STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	**Preparation and execution of this plan of correction does not constitute Carroll Manor's admission to or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies, and such liability is specifically denied. The plan of correction is prepared and executed pursuant to Carroll Manor's obligations under federal and state law.**	

An unannounced Recertification Survey was conducted at this facility from May 16 - 30, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 173 and the survey sample included 41 residents.

The following Facility Reported Incidents were investigated during this survey: DC00010784, DC00010794, DC00010998, DC00010942, DC00011067, DC00011232, DC00011509, DC00011520, DC00011746, DC00011818, and DC00011900.

The following Complaint was investigated during this survey: DC00010368.

Federal and/or Local deficiencies were cited related to the investigation(s) of DC00010942, DC00011067, and DC00011746.

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rakisha McClinton	Executive Director	7/19/2023

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

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
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
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2	F 000		

M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen
PA - Physician's Assistant
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic 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
SW - Social Worker
TAR - Treatment Administration Record
Ug - Microgram

F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was	F 584	F 584 **I.Corrective action for residents noted to have been affected by the deficient practice.** The Environmental Services Manager made rounds of the curtains of occupied resident rooms on 5/20/3023. Curtains that were detached from curtain hooks were re-attached immediately by the EVS manager. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Environmental Services Manager made rounds of the curtains of occupied resident rooms on 5/20/2023. Curtains that were detached from curtain hooks were re-attached immediately by the EVS manager. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The Environmental Services manager or Designee will re-educate housekeeping staff on or before 7/27/2023 on maintaining privacy curtains on hooks. The Environmental Services Manager or designee will randomly make rounds on a weekly basis times 3 months to ensure that privacy curtains are attached on hooks. Findings from the review will be corrected by the EVS manager or designee immediately. **(F584 continued on next page)**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 determined that facility staff failed to provide housekeeping services necessary to maintain a safe, and comfortable environment, as evidenced by privacy curtains that were hanging loose, detached from curtain hooks, in 75 of 192 residents' rooms. The findings include: During an environmental tour of the facility on May 19, 2023, between 9:15 AM and 11:30 AM, privacy curtains in residents' rooms were hanging loose off curtain tracks, and detached from curtain hooks on all occupied floors. The observations included: -Fifth floor: 35 of 48 residents' rooms; -Fourth floor: 18 of 48 resident's rooms; -Third floor: unoccupied; -Second floor: 17 of 48 residents' rooms; -First floor: five (5) of 48 residents' rooms. These observations were acknowledged by Employee #11 during a face-to-face interview on May 19, 2023, at approximately 2:00 PM.	F 584	(F584 continued) IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed rounds results and trends will be completed by the Environmental Services Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date**:7/27/2023.	7/27/2023 7/27/2023
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 5 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews for two (2) out of 41 sampled residents, facility staff failed to provide notification to resident representatives that included the facility's bed hold policy or the number of bed hold days available for each Resident when they transferred to the hospital. (Resident #94 and #139) 1. Resident #94 was admitted to the facility on 11/23/22 with diagnoses including: Cerebral Infarct, Metabolic Encephalopathy, Altered Mental Status, Generalized Muscle Weakness, and Age-Related Cognitive Decline.	F 625	F625 **I.Corrective action for residents noted to have been affected by the deficient practice.** Resident #139's and #94 representatives were provided a copy of the bedhold policy on 6/26/2023. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** A copy of the bedhold policy was provided to current residents by the Activities Staff on 6/26/2023. A copy of the bedhold policy was also emailed/ and mailed to current resident representatives by the Executive Director via email and letter on 6/26/2023. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The staff education nurse or designee will re-educate the licensed nurses , social workers and admissions staff on providing residents and/or resident representatives a copy of the bedhold policy on admission, hospital discharge, and therapeutic leave on or before 7/27/2023. IDT notes will be reviewed by the Interdisciplinary Team during the daily clinical meeting for compliance with providing a copy of the Bedhold policy (including bedhold days) to residents and or resident representatives on admission, hospital discharge and Therapeutic leave for 3 months. **(F625 continued on next page)**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 6 A review of Resident #94's medical record showed a Quarterly Minimum Data Set (MDS) assessment dated 02/28/23 showing that the Resident had severely impaired cognition, exhibited trouble falling asleep or sleeping too much for 2-6 days poor appetite or overeating for 7-11 days, required extensive assistance for assisted daily living skills, (transfers. Eating, grooming, toileting, personal hygiene). A Nurses Note on 04/18/23 at 8:55 AM documented, " ...around 10:00 am resident('s) son came to the nurse's station and said sister wanted to speak to doctor ....resident ('s) daughter) called and stated, 'You need to call wheelchair transportation, so I can take my mother to the ER cause she is going downhill by the hour"... [Physician's Name] was informed of the Resident's daughter's request to transfer the Resident to the nearest ER for further evaluation.. [Physician's Name] give (gave) an order to transfer the Resident to the nearest ER. Of note, there was no documented evidence that Resident #94's Representative provided the bed hold policy. A Department of Health (DOH) Notice of Discharge Transfer or Relocation Form dated 04/18/23 at 4:07 pm documented: "...This proposed action is an "a) Transfer - Hospital/Rehab facility/ Nursing home (2) Must list the specific reason(s) for the action: Resident was transferred to ER due to change in medical condition ... (5) If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is the facility's bed hold policy. Your available number of bed hold days is: "N/A" In addition, there was no copy of the facility's bed hold policy attached to the form.	F 625	F625 (Continued) Findings from the review will be corrected immediately by the Unit Manager or Designee. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date**:7/27/2023.	7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 7	F 625		

A review of Resident #94's medical record lacked documented evidence that facility staff provided the facility's bed hold notice to the Resident or their representative, which included how long the facility would hold the bed, how the Resident or their Representative could make reserve payments and the conditions upon which the Resident could return to the facility.

During a face-to-face interview on 05/26/23 at 2:54 PM, Employee #19 (Director of Social Work) stated that the family chose to have Resident #94 transferred to the hospital. The Employee then acknowledged that the "Notice of Discharge Transfer or Relocation Form" did not indicate the number of bed hold days available to the Resident and acknowledged no bed hold policy was attached to the notice.

2. Resident #139 was admitted to the facility on 02/18/22 with diagnoses including: Alcohol Dependence with Alcohol-Induced Dementia, Delusional Disorders, Personal History of Other Mental and Behavioral Disorders, and Restlessness and Agitation.

