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 _____	R-C 12/04/2024

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

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{L 000}	Initial Comments An unannounced Long Term Care Recertification Revisit Survey was conducted at this facility from November 20, 2024 through December 4, 2024. Survey activities consisted of a review of 21 sampled residents. The following deficiencies are based on observations, record reviews and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of the District of Columbia Municipal Regulations (DCMR) Title 22B Chapter 32 requirements for Long Term Care Facilities. The resident census on the first day of the survey was 186 and the facility licensed for 240 beds. Facility reported incident DC~13202 was investigated during this survey. Federal and Local deficiencies were cited related to this investigation DC~13202. During this survey, a harm level deficiency was identified at F689 for Resident #276. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner	{L 000}		

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{L 000}	Continued From page 1	{L 000}		

D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
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)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic

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{L 000}	Continued From page 2 Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	{L 000}		
{L 052}	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection;	{L 052}		

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{L 052}	Continued From page 3 (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interviews, for one (1) of 21 sampled residents, the facility's staff failed to adequately supervise a resident who was documented as being disoriented and having erratic behavior. Subsequently, Resident #276 had an unwitnessed fall, and sustained a forehead laceration, resulting in hospitalization. Actual harm was identified related to the fall that occurred on 10/16/24 for Resident #276. The findings included:	{L 052}	1. Resident #276 is not currently a resident of the facility as of 10/16/24. Resident #276 was assessed and dressing was applied to affected area with laceration on 10/16/24 by licensed nurse and resident was then transferred back to the emergency room on 10/16/24. 2. All new residents who were admitted since 12/4/24 and have low cognition and are at risk for falls have the potential to be affected. Care plans will be reviewed by DoN or Licensed nurse to ensure adequate interventions and supervision are in place and implemented. 3. All licensed staff will be re-educated by the DoN or designee on falls precaution/interventions for residents with erratic behaviors/low cognition. 4. Weekly auditing will be conducted for the next 90 days by the DoN or designee. All findings will be taken to the QAPI Committee for review and all negative findings will be immediately addressed. 5. Completion Date: 1/11/25	

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{L 052}	Continued From page 4 A review of a hospital discharge summary for Resident #276 dated 10/16/24 at 8:07 AM revealed that the resident was on for 1 to 1 observation, fall precautions, and bedrest during the hospital stay of 10/07/24 to 10/16/24. Resident #276 was admitted to the facility from the hospital on 10/16/24 with multiple diagnoses including Cerebral Infarct, Hemiplegia, Aphasia, Mood Affective Disorder, and Depression. A fall risk assessment dated 10/16/24 at 7:52 PM documented the resident had a fall risk score of "45" indicating the resident was a "high risk" for falls. A nursing progress note dated 10/16/24 at 9:50 PM documented in part, "Per the discharge summary [hospital's name], Resident #276 was admitted on 10/07/24 ...to r/o (rule out) CVA (cerebral vascular accident)." A nursing progress note dated 10/16/24 at 9:57 PM documented in part, "Resident was admitted this evening at 4 PM, was observed with disoriented and erratic behavior. She was encouraged not to ambulate by herself due to fall risk however due to poor cognition teaching was not effective ...patient was found laying on the floor in her bathroom (5:30 PM) ...mild bleeding from forehead observed ...fall unwitnessed ...Resident noted with a soft raised area [forehead] with laceration. The measurement 4.0 X 3.0 cm. The laceration itself measured 2.0 X 0.5 cm. ABD and gauze pad applied to affected area ...bleeding subsided ...NP notified ... orders transfer resident to nearest emergency room for evaluation ...[Emergency Medical Service] transferred resident out via stretcher to	{L 052}		

