/04/2021, at approximately 10:30 AM with	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Prigry TAG CACH DEPICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION PRETX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENTION DEFICIENCY F 580 Continued From page 3 that is a composite distinct part (as defined in \$483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under \$483.15(c)(9). F 580 Based on record review and staff interview, for one (1) of nine (9) sampled residents, facility staff delayed informing the resident's physician of a change in physical and mental status. Resident #2. Findings included Resident #2 was admitted to the facility on 02/04/2019, with diagnoses that included, Dementia, Constipation, Being Prostatic Hypertension (BPH) and Allergic Rhinitis. Review Resident #2's medical record showed the following nursing progress note: " 12/4/2020, at 9:15 AM [Resident #2] was found on the floor CRNP (Certified Registered Nurse Practitioner) notified" Juite approximately 10:30 AM with	CARROLI	L MANOR NURSING &	REHAB			·		
 that is a composite distinct part (as defined in §433.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §433.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of nine (9) sampled residents, facility staff delayed informing the resident's physican of a change in physical and mental status. Resident #2. Findings included Resident #2 was admitted to the facility on 02/04/2019, with diagnoses that included, Dementia, Constipation, Benign Prostatic Hypertension (BPH) and Allergic Rhinitis. Review Resident #2's medical record showed the following nursing progress note: 12/3/2020: 13:10 (1:10 PM)" Resident had a change in condition was not able to walk around the unit as usual, and more confused poor appetite " 12/4/2020, at 9:15 AM [Resident #2] was found on the floor CRNP (Certified Registered Nurse Practitioner) notified* During a face-to-face interview conducted on 02/04/2021, at approximately 10:30 AM with 	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
nursing staff are trained and educated to report any change in condition to the physician	F 580	that is a composite of §483.5) must disclosits physical configura locations that comprand must specify the changes between its §483.15(c)(9). This REQUIREMEN Based on record ret (1) of nine (9) sample delayed informing the change in physical a Findings included Resident #2 was ad 02/04/2019, with dia Dementia, Constipat Hypertension (BPH) Review Resident #2 following nursing prot 12/3/2020: 13:10 (1: change in condition unit as usual, and m " 12/4/2020, at 9:15 A the floor CRNP (C Practitioner) notified During a face-to-fac 02/04/2021, at appro Employee #2 (Direc nursing staff are trai	distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct part, e policies that apply to room s different locations under IT is not met as evidenced by: view and staff interview, for one led residents, facility staff he resident's physician of a and mental status. Resident #2. mitted to the facility on ignoses that included, tion, Benign Prostatic and Allergic Rhinitis. 's medical record showed the ogress note: 10 PM)" Resident had a was not able to walk around the fore confused poor appetite M [Resident #2] was found on Certified Registered Nurse I" e interview conducted on porimately 10:30 AM with tor of Nursing), she stated that ned and educated to report any	F	580			

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Facility ID: CARROLLMANO

If continuation sheet Page 4 of 13

PRINTED: 03/05/2021 FORM APPROVED

CENTER	<u>SFOR MEDICARE (</u>	& MEDICAID SERVICES				<u> JMR NO</u>	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING _			01/2	29/2021
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CARROL	L MANOR NURSING &	REHAB			S BUCHANAN ST., NE ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 580 F 726 SS=D	of the interview, Em findings. During a telephone i 02/08/2021, at 10:42 Practical Nurse) star medical doctor or nu in the resident's com practitioner aware b document it." Facility staff delayed physician (20 hours in physical and men Competent Nursing CFR(s): 483.35(a)(3 §483.35 Nursing Se The facility must hav the appropriate com provide nursing and resident safety and practicable physical well-being of each re	tt she will look into it. At the time ployee #2 acknowledged the interview conducted on 2 AM, Employee #12 (Licensed ted, "We have to call the urse practitioner for any changes dition. I did make the nurse ut I remember why didn't d informing Resident #2's later) of the resident's change tal status. Staff b)(4)(c)	F 5		DEFICIENCY		
	of the facility's reside	number, acuity and diagnoses ent population in accordance essment required at §483.70(e).					
	nurses have the spe sets necessary to ca	acility must ensure that licensed ecific competencies and skill are for residents' needs, as sident assessments, and n of care.					
	§483.35(a)(4) Provid	ding care includes but is not					

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Facility ID: CARROLLMANO If continuation sheet Page 5 of 13

