DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED									
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED			
		095034	B. WING			09/27/2019			
NAME OF PF	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	E				
	L MANOR NURSING &	DELLAR		725 BUCHANAN ST., NE					
			L	WASHINGTON, DC 20017					
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
F 000	INITIAL COMMENT	S	FOC	00					
	conducted at Carrol from September 23, 2019. Survey activ sampled residents. based on observatio and staff interviews. it was determined the compliance with the 483, Subpart B, and	ong Term Care Survey was I Manor Nursing & Rehabilitation 2019 through September 27, ities consisted of a review of 54 The following deficiencies are on, record review and resident After analysis of the findings, hat the facility is not in requirements of 42 CFR Part I Requirements for Long Term e resident census during the							
		rectory of abbreviations and/or be utilized in the report:							
	ARD - Assess AV- Arteriovend BID - Twice- B/P - Blood cm - Centin CFR- Code o CMS - Center Services CNA- Certifie CRF - Comm CRNP- Certifie D.C District	- a-day I Pressure neters of Federal Regulations rs for Medicare and Medicaid ed Nurse Aide unity Residential Facility ed Registered Nurse Practitioner of Columbia of Columbia Municipal							
	director's or provider,	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE Executive Director		(X6) DATE 11-25-2019			
V 1 1 1						11-20-2019			

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	CONNECTION		A. BUILD	NG				
		095034	B. WING			0	9/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE			
CARROLL MANOR NURSING & REHAB					725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	COMPLÉTIC DATE	
F 000	Continued From page	1e 1	Í -	000				
1 000		Je i		000				
	Regulations D/C- Disco	ntinue						
	DI- Deciliter	intinde						
		nent of Mental Health						
	DOH- Departm	ent of Health						
		Electrocardiogram						
		ncy Medical Services (911)						
	F - Fahrenheit FR Frenc							
		stomy tube						
	HR- Hour							
		n Service Center						
		ventilation/Air conditioning						
		ectual disability						
		sciplinary team						
		on Prevention and Control						
	Program							
	LPN- License L - Liter	ed Practical Nurse						
		ls (unit of mass)						
		tion Administration Record						
		al Doctor						
		m Data Set						
		ams (metric system unit of						
	mass)							
	M- minut							
	mL - millilit volume)	ers (metric system measure of						
		ams per deciliter						
		ters of mercury						
	MN midni							
	N/C- nasa	al canula						
	Neuro - Neurolo							
		Fire Protection Association						
		Practitioner						
	O2- Oxyge							
	PASRR - Preadmis Review	ssion screen and Resident						
		eous Endoscopic Gastrostomy						

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Facility ID: CARROLLMANO

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 09/27/2019 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 (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 Continued From page 2 Carroll Manor makes its best effort to operate in substantial compliance F 000 with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, POby mouth it's officer, directors, employees or agents as the truth of the facts POA -Power of Attorney alleged or the validity of the conditions set forth on the statement of physician 's order sheet deficiencies. This plan of correction (POC) is prepared and/ or POS executed because it is required by the State and Federal laws. Prn -As needed Pt -Patient Q-Every QIS -**Quality Indicator Survey** RD-**Registered Dietitian** Registered Nurse RN-Range of Motion ROM RP R/P -Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol-Solution TAR -**Treatment Administration Record** Ug -Microgram F 567 Protection/Management of Personal Funds F 567 10/27/2019 1) The resident account authorizations for residents #116, 215, 214. CFR(s): 483.10(f)(10(i)(ii) 103, and 15 were obtained by the finance department on or before SS=E 10/27/2019 2) The Business office manager or designee reviewed the current accounts for the current residents to ensure that account authorizatio §483.10(f)(10) The resident has a right to manage were in place to manage their funds on or before 10/27/2019. his or her financial affairs. This includes the right to 3) The Business Office Manager educated the finance office associate on ensuring that there are account authorization in place to manage know, in advance, what charges a facility may resident funds on or before 10/27/2019. impose against a resident's personal funds. The Business Office Manager or designee will audit 100% of the new resident account on a monthly basis times 3 months to ensure that (i) The facility must not require residents to deposit account authorizations are in place to manage resident funds. 4) Results of the monthly audits will be discussed in the monthly QAP their personal funds with the facility. If a resident meeting times 3 months to ensure substantial compliance. chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)( I0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in

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Facility ID: CARROLLMANO

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	13 FOR MEDICARE				(		. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/27/2019	
	ROVIDER OR SUPPLIER	REHAB		7	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 INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 567	separate from any o accounts, and that of resident's funds to the accounts, there must each resident's share resident's personal fa a non-interest bearin account, or petty case (B) Residents whose The facility must dep funds in excess of \$ account (or account the facility's operation interest earned on re (In pooled accounts accounting for each must maintain perso \$50 in a noninterest interest-bearing acc This REQUIREMEN Based on record re (5) of 197 sampled account, facility staff authorization for the personal funds. Findings include Review of the facility Service" form docum I hereby authorized established and man Insurance Corporati	account (or accounts) that is if the facility's operating credits all interest earned on that account. (In pooled at be a separate accounting for re.) The facility must maintain a funds that do not exceed \$100 in ng account, interest-bearing sh fund. e care is funded by Medicaid: cosit the residents' personal 50 in an interest bearing s) that is separate from any of ng accounts, and that credits all esident's funds to that account. , there must be a separate resident's share.) The facility onal funds that do not exceed	F	567			

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Facility ID: CARROLLMANO If continuation sheet Page 4 of 29

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 09/27/2019 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 DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 567 1) The Advance Directive information was offered and 10/27/2019 Continued From page 4 F 567 for resident #'s 123,77,82,106,117 and 149 and their responses were documented in their medical record on or before 10/27/2019. Review of the facilities trial balance as of 2) The Social Worker or designee reviewed current resident documentation to ensure that advanced September 24, 2019, showed the following directives were offered, obtained and documented in residents had asterisk (\*) next to their names the resident records. indicating that the resident's, that had transferring 3) The Director of Social Services or designee accounts (automatic transfer of care cost payments educated the social services team on ensuring that advance directives are offered, obtained and due the facility) were missing an application: documented in the residents' records. The Social Workers will randomly audit 33 percent Resident # 116 of the residents Resident # 215 medical records on a monthly basis times 3 months to Resident # 14 ensure that advance directive information is offered, obtained, and documented in the resident medical Resident # 109 records. Resident #15 4) The results of the audits will be discussed during the monthly QAPI meeting times 3 months to ensure substantial compliance. There was no evidence that facility staff ensured that five (5) of the 197 resident accounts had signed applications authorizing the facility to manage their funds. The Employee representing the business office was asked to provide proof that the five (5) residents had given the facility authorization to manage their funds. Employee #17, acknowledged the findings, during a face-to-face interview on 9/21/19, at 10:25 AM. Facility staff failed to show written authorization for the facility to manage five (5) residents' personal funds. F 578 Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir F 578 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) SS=E §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: CARROLLMANO