A review of Resident #139's medical record showed an Annual Minimum Data Set (MDS) Assessment dated 02/21/23 showed that the Resident had severely impaired cognition, required supervision for walking in the corridor and the room, locomotion on the unit, and eating, used a wheelchair for mobility, and had no swallowing disorder.

A Nurses Note dated 04/02/23 at 4:49 PM documented: "During lunchtime, around 12:50 pm, I was in the dining room serving residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 8	F 625		

their meal and sitting with other residents. The Resident was seated at [pronoun] seat, and the writer brought in [pronoun] tray, opened [pronoun] food, and went to go get [pronoun] coffee. As the writer was fixing the coffee, [pronoun] heard the Resident screaming and observed the Resident choking, started Heimlich Maneuver, and called for help; another nurse called for 911, Resident was still unresponsive ...The supervisor came in, and suctioning was initiated, with some food particles noted. 911 arrived at the unit ...Narcan was administered by 911, and the Resident was transferred via stretcher to [Local Hospital] ...MD (Medical Doctor) called ...RR [Name of Representative] contacted."

A Department of Health (DOH) Notice of Discharge Transfer or Relocation Form dated 04/03/23 at 10:12 am documented: " ...This proposed action is an a) Transfer - Hospital/Rehab facility/ Nursing home (2) Must list the specific reason(s) for the action: Change in medical status. RR [Name of Representative] informed of transfer and change in medical condition ...(5) If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is the facility's bed hold policy. Your available number of bed hold days is: "N/A." In addition, there was no copy of the facility's bed hold policy attached to the form.

A review of Resident #139's medical record lacked documented evidence that facility staff provided the facility's bed hold notice to the Resident or their Representative, which included how long the facility would hold the bed, how the Resident or their representative could make reserve payments and the conditions upon which the Resident could return to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 9 During a face-to-face interview on 05/26/23 at 2:54 pm, Employee #19 (Director of Social Work) stated that facility staff provided Resident #139's Representative with the Notice of Discharge Transfer or Relocation Form. The Employee then acknowledged that the notice did not indicate the number of bed hold days available to the Resident and had no bed hold policy attached. Cross reference 22B DCMR sect. 3270.1.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for one (1) of 41 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) assessment to include falls without injury for one (1) resident. (Resident #132). The findings include: Resident #132 was admitted to the facility on 10/11/2021, with multiple diagnoses including, Hyperlipidemia, Diabetes Mellitus, Osteoarthritis, Atherosclerosis Heart Disease, Dementia, and Alzheimer's. Review of a Quarterly MDS assessment with an Assessment Reference Date of 04/10/2023 revealed the following coding:	F 641	**F641 (Desk Review Requested)** **I. Corrective action for residents noted to have been affected by the deficient practice.** a) Resident #48 was referenced in error. Resident # 48 did not sustain falls during the ARD period. b) Resident # 132 sustained a fall on 10/11/2022, which was coded on MDS with ARD 12/14/2022 (in section J1800) ; Resident #132 sustained a fall on 4/24/2022, which was coded and captured on MDS with ARD 6/28/2022 (in section J1800) ; Resident #132 sustained a fall on 2/2/2022, which was coded and captured on MDS with ARD 4/5/2022 (in section J1800) II.**How will the facility identify other residents having the potential to be affected by the same deficient practice?** (F641 continued on next page)	7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10 In Section C (Cognitive Patterns), C1000 Cognitive skills for daily decision-making was coded "3", indicating severely impaired cognition - never/rarely made decisions; In Section G (Functional Status), the upper extremity and lower extremity was coded as, "2" indicating impairment on both sides; In Section J (Health Conditions) J1800 "Has the resident had any falls since admission/entry or reentry or the prior assessment" was coded as "0" indicating no. Review of the interdisciplinary progress notes showed the following: 10/11/2022 at 14:57 PM [2:57 PM], "At 12 pm CNA brought the resident on the hallway on the shower chair to give resident a shower and reported to the writer the [resident husband] stated that resident had a fall in the room. This writer went to room and ask resident husband what had happen he stated that resident was sitting on the Geri chair, had a BM and he took her to the bathroom to change her. He left her standing turn around to go take something to the room, resident sit down on the floor in a sitting position, resident husband denies resident did not hit her head ..." "04/24/2022 20:38pm [7:38 PM], Resident ambulates independently in the unit in front of the nursing station. Resident sat on the side of the chair while her left buttocks not completely in the chair end up falling in a sitting position at 7:42pm. On assessment no apparent injury noted ..." Review of the Resident's Care Plan showed	F 641	**(F641 continued)** There were no other residents identified to be affected by this potential deficient practice. **III.**The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The MDS Manager will re-educate the MDS team on coding falls in section J1800 on or before 7/27/2023. Residents with falls will be reviewed by the Interdisciplinary Team during the daily clinical meeting for compliance of F641. . During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with falls. The review will be documented in the Resident's clinical record. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the MDS coordinator or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date:** 7/27/2023	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 "Category Falls: [resident name] had a fall-related to dementia/gait disorder '02/02/2022 had a fall by the door in her room, 04/24/2022 fall while attempting to sit, 10/11/2022 had a fall the door entering her room ..." The MDS lacked documented evidence that the facility staff accurately coded the MDS to reflect that Resident #48 had three falls without injury since admission to the facility. During a face-to-face interview conducted on 05/25/2023 at 2:40 PM, Employee #20 [MDS Coordinator] acknowledged the findings.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 12 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documented evidence that residents' representatives were provided with a copy of the Base Line Care Plan for two (2) of 41 sampled residents (Residents #28 and #323). Findings included: 1. Resident #28 was admitted to the facility on 02/13/23 with multiple diagnoses including Abnormalities of Gait Mobility, Repeated Falls, Pain in Right Hip, Sever Protein-Calorie Malnutrition. and Dementia. A review of Resident #28's face-sheet showed the resident had a legal guardian.	F 655	**F 655** **Plan of Correction:** I.**Corrective action for residents noted to have been affected by the deficient practice.** The Baseline Care Plan can not be re-created however; the comprehensive care plans were given to the Resident Representatives. A) Resident #28's representative was provided a copy of her comprehensive Care plan on 7/10/2023. B) Resident #323's representative was provided a copy of her comprehensive Care plan on 7/10/2023. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** Current residents, who were admitted from May to July were reviewed on or before 7/27/2023 by the unit manager or designee to verify receipt of baseline care plan. Findings from the review will be corrected immediately by the unit manager or designee. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Current licensed nurses will be re-educated by the Nurse Educator or designee on or before 7/27/2023 on reviewing the baseline care plan with the resident/ and or representative on admission and providing them with a copy. **(F655 continued on next page)**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 13 A review of the resident's medical record revealed a baseline care plan dated 02/13/23. However, review of the progress notes from 02/13/23 to 02/23/23 lacked documented evidence that Resident #28's representative received a copy of the previously mentioned Baseline Care Plan. 2. Resident #323 was admitted to the facility on 05/10/23 with multiple diagnoses including Vascular Dementia, Type 2 Diabetes mellitus, and Chronic Kidney Disease Stage 3 ... A review of Resident #323's face-sheet showed the resident's daughter as the representative. A review of the resident's medical record revealed a baseline care plan dated 05/10/23. However, review of the progress notes from 05/10/23 to 05/22/23 lacked documented evidence that Resident #323's representative received a copy of the previously mentioned Baseline Care Plan. During a face-to-face interview on 05/23/23 at 12:30 PM, Employee #12 (Unit Manager/RN) stated that she had conducted telephone conferences with Resident #28 and #323's representatives to discuss their Baseline Care Plans but had not provided a copy since the representatives had not come to the facility to retrieve them.	F 655	Interdisciplinary team has reviewed Care plan policy and procedure and it is in compliance with the CMS regulation F 655. Residents who are admitted will be reviewed by the Interdisciplinary Team during the daily clinical meeting for compliance of distribution of the baseline care plan to the resident and or representative. If findings are found the unit manager or designee will make corrections immediately. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents for documentation of the development and distribution of the baseline to the resident and or resident representative. The unit manager or designee will complete random reviews of the medical records monthly times 3 months. Findings from the review will be corrected by the Unit Manager or designee immediately. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **IV.Completion Date:** 7/27/2023	7/27/2023
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656	**F 656** **Plan of Correction:** **I.Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #139's careplan was updated to include dysphagia and risk for aspiration on 5/24/2023. B) Resident #28's careplan was updated to include hip fracture repair on 5/21/2023. C) Resident #20's careplan was updated on 3/13/2023 to include UTI. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Unit Manager or designee will review current residents care plans for documentation related to dysphagia, risk for aspiration, UTI, and hip fracture on or before 7/27/2023. Findings from the review will be corrected immediately by the unit manager or designee. **III. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Current associates will be re-educated by the Nurse Educator or designee on or before 7/27/2023 on person-centered care plans. Interdisciplinary team has reviewed Care plan policy and procedure and it is in compliance with the CMS regulation F 656.	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 41 sampled residents, the facility staff failed to develop person-centered care plans with goals and interventions to address (1) a resident's choking incident, (2) a resident's recent right femur (hip) fracture and (3) a resident who had a UTI. (Residents #20, #28, and #139). The findings included: 1. Facility staff failed to update a care plan for a resident that included Resident #139's dysphagia and risk for aspiration after choking in the facility's first-floor dining room on 04/03/23. Resident #139 was admitted to the facility on 02/18/22 with diagnoses including: Alcohol Dependence with Alcohol-Induced Dementia, Delusional Disorders, Personal History of Other Mental and Behavioral Disorder, and Restlessness and Agitation. A review of Resident #139's medical record showed: A Nurses Note dated 04/02/23 at 4: 49 PM documented: During lunchtime, around 12:50 pm, I was in the dining room serving residents their meal and sitting with other residents. The Resident was seated at his seat, and the writer brought in his tray, opened his food, and went to go get his coffee. As the writer was fixing the coffee, he heard the Resident screaming and observed the Resident choking, started Heimlich Maneuver, and called for help; another nurse	F 656	Residents documentation will be reviewed by the Interdisciplinary Team during the daily clinical meeting for person centered care plan interventions related to dysphagia, risk for aspiration, UTI, and hip fracture . Findings will be corrected by the unit manager or designee immediately. The unit manager or designee will complete random reviews of resident records for person-centered care plans related to dysphagia, risk for aspiration, UTI, and hip fracture on a monthly basis times 3 months. Findings from the review will be corrected by the Unit Manager or designee immediately. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date:** 7/27/2023	7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16	F 656		