PRINTED: 03/05/2021
FORM APPROVED
OMD NO 0020 0201

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095034	B. WING		01/	29/2021
	ROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 726	limited to assessing implementing resider resident's needs. §483.35(c) Proficient The facility must en- demonstrate compe- necessary to care for through resident assignan of care. This REQUIREMEN Based on record re of nine (9) sampled provide competent re promotes the resider Findings included Resident #2 was ad 02/04/2019, with dia Dementia, Constipa Hypertension (BPH) Review Resident #2 following nursing pro- 12/3/2020: 13:10 (1 change in condition unit as usual, and m " 12/4/2020, at 9:15 A the floor CRNP (C Practitioner) notified	, evaluating, planning and ent care plans and responding to acy of nurse aides. Sure that nurse aides are able to tency in skills and techniques or residents' needs, as identified sessments, and described in the IT is not met as evidenced by: view and interview, for one (1) residents, facility staff failed to nursing care in a manner that ent's well-being. Resident #2. mitted to the facility on agnoses that included, tion, Benign Prostatic o and Allergic Rhinitis. I's medical record showed the ogress note: :10 PM)" Resident had a was not able to walk around the hore confused poor appetite M [Resident #2] was found on Certified Registered Nurse	F 726	 F726 1. The licensed nurse #12 educated on notifying physicians/physician et of resident change of c in a timely manner. 2. The licensed staff merr were re-educated on m physicians/physician et of resident change of c in a timely manner. 3. The educator or design educate new licensed a on notifying physicians/physician et of resident change of c in a timely manner dur orientation process. T Manager or designee w randomly review resid change of conditions 3 per week, times 3 mor ensure timely notificat licensed nurses. 4. The results of the rand reviews will be discuss the monthly QAPI, time months to ensure subs compliance. 	extenders conditions hbers otifying extenders conditions hee will associates extenders conditions ing the he Unit vill ent times ths to ion by om ed during es 3	3/20/2021

PRINTED: 03/05/2021 FORM APPROVED

	S FOR MEDICARE	& MEDICAID SERVICES			(<u> אואר אוער</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095034	B. WING _			01/2	29/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARROL	L MANOR NURSING &	REHAB			25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	Employee #2 (Direct nursing staff are trai change in condition and that she will loo interview, Employee During a telephone i 02/08/2021, at 10:42 Practical Nurse) stat medical doctor or nu in the resident's con practitioner aware be document it."	ge 6 tor of Nursing), she stated that ned and educated to report any to the physician immediately k into it. At the time of the e #2 acknowledged the findings. interview conducted on 2 AM, Employee #12 (Licensed ted, "We have to call the urse practitioner for any changes idition. I did make the nurse ut I remember why didn't o provide competent nursing at promotes the resident's	F	726			
F 880 SS=E	CFR(s): 483.80(a)(1 §483.80 Infection Co The facility must est prevention and contr a safe, sanitary and help prevent the dev communicable disea §483.80(a) Infection program. The facility must est and control program minimum, the follow §483.80(a)(1) A syst reporting, investigati)(2)(4)(e)(f) ontrol ablish and maintain an infection rol program designed to provide comfortable environment and to velopment and transmission of ases and infections. a prevention and control ablish an infection prevention a (IPCP) that must include, at a	F٤	380			

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PRINTED: 03/05/2021 FORM APPROVED