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PRINTED:	11/25/2019
FORM	APPROVED
OMB NO	0938-0391

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NAME OF PROVIDER OR SUMPLIER     STREET ADDRESS. CITY, STATE JP CODE       CARROLL MANOR NURSING & REHAB     STREET ADDRESS. CITY, STATE JP CODE       (M) ID PPROVIDER OR SUMPLIER     EMMANAY STATEMENT OF DEPORTMENTS       (EACH DEFINITION OF DEPORTMENTS     PROVIDER OF LAD CORRECTION E OF LSC IDENTIFYING INFORMATION       (EACH DEFINITION OF DEPORTMENTS     PROVIDER OF LAD CORRECTION E CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       F 578     Continued From page 5 to participate in experimental research, and to formulate an advance directive.       \$483.10(c)(8)     Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.       \$483.10(c)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart 1 (Advance Directives).       (i) These requirements include provisions to inform and provide write information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the requirements of this section are medi.       (ii) Facilities are permitted to contract with other entities to furnish this information on the facility's policies to implement advance directives and applicable State law.       (iii) Facilities are permitted to contract with other entities to furnish this inclapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.       (vi) The facility is normation. To elow of th	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ´				
75 BUCHANAN ST., NE WASHINGTON, DC 2017         PROPRINT OF DEFICIENCIES         PREERX       (EACH DEFICIENCY MUST BE PRECEDED BY VILL REGULATORY TAGE)       D       PROVIDER'S FLAN OF CORRECTION CONNECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)       CONTECTION         F 578       Continued From page 5       F 578			095034	B. WING			09/27/2019	
CARPOLL MANOR NURSING & REHAB     WASHINGTON, DC 20017            (Mu) ID PREEK TAG           (EACH DEFICIENCY WILLSTEP RECORDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)           PD PROVEMENT OF DEFICIENCY TAG           PROVEMENT PLAN OF CORRECTION (EACH DEFICIENCY WILLSTEP RECORDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)           PD PROVEMENT PLAN OF CORRECTION (EACH DEFICIENCY)           OWEFTOR (EACH CORRECTION SHOLLD BE (EACH CORRECTION THE APPROVEMENT OF DEFICIENCY)           OWEFTOR PROVEMENT             F 578           Continued From page 5         to participate in experimental research, and to formulate an advance directive. Ş483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements specified in 42 CFR part 489, subpart I (Advance Directives). (ii) The includes a witten description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furmis this information but are still legally responsible for ensuring that the requirements of this section are met.         (iv) If an adult individual include at the time of admission and is unable to receive information or advance directive, the facility may give advance directive information to the individual resident representative in accordance with State Law.         (v) The facility is not relived of its obligation to procedures must be in pla	NAME OF PF	ROVIDER OR SUPPLIER				, , ,		
PREFIX TAG       (EACH EDREDIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTFYING INFORMATION)       PREFIX TAG       (EACH EDRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMMENTION DEFICIENCY)         F 578       Continued From page 5 to participate in experimental research, and to formulate an advance directive.       F 578         §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.       F 578         §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directive).       I) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or reluse medical or surgical treatment and, at the resident's option, formulate an advance directives and applicable State law.       (ii) This includes a written description of the facility's policients to implement advance directives and applicable State law.         (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's isolekated representative in accordance with State Law.         (v) If an adult individual's incapacitated at the time of she is able to receive such information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.         (v) The facility is n	CARROLI	L MANOR NURSING &	REHAB			·		
to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	PRÉFIX	(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
	F 578	to participate in exper formulate an advance §483.10(c)(8) Nothin construed as the rig provision of medical deemed medically u §483.10(g)(12) The requirements specifi I (Advance Directive (i) These requirement and provide written in concerning the right surgical treatment a formulate an advance (ii) This includes a w policies to implement applicable State law (iii) Facilities are per entities to furnish this responsible for ensu- this section are met. (iv) If an adult individe of admission and is articulate whether of advance directive, the directive information representative in acci- (v) The facility is not provide this informati- she is able to receiv procedures must be information to the im appropriate time.	erimental research, and to be directive. Ing in this paragraph should be the of the resident to receive the direatment or medical services innecessary or inappropriate. facility must comply with the ied in 42 CFR part 489, subpart es). Ints include provisions to inform information to all adult residents to accept or refuse medical or nd, at the resident's option, ce directive. written description of the facility's at advance directives and d. rmitted to contract with other is information but are still legally uring that the requirements of dual is incapacitated at the time unable to receive information or r not he or she has executed an he facility may give advance to the individual's resident cordance with State Law. t relieved of its obligation to tion to the individual once he or re such information. Follow-up in place to provide the dividual directly at the	F	578			

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Facility ID: CARROLLMANO

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/	27/2019
-					TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE		
CARROL	L MANOR NURSING 8	، REHAB		V	VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	seven (7) of 54 sam failed to allow the R right to request, refu- treatment, to particip experimental resear directive. Resident #117, and #149. Findings include 1. Resident #23 was 1/9/19, with diagnos Fibrillation, Chronic Hypertension, and F A review of the clinic medical records (EN Resident #23 or his/ informed and provid concerning the right surgical treatment a formulate an advance During a face-to-fac approximately 11:00 employee acknowle 2. Resident #77 was 2/25/08 with diagnos Dementia, Hyperlipi Mellitus, Peripheral	eview and staff interview for spled residents, facility staff esident/Healthcare Agent the use, and/or discontinue pate in or refuse to participate in rch, and to develop an advance ts' #23, #77, #82, #106, #108,	F	578			
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Event ID: EB9J11

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PRINTED: 11/25/2019 FORM APPROVED AD NO 0020 0201

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			(	<u> JINIR INO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COI	SURVEY MPLETED
		095034	B. WING			09/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	25 BUCHANAN ST., NE		
	L MANOR NURSING &	REHAB			VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Resident #77 or his informed and provid concerning the right surgical treatment a formulate an advance	AR) failed to show evidence that s/her representative was ed written information to accept or refuse medical or nd, at the resident's option to ce directive.	F	578			
		e interview with Employee #9 at ) AM on 9/26/19. The dged the finding.					
	7/29/17 with diagnos Hyperlipidemia, Hyp	admitted to the facility on ses which include Anemia, ertension, Diabetes Mellitus, Disease, and Major Depressive					
	medical records (EM Resident #82 or his/ informed and provid concerning the right	cal record and the electronic /IR) failed to show evidence that /her representative was ed written information to accept or refuse medical or nd, at the resident's option to ce directive.					
		e interview with Employee #9 at AM on 9/26/19. The dged the finding.					
	9/17/09 with diagnos Disease, Cerebrova	as admitted to the facility on ses which include Parkinson's scular Disease, Hypertension, Disease, Atrial Fibrillation, and					