called for 911, Resident was still unresponsive ...The supervisor came in, and suctioning was initiated, with some food particles noted. 911 arrived at the unit ...Narcan was administered by 911, and the Resident was transferred via stretcher to {Local Hospital] ...Md called ...RR [Name of Representative] contacted."

A Hospital Discharge Summary dated 04/08/23 documented:
"Hospitalization Summary ...presented to the emergency room after a [incident] when he appeared to be choking followed by lethargy. Improved with Narcan, after which he became combative. UDS (urine drug screen) negative ..."

"Discharge Instructions: Acute and chronic encephalopathy - no acute stroke fragment. Returned to baseline ...Dysphagia. Evaluated by speech and swallow. A diet modified to puree', thin liquids; Behavioral modifications while eating; 1:1 feeding assistance; Small bites/sips., slow rate; Feed only when awake/alert; oral care 3-4 x (times) per day; and Aspiration precautions ..."

A Care Plan dated 04/08/23 with a Category: Functional/Rehab Potential ...Eating: I need assistance with meals and snacks ..."
A Speech Therapy Initial Assessment dated 04/11/23: " ...Standardized Tests: Clinical swallow evaluation revealed moderate oropharyngeal dysphagia. Pt (patient) is edentulous and is currently downgraded to a puree diet, thin liquids with 1:1 feeding. Previously able to self-feed finger foods pr nursing...Goal: The patient/caregivers will use safety strategies for purees and thin liquids with 80% accuracy with 1:1 feeding when fully alert with verbal, tactile, and visual instruction/cues..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17	F 656		

During a face-to-face interview on 05/24/23 at 12:19 pm, Employee # 12 (First Floor Unit Manager) stated she was responsible for updating care plans, and she acknowledged that Resident #139's comprehensive care plan did not include the Resident's dysphagia and risk for aspiration after choking on 04/08/23.

[Cross-over DCMR 3210.4(a)]

2.The facility's staff failed to develop a care plan with goals and interventions to address Resident #28's recent hip fracture.

Resident #28 was admitted to the facility on 02/10/23. The resident had a history of Fracture of Right Femur, Abnormalities of Gait Mobility, Repeated Falls, Pain in Right Hip, Dementia, and Sever Protein-Calorie Malnutrition.

A review of a quarterly minimum data set dated 02/02/23 documented the resident had a Brief Interview for mental Status summary score of "04" indicating Resident #28's had severely impaired cognitive status. The resident was not coded for wandering. In addition, the resident was coded for requiring supervision of one staff member for walking in room and walking in corridor.

