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

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Carroll Manor Nursing and Rehabilitation Facility September 6, 2016 through September 9, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 28 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters C. Diff - Clostridium Difficile CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)	F 000	Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and state laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, it's officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and/or executed because it is required by the State and Federal laws	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bonnie Williams	Administrator	10/11/16

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Infectious Disease ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set mcg/act - micrograms/actuation Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on an isolated observation of one (1) of 28 Stage 2 sampled residents it was determined that facility staff failed to maintain/enhance dignity for one (1) resident as evidenced by a staff member standing while feeding Resident #266. The findings include: During the initial tour conducted on September 6, 2016 at approximately 9:00 AM, Employee #12 was observed standing at a dining table next to Resident #266 feeding him/her. At this time Employee #13 came over to the employee and gestured for him/her to take a seat. Employee #12 reached for a chair to sit down. A face-to-face interview was conducted on September 8, 2016 at approximately 1:00 PM with Employee #12. The employee stated that he/she was standing because the resident had spilled something and [he/she] had just wiped it up. Facility staff failed to maintain/enhance Resident #266's dignity during dining.	F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1..Resident #266 dignity was maintained/enhanced immediately as staff sat down to provide feeding assistance. 2.There were no other observations made of staff standing to feed residents. 3.Staff have been in-serviced on maintaining/enhancing resident dignity during dining by sitting to provide feeding assistance at all times. 4.Random observations will be done by nurse manager or designee to ensure no staff is standing to feed residents. Results will be submitted to DON or designee for review and presentation at quarterly QA/QI meeting.	9/6/16 10/10/16 10/10/16 ongoing
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272	.	

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 28 Stage 2 sampled residents, it was determined that facility staff failed to code the quarterly Minimum Data Set (MDS) under Section I (Active Diagnoses) for cataracts. Resident # 315. The findings include: A review of Resident #315's medical record revealed an Ophthalmology follow up consultation report dated June 29, 2016 that read, "B/L [Bilateral] mature Cataract ". The resident' s quarterly MDS with an Assessment Reference Date (ARD) of August 7, 2016 revealed that under Section I (Active Diagnoses) Cataract was not coded. A face-to-face interview was conducted with Employee # 9 at 3:00 PM on September 8, 2016. After reviewing the MDS, the employee acknowledged that the MDS was not coded to reflect the resident's diagnosis of bilateral cataracts. The record was reviewed on September 8, 2016.	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS 1. MDS section I for resident #315 was updated immediately to include cataract on the list of active diagnoses. 2.No other residents were identified who needed corrections for MDS section I. 3.MDS nurses were in-service on coding for section I. 4.MDS coordinator or designee will conduct monthly audits of MDS coding. Results will be presented at the quarterly QA/QI meeting for review.	9/8/16 10/10/16 10/10/16 ongoing
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations made on September 8, 2016 at approximately 3:45 PM, it was determined that facility staff failed to store and prepare foods under sanitary conditions as evidenced by 5 of 20 fruit bowls of strawberries prepared to be served were observed stored in third floor pantry uncovered and two (2) of two (2) partially consumed bottles of water were observed on the counter of the third floor pantry. The findings include: 1. Five (5) of 20 fruit bowls of strawberries stored in the third floor pantry were observed uncovered on a serving cart. 2. Two (2) of two partially consumed bottles of water were observed on the counter of the third floor pantry. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1: 1.Five uncovered bowls of strawberries were discarded Immediately. 2.There were no other uncovered bowls of food items identified. 3.Dietary staff have been in-service to ensure all food items are covered. 4.Dietary manager or designee will conduct random inspection of food items to ensure all items are covered. Results will be presented at quarterly QI/QA meeting for review.	9/8/16 9/8/2016 10/10/16 on-going
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 6 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on a review of the facility's Infection Control Program and staff interview, it was determined that the facility failed to ensure the implementation of an Infection Control Program	F 441	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 2. 1. Partially consumed bottles of water were removed discarded immediately. 9/8/16 2. No other partially consumed bottles of water were observed in any other pantries. 9/8/16 3.Dietary staff have been in-serviced Not to leave personal items in pantry. 10/10/16 4. Dietary manager or designee will conduct random audits of pantries. Results will be presented at quarterly QI/QA Meeting for review. ongoing	

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. The findings include: A review of the facility ' s infection control surveillance documentation, " Infection Control Log " for the period of October 2015 to September 2016 revealed that the documents lacked evidence of a methodology to consistently collect, analyze, interpret and disseminate data related to infections in the facility. The facility ' s documentation on the " Infection Control Log " was inconsistent for the following items: organism type, culture date, treatment start date, and resolved date. In response to a request for copies of the facility's line listing (list of infections) for the period of October 2015 through September 2016 the Infection Preventionist (IP) presented an incomplete listing of infections for the month of September, 2016. The listing identified two (2) residents who were treated for UTI (Urinary Tract Infections). Seven (7) other residents were identified on the form but the form lacked consistent documentation of the onset of symptoms and/or treatment; whether the infections were acquired within the facility or from the community or whether the infections were resolved and/or the date of resolution. There was no evidence that the facility's Infection Control Program included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Facility infection control program has been revised to include a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. 2.No residents were identified with untreated infections and there were no identified episodes of outbreak in the facility. 3.Infection control nurse has been In-serviced on the importance of maintaining consistent and systematic collection, analysis and interpretation of data to identify infections and infection risk in the facility. 4.Monthly infection control logs will be given to QI director and DON or designee for review and presentation at quarterly QI/QA meeting	9/9/16 9/9/16 10/10/16 ongoing

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 _____	09/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8 The IP (Infection Preventionist) was queried regarding the surveillance logs for October 2015 through September 2016. He/she responded " This is all I have. " Further stated, [he/she]was in the process of implementing a new surveillance sheet that will have consistent tracking and treading such as: "Type of Infections, Organism, Symptoms, Treatments (Antibiotics), and if Infection was facility or community acquired; also resolution dates. A face-to-face interview was conducted with Employee's #1, #2 and the IP at approximately 3:00 PM on September 9, 2016. All acknowledged that the" Line Listings" of the facility 's infections were incomplete, lacked inclusion of all of the aforementioned information and did not accurately track the infections within the facility.	F 441		