S FOR MEDICARE &	& MEDICAID SERVICES			(DMB NO	. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY PLETED
	095034	B. WING			01/2	29/2021
OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	DEUAD		7	25 BUCHANAN ST., NE		
MANOR NORSING &	REHAD		V	ASHINGTON, DC 20017		
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY					(X5) COMPLETION DATE
staff, volunteers, vis providing services u based upon the facil according to §483.7 national standards; §483.80(a)(2) Writte procedures for the p are not limited to: (i) A system of surve possible communication infections before the in the facility; (ii) When and to who communicable diseat reported; (iii) Standard and tra- be followed to preve (iv)When and how is resident; including b (A) The type and du depending upon the involved, and (B) A requirement the least restrictive poss- circumstances. (v) The circumstance prohibit employees v infected skin lesions residents or their foo- the disease; and (vi)The hand hygien staff involved in dire §483.80(a)(4) A sys- identified under the	itors, and other individuals nder a contractual arrangement lity assessment conducted O(e) and following accepted en standards, policies, and program, which must include, but eillance designed to identify able diseases or ey can spread to other persons on possible incidents of ase or infections should be ansmission-based precautions to ent spread of infections; solation should be used for a jut not limited to: ration of the isolation, infectious agent or organism the isolation should be the sible for the resident under the es under which the facility must with a communicable disease or a from direct contact with od, if direct contact will transmit e procedures to be followed by ct resident contact. tem for recording incidents facility's IPCP and the corrective	F	880			
	F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER MANOR NURSING & SUMMARY ST. (EACH DEFICIENCY MUST OR LSC IDE Continued From pag staff, volunteers, vis providing services u based upon the faci according to §483.7 national standards; §483.80(a)(2) Writte procedures for the p are not limited to: (i) A system of surve possible communica infections before the in the facility; (ii) When and to who communicable disea reported; (iii) Standard and tra be followed to preve (iv)When and how is resident; including b (A) The type and du depending upon the involved, and (B) A requirement the least restrictive poss circumstances. (v) The circumstance prohibit employees v infected skin lesions residents or their foo the disease; and (vi)The hand hygien staff involved in dire §483.80(a)(4) A sys identified under the	CORRECTION IDENTIFICATION NUMBER: 095034 OVIDER OR SUPPLIER MANOR NURSING & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections; (iv)When and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI OVIDER OR SUPPLIER 095034 B. WING MANOR NURSING & REHAB ID PREFI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 7 F i staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; F i §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (V) The hand hygiene procedures to be followed by sta	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ B. WING	F GEFICIENCIES DORRECTION (X1) PROVIDERSUPPLIERCLA. DENTIFICATION NUMBER: DENTIFICATION NUMBER: 095034 (X2) MULTIPLE CONSTRUCTION A. BUILDING OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TZS BUCHANNA ST., NE WASHINGTON, DC 20017 STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES OR LSC DEENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTIVE CROSS REFERENCED OF THE REPOLUTORY OR LSC DEENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE CROSS REFERENCED TO THE APPROPRI DEFICIENCY) Continued From page 7 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; F 880 S483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or in the facility; (ii) When and to whom possible incidents of communicable disease or infections; (iii) Wan and to move solato be used for a resident; including but not limited to: (c) The type and duration should be used for a resident; including but not limited to: (c) The eircumstances. (c) The eircumstances under which the facility must prohibit employees with a communicable disease or infected skin, lesions from direct contact with residents or their food, if SIPCP and the corrective	FERENCINCIES (11) PROVIDENSIPPUERCIAL DENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING (03) DOTE A BUILDING OVIDER OR SUPPLIER 095034 B. WING 01// MANOR NURSING & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017 01// SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY AUST BE PRADED BY FULL REGULTORY OR LSC IDENTIFYING MERCINATION) D PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIVE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE SHARE ACTION SHOULD BE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE SHARE ACTION SHOULD ACTION SHOULD BE CROSS-REFEREN

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		095034	B. WING _			01,	/29/2021
-	ROVIDER OR SUPPLIER	REHAB		72	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE ASHINGTON, DC 20017	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	 §483.80(e) Linens. Personnel must han transport linens so a infection. §483.80(f) Annual re The facility will cond and update their pro This REQUIREMEN Based on observati interview, the facility Standards of Practic protocol with doffing (PPE) when exiting 3 Standards of Practic protocol for keeping on the COVID-19 ur shield in accordance practice. Findings included 1. Facility staff failed before exiting Resid According to Center guidance on the use Equipment, How to 3 Protective Equipment documented to "Rer patient room except https://www.cdc.gov On 01/27/2021, at a observation of the 2 	dle, store, process, and as to prevent the spread of eview. uct an annual review of its IPCP ogram, as necessary. T is not met as evidenced by: on, record review and 's staff failed to follow ce and the facility's practice and Personal Protective Equipment a resident's room, follow ce and the facility's practice and a resident's room door closed bit and properly don a face to professional standards of d to doff PPE (gown and gloves) ent's Room #226. for Disease Control (CDC) of Personal Protective Safely Remove Personal	F	880	 Associate #9 was re-educate Donning and Doffing and kee closed per the infection cont Associate #7 was provided en on wearing her mask approp provided another mask. The housekeeping associates educated on Donning and Dok keeping doors closed per the control policy. The associate educated on wearing their m appropriately and a mask qu was completed to determine were barriers to wearing the properly? An alternate mask provided if indicated. New associates will be educated Donning and Doffing, wearin appropriately, and keeping do closed per the infection cont during the new hire orientatt process. The Unit Manager or designe make random observations 3 week, times 3 months to ens housekeeping staff Don and are closed, and associates will be discusse the monthly QAPI, times 3 m ensure substantial complianted 	ping doors of policy. lucation iately and were re- ffing and infection s were asks estionnaire if there r mask type was ted on g PPE pors of policy on e will x's per ure that Doff, doors ar their nfection the d during ponts to	3/20/2021

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DEPARTMENT OF HEALTH AND HUMAN SERVICES DS EOD MEDICADE & MEDICAID SEDVICES