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

PRINTED: 11/25/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CONCEPTION	IDENTITION NOMBER.	A. BUILD	ING _			
		095034	B. WING			09/27/2019	
_	Rovider or supplier	REHAB		7	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From pag	ge 8	F	578			
	medical records (EM Resident #106 or his informed and provid concerning the right	cal record and the electronic (IR) failed to show evidence that s/her representative was ed written information to accept or refuse medical or nd, at the resident's option to ce directive.					
		e interview with Employee #9 at AM on 9/26/19. The dged the finding.					
	12/3/03, with diagno Hyperlipidemia, End	as admitted to the facility on uses to include Hypotension, I-stage renal disease, Dementia, lajor Depression, and Cataract.					
	medical records (EM Resident #108 or h informed and provid concerning the right	cal record and the electronic MR) failed to show evidence that his/her representative was ed written information to accept or refuse medical or nd, at the resident's option to ce directive.					
		e interview with Employee #8 at ) AM on 9/26/19. The dged the finding.					
	6. Resident #117 wa	as admitted to the facility on					

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ULNILN	S FUR MEDICARE				(		. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/	27/2019
	ROVIDER OR SUPPLIER	REHAB		7	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		2172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Vascular Disease, A Hypertension, Osted A review of the clinic medical records (EM Resident #117 or h informed and provid concerning the right surgical treatment a formulate an advance During a face-to-fac approximately 11:00 employee acknowled 7. Resident #149 wa 12/4/18 with diagnos Heart Failure, Diabe Hypertension, and M A review of the clinic medical records (EM Resident #149 or h informed and provid concerning the right surgical treatment a formulate an advance During a face-to-fac	es which include Peripheral trial Fibrillation, Heart Failure, parthritis, and Dementia. cal record and the electronic (IR) failed to show evidence that his/her representative was ed written information to accept or refuse medical or nd, at the resident's option to ce directive. e interview with Employee #9 at 0 AM on 9/26/19. The dged the finding. as admitted to the facility on ses which include Osteoarthritis, tes Mellitus, Anemia, Macular Degeneration. cal record and the electronic (IR) failed to show evidence that his/her representative was ed written information to accept or refuse medical or nd, at the resident's option to ce directive. e interview with Employee #9 at 0 AM on 9/26/19. The	F	578			
F 641	Accuracy of Assess	ments	F	641			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2019 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
		095034	B. WING			09/27/2019		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARROL	L MANOR NURSING &	REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641 SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mu- resident's status. This REQUIREMEN Based on observati- interview for two (2) facility staff failed to Data Sets (MDS) for diagnosis of Anxiety diagnosis of Anxiety diagnosis of Hypothy #115 Findings included 1. The facility staff fa MDS for Resident #8 Resident #95 was ar 10/21/15, with diagn Peripheral Vascular Hyperlipidemia, Chra and Cataract. Review of the Annua dated 7/23/19, show [Cognitive Patterns] living Resident #95 was indicates the resider impaired (never rare Section, I [Active Dia	y of Assessments. Ist accurately reflect the IT is not met as evidenced by: ion, record review and staff of 54 sampled residents, accurately code the Minimum r one (1) resident with a y, and for one (1) resident with a yroidism. Residents' #95 and  ailed to accurately code the 95's diagnosis of Anxiety. dmitted to the facility on noses to include Osteoarthritis, Disease, Hypertension, onic Kidney Disease, Anxiety, al Minimum Data Set [MDS] yed that under Section C C1000 Cognitive Skills for daily was coded as a "3" which nt's cognition is severely ely made decision). Under agnoses], I5700 [Anxiety tor box was left blank indicating	F	641	<ol> <li>The assessment for resident #115's MDS modified on 9/30/2019 to include the diagnos hypothyroidsm.</li> <li>The MDS coordinators conducted and auc current residents' most recent MDS to ensure active diagnosis are coded in section 1 of the 3) The MDS coordinators were educated by manager on ensuring that current diagnosis' in section 1 of the MDS.</li> <li>The MDS coordinators will randomly audit 33 the MDS assessments times 3 months to enarctive diagnosis' are coded in the MDS.</li> <li>The results of the monthly audits will be dit the monthly QAPI meeting times 3 months to substantial compliance.</li> </ol>	sis of dit of e that MDS. the MDS are coded 3 percent of sure that iscussed ir	þf	

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Facility ID: CARROLLMANO

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CENTER	<u>SFOR MEDICARE (</u>	& MEDICAID SERVICES				<u> JMR NO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COI	SURVEY MPLETED
		095034	B. WING			09/	27/2019
	ROVIDER OR SUPPLIER	REHAB		7	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 ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From pag	ge 11	F	641			
	at approximately 11:	view was conducted on 9/26/19 :04 AM with Employee #12. owledged the findings.					
	2. The facility staff fa MDS for Resident # Hypothyroidism.	ailed to accurately code the 115's diagnosis of					
	8/13/18, with diagno	admitted to the facility on oses to include Hypertension, rial Fibrillation, Dementia, I Hypothyroidism.					
	dated 7/30/19, show [Cognitive Patterns] living Resident #95 the resident's cognit rarely made decision Diagnoses], I3400 [	al Minimum Data Set [MDS] ved that under Section C C1000 Cognitive Skills for daily coded as a "3" which indicates tion is severely impaired (never n). Under Section, I [Active Thyroid Disorder] the indicator ndicating "not coded for					
	at approximately 11:	view was conducted on 9/26/19 :04 AM with Employee #12. owledged the findings.					
F 656 SS=D	Develop/Implement CFR(s): 483.21(b)(1	Comprehensive Care Plan	F	656			
	implement a compre	acility must develop and ehensive person-centered care nt, consistent with the resident					

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	S FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-039						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IULTIPLE CONSTRUCTION		(X3) DATE COI	SURVEY MPLETED		
		095034	B. WING			09/2	27/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	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 NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 656	and timeframes to m nursing, and mental are identified in the The comprehensive following - (i) The services that maintain the resider mental, and psychos under §483.24, §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclu- treatment under §48 (iii) Any specialized rehabilitative service as a result of PASAI facility disagrees wit must indicate its rati- record. (iv)In consultation w resident's represents (A) The resident's pro- future discharge. Fa- the resident's desire assessed and any re- agencies and/or oth purpose. (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN	ncludes measurable objectives neet a resident's medical, and psychosocial needs that comprehensive assessment. care plan must describe the are to be furnished to attain or it's highest practicable physical, social well-being as required 3.25 or §483.40; and twould otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 3.10(c)(6). services or specialized es the nursing facility will provide RR recommendations. If a h the findings of the PASARR, it onale in the resident's medical ith the resident and the ative(s)- bals for admission and desired reference and potential for cilities must document whether to return to the community was eferrals to local contact er appropriate entities, for this in the comprehensive care , in accordance with the th in paragraph (c) of this T is not met as evidenced by:	F	656	<ol> <li>Resident #107's careplan was updated psychotropic medication on 9/27/20169. F #117s Careplan was updated to include ne treatment usage on 9/26/2019.</li> <li>Based on the record review there were ne resident care plans identified to need an u 3) The Nurse Manager or designee will au the resident care plans on a monthly basis months to ensure that the careplans are person-centered.</li> <li>The results of the audits will be discussed monthly QAPI times 3 months to ensure si compliance.</li> </ol>	Resident ebulizer no other pdate. dit 33% of times 3 ed during th	10/27/2019		
		view and staff interview for two sidents, facility staff							