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{L 052}	Continued From page 5 [hospital's name] ...123/71 [blood pressure], 73 [pulse], 98% [oxygen saturation level] on room air ..." A care plan dated 10/16/24 documented in part, "Problem- [Resident #276] has the potential for falls related to recent admission to [the] community. Goal- [Resident #276] is at risk for falls related to change in environment. [Resident #276] wants to remain free from injury related to falls over the next review period. Interventions- Keep bed at the appropriate height. Transfer per intake information until seen by therapy, then follow therapy recommendations. Orient to room and call light. Position pathways clear and provide adequate lighting." According to a Discharge Assessment -Return Anticipated Minimum Date Set (MDS) assessment dated 10/16/24, the resident had a Brief Interview for Mental Status (BIMS) summary score of '00' which indicated that the resident's cognitive function was severely impaired. The resident required maximum assistance from staff for the following: indoor ambulation, changing from a lying to a sitting position while in bed, changing from a sitting to a standing position from the bed or chair, transferring on and off the toilet. Additionally, the resident required maximum assistance from staff when using a wheelchair. A State Survey Agency Intake Inform (DC~13202) dated 10/16/24 at 11:54 PM documented, "Resident was admitted this evening at 4 PM, was observed with disoriented and erratic behavior. She was encouraged not to ambulate by herself due to fall risk however due to poor cognition teaching was not effective ...patient was found laying on the floor in her bathroom (5:30	{L 052}		

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{L 052}	Continued From page 6 PM) ...mild bleeding from forehead observed ...fall unwitnessed ...Resident noted with a soft raised area [forehead] with laceration. The measurement 4.0 X 3.0 cm (centimeters). The laceration itself measured 2.0 X 0.5 cm. ABD (abdominal) and gauze pad applied to affected area ...bleeding subsided ...NP notified ... orders transfer resident to nearest emergency room ....transferred ... to [hospital's name] ..." A nursing note dated 10/17/24 at 5:35 AM documented, "Writer called [hospital's name] to check on resident's status, was told resident was admitted to ICU (intensive care unit). A review of the facility's investigation dated 10/17/24 revealed the admitting hospital's Health Record dated 10/17/24 documented in part, "Assessment/Plan ...history recent L (left) MCA (middle cerebral artery) stroke BIBA (brought in by ambulance) s/p (status post) fall no DAPT (dual antiplatelet therapy). Found to have small area of hemorrhage within subacute L MCA ...admit to ICU ..." During a face-to-face interview conducted on 11/22/24 at 11:40 AM, Employee #10 (Admissions Manager) stated that he did not have copies of Resident #276's initial admission referral documents sent by the hospital's case manager. After receiving the referral documents, he provided a copy to an available unit manager for review. After reviewing the documents, the unit manager determined that the facility could provide care for Resident #276, and she could be admitted. The employee could not recall which unit manager reviewed the documents. During a face-to-face on 11/22/24 at 1 PM, Employee #11 (Unit Manager for the floor the	{L 052}		

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{L 052}	Continued From page 7 resident was admitted to) stated that her staff informed her that the family informed them that the resident was receiving 1 on 1 observations while in the hospital. The employee reported that she did not review the resident's initial hospital documents and was unaware the resident required 1 to 1 observation. The nurse explained that the facility wouldn't have admitted the resident if they knew she needed 1-to-1 observation since they don't provide that service. During a face-to-face interview on 11/26/24 at 3:30 PM, Employee #3 (Nursing Supervisor) stated that she documented the resident had erratic behavior because she was laughing inappropriately, when answering questions she would talk about something unrelated, and she kept trying to remove her clothes and get out of bed. The employee said that because she didn't think the safety teaching that she provided for the resident to call for assistance when she needed to use the bathroom was effective, she lowered the resident's bed in the lowest position, placed a fall mat beside her bed, and instructed staff to closely monitor the resident. When asked what closely monitor meant, the employee said that because the staff had their own team, they could just observe the resident from the hallway. The employee said that when the assigned nurse called the family to make them aware of the resident's fall, the family asked why the resident was left alone because in the hospital the resident was on 1 to 1 monitoring. The employee said that the facility was not made aware the resident was to be on 1 to 1 monitoring. During a telephone interview on 11/27/24 at 11:25 AM, Employee #8 (assigned CNA) stated that since the resident was confused and was a new admission, she placed the resident's bed in the	{L 052}		

