Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING: ______ B. WING ______	01/29/2021

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

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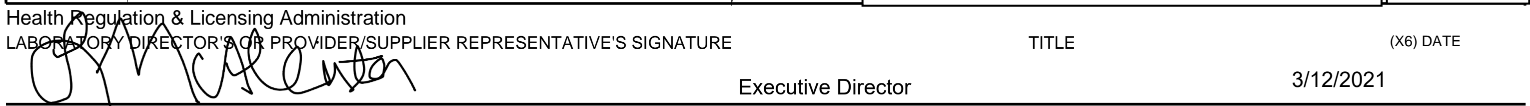
L 000	Initial Comments	L 000	Carroll Manor makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged 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.	3/20/2021

A COVID-19 Focused Infection Control Survey was conducted at Carroll Manor from January 27, 2021 through January 29, 2021. Survey activities consisted of a review of nine (9) sampled residents. The survey was conducted under Title 22B District of Columbia Municipal Regulations, Chapter 32 Nursing Facilities. The resident census during the survey was 146.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE



Executive Director | 3/12/2021

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L 000	Continued From page 1 IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	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;	L 051		

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L 051	Continued From page 2	L 051		

(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:

A. Based on record review and staff interview, for one (1) of nine (9) sampled residents, the charge nurse 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, 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 ..."

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L 051	Continued From page 3	L 051		

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Further review of the nursing progress notes showed that there was a delay in notifying the physician of the resident's change of condition. Physician notification was not made until 12/4/2020, at 9:15 AM when a nursing note documented that 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 Employee #2 (Director of Nursing), she stated that nursing staff are trained and educated to report any change in condition to the physician immediately and that she will look into it. At the time of the interview, Employee #2 acknowledged the findings.

During a telephone interview conducted on 02/08/2021, at 10:42 AM, Employee #12 (Licensed Practical Nurse) stated, "We have to call the medical doctor or nurse practitioner for any changes in the resident's condition. I did make the nurse practitioner aware but I didn't document it."

The charge nurse delayed informing Resident #2's physician of the resident's change in physical and mental status on 12/03/2021.

B. Based on record review and interview, for one (1) of nine (9) sampled residents, the charge nurse failed to provide competent nursing care in a manner that promotes the resident's well-being. Resident #2.

Findings included ...

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L 051	Continued From page 4 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's medical record showed the following 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 ..." Further review of the nursing progress notes showed that there was a delay in notifying the physician of the resident's change of condition. Physician notification was not made until 12/4/2020, at 9:15 AM when a nursing note documented that 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 Employee #2 (Director of Nursing), she stated that nursing staff are trained and educated to report any change in condition to the physician immediately and that she will look into it. At the time of the interview, Employee #2 acknowledged the findings. During a telephone interview conducted on 02/08/2021 at 10:42 AM, Employee #12 (Licensed Practical Nurse) stated, "We have to call the medical doctor or nurse practitioner for any changes in the resident's condition. I did make the nurse practitioner aware, but I didn't document it." The charge nurse failed to provide competent	L 051	L051 1) The Physician extender was notified of resident #2's change of condition on 12/4/2020. 2) The unit managers or designee reviewed the residents with current change in condition, who were inhouse on 3/8/2021 to ensure that the physician/ physician extenders were notified. 3) The staff educator or designee will educate the licensed nurses on the timely notification of physicians/ physician extenders of resident change of conditions. The Unit Manager or designee will review resident change of conditions 3 x's per week X's 3 months to ensure that physicians/physician extenders are notified of resident change of conditions in a timely manner. 4) The results of the resident change of condition reviews will be discussed during the monthly QAPI, times 3 months to ensure substantial compliance.	3/20/2021