A review of the resident's medical record revealed a nursing progress note dated 03/03/23 at 7:11 AM documented, "At approx. 5:55 ...[Resident #28] said my leg hurting ... [pro-noun] was rubbing entire right leg esp (sp) right thigh and hip

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18	F 656		

area with external rotation.....[Resident #28] was not able to explain what happen....offered Tylenol for pain but [pro-noun] refused. Temperature 98.1, Respiration 20, Blood Pressure 165/84, Oxygen Saturation Rate 96% on Room Air .. 911 called awaiting transfer."

A review of a re-admission nursing progress note dated 03/08/23 at 8:47 PM documented, " ... [Resident #28] was transferred to ER (emergency room) on 03/03/23 for c/o (complaint) RT. (right) hip pain. During hospital stay resident was found to have Right Intertrochanteric Femur fracture. Resident underwent surgery of Right ORIF (Open Reduction and Internal Fixation) Intertrochanteric Fracture ... "

A review of Resident #28's care plans showed there was no documented evidence that facility staff developed a care plan outlining goals and interventions to address Resident #28's right hip fracture.

During a face-to-face interview on 05/22/23 at approximately 2:00 PM, Employee #12 (Unit Manager/RN) stated that she did not develop a care plan for Resident #28's right hip fracture, but she provided staff education on how to care for the resident. When asked if she had documentation of the training she provided? Employee # 12 stated, "No".

3. Failed to develop a comprehensive care plans with measurable goals, timeframes, and approaches to address resident care concerns for diagnoses of UTI [Urinary tract infection] for Residents #20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19	F 656		

Resident #20 was admitted to the facility on 02/15/2018 with multiple diagnoses including Peripheral Vascular Disease, Hypertension, Osteoarthritis, Hypercholesterolemia, Alzheimer ' s, and Major Depressive Disorder.

An Annual Minimum Data Set (MDS) dated 04/11/2023 showed that facility staff coded the following:

In section C BIMS (Brief Interview for Mental Status) C0500 coded "10" indicating moderately impaired cognition.

In Section I (Active Diagnoses), I2300 Urinary tract Infection (UTI) (last 30 days).

Review of Resident #3's medical record revealed the following:

"03/08/2023 13:36 Resident was seen by [NP (nurse practitioner) name] with POA (power of attorney) [son] at the bedside. After discussing orders were written for CBC, CMP, and UA C&S in the AM 03/09/2023."

"03/10/2023 21:09 Resident lab result was reviewed by (NP name) she called later and gave an order for Ciprofloxacin 250mg POq12 hrs x 7 days for UTI, medication taken from entry box and given ..."

"03/14/202319:36 Resident urine culture result received (MD name) notified new order given to Discontinue Cipro250mg PO q12hrs, start Nitrofurantoin 100mg BID x 5 days for UTI Medication taken from entry box and given ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20 03/08/2023 10:24 [physician's order] Directed, "Check CBC, CMP in am, UA C+S straight catch if needed." 03/10/2023 16:10 [Physician's order] Directed, "Cipro 250mg Po Q12 hrs x7 days for UTI." 03/14/2023 19:00 [Physician's order] Directed, "D/C [discontinue] Cipro 250mg start Nitrofurantoin 100mg BID x5 days for UTI." Review of the comprehensive care plan showed no care plan was developed with a category for Diagnosis of UTI. The evidence showed that Resident#20's comprehensive care plans lacked documented evidence of the category, goals, approaches, and interventions to address care for the resident diagnosis of UTI. A face-to-face interview was conducted on 05/25/2023 at 2:25 PM with Employee #17 (Nurse Manager) and she acknowledged the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21	F 657	**F657**	

resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews for three (3) out of 41 residents, facility staff failed to update and revise person-centered care plans. (Residents #6, #375 and #35).

The findings included:

1.Facility staff failed to update and revise the interventions on a Resident's person-centered care plan after the Resident had a second fall and sustained an injury. Resident #6.

Resident #6 was admitted to the facility on 12/07/22 with diagnoses including Heart Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Volume Overload, and Generalized Muscle Weakness.

A Nurse's Note dated 03/28/23 at 3:41 pm documented: " ...At 11:30 nurse was called to [Resident #6's room] by assigned Certified Nurse

I.Corrective action for residents noted to have been affected by the deficient practice. 7/27/2023

A) Resident #6's fall care plan was updated on 4/24/2023.

B) Resident #375 was discharged on 4/28/2023.

C) Resident # 35 was discharged on 5/17/2023.

II. How will the facility identify other residents having the potential to be affected by the same deficient practice? 7/27/2023

Other Current residents residing at the community have the potential to be affected by this deficient practice.

The Unit Manager or designee will review the current resident care plans on or before 7/27/2023 for person-centered interventions to address falls, hospice contact information, IV's and Infection.