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	STOR MEDICARE		-		(		. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/2	27/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARROLI	L MANOR NURSING &	REHAB			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	person-centered car psychotropic medica the use of nebulizer Residents' #107 and	d implement a comprehensive re plan for the use of ations for one (1) resident and treatments for one (1) resident.	F	656			
	Findings include						
	June 30, 2017 with o Disorder, Depressio	as admitted to the facility on diagnoses to include Anxiety n and Psychotic Disorder; ypertension and Diabetes.					
	Physician's Orders of directed Risperidone mental/mood disord psychotic episodes a	cian's Order Sheet showed a dated February 11, 2019 which e (used to treat certain ers) 0.5mg PO daily for and behavior disturbances and reat depression and anxiety) epression.					
	Section N0410 (Med	MDS dated May 14, 2019 dications Received) showed the for receiving Antidepressant nedications.					
	to show any evidence	the resident's care plans failed ce of a care plan that was sident's use of Antidepressant c medications.					
		o develop and implement a son-centered care plan for					

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	S FUR MEDICARE	& MEDICAID SERVICES					<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/:	27/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	25 BUCHANAN ST., NE		
	L MANOR NURSING &	REHAB		v	VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
<b>F</b> 0.50							
F 656	Continued From page	ge 14	F	656			
		of psychotropic medications.					
		wledged the finding during					
		w on September 27, 2019 at					
	approximately 11:00	AM.					
	2 Posidont #117 w	as admitted to the facility on					
		es which include Atrial					
		ailure, Hypertension, Pulmonary					
	Edema, and Demen						
		cian's Order Sheet dated					
		following current medication					
	orders:						
	E/24/40 " Albutaral C	Sulfate colution (used to treat					
		Sulfate solution (used to treat ness of breath) for Nebulization					
		ster 1 vial via nebulizer three					
	times a day as need						
		izer cup and allow to dry after					
		before storage 3 times per day					
	during the day, ever						
		tubing and neb cup every week					
		er day every Monday"					
		gen tubing every week on					
	Monday 1 time per o	day every Monday"					
		rterly Minimum Data Set dated					
		t under Section I [Active					
		esident #117 was coded for					
	Pulmonary edema).	congestive heart failure and					
	i annonary euenia).						
	A review of the resid	lent's care plan failed to show					
		es for the resident's use of					
	nebulizer treatment						

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					L. L		. 0330-0331	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/2	27/2019	
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE			
CARROL	L MANOR NURSING &	REHAB			ASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES ' BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pag	ge 15	F	656				
F 657 SS=D	Care Plan Timing ar CFR(s): 483.21(b)(2		F	657	<ol> <li>The Careplan for resident #43 was revised/ updated include resident-centered goals and approaches for oxy therapy. Resident #415's careplan was updated on 9/2' to include resident-centered goals and appraches for for</li> </ol>	/gen 7/2019	0 10/27/2019	
	<ul> <li>(i) Developed within comprehensive asse</li> <li>(ii) Prepared by an inicudes but is not line (A) The attending ph</li> <li>(B) A registered nurse resident.</li> <li>(C) A nurse aide with (D) A member of foce (E) To the extent pratesident and the rese explanation must be record if the participaresident representate practicable for the d care plan.</li> <li>(F) Other appropriate disciplines as deterration as requested by the (iii)Reviewed and rese team after each ass comprehensive and This REQUIREMEN</li> </ul>	nprehensive care plan must be- 7 days after completion of the essment. Interdisciplinary team, that mited to hysician. Se with responsibility for the the responsibility for the resident. Se with responsibility for the resident. The and nutrition services staff. acticable, the participation of the ident's representative(s). An e-included in a resident's medical ation of the resident and their ive is determined not evelopment of the resident's e staff or professionals in nined by the resident's needs or resident. vised by the interdisciplinary essment, including both the quarterly review assessments. T is not met as evidenced by:			<ul> <li>a) The Nurse Managers were educated on updating cares.</li> <li>3) The Nurse Managers were educated on updating cares using the they are person-centered.</li> <li>The Nurse Managers or designee will audit 33 percent care plans on a monthly basis time 3 months to ensure plans are person-centered.</li> <li>4) The results of the audits will be discussed during the QAPI times 3 months to ensure substantial compliance</li> </ul>	careplans replans to of the resider that the care monthly	nt	
	Based on medical I	record review and staff						

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		& MEDICAID SERVICES			(		. 0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		095034	B. WING			09/	27/2019
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 725 BUCHANAN ST., NE WASHINGTON, DC 20017		<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	staff failed to revise/ resident-centered go resident's use of oxy	ge 16 of 54 sampled residents, facility /update care plan with oals and approaches for one (1) ygen and for Foley catheter care Residents' #43 and #415.	F	657			
	Findings included						
	showed resident wa 12/4/13 ,with the dia Hypertension, Gastr	ent 's #43 admission record s admitted to the facility on agnoses which include roesophageal Reflux Disease, , Edema and Heart Failure.					
	dated 7/9/19, showe Interview for Mental	ssion Minimum Data Set [MDS] ed, Section C [Cognition] a Brief Status [BIMS] score of "12" ent is cognitively intact.					
	showed "02 (Oxyger	cian's order sheet dated 8/1/19 n) 2L/M (minute) nasal cannula Shortness of Breath (SOB)."					
		e Treatment Administration 2 2L/M N/C as needed for SOB"					
	which did not includ	cal record showed a care plan e goals and approaches for a /gen therapy (as needed).					
	Facility staff failed to	o show evidence of a					