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L 051	Continued From page 5 nursing care in a manner that promotes the resident's well-being.	L 051		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure 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 observation, record review and interview, the facility's staff failed to follow Standards of Practice and the facility's practice and protocol with doffing Personal Protective Equipment (PPE) when exiting a resident's room, follow Standards of Practice and the facility's practice and protocol for keeping a resident's room door closed on the COVID-19 unit and properly don a face shield in accordance to professional standards of practice. Findings included ... 1. Facility staff failed to doff PPE (gown and gloves) before exiting Resident's Room, #226. According to Center for Disease Control (CDC) guidance on the use of Personal Protective Equipment, How to Safely Remove Personal Protective Equipment (PPE) Example 2, documented to "Remove all PPE before exiting the patient room except a respirator, if worn ..." https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf On 01/27/2021, at approximately 11:00 AM,	L 091		

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L 091	Continued From page 6	L 091		

observation of the 2nd Floor showed Employee #9 (Housekeeper), donning gloves, a gown, and a surgical mask entering Resident's Room #226 with bathroom cleaning supplies to include a toilet brush.

Continued observation revealed a sign on the resident's door that documented, "Remove and dispose gloves ... Remove and dispose gown ...UPON EXITING THE ROOM."

Employee #9 was observed cleaning the resident's bathroom. After cleaning the resident's bathroom, she then was observed exiting the resident's room wearing the gloves and gown that she used to clean the resident's bathroom.

The emplyee then walked into the hallway to access her cleaning cart, touching the room's door frame and her cart with the gloves she failed to doff before leaving the resident's room. [It should be noted that the resident in room #226 was under quarantine due to a recent COVID-19 outbreak in the facility].

During a face-to-face interview on 01/27/2021, at approximately 11:15 AM, Employee #9 stated that she removes her gown and gloves after she finishes cleaning a resident's room.

During a face-to-face interview on 01/27/2021, at approximately 12:00 PM, Employee #11, Environmental Services Director, acknowledge the finding and stated that staff had been instructed to remove gloves and gowns before exiting residents' rooms.

At the time of the survey, Employee #9 failed to doff her gown and gloves prior to exiting resident's room, #226.

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L 091	Continued From page 7	L 091		

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/infection-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

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L 091	Continued From page 8	L 091		

was not allowed to take her cart into resident's rooms on the COVID-19 unit.

During a face-to-face interview on 01/27/2021, at approximately 12:00 PM, Employee #11, (Environmental Services Director) acknowledged the finding and stated that she instructed her staff to keep the resident's room door open on the COVID-19 Unit so that they could have access to their cleaning supplies.

At the time of the survey, Employee #10 failed to keep the door closed for resident room #345.

3. Facility staff failed to properly don a face mask in accordance to professional standards of practice.

According to the Center for Disease Control and Prevention's website, Title: Medical procedure masks (sometimes referred to as Surgical Masks or Disposable Face Masks). Medical procedure masks are single-use masks ... make sure your medical procedure mask fits close to your face without large side gaps and completely covers your nose and mouth. Bring extra medical procedure masks with you in case you need to change out a dirty or wet mask.
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html

During an observation of the 5th floor on 01/27/2021, at approximately 11:30 AM, Employee #6 (Licensed Practical Nurse) was observed in the hallway standing at the medication cart wearing a surgical face mask that was not donned in accordance with the professional standards of practice. The mask was observed over her mouth and did not cover her nose.

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L 091	Continued From page 9 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 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 mask." Facility staff failed to properly don a face mask in accordance with the professional standards of practice.	L 091	1. Associate #9 was re-educated on Donning and Doffing and keeping doors closed per the infection control policy. Associate #7 was provided education on wearing her mask appropriately and provided another mask. 2. The housekeeping associates were re-educated on Donning and Doffing and keeping doors closed per the infection control policy. The associates were educated on wearing their masks appropriately and a mask questionnaire was completed to determine if there were barriers to wearing their mask properly? An alternate mask type was provided if indicated. 3. New associates will be educated on Donning and Doffing, wearing PPE appropriately, and keeping doors closed per the infection control policy during the new hire orientation process. 4. The Unit Manager or designee will make random observations 3x's per week, times 3 months to ensure that housekeeping staff Don and Doff, doors are closed, and associates wear their masks appropriately per the infection control policy. The results of the observations will be discussed during the monthly QAPI, times 3 months to ensure substantial compliance.	3/20/2021