III**. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** 7/27/2023

F657 continued on next page

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 Aide (CNA) that [Name of Resident #6] is on the floor. The nurse went to [pronoun] room and found Resident in a sitting position, leaning back on the commode ...RN and nurse assessed the Resident; no apparent injury was noted ...The Resident was encouraged to use the call light to call for help....." A Nurse's Note dated 04/22/23 at 12:35 pm documented: " ....about 10:45 am, the writer's (writer's) attention was called to [the Resident's] room by the assigned CNA. Upon arrival to the room, [the] Resident was observed sitting on the floor with her hand over[pronoun] face and was noted with blood gushing out from the left side of[pronoun] head. Immediately, pressure was applied to the site... MD (Medical Director) was notified of an unwitnessed fall with a head injury. Order obtained to send (send) to the nearest ER (Emergency Room) for further evaluation " A Care Plan revised on 04/22/23 documented: "Category: Falls... Problem: [Name of Resident#6] had a fall on 03/28/23. Goal: 1. [Resident #6's Name] will be free of injury related to falls over the next review period. Interventions: 1.PT/OT (Physical Therapy/Occupational Therapy) Screen s/p fall 3/28/23. 2) Ensure that residents wear non-skid socks....Problem [Name of Resident#6] had a fall on 4/22/23. Goal: 1. [Resident #6's Name] will be free of injury related to falls over the next review period. Interventions: 1.PT/OT Screen s/p fall 4/22/23. 2) Ensure that the Resident wears non-skid socks....Of note, the fall prevention interventions that facility staff added from the Resident's fall on 03/28/23 to the Resident's fall on 04/22/23 were the same. There was no documented evidence that facility staff updated or	F 657	The Staff education nurse or designee will re-educate current licensed nurses on or before 7/27/2023 on person-centered Care plan interventions to address falls, hospice contact information, and IV's and infection. Residents with new or changed status will be reviewed by the Interdisciplinary Team during the daily clinical meeting for person centered care plan interventions to address falls, hospice contact information, IV's and infection. Findings will be corrected by the unit manager or designee immediately. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with new or changed status for person centered care plan interventions to address falls, hospice contact information, IV's and infection. The review will be documented in the Resident's clinical record. Findings will be corrected by the unit manager or designee immediately. The Unit Manager or designee will randomly review resident care plans on a monthly basis times 3 months to ensure that infection care plan, IVs, falls, and hospice are implemented. Findings from the review will be corrected by the Unit Manager or designee immediately. (F657 continued on next page)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23 revised the interventions to prevent Resident #6 from sustaining another fall. During a face-to-face interview on 05/26/23 at approximately 12:11 pm, Employee #7 (Unit Manager) acknowledged that facility staff should have updated and revised the fall prevention interventions on Resident # 6 comprehensive care plan after the Resident had a second fall on 04/22/23. 2.Facility staff failed to update the person-centered comprehensive care plan to include the name and phone number of the hospice agency for a resident who received hospice services. Resident #375. Resident # 375 was re-admitted to the facility on 12/07/22 with diagnoses including Alzheimer's Disease, Dementia, Peripheral Vascular Disease, Pathological Fracture of Left Femur, Psychosis Not Due to A Substance, Anorexia, Unspecified Pain and Pressure Ulcer of Sacral Region. A review of Resident #375's medical record revealed: A Nurse Note dated 02/23/23 3:11 pm documented: "Resident was admit[ted] to [Name of Hospice Agency] routine hospice code status DNR/DNI/DNH (do not resuscitate, do not intubate, do not hospitalize), D/C (discharge labs, weight(s) vital signs, continue routine medication and diet," A Long Term Care Billing Information Sheet showed that as of 02/23/23, Resident # 375 began to receive hospice services from [Name of Hospice agency], Hospice Social Worker and	F 657	**(F657 Continued)** **IV. Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed care plan results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. V.**Completion Date** 7/27/2023	7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24	F 657		

Hospice Chaplain visits as per order, and prn (as needed) Hospice volunteer visits as indicated ...". A Physician's Order dated 02/24/23 at 11:00 am directed: "Admit to [Name of Hospice Agency] Code status DNR/DNI/DNH."

A Care Plan dated 03/08/23 documented: "Category: End of Life ...Problem: Hospice Services: Resident #375 will be free of pain and suffering and die a peaceful, dignified death ...Interventions: Hospice referral and services through review date. Hospice Nurse visits as per ordered with times per week with prn visits.

A progress note dated 03/20/23 at 2:43 pm: "Transfer Note: Resident is to be transferred to [2nd Floor Room] since [pronoun] is no longer an elopement risk ...is currently on hospice care with [Name of Hospice Agency] and [an] aide visit 2-3 times weekly. "

During a face-to-face interview on 05/26/23 at 2:14 pm, Employee # 12 (First Floor Manager) stated that Resident #375 was placed on hospice before moving to the second floor. The Employee then acknowledged that Resident #375's comprehensive care plan did not identify the hospice agency's name or the agency's telephone number.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25	F 657		

3.Facility staff failed to update the comprehensive care plan with goals and approaches that address the resident's recieving Intravenous Fluid. Residents' #35.

Resident #35 was admitted to the facility on 04/17/2023 with the following diagnoses: Chronic Kidney Disease, Hypertension, Peripheral Vascular Disease, Heart failure, and Hyperlipidemia.

A review of Resident #35's medical record showed:

Reviewed Progress note dated 05/16/2023 11:55 showed, "Resident is alert and verbally responsive, no acute distress noted. She was seen by [NP (nurse practitioner) name] due to pus-like drainage reported coming from the right ischium wound ... after reassessment, orders were written to apply warm compression for 10 mins to the right ischium abscess twice daily times 2 days ... Insert IV [intravenous] and start D51/2 NS@75ml[milliliters]/hr[hour] 2L [liters], then repeat CBC [complet blood count], BMP [Basic Metabolic Panel] on Thursday 5/18/2023. ..."

Reviewed Progress note dated 05/16/2023 20:10 showed, " ... she was started on Sodium Chloride o.45% @75ml/hr at 3 pm while awaiting D51/2NS to be delivered. D51/2NS was received about 7:30pm and was started as ordered. IV infusing well. No infiltration was noted. ..."