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STATUMENT OF DEFICIENCIES       (P1) PEOPLERSUMPTURENT       D21 MULTIPLE CONSTRUCTION       D21 MULTIPLE CONSTRUCTION       D21 MULTIPLE CONSTRUCTION       D22 MULTIPLE       D23 MULTIPLE		S FUR MEDICARE	& MEDICAID SERVICES					<u>. 0938-0391</u>	
INME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY, STATE, 2P CODE       CARROLL MANOR NURSING & REHAB     STREET ADDRESS. CITY, STATE, 2P CODE       OWING     IEACH DEFIDERCY WINTER PERCEDENCES     PROVIDER OF DESIDENCES       IFAC     IEACH DEFIDERCY WINTER PERCEDENCES     PROVIDER OF DESIDENCES       OR LSC IDENTFYING INFORMATION     PRETX     TAG       IFAC     Continued From page 17     revised/updated resident-centered care plan to include goals and approaches for oxygen therapy for Resident #43.     F 657       During a face-to-face Interview on 9/27/19 at 11:30 AM, Employee #8 acknowledged the findings.     F 657       2. Review of Resident 's #415 admission record showed resident was admitted to the facility on 77/15/19, with the diagnoses which include Hypertension, Gastrosophageal Reflux Disease, Urinary Tract Infection and Heart Failure.       Review of the Admission Minimum Data St (MDS) dated 7/22/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of '15'' which indicates resident is cognitively intact. Further review of the MDS Showed Section H [Bladder and Bowel] H0100 Appliances, Indwelling catheter (including suppablic catheter (folgy).       Review of the physician's order sheet dated 8/1/19 showed, 'change Folgy bag 1 time pre day every 7 days during right''       Review of the medical record showed a care plan "Problem: Indwelling catheter for urinary retention." Approaches: Assess fluid and hydraiion status and record the findings, Assess for any previous diagnostic test, urine culture post residual void, Monitor for acute pathologies putting resident at risk for urinary incontinence'									
725 BUCHANAN ST, NE WASHINGTON, DC 20017       PREFIX TAG     ILEACH DEFICIENCY MUST BE FRANCE OF DEFICIENCES DEFICIENCY MUST BE PRANCE ACTION SHOULD BE OR LSCI DENTIFYING ENFORMATION     D.       F 657     Continued From page 17 revised/updated resident-centered care plan to include goals and approaches for oxygen therapy for Resident #43.     F 657       During a face-to-face Interview on 9/27/19 at 11:30 AM, Employee #8 acknowledged the findings.     F 657       2. Review of Resident's #415 admission record showed resident was admitted to the facility on 7/15/19, with the diagnoses which include Hypertension, Castrosophageal Reflux Disease, Urinary Tract Infection and Heart Failure.       Review of the Admission Minimum Data Set [MDS] dated 7/22/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of "15" which indicates resident is cognitively intact. Further review of the Mobiling catheter (Foley).       Review of the physician's order sheet dated 8/1/19 showed, 'change Foley bag 1 time pr day every 7 days during right' Review of the medical record showed a care plan "Problem: Indvelling catheter (Foley).       Review of the medical record showed a care plan "Problem: Indvelling subtered to ruinary retention." Approaches: Assess fluid and hydration status and record the findings, Assess for any previous diagnostic test, urine culture post residual void, Monitor for acute pathologies putting resident at risk for unary incontinence"			095034	B. WING			09/	27/2019	
CARROLL MANOR NURSING & REHAB     WASHINGTON, DC 2017       (PM)ID PRETX TAG     IEACH DEFICIENCY UNITE REFECTOR DEFICIENCIES ORLSC DENTIFYING INFORMATION     PB     PROVIDE STATEMENT OF DEFICIENCIES CROSS-REPRETER SPLAN OF CORRECTION BOLDSC DENTIFYING INFORMATION     PD     PROVIDE SPLAN OF CORRECTION CROSS-REPRETER SPLAN OF CORRECTION CROSS-REPRETER SPLAN OF CORRECTION CROSS-REPRETER SPLAN OF CORRECTION SHOULD BE CROSS-REPRETER SPLAN OF CORRECTION CROSS-REPRETER SPLAN OF CORRECTION SPLAN OF CROSS-REPRETER SPLAN OF CORRECTION CROSS-REPRETER SPLAN OF CORRECTION CROSS-REPRETER SPLAN OF CORRECTION SPLAN OF CROSS-REPRETER SPLAN OF CROSS-REPRETER SPLAN OF CORRECTION SPLAN OF CROSS-REPRETER SPLAN OF CROSS-REPRETER SPLAN OF CORRECTION SPLAN OF CROSS-REPRETER SPLAN OF CROSS-REPRETER SPLAN OF CROSS-REPRETER SPLAN OF CROSS-REPRETER SPLAN OF CROSS-REPR	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
Principul TAG         IEACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR US CIDENTIFYING INFORMATION)         PREFIX TAG         CEACH CORRECTIVE ACTION MOUD BE CROSS-HEFFERENCED TO HE APPROPRIATE         COMPLETION INTERCENCY           F 657         Continued From page 17 revised/updated resident-centered care plan to include goals and approaches for oxygen therapy for Resident #43.         F 657           During a face-to-face interview on 9/27/19 at 11:30 AM, Employee #6 acknowledged the findings.         F 657           2. Review of Resident's #415 admission record showed resident was admitted to the facility on 77/15/19, with the diagnoses which include Hypertension, Gastroesophageal Reflux Disease, Urinary Tract Infection and Heart Failure.         F           Review of the Admission Minimum Data Set [MDS] dated 7/22/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of "15" which indicates resident is cognitively intact. Further review of the MDS showed Section H [Bladder and Bowel] H0100 Appliances, Indwelling catheter (including suprapubic catheter and nephrostomy tube) is selected to indicate the resident has an indwelling catheter (Foley).           Review of the medical record showed a care plan "Problem: Indwelling catheter for urinary retention." Approaches: Assess fluid and hydration status and record the findings, Assess for any previous diagnostic test, urine culture post residual void, Monitor for acute pathologies putting resident at risk for urinary incontinence*	CARROL	L MANOR NURSING &	REHAB			·			
revised/updated resident-centered care plan to include goals and approaches for oxygen therapy for Resident #43. During a face-to-face interview on 9/27/19 at 11:30 AM, Employee #6 acknowledged the findings. 2. Review of Resident 's #415 admission record showed resident was admitted to the facility on 7/15/19, with the diagnoses which include Hypertension, Gastroesophageal Reflux Disease, Urinary Tract Infection and Heart Failure. Review of the Admission Minimum Data Set [MDS] dated 7/22/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of "15" which indicates resident is cognitively intact. Further review of the MDS showed Section H [Bladder and Bowel] H0100 Appliances, Indwelling catheter (including suprapubic catheter and nephrostomy tube) is selected to indicate the resident has an indwelling catheter (Foley). Review of the mysician's order sheet dated 8/1/19 showed, "change Foley bag 1 time per day every 7 days during night" Review of the medical record showed a care plan "Problem: Indwelling catheter for urinary retention." Approaches: Assess for any previous diagnostic test, urine culture post residual void, Monitor for acute pathologies putting resident at risk for urinary incontinence"	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION	
	F 657	revised/updated resinclude goals and ap for Resident #43. During a face-to-fac AM, Employee #6 ad 2. Review of Reside showed resident wa 7/15/19, with the dia Hypertension, Gastr Urinary Tract Infection Review of the Admis dated 7/22/19, show Brief Interview for M "15" which indicates Further review of the [Bladder and Bowel] catheter (including sinephrostomy tube) i resident has an indv Review of the physic showed, "change Fo days during night" Review of the medic "Problem: Indwelling Approaches: Assess record the findings, diagnostic test, uring Monitor for acute pa for urinary incontine	ident-centered care plan to oproaches for oxygen therapy e interview on 9/27/19 at 11:30 cknowledged the findings. Int 's #415 admission record s admitted to the facility on ognoses which include to esophageal Reflux Disease, on and Heart Failure. Ission Minimum Data Set [MDS] ved, Section C [Cognition] a lental Status [BIMS] score of the resident is cognitively intact. MDS showed Section H [H0100 Appliances, Indwelling suprapubic catheter and s selected to indicate the velling catheter (Foley). cian's order sheet dated 8/1/19 obey bag 1 time per day every 7 cal record showed a care plan g catheter for urinary retention." s fluid and hydration status and Assess for any previous e culture post residual void, thologies putting resident at risk nce"	F	657				