<u>CENTER</u>	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>DMR NO</u>	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095034	B. WING			01/2	29/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CARROL	L MANOR NURSING &	REHAB			25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From pag	ge 9	F٤	380			
		ering Resident's Room #226 ing supplies to include a toilet					
	resident's door that	on revealed a sign on the documented, "Remove and emove and dispose gown THE ROOM."					
	bathroom. After clear she then was observe	bserved cleaning the resident's aning the resident's bathroom, ved exiting the resident's room and gown that she used to clean bom.					
	her cleaning cart, to and her cart with the leaving the resident the resident in room	valked into the hallway to access uching the room's door frame e gloves she failed to doff before s room. [It should be noted that #226 was under quarantine /ID-19 outbreak in the facility].					
	approximately 11:15	e interview on 01/27/2021, at 5 AM, Employee #9 stated that wn and gloves after she finishes s room.					
	approximately 12:00 Environmental Servi finding and stated th	e interview on 01/27/2021, at) PM, Employee #11, ices Director, acknowledge the hat staff had been instructed to gowns before exiting residents'					
		rvey, Employee #9 failed to doff s prior to exiting resident's					

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 095034 **B** WING 01/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE **CARROLL MANOR NURSING & REHAB** WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 880 Continued From page 10 F 880 2. Facility staff failed to keep a COVID-19 positive resident's room door closed while cleaning it. According to CDC's guidance on Airborne Infection Isolation Rooms, "Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized." https://www.cdc.gov/coronavirus/2019-ncov/hcp/infe ction-control-recommendations.html On 01/27/2021, at approximately 11:30 AM, observation of the 3rd Floor (3 West) showed Employee #10 cleaning a resident's room (#345), who was positive for COVID-19. Continued observation revealed a white sign and a yellow sign on the wall beside room #345. The untitled yellow sign documented, "PLEASE KEEP DOOR CLOSE." And the white sign entitled "Enhanced Respiratory Precautions", documented, "Door should be kept CLOSED." Further observation showed the employee cleaning resident room #345 with the door opened. Employee # 10's cart was positioned in the doorway of room #345. Due to Employee #10's cart positioning, the resident's room door was unable to be closed. During a face-to-face interview on 01/27/2021, at approximately 11:40 AM, the surveyor pointed to the two signs posted on the wall and asked the employee, why did she clean the resident's room with the door opened, Employee #10 stated that her supervisor instructed her to block the doorway of residents' rooms with her cart, so she can easily get to her cleaning supplies since she was not allowed to take her cart into resident's

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			-				. 0330-0331
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER		. ,			(X3) DATE SURVEY COMPLETED	
		095034	B. WING			01/	29/2021
	ROVIDER OR SUPPLIER	REHAB	-	72	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	rooms on the COVII During a face-to-fac approximately 12:00 (Environmental Serv the finding and state keep the resident's fi COVID-19 Unit so the their cleaning supplie At the time of the sur keep the door close 3. Facility staff failed accordance to profe According to the Ce Prevention's website masks (sometimes fi Disposable Face Ma are single-use mask procedure mask fits side gaps and comp mouth. Bring extra r you in case you nee mask. https://www.cdc.gov -getting-sick/cloth-fa During an observatio 01/27/2021, at appre #6 (Licensed Practio hallway standing at surgical face mask t	D-19 unit. e interview on 01/27/2021, at 0 PM, Employee #11, vices Director) acknowledged ed that she instructed her staff to room door open on the nat they could have access to es. rvey, Employee #10 failed to d for resident room #345. d to properly don a face mask in ssional standards of practice. nter for Disease Control and e, Title: Medical procedure referred to as Surgical Masks or asks). Medical procedure masks is make sure your medical close to your face without large oletely covers your nose and nedical procedure masks with d to change out a dirty or wet v/coronavirus/2019-ncov/prevent ice-cover-guidance.html on of the 5th floor on oximately 11:30 AM, Employee cal Nurse) was observed in the the medication cart wearing a hat was not donned in e professional standards of was observed over her mouth	F	880			

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DEPARTMENT OF HEALTH AND **CENTERS FOR MEDICARE & M**

my ears and causes my glasses to fall off." She did attempt to readjust her face mask to cover her nose.

During a face-to-face interview on 01/27/2021, at approximately 1:00 PM, Employee #7 (Nurse Manager) acknowledged the finding and stated, "She will be educated on proper donning of face mask and she will be offered another style face

Facility staff failed to properly don a face mask in accordance with the professional standards of

STATEMENT OF DEFICIENCIES

mask."

practice.

AND PLAN OF CORRECTION

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/05/2021 APPROVED 0938-0391
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING			01/29/2021	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 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		(EACH CORRECTIVE ACTION SHOULD I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 880	Continued From page 12		F 880				
	During a face-to-face interview on 01/27/2021, at approximately 11:35 AM, Employee #6 was asked, is there a reason why her face mask was not covering her nose. Employee #6 stated, "It irritates						

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