Reviewed Progress note dated 05/17/2023 00:06 showed, " ... insert IV and start D51/2NSat 75ml/hrs x2L ... D51/2 NS not available in house,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 26 order given by NP to start sodium chloride 0.45% at 75ml while awaiting D51/2NS. A peripheral IV line inserted to the right arm and the resident started on IV fluids as ordered. ..." A review of Resident #35's comprehensive care plan showed a Category area of Infection and IVs that lacked information that pertained to the goals, approaches, and iterventions for the care and treatment of the resident receiving intravenous fluid. During a face-to-face interview conducted on 05/26/2023, at approximately 1:15 PM with Employee #17 (Nurse Manager), she acknowledged the findings. [Cross-over DCMR 3210.4 (c)]	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, facility staff failed to adequately monitor and provide supervision to a Resident who was a smoker. Resident #136. Resident #136 was admitted to the facility from the hospital on 01/20/22 with diagnoses including:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 Hemiplegia following Cerebral Infarct, Atrial Fibrillation, Essential Hypertension, Abnormal Levels of Serum Enzymes, and Anxiety Disorders. A review of Resident #136's medical record revealed the following: A Hospital Discharge Summary dated 01/20/22 that documented Discharge Diagnosis: Smoking Hx (History) ...Hospital Course: History of cigarette smoking- Nicotine patch d/c discharge as patient refusing ..." An Admission Assessment dated 01/20/22 at 7:51 pm documented that the Resident had no desire to smoke: " ...Smoking Evaluation: Resident desires to smoke(?): No." Of note, Resident #136's medical record lacked documented evidence that facility staff conducted any subsequent smoking evaluations/assessments for the Resident after admission. A review of the facility's "Smoking Policy -Residents" approved on 06/2022 documented: "Prior to, and upon admission, residents shall be informed of any limitations on smoking, including designated smoking areas ...The use of tobacco on property is restricted to designated resident smoking areas, which are located outside of the building ...The Resident should be evaluated on admission to determine smoking preference...The Resident's ability to smoke safely should be re-evaluated quarterly upon a significant change (physical or cognitive) or as determined by staff. The Resident's care plan will be updated accordingly ...Smoking-related privileges, restrictions, and concerns are noted in the care plan. Residents are not permitted to keep smoking materials, including lighters and matches with other residents ... Smoking is not	F 689	**F689** **I.Corrective action for residents noted to have been affected by the deficient practice.** Resident #136 was re-educated on the smoking policy; care plan was updated; and his smoking materials were removed by the licensed nurse on 5/18/2023. Resident was also encouraged to participate in a smoking cessation program on 5/18/2023. II.**How will the facility identify other residents having the potential to be affected by the same deficient practice?** Other current residents were educated on the smoking policy by the leadership team and no other smokers were identified on 5/18/2023. Other current resident rooms were also searched (with permission by the residents) and no smoking materials were found 5/18/2023 **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Current associates and residents were re-educated on the smoking policy on or before 7/27/2023 by the Nurse Educator or designee. The Executive Director shared the policy with resident representatives on 5/18/2023. Interdisciplinary team has reviewed smoking policy and procedure and it is in compliance with the CMS regulation F689. **(F689 continued on the next page)**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 permitted while oxygen is in use ..." A review of Resident #136's comprehensive care plan, initiated on 01/20/22 and last updated on 05/0423, failed to address the Resident's history of smoking or current use of tobacco. A review of the Nurses' Notes from 03/21/23 to 05/18/23 lacked documented evidence that Resident #136 was a smoker or had smoking materials (cigarettes, lighter, matches) in [pronoun] current possession. During a face-to-face interview on 05/18/23 at approximately 2:00 pm, Employee #3 (Assistant Director of Nursing/ADON) stated that no residents on the second floor or in the entire facility smoked. During a face-to-face interview on 05/18/23 at 2:06 pm, Employee# 4 (Certified Nurse Assistant)/CNA), Employee stated that [pronoun] had never observed any of the Residents smoking. About one month ago, while cleaning Resident #136's room, [pronoun] noticed a pack of cigarettes in a bag sitting on the windowsill of the Resident's room. The Employee reported that [she] notified a licensed nurse and left the cigarettes in the Resident's room. When asked which nurse was notified, the Employee stated that [pronoun] could not remember. A review of Resident #136's entire medical record lacked documented evidence that after Employee #4 observed smoking materials in the Resident's room, that facility staff: 1) Reported the observation and investigated the incident; 2) Confiscated the cigarettes and other smoking material from the Resident or the Resident's	F 689	(F689 Continued) Unit Manager or designee will make random rounds of resident rooms to ensure that residents do not possess smoking materials on a weekly basis times 3 months. Findings will be corrected immediately by the unit manager or designee. **IV.Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed rounds results and trends will be completed by the unit manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date:7/27/2023**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

room;
3) Supervised or monitored the Resident to ensure the Resident was not smoking in the facility; or
4) Updated the Resident's care plan.

During an observation and face-to-face interview on 05/18/23 at 2:20 pm, Resident #136 was lying on his bed. When asked if he smoked, the Resident said, "Yes, I used to smoke and drink every day. Now I smoke now and then. The last time I had a cigarette was last week. I do not smoke in the facility or on the premises. I do not share cigarettes with other residents. I buy cigarettes myself and smoke cigarettes when I am out with my family or friends. I know there is no designated area to smoke in the facility, and I know there is no smoking in the building because I have seen the signs at the front door." The Resident then stated that [pronoun] currently had cigarettes in [pronoun] possession and pointed to a bag on his windowsill. The Resident then opened the bag to show the surveyors a pack of Newport cigarettes. When asked if [pronoun] had a cigarette lighter in his possession, the Resident stated that [pronoun] did but did not show the cigarette lighter to the surveyors. Of note, Resident #136's room was close to three (3) residents receiving oxygen therapy.

