| 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 _____ | 01/05/2021 |

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| CARROLL MANOR NURSING & REHAB | 725 BUCHANAN ST., NE WASHINGTON, DC 20017 |

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| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control Survey was conducted on December 29, 2020 through January 5, 2021. Survey activities consisted of a review of six (6) sampled residents. It was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. This includes the facility's non compliance with 42 CFR §483.80 infection control regulations. The resident census was 176.<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>Abbreviations<br>AMS - Altered Mental Status<br>ARD - Assessment Reference Date<br>AV- Arteriovenous<br>BID - Twice- a-day<br>B/P - Blood Pressure<br>cm - Centimeters<br>CMS - Centers for Medicare and Medicaid Services<br>CNA- Certified Nurse Aide<br>CRF - Community Residential Facility<br>D.C. - District of Columbia<br>DCMR- District of Columbia Municipal Regulations<br>D/C Discontinue<br>Dl - deciliter<br>DMH - Department of Mental Health<br>EKG - 12 lead Electrocardiogram<br>EMS - Emergency Medical Services (911) | F 000 | Carroll Manor makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws. | 1/25/2021 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Executive Director | 1-18-2021 |

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

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| F 000 | Continued From page 1<br>G-tube Gastrostomy tube<br>HR- Hour<br>HSC - Health Service Center<br>HVAC - Heating ventilation/Air conditioning<br>ID - Intellectual disability<br>IDT - interdisciplinary team<br>L - Liter<br>Lbs - Pounds (unit of mass)<br>MAR - Medication Administration Record<br>MD- Medical Doctor<br>MDS - Minimum Data Set<br>Mg - milligrams (metric system unit of mass)<br>mL - milliliters (metric system measure of volume)<br>mg/dl - milligrams per deciliter<br>mm/Hg - millimeters of mercury<br>MN midnight<br>Neuro - Neurological<br>NP - Nurse Practitioner<br>O2- Oxygen<br>PASRR - Preadmission screen and Resident Review<br>Peg tube - Percutaneous Endoscopic Gastrostomy<br>PO- by mouth<br>POS - physician ' s order sheet<br>Prn - As needed<br>Pt - Patient<br>Q- Every<br>QIS - Quality Indicator Survey<br>ROM Range of Motion<br>Rp, R/P - Responsible party<br>SCC Special Care Center<br>Sol- Solution<br>TAR - Treatment Administration Record | F 000 | | |
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | F 842 | | |

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| F 842 | Continued From page 2<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. | F 842 | | |

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| F 842 | Continued From page 3<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview, facility staff failed to record the initials and or names of the designated employees responsible for conducting the staff COVID-19 screening on the facility's screening questionnaire form.<br><br>Findings included ...<br><br>A review of the facility's COVID-19 screening questionnaires forms from November 1, 2020, | F 842 | 1. The referenced designated screener was re-educated on the screening questionnaire process including recording their names and initials on December 29, 2020 by the AIT.<br>2. The remaining designated screeners were re-educated on the screening questionnaire process including recording their names and initials on December 29, 2020 by the AIT.<br>3. Future designated screeners will be educated on the screening questionnaire process including recording their names and initials during the orientation process.<br>4.The Infection Prevention Nurse or designee will review the screening questionnaires on a weekly basis, times 3 months to ensure that the screeners sign and initial the questionnaires. The results of the weekly reviews will be reported at the monthly QAPI committee meeting for review to ensure substantial compliance. | 1/25/2021<br><br>1/25/2021<br><br>1/25/2021<br><br>1/25/2021 |

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| F 842 | Continued From page 4<br>through December 27, 2020, showed the facility's designated screener (a staffer responsible for the screening of all employees and approves their access for entry into the facility) failed to consistently record their names and or initials on the questionnaire attesting that they screened staff and that the information recorded was correct.<br><br>Facility staff failed to consistently record the designated screener's name and or initials on the screening questionnaire.<br><br>During a face-to-face interview conducted on 12/28/2020, at approximately 2:55 PM, Employee #3 (Quality Director/Infection Control) stated that the front desk screeners have been trained on the screening process and the screening tool is collected at the end of the day and audited for quality and infection surveillance purposes. Employee #3 also acknowledged the findings at the time of the interview. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention | F 880 | | |

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| F 880 | Continued From page 5 | F 880 | | |

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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 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 with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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| F 880 | Continued From page 6<br>by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview, in one (1) of one (1) employee observation, facility staff failed to wear required personal protective equipment (PPE) while in a resident care area. Employee #5.<br><br>Findings included ...<br><br>According to District of Columbia's Coronavirus 2019 (COVID-19) Reopening Guidance (Phase One & Phase Two) for Skilled Nursing Facilities & Assisted Living Residences ... "goggles or face shield at all times while in the facility for staff who provide direct patient care or are in the patient care areas."<br><br>https://coronavirus.dc.gov/sites/default/files/dc/sites/dcps/page_content/attachments/06122020_DCHealth-Long-Term-Care-Phased-Guidance.pdf<br><br>Review of the facility's policy entitled, "Standard | F 880 | 1.Employee #5 will be re-educated on PPE and COVID-19 (Personal Protective Equipment) on or before 1/25/2021 by the staff educator or designee.<br>2.The ED and AIT made rounds on 1/5/2021 to ensure that associates were wearing masks and eye protection. All associates were observed to be wearing eye protection as required.<br>3.The associates will be re-educated on PPE and COVID-19 (Personal Protective Equipment) on or before 1/25/2021 by the staff educator or designee.<br>4.The Unit Manager or designee will make rounds on a weekly basis, times 3 months to ensure that associates wear masks and eye protection. The results of the rounds will be reported at the monthly QAPI committee meeting for review to ensure substantial compliance. | 1/25/2021<br><br>1/25/2021<br><br>1/25/2021<br><br>1/25/2021 |

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| F 880 | Continued From page 7 | F 880 | | |

Precautions" dated 1/2020, showed, "Standard precautions shall apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease ... wear a mask and eye protection or a face shield to protect the mucous membranes of the eyes, nose and mouth ..."

During a tour of the 2nd floor on 12/28/2020, at approximately 12:30 PM, Employee #5 (certified nursing aide, CNA) was observed in the hallway not wearing a face shield or goggles.

Facility staff failed to wear the required PPE while in a resident care area.

During a face-to-face interview conducted on 12/28/2020, at approximately 12:30 PM, Employee #5 stated, "I am aware of the policy for eye protection in the building. I was just sitting here doing my charting, but I do put on my face shield when performing resident care."

Employee #6 acknowledged the findings at the time of the interview.