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{L 052}	Continued From page 8 lowest position and placed a fall mat next to the bed then left the room to pass dinner trays. As she passed the dinner trays, she heard screaming coming from the resident's room. As she entered the resident's room, she saw the resident alert, lying on the floor in the bathroom with a laceration on her forehead. After getting the nurses, she left the room. According to the employee, neither the assigned nurse nor the nursing supervisor instructed her to closely monitor the resident. During a face-to-face interview on 11/27/24 at approximately 3:30 PM, Employee #9 (assigned RN) stated that after assessing the resident, he and the nursing supervisor went to the desk to review the hospital discharge documents, however, the resident fell before he could review them. The employee said he was not aware the resident was receiving one-to-one monitoring in the hospital until the resident's daughter told him when he called to inform her the resident had fallen.	{L 052}		
{L 056}	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by:	{L 056}		

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{L 056}	Continued From page 9 Based on a review of the facility's records and a staff interview, the facility failed to comply with the State Regulation (DCMR 3211.5) for daily staffing ratios. As evidenced by not providing the minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, with at least six tenths (0.6) hours being provided by a registered nurse for 12 of 12 sampled days. The findings included: A review of the facility's daily staffing sheets revealed the following: On 10/16/24 the facility's resident census was 182. In addition, residents received 3.5 hours of direct nursing care with .35 of those hours being provided by a registered nurse. On 10/18/24 the facility's resident census was 184. In addition, residents received 3.4 hours of direct nursing care with .26 of those hours being provided by a registered nurse. On 10/19/24 the facility's resident census was 184. In addition, residents received 3.1 hours of direct nursing care with .21 of those hours being provided by a registered nurse. On 10/20/24 the facility's resident census was 184. In addition, residents received 3.1 hours of direct nursing care with .13 of those hours being provided by a registered nurse. On 11/08/24 the facility's resident census was 186. In addition, residents received 3.3 hours of direct nursing care with .25 of those hours being provided by a registered nurse.	{L 056}	1. No resident was specifically identified as being impacted by this deficient practice. 2. All residents that reside in the facility have the potential to be affected. Each resident will be assessed for unmet care needs. Any needs identified will be provided. 3. Staffing patterns and schedules were reviewed by DoN and Staffing Coordinator on 12/11/24. The facility has contracted staffing agencies and has one (1) contracted, increased job postings and also added bonus pay per shifts covered by nursing staff to maintain staffing ratios. 4. Under the direction of the QAPI Committee, the DoN or designee, weekly auditing of staffing ratios will be conducted for 90 days to ensure staffing ratios are met. Findings will be taken to the QAPI Committee for review and all negative findings will be immediately addressed. 5. Completion Date: 1/11/25	

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{L 056}	Continued From page 10 On 11/09/24 the facility's resident census was 183. In addition, residents received 3.4 hours of direct nursing care with .21of those hours being provided by a registered nurse. On 11/10/24 the facility's resident census was 183. In addition, residents received 2.7 hours of direct nursing care with .30 of those hours being provided by a registered nurse. On 11/28/24 the facility's resident census was 168. In addition, residents received 3.9 hours of direct nursing care with .33 of those hours being provided by a registered nurse. On 11/29/24 the facility's resident census was 176. In addition, residents received 3.2 hours of direct nursing care with .31 of those hours being provided by a registered nurse. On 11/30/24 the facility's resident census was 173. In addition, residents received 3.3 hours of direct nursing care with .18 of those hours being provided by a registered nurse. On 12/01/24 the facility's resident census was 174. In addition, residents received 3.1 hours of direct nursing care with .09 of those hours being provided by a registered nurse. On 12/03/24 the facility's resident census was 178. In addition, residents received 3.1 hours of direct nursing care with .26 of those hours being provided by a registered nurse. During a face-to-face interview on 12/05/24 at 12 PM, Employee #5 (Staffing Coordinator) stated that staffing was low due to staff calling in, going on vacation, or taking family medical leave. In addition, the employee said that his supervisor	{L 056}		