During a face-to-face interview on 05/18/23 at 3:03 pm with Employee #1 (Executive Director) and Employee #2 (Director of Nursing/DON), Employee #1 reiterated that, to their knowledge, the facility had no residents that smoke. When asked about the facility's smoking policy, Employee #1 stated, "If a resident is admitted and they smoke, we inform them that they cannot smoke onsite. We review our smoking policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30 included in the Residents' admission packets. We inform them that they are not allowed to have smoking materials in their possession for safety." The survey team then notified Employees #1 and #2 that Resident #136 was observed with smoking materials in [pronoun] and admitted to smoking. On 05/18/23 at 5:31 pm, Employee #1 reported that facility staff had spoken with Resident # 136, had confiscated the smoking materials from the Resident's room, and had re-educated the Resident about the facility's smoking policy. [Cross-over DCMR 3211.1(d)]	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview for one (1) of 41 sampled	F 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 31 residents, facility staff failed to obtain physician orders that include the resident ' s use of continuous oxygen therapy. Resident #143. Findings included: Resident #143 was admitted to the facility on 03/01/2023 with diagnoses that include Heart Failure, Pulmonary Hypertension, Respiratory Failure, Hyperlipidemia, Peripheral Vascular Disease, Anemia, Chronic Kidney Disease, and Dementia. Review of the Quarterly Minimum Data Set dated 03/08/2023 showed that under Section C [Cognition] resident is coded as "7" to indicate severely impaired cognition. Review of the pulmonary Critical Care Associates consultation report dated 04/20/2023 at 12:18 PM showed "Very elderly woman brought from [facility name] in wheelchair without oxygen alert, conversant, breathing regularly; lungs good airflow. A/P [action/plan] Chronic Obstructive Pulmonary Disease [COPD], use face mask for nebulizer machine and for inhalers for better delivery. Hypoxemia, Use pulse oxim at home to measure O2 saturations after exercise exertion; if sats fall below 88%-> we need order Oxygen, Pulmonary embolism, Hypertensive heart disease. 1. Return office appointment 4 months. 2. Continue Symbicort inhaler Q12hrs, Albuterol inhaler, Montelukast QDy [every day] Spiriva, 3. Continue to monitor O2 sats with pulse oxim." 04/27/2023 10:01 [interdisciplinary notes] showed " ... Oxygen 2L/M via nasal cannula was initiated for SOB/COPD ..... "	F 711	F711 **I.Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #143s provided and order for oxygen on **a** 7/6/2023 **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** Other Current residents residing at the community have the potential to be affected by this deficient practice. The unit manager or designee will make rounds on or before 7/27/2023 to ensure that residents on oxygen have orders for oxygen. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The staff education nurse or designee will re-educate current licensed nurses on obtaining orders for oxygen for residents, who need oxygen on or before 7/27/2023. Residents with oxygen will be reviewed by the Interdisciplinary Team during the daily clinical meeting for compliance of F711. Findings will be corrected immediately by the unit manager or designee **(711 continued on next page)**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 32 Review of Physician order sheet for April 2023, and May 2023 showed no physician ' s order for continuous oxygen Review of the care plan showed, "started 05/02/2023 Category Pulmonary [resident name] has potential for SOB [shortness of breathe] and/or respiratory complications related to COPD ... Monitor Oxygen saturation and administer oxygen per Physician orders..... " 05/02/2023 22:04 [interdisciplinary notes] showed " ... continues O2 no SOB noted....." During a resident observation on 05/16/2023 through 05/26/2023 Resident #143 was noted to be in her bed and on continuous Oxygen at 2l/ml via Nasal cannula. On 05/26/2023, the oxygen humidifier was changed. Inquiry made with employee#16 concerning the treatment administration record that had no Physician ' s order for continuous oxygen. The evidence showed medical that facilitystaff failed to obtain a physician's order for the resident continuous use of oxygen therapy. During a face-to-face interview on 05/26/2023 at 3:30 PM with Employee #17, [Nurse Manager] acknowledged the findings when stated, "No, I don't see the order I will look.	F 711	(F11 Continued) During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with oxygen times 3 months. The review will be documented in the Resident's clinical record. Findings will be corrected immediately by the unit manager or designee IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V. Completion Date:7/27/2023.**	7/27/2023 7/27/2023
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 33 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of four (4) nursing units, the facility staff failed to ensure the system used for an acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was being followed by staff. Findings included...	F 755	**F755** **I.Corrective action for residents noted to have been affected by the deficient practice.** A) The licensed nurses were re-educated on the narcotic count including the process of reconciling controlled medication on or before 7/27/2023. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The unit manager reviewed the narcotic book on 6/2/2023 to ensure they were consigned by two nurses. There were no findings noted. III.**The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The staff education nurse or designee will re-educate current licensed nurses on the narcotic count process including the process of reconciling controlled medication on or before 7/27/2023. The Unit Manager or designee will randomly observe licensed nursing during the process of reconciling controlled medication on a monthly basis times 3 months to ensure that the licensed nurses are following the appropriate process. Observed deviations will be corrected immediately by the unit manager or designee. (F755 continued on next page)	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 34 Review of the Controlled Drug Shift Change Audit Sheet on unit #5 on the fifth floor showed that the controlled drugs (scheduled II to schedule V) system that is to be counted by two nurses at the change of shift, the nurse going off duty and the nurse coming on was not being followed. Further Review of the "Controlled Drug Shift Change Audit Sheet" showed the spaces allotted for nurse signature going off duty and coming on duty to reconcile the narcotic count for the 3:00 PM to 11:00 PM shift on the following dates was done by the same nurses signatures" on the folowing dates and shift. 05/13/2023 3p -11p 05/14/2023 3p-11p 05/17/2023 3p-11p 05/19/2023 3p-11p The evidence showed that the system used for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was not followed by the nursing staff. A face-to-face interview was conducted with Employee #15 [Nurse Manager] on 05/26/2023, at 9:30 AM on the fifth floor concerning the reconciling of controlled medication, and she acknowledged the finding.	F 755	(F755 Continued) IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V. Completion Date:7/27/2023.**	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 35 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to store and prepare foods in accordance with professional standards of practice for food services safety as evidenced by eight (8) of nine (9) four-inch-deep soiled bullet pans and two (2) of five (5) two-inch deep soiled bullet pans stored on a ready-for-use shelf, one (1) of one (1) six-pound, four-ounces can of Sysco Fancy Shredded Sauerkraut labeled with a best-by date of October 2022, six of six (6) six-pound, four-ounces cans of Jalapeno slices with a best-by date of January 21, 2023, and fire sprinkler blow off caps that were soiled with grease and/or foreign substances. The findings include: During a walkthrough of the facility's kitchen on May 16, 2023, at approximately 9:00 AM, the following observations were made:	F 812	**F812** I.**Corrective action for residents noted to have been affected by the deficient practice.** a.The stained bullet pans were cleaned by the dietary associate on 5/16/2023. b.The Fancy Shredded Sauerkraut was discarded by dietary staff on 5/16/2023 c.The Jalapeno slices were discarded by the dietary staff on 5/16/2023 d.The rubber blow off caps were dusted and cleaned by the dietary staff on 5/16/2023. **II. How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. The Dining Services Manager made rounds on May 16, 2023 to ensure that outdated food items were discarded; pans were clean; and rubber blow off caps were dusted and cleaned. Findings were corrected immediately by the Dining Services Manager. **III. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur**. Kitchen staff was re-educated on the proper cleaning of pans, use date of food items; and the cleaning and dusting of the rubber blow off caps by the Dining Services Manager or designee on or before 7/27/2023. The Dining Services Manager or designee will make rounds 3 times per week times 3 months to ensure that outdated food items are discarded; pans are clean; and rubber blow off caps are dusted and cleaned. (F812 Continued on next Page)	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 36 1. Eight (8) of nine (9) four-inch-deep bullet pans and two (2) of five (5) two-inch deep bullet pans stored in the designated clean, and ready for use area of the kitchen, were stained throughout. 2. One (1) of one (1) six-pound, four-ounces can of Sysco Fancy Shredded Sauerkraut stored in dry storage had a best-by date of October 2022. 3. Six of six (6) six-pound, four-ounces cans of Jalapeno slices stored in dry storage had a best-by date of January 21, 2023. 4. Rubber blow off caps attached to seven (7) of seven (7) fire sprinkler heads located above two (2) deep fryers, and the gas stove were soiled with dust and/or foreign substance. These observations were acknowledged by Employee #13 during a face-to-face interview on May 25, 2023, at approximately 11:00 AM.	F 812	F812 Continued Findings will be corrected immediately by the Dining Services Manager or designee. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V. Completion Date:7/27/2023.**	7/27/2023 7/27/2023
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 37 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842	**F842** **I.Corrective action for residents noted to have been affected by the deficient practice.** A) Resident #50s enteral feeding order was updated by the physician to include a down time on 7/7/2023 II.**How will the facility identify other residents having the potential to be affected by the same deficient practice?** Other Current residents residing at the community have the potential to be affected by this deficient practice. The unit manager or designee reviewed the enteral feeding of current residents on or before 7/27/2023 to ensure that the feeding time was included in the orders. **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** The staff education nurse or designee will re-educate current licensed nurses on the enteral feeding policy to include duration of the feeding. The Unit Manager or designee will make rounds and review enteral feeding 3x's per week times 3 **(F842 continued on next page)**	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 38 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 41 sampled residents, facility staff failed to maintain accurate documentation in a resident's medical record as evidenced by not completing the physician's tube feeding order at the time ordered to take it down. (Resident #50) The findings included: Resident #50 was admitted to the facility on 12/06/21 with multiple diagnoses that included: Dementia, Metabolic Encephalopathy, Adult Failure to Thrive, Gastrostomy Status, Dysphagia, Malignant Neoplasm of Major Salivary Gland, Flaccid Hemiplegia of Right Side, Type 2 Diabetes Mellitus, Hypertension. A Physician's Order dated 12/03/22 documented "Glucerna 1.5 @ 40 ml/hr x 10 hrs (40 milliliter per hour for 10 hours) to provide 400ml (milliliter) total volume, 600kcal (kilocalories), 33g (grams)	F 842	(F842 continued) months to ensure that enteral feeding is removed at the ordered duration. Findings from the review will be corrected by the Unit Manager or designee immediately. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed review results and trends will be completed by the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V. Completion Date:7/27/2023.**	7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 39	F 842		