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Event ID: EB9J11

Facility ID: CARROLLMANO

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					L L L L L L L L L L L L L L L L L L L		. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/2	27/2019
	ROVIDER OR SUPPLIER	REHAB		72	IREET ADDRESS, CITY, STATE, ZIP CODE 2 <b>5 BUCHANAN ST., NE</b>		
				W	ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	include goals and ap care. During a face-to-face AM, Employee #6 ac	ident-centered care plan to oproaches for Foley catheter e interview on 9/27/19 at 10:40 cknowledged the findings.		657			
F 658 SS=D	CFR(s): 483.21(b)(3 §483.21(b)(3) Comp The services provide outlined by the comp (i) Meet professiona	d Meet Professional Standards )(3)(i) mprehensive Care Plans vided or arranged by the facility, as omprehensive care plan, must- nal standards of quality. ENT is not met as evidenced by:		658	<ol> <li>The medication regimen review form was signed by th on 9/27/2019</li> <li>Based on record review, there were not other medicat review forms signed by a nurse.</li> <li>Lincensed nursed were inserviced on "not to sign" me review forms that are addressed to physicians. The unit manager or desingee will audit 33 percent of the regimen review forms times 3 months to ensure that the by the prescriber of physician</li> <li>Results of the audits will be discussed during the monti meeting times 3 months to ensure sustantial compliance</li> </ol>	ion regimen dication e medication y are signed hly QAPI	10/27/2019
	staff failed to provide acceptable standard registered nurse sig form intended for the complete and sign.	view and staff interview, facility e care in accordance with ls of practice as evidenced by a ning and placing an order on a e physician/prescriber to Resident # 214.					
	Findings included						
	showed resident wa	# 214 discharge summary s admitted to the facility on ged to home on 8/1/19.					

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FORM	APPROVED
OMB NO	0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						<u> 3MB NO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/	27/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARROL	L MANOR NURSING &	REHAB			25 BUCHANAN ST., NE NASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Review of Residen 9/27/19 at 3:00 PM s to Attending Physicia which reads "Colchi swelling and lesseni crystals that cause p be used cautiously in recommend review candidate for further Further review of the and the box was che recommendation wa the form showed "or colchicine and colled is signed by a regist was intended for the physician/prescriber the pharmacist recon Facility staff failed to standards of praction nurse signing and pl intended for the phy and sign. During a face-to-face PM Employee #4 sta nurse should have m	t # 214's closed record on showed [Pharmacy Name] note an/Prescriber dated 7/24/19 cine (works by decreasing ing the buildup of uric acid bain in the affected joint) should n geriatric patients w and determine if she is a r dose reduction. e form showed a box "Agree" ecked to indicate the as accepted. A further review of rder to d/c (discontinue) ct lab." The form dated 7/29/19 ered nurse; however, the form a signature of a to either agree or disagree with	F	658			
F 684 SS=D		undamental principle that ent and care provided to facility	F	684			

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/2	27/2019
-	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	that residents receiv accordance with pro- the comprehensive p the residents' choice This REQUIREMEN Based on medical p for one (1) of 54 sam failed to ensure trea accordance with pro- according to physici Findings included Facility staff failed to insert a Foley cather inserted into your bla fr.(French). Review of Resident showed resident wa 7/15/19, with the dia Hypertension, Gastr Urinary Tract Infection Review of the Admis dated 7/22/19, show Brief Interview for M "15" which indicate p Further review of the [Bladder and Bowel] catheter (including s nephrostomy tube) i	ident, the facility must ensure ve treatment and care in ofessional standards of practice, person-centered care plan, and	F	684	<ol> <li>Physician order for foley size for resident #415 was up reflect the current cather inserted size of 18 on 9/27/2013</li> <li>Based on record review and resident assessment, the other foley catheter orders that needed to be updated wit cather size.</li> <li>Licensed nursing staff was inserviced on ensuring that was in occordence with physuician order. The unit manager or designee will audit 100 percent of refoley catheters on a monthly basis times 3 months to ensu inserted reflects physician orders.</li> <li>The results of the audit will be discussed during the m times 3 months to ensure substantial compliance.</li> </ol>	<ol> <li>re were no</li> <li>the actual</li> <li>treatment</li> <li>esidents with</li> <li>re that the size</li> </ol>	10/27/2019

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u> </u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE CO	E SURVEY MPLETED
		095034	B. WING			09/	27/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CARROL	L MANOR NURSING 8	REHAB			25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Review of the physi showed "insert Fole with 10 cc balloon e needed) for urinary Observation on 9/27 Employee #11 provi Employee #11 was catheter? Employee size 18 but let me cl catheter tubing (inse "it is a size 16 not 14 catheter inserted wa Facility staff failed to accordance to phys During a face-to-fac	cian's order sheet dated 8/1/19 y catheter 16 French, inflate very 30 days and prn (as retention time per day every" 7/29 at 10:00 AM showed ding catheter care. asked what size is the Foley ee #11 responded it should be heck. Employee #11 showed the erted into the patient) and stated 8." Writer noted the Foley as a size 18.	F	684			
F 698 SS=D	dialysis receive such professional standa comprehensive pers residents' goals and This REQUIREMEN Based on observat interview for one (1)	son-centered care plan, and the preferences. IT is not met as evidenced by: ion, record review and staff of 54 sampled residents, facility the dialysis communication	F	698			