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{L 056}	Continued From page 11 (DON) monitors the staffing ratios. During a face-to-face interview on 12/05/24 at 12:15 PM, Employee #2 (DON) stated that staffing was low due to staff calling in.	{L 056}		
L 207	3232.5 Nursing Facilities Incidents of abuse or neglect resulting in injury to a resident, or incidents of misappropriation of a resident's funds, shall be reported immediately to the appropriate agencies, including the Department of Health, the Metropolitan Police Department, the Long Term Care Ombudsman and Adult Protective Services. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to immediately report an incident resulting in serious bodily injury to the State Survey Agency after the incident occurred for one (1) of 21 sampled residents. (Resident #276) The findings included: A review of the Abuse Investigation and Reporting Policy with a revised 11/2023 documented in part, "All alleged violation involving abuse, neglect, exploitation, or mistreatment ...will be reported to ...the following other officials or agencies. The State licensing/certification agency responsible for surveying/licensing the community ....Alleged violations involving abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property will be reported ...Serious Bodily Harm-immediately but not later than 2 hours ..."	L 207	1. Resident #276 is not currently a resident of the facility as of 10/16/24. Resident #276 was assessed and dressing was applied to affected area with laceration on 10/16/24 by licensed nurse and resident was then transferred back to the emergency room on 10/16/24. 2. The residents that had a fall since 12/4/24 have the potential to be affected. These fall investigations will be reviewed to ensure any falls resulting in serious injury was reported to the State Agency within two hours if a resident suffers a serious injury due to a fall. 3. All licensed staff will be re-educated by the DoN or designee on safety measures and fall interventions upon admission of a resident and on timely notification to State Survey Agency of any Abuse Neglect or exploitation within 2 hours. 4. Weekly auditing will be conducted for the next 90 days by the DoN or designee on appropriate fall risk interventions and timely reporting of an incident within 2 hours if a resident suffers a serious injury due to a fall. Findings will be taken to the QAPI Committee for review and all negative findings will be immediately addressed. 5. Completion Date: 1/11/25	

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L 207	Continued From page 12 Resident #276 was admitted to the facility on 10/16/24 with multiple diagnoses including Cerebral Infarct, Hemiplegia, Aphasia, Mood Affective Disorder, and Depression. A nursing progress note dated 10/16/24 at 9:57 PM documented in part, "Resident was admitted this evening at 4 PM, was observed with disoriented and erratic behavior. She was encouraged not to ambulate by herself due to fall risk however due to poor cognition teaching was not effective ...patient was found laying on the floor in her bathroom (5:30 PM) ...mild bleeding from forehead observed ...fall unwitnessed ...Resident noted with a soft raised area [forehead] with laceration. The measurement 4.0 X 3.0 cm. The laceration itself measured 2.0 X 0.5 cm. ABD and gauze pad applied to affected area ...bleeding subsided ...NP notified ... orders transfer resident to nearest emergency room for evaluation ...[Emergency Medical Service] transferred resident out via stretcher to [hospital's name] ...123/71 [blood pressure], 73 [pulse], 98% [oxygen saturation level] on room air ..." A review of the facility's investigation revealed that the facility provided written notification of Resident #276 injury to the State Survey Agency on 10/16/24 at 11:54 PM (which was approximately 6 ½ hours after having knowledge of the injury). During a face-to-face interview on 11/21/24 at 3:13 PM, Employee #3 (RN/Nursing Supervisor) stated that she was unable to provide a specific time frame when she was to notify the State Survey Agency when a resident had an incident of a serious bodily injury. She said she may have covered the time frame in orientation, but she	L 207		

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 _____	R-C 12/04/2024

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

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L 207	Continued From page 13 couldn't recall it at the time of this interview. In addition, Employee #3 stated that she considered the resident's injury serious, because the resident hit her head. Cross reference: 483.25 Quality of Care (F689)	L 207		