pro (protein), 303ml (milliliter) free H2O (water) Up @ (at) 8:00PM and Down @ (at) 06:00 (6:00AM) - Every Day for Nutritional Support."

A Care Plan dated 12/06/21 documented, " ...EATING: on G-tube feeding ..."

A Care Plan dated 12/15/21 documented, " ...Administer the tube feeding formula as ordered ..."

A Quarterly Minimum Data Set (MDS) assessment dated 05/09/23 documented Resident #50 had a Brief Interview for Mental Status score of "05" indicating the resident had a severely impaired cognitive status and Functional Status for Activities of Daily Living indicating 1-person physical assistance for bed mobility, transfer, dressing, eating, toilet use and personal hygiene.

During an observation of Resident #50's room on 5/16/23 at 11:00AM, it was noted that a Tube Feeding bottle of Glucerna 1.5 with a label that documented, "Resident's Name, Date 5/15/23, Start 2000 (8:00PM)" and contained 500ML (milliliter) of a total volume of 1000ML was hanging at the bedside, on an IV (intravenous) pole 5 hours after the physician's order directed staff to "take down at 0600 (6:00AM)."

During an observation of Resident #50's wound care on 05/22/23 that began at 11:10AM and ending at 11:45AM, a Tube Feeding bottle of Glucerna 1.5 with a label that documented "Resident's name, Date 5/21/23, Start 2000 (8:00PM), Rate 40ml/hr (milliliter per hour)" and contained 700ML (milliliter) of a total volume of 1000ML was hanging at the bedside, on an IV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 40	F 842		

(intravenous) pole 5 hours and 45 minutes after the physician's order directed staff to "take down at 0600 (6:00AM)."

During a face-to-face interview on 5/22/23 AT 11:45AM with Employee #5 (5th Floor, Licensed Practical Nurse), after completion of Resident #50's wound care, she was asked about the tube feeding bottle of Glucerna 1.5 that was hanging at the resident's bedside and she stated, "the tube feeding is finished, it's not running it's just hanging there because it's good for 24 hours...it was started at 8PM (8:00 PM) last night ...but they should have taken it down because it can't be used again."

During a face-to-face interview on 5/22/23 AT 2:01PM with Employee #2 (Director of Nursing), she was asked about the tube feeding bottle left hanging at the resident's bedside nearly 6 hours after the physician's order directed that staff "take down at 0600 (6:00AM)." Employee #2 stated, "It looks like no one signed to take it down, I have to check to see if we can get a separate order for 6AM to take down the tube feeding since it can't be used again anyway. Our staff only does 8 hour shifts so it's documented that she hung the tube feeding, but if you saw it twice after that time it looks like it was documented, but not done. Let me make a note to get order changed so staff can remember to do it and sign off in a separate place at 6AM (6:00AM)."

During an observation of Resident #50's room on 5/24/23 at 08:35AM, it was noted again after staff interviews that a Tube Feeding bottle of Glucerna 1.5 with a label that documented "Resident's Name, Date 5/23/23, Start 2000 (8:00PM)" and contained 700ML (milliliter) of a total volume of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 41 1000ML (milliliter) was hanging at the bedside, on an IV (intravenous) pole 2 hours and 35 minutes after the physician's order directed staff to "take down at 0600 (6:00AM)." While exiting Resident #50's room, I encountered Employee #5 entering the resident's room and she stated, "Did they leave it up again, I always have to take it down on my shift. I usually do it when I'm doing my rounds" then proceeded to take down the Tube Feeding that the physician's order had directed staff to "take down at 0600 (6:00AM)."	F 842	**F 919**	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow 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 from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 43 resident's rooms that failed to initiate an alarm when tested. The findings include: During an environmental tour of the facility on May 22, 2023, at approximately 2:00 PM, call bells in two (2) of 48 resident's rooms (#129,	F 919	**F919** **I.Corrective action for residents noted to have been affected by the deficient practice.** The call bells in room #'s 129 and 455 were re-tested by the Facilities Manager and alarmed as intended on 6/30/2023. **II.How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Facilities manager rounded on 6/30/2023. No other call bells were identified to be in need of repair **III.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** (F919 Continued on next page)	7/27/2023 7/27/2023 7/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	**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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 42 #455) did not alarm when tested. These breakdowns could prevent or delay staff from responding to residents' needs in a timely manner. These observations were acknowledged by Employee #13 during a face-to-face interview on May 25, 2023, at approximately 11:00 AM.	F 919	(F919 Continued) The maintenance staff was in-serviced on maintaining the call bell system in good working order by the Facilities Manager. The Maintenance manager or designee will randomly audit the resident call bells on a weekly basis times 3 months to ensure that they are in good working condition. If there are any findings the Facilities manager or designee will be corrected immediately. IV.**Quality Assurance Plans to monitor facility compliance to make sure that corrections are achieved and permanent.** Monthly review of completed audit results and trends will be completed by the Facilities Manager or designee and reported to the facility's QAPI Committee for the next 3 months and then re-evaluated to determine if further monitoring is indicated. **V.Completion Date:**7/27/2023	7/27/2023 7/27/2023