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					· · · · · · · · · · · · · · · · · · ·		. 0330-0331
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/	27/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	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 NTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 698	collaboration betwee was included in the #108. Findings included Facility staff failed to communication form collaboration betwee staff was included in record. Resident #108 was	en the facility and dialysis staff medical record for Resident o ensure the dialysis o used to reflect ongoing en the facility staff and dialysis o Resident #108's medical	F	698	<ol> <li>The dialysis communication form for resident #108 was include resident's medical record on 9/25/2019.</li> <li>Dialysis communication forms were included in the medical re other resident, who revieves dialysis on 9/25/2019.</li> <li>The Unit Managers were inserviced to ensure that the dialysis communication form is included in the medical record of residen receive dialysis.</li> <li>The unit manager or designee will audit 100 percent of the medi of the residents, who recieve dialysis to ensure that the dialysis communication forms are in the medical records.</li> <li>The result of the audits will be discussed during the monthly of meeting to ensure substantial compliance.</li> </ol>	cord of the s, ts, who cal records	10/27/2019
	12/3/03, with diagno Hyperlipidemia, End Diabetes Mellitus, M Review of the Resid 7/26/19 to 9/26/19, s goes to Dialysis on Saturdays. The resic communication betw facility was not inclu medical record. Observation made of 10:46 AM of the resi record and the medi were maintained in s part of the resident's A face-to-face interv	sess to include Hypotension, l-stage renal disease, Dementia, lajor Depression, and Cataract. ent #108's medical records from showed that Resident #108 a Tuesdays, Thursdays, and dent's dialysis record for veen the dialysis center and the ded as part of the resident's on 9/25/19, at approximately ident's dialysis communication cal record showed that they separate binder and not as a s active clinical record.					

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					, c		. 0330-0331
STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/2	27/2019
	ROVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		25 BUCHANAN ST., NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812 SS=E	CFR(s): 483.60(i)(1) §483.60(i) Food safe The facility must - §483.60(i)(1) - Proce or considered satisfa authorities. (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using gardens, subject to orgoning and food-ha (iii) This provision do facilities from using gardens, subject to orgoning and food-ha (iii) This provision do facilities from using gardens, subject to orgoning and food-ha (iii) This provision do facilities from using gardens, subject to orgoning and food-ha (iii) This provision do source safety. This REQUIREMEN Based on observat staff failed to serve fa as evidenced by soi resident care units. Findings included During observations approximately 10:00 five (5) resident care (dirt dark in color) th Employee #13 acknowleds	ety requirements. ure food from sources approved actory by federal, state or local food items obtained directly s, subject to applicable State gulations. les not prohibit or prevent produce grown in facility compliance with applicable safe andling practices. bes not preclude residents from it procured by the facility. e, prepare, distribute and serve with professional standards for T is not met as evidenced by: ions and staff interview, facility oods under sanitary conditions led floors on five (5) of five (5) on September 23, 2019, at 0 AM, Pantry floors on five (5) of e units were soiled with grime roughout. owledged the findings during a w on September 23, 2019, at	F	812	<ol> <li>The pantry floors on the 5 residen units w cleaned on 9/23/19.</li> <li>Upon observation there were no other ide that needed to be cleaned.</li> <li>The pantry workers were inserviced on er cleanliness of the pantry floors.</li> <li>The Dining Services Manager willrandomly of 2 units per week times 3 months to ensure fl cleanliness.</li> <li>Results of the observations will be discuss the monthly QAPI to ensure substantial com</li> </ol>	ntified are isuring observe oor ed during	10/27/2019 as

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CENTERS FOR MEDICARE & MEDICAID SERVICES				(		. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVID IDENT         NAME OF PROVIDER OR SUPPLIER         CARROLL MANOR NURSING & REHAB         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF I (EACH DEFICIENCY MUST BE PRECEDE OR LSC IDENTIFYING INFO OR LSC IDENTIFYING INFO         F 880       Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)         §483.80       Infection Control The facility must establish and prevention and control program a safe, sanitary and comfortab help prevent the development communicable diseases and in §483.80(a) Infection prevention program. The facility must establish an in and control program (IPCP) that minimum, the following element \$483.80(a)(1) A system for pre- reporting, investigating, and co and communicable diseases for volunteers, visitors, and other in services under a contractual and upon the facility assessment co to §483.70(e) and following act standards;		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/:	27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARROL	L MANOR NURSING &	REHAB			25 BUCHANAN ST., NE VASHINGTON, DC 20017		
PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	CFR(s): 483.80(a)(1 §483.80 Infection Co The facility must est prevention and cont 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 sys: reporting, investigati and communicable of volunteers, visitors, services under a con upon the facility ass to §483.70(e) and for standards; §483.80(a)(2) Written procedures for the p are not limited to: (i) A system of surver possible communication infections before the in the facility; (ii) When and to who communicable disea reported; (iii) Standard and tra- be followed to prever	)(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. • prevention and control ablish an infection prevention • (IPCP) that must include, at a ing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, staff, and other individuals providing ntractual arrangement based essment conducted according ollowing accepted national en standards, policies, and orogram, which must include, but eillance designed to identify able diseases or ey can spread to other persons om possible incidents of ase or infections should be ansmission-based precautions to ent spread of infections; solation should be used for a	F	880	<ol> <li>The solution for the 3 compartment sink was mixed correctly on The pans were air-dried on 9/23/2019.</li> <li>The solution for the 3 compartment sink solution was mixed corr 9/23/2019. Based on the observation , the other cookware was drie appropriately on 9/23/2019.</li> <li>The Dining staff was inserviced on ensuring that the 3 compartm solution is tested correctly and that cookware is dried appropriately services on a weekly basis times 3 months to ensure that the cook dried appropriately.</li> <li>The Dining staff was inserviced on ensuring the discussed during the mor times 3 months for substantial compliance.</li> </ol>	ectly on ed nent sink . The dining ware is	10/27/2019

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CENTER	S FUR MEDICARE	& MEDICAID SERVICES			Ĺ	<u> JIVIB INU</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/:	27/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARROL	L MANOR NURSING 8	REHAB			725 BUCHANAN ST., NE NASHINGTON, DC 20017		
0(4) 15		ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(75)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	-	F	880			
	depending upon the	ration of the isolation, infectious agent or organism					
	least restrictive poss	nat the isolation should be the sible for the resident under the					
		es under which the facility must with a communicable disease or					
	infected skin lesions residents or their foo the disease; and	s from direct contact with od, if direct contact will transmit he procedures to be followed by					
		tem for recording incidents facility's IPCP and the corrective facility.					
		ndle, store, process, and as to prevent the spread of					
	and update their pro	eview. duct an annual review of its IPCP ogram, as necessary. IT is not met as evidenced by:					
	staff failed to prepar conditions as evider correctly test the sa three-compartment sanitizing solution is to properly handle c	tions and staff interview, facility re foods under sanitary need by failure of staff to nitizing solution from the sink and ensure that the s mixed correctly, failure of staff lean cookware and soiled floors ) resident care units.					

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CENTER	<u>RS FOR MEDICARE </u>	& MEDICAID SERVICES				<u> </u>	<u>. 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING			09/	27/2019
NAME OF P	ROVIDER OR SUPPLIER		-	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	725 BUCHANAN ST., NE		
	L MANOR NURSING &	REHAB		l v	WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES <sup>°</sup> 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)		(X5) COMPLETION DATE
	Continued From pag Findings included During observations September 23, 2019 1. An employee was three-compartment and pans. When asl to test the saniti three-compartment test strip into the sol and quickly without unable to verbalize for remain inserted in the sanitizing solution of the test should be Employee #8 who asked to test the san completed the test. However, the san than 200 Parts per M manufacturer's recommendation solution are to dip the ten (10) seconds an the color change a level between 2000 solution was discarded and an	a of dietary services on b, at approximately 10:00 AM: c observed using the sink to clean and sanitize pots ced zing solution from the sink, Employee #11 dipped the lution Irew it. Employee #11 was how long the test strip should be n and what the expected result c. o was present at the time was nitizing solution tested at less Million (PPM). Posted s for testing the sanitizing he test strip in the solution for d to the test strip should indicate to 400 PPM. The sanitizing nother solution was initiated. At ion, Employee #13 had just	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
		ed using paper towels to dry been cleaned through the ne.					
	There was no evide	nce that facility staff used the					

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CENTER	<u>S FUR MEDICARE (</u>	<u> MEDICAID SERVICES</u>			Ĺ		. 0938-0391			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
095034		B. WING			09/27/2019					
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET 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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE				
F 880	Continued From pag	ae 27	F 880							
	appropriate drying method (such as drip dry) to reduce the spread of bacteria on the cookware.		1 000							
		owledged the findings during a w on September 23, 2019, at PM.								
F 908 SS=D	Essential Equipmen CFR(s): 483.90(d)(2	t, Safe Operating Condition )	F	908	<ol> <li>The ceiling light on the 5th floor was covered on 9/24 freezer gasket was replaced on 9/25/2019.</li> <li>No other ceiling lights were identified to need gaskets</li> </ol>		_			
	and patient care equicondition.	ain all mechanical, electrical, lipment in safe operating T is not met as evidenced by:			<ul> <li>3) The dining services staff was educated on the proces items in need of repair.</li> <li>The dining services maager will randomly observe the d and kitchen on a weekly basis to ensure that maintenance reported to maintenance.</li> <li>4) Results of the observbation will be reporte during the times 3 months to ensure substantial compliance.</li> </ul>	ning rooms ce needs are				
	failed to maintain me equipment in good o	ions and interview, facility staff echanical and electrical condition as evidenced by torn k-in freezer and one (1) ceiling protective cover.								
	Findings included									
		ental tour of the facility on ), between 10:30 AM and 12:30								
		ing lights located in the dining or did not have a protective								
	2019, at approximat loose from	ietary services on September 9, ely 10:00 AM, a gasket hanging oor to one (1) of one (1) walk-in								
		e interview on September 24, ely 12:30 PM, Employee #13								

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FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUI COMPL	
	095034	B. WING			09/2	27/2019
DER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
NOR NURSING &	REHAB			•		
			V			
CH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
ntinued From pag	e 28	F	908			
d/or Employee #15	5 acknowledged the findings.					
		F	919	1) The call bells in residnet room #'s 309, 342, 450, 5	22 were	10/27/2019
R(s): 483.90(g)(2)				repaired don 9/24/2019.		
\$482.00(a) Desident Call System				3) Maintenance staff was inserviced on maintaining t		
				The Maintenance manager or designee will randomly	omly audit 33	to
residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities.				ensure that they are in good working condition .	mes o montris	lisito
ff failed to maintai rking condition as of 95 resident's ro	n the call bell system in good evidenced by call bells in four ooms that did not emit an audio					
dings included						
During an environmental walkthrough of the facility on September 24, 2019, between 10:30 AM and 12:30 PM, call bells in resident rooms #309, #342, #450 and #522 did not alarm when tested, four (4) of 95 resident's rooms.						
above findings du	uring a face-to-face interview					
	NOR NURSING & SUMMARY STA CH DEFICIENCY MUST OR LSC IDEN Attinued From page /or Employee #18 sident Call System R(s): 483.90(g)(2) 3.90(g) Resident facility must be a dents to call for s munication system staff member or 3.90(g)(2) Toilet a sed on observation failed to maintai king condition as of 95 resident's ro- isual alarm when dings included ing an environme September 24, 20 30 PM, call bells i 0 and #522 did m- 5 resident's room s breakdown coul dents in an emergen ployee #14 and/o above findings du September 24, 20	ER OR SUPPLIER NOR NURSING & REHAB SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Thinued From page 28 /or Employee #15 acknowledged the findings. Sident Call System R(s): 483.90(g)(2) 3.90(g) Resident Call System facility must be adequately equipped to allow dents to call for staff assistance through a munication system which relays the call directly staff member or to a centralized staff work area. 3.90(g)(2) Toilet and bathing facilities. S REQUIREMENT is not met as evidenced by: sed on observations and staff interview, facility f failed to maintain the call bell system in good king condition as evidenced by call bells in four of 95 resident's rooms that did not emit an audio isual alarm when tested. dings included ing an environmental walkthrough of the facility September 24, 2019, between 10:30 AM and 30 PM, call bells in resident rooms #309, #342, 0 and #522 did not alarm when tested, four (4) 5 resident's rooms. s breakdown could prevent or delay care to dents in an emergency. ployee #14 and/or Employee #15 acknowledged above findings during a face-to-face interview September 24, 2019, at approximately 12:30	ER OR SUPPLIER         NOR NURSING & REHAB         SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFI TAG         Attinued From page 28 /or Employee #15 acknowledged the findings. sident Call System R(s): 483.90(g)(2)       F         3.90(g) Resident Call System facility must be adequately equipped to allow dents to call for staff assistance through a munication system which relays the call directly staff member or to a centralized staff work area.       3.90(g)(2) Toilet and bathing facilities. 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F 919         3.90(g)(2) Toilet and bathing facilities. s REQUIREMENT is not met as evidenced by:       F 919         sed on observations and staff interview, facility failed to maintain the call bell system in good king condition as evidenced by call bells in four of 95 resident's rooms that did not emit an audio isual alarm when tested.       The sell bells in resident rooms #309, #342, 0 and #522 did not alarm when tested, four (4) 5 resident's rooms.         Se breakdown could prevent or delay care to dents in an emergency.       B breakdown could prevent or delay care to dents in an emergency.         oloyee #14 and/or Employee #15 acknowledged above finding suring a face-to-face interview September 24, 2019, at approximately 12:30	RC R SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE       NOR NURSING & REHAB     725 BUCHAANA ST., NE       WASHINGTON, DC 20017     PROVIDER'S FLAN OF CORRECTION       SUMMARY STATEMENT OF DEFICIENCIES     ID       CH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFX       TAG     PROPORT TO THE PROPORTITE DEFICIENCY       Status of the provide state of the state of

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