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 _____	08/14/2009

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 annual re-certification survey was conducted on August 10 through 14, 2009. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 30 residents based on a census of 248 the first day of survey, with 18 supplemental residents. Also investigated were the following complaints and incidents: C-09-113, DC00001830 C-09-114, DC00001831 09-I-4071, DC00001811 09-I-4136, DC00001810 09-I-4374, DC00001809 09-I-5002, DC00001836	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, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This Plan of Correction (POC) is prepared and/or executed because it is required by the state and federal laws.**	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carole Pallara Acting Nursing Home Administrator 9/25/09

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 _____	08/14/2009

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 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to notify the physician of the resident's increased use of breakthrough pain medication. Resident #21. The findings include: Facility staff failed to notify the physician of the resident's increased use of breakthrough pain medication. The resident was observed on August 13, 2009 at approximately 12:30 PM seated in his/her wheelchair across from the nursing station. During a face-to-face interview conducted with Resident #21 on August 13, 2009 at approximately 1:40 PM , he/she responded appropriately to name, place and time. A review of the resident's clinical record revealed the following progress notes: May 23, 2009 at 1840: Writer was informed ...that the resident was assisted to the floor while	F 157	**F157 483.10(b) (11) NOTIFICATION OF CHANGES** 1. Resident #21 was assessed for pain. he / she was pain free. He / she was placed on neurontin. His/ her pain status will be checked and documented daily. 2. All residents receiving PRN pain medications were assessed for effectiveness. 3. Staff will be in serviced on the facility pain management protocol. 4. Monthly pain management competencies will be done by Nurse Managers on licensed staff and the results will be submitted to the DON for presentation at the quarterly QI/QA meeting.	8/9/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 157	Continued From page 2 transferring resident from the commode to the wheelchair ...no physical injury or bleeding noted. Supervisor, MD [Medical Doctor] and responsible party were informed ..." May 25, 2009 at 0730 "S/P fall, pain...Resident C/O [complained of] pain on the legs. Tylenol 650mg given at 01:00 AM. Medication was effective for few hours, by 6:30AM, C/O pain again, 650 mg Tylenol given at 7:00AM. Pain controlled with meds [medications]." May 27, 2009 at 1513, "Resident in stable condition. C/O of leg pain @about 13:30 PM. Tylenol 650mg admin. With good effects." May 28, 2009 at 0830 "Resident screaming out as if in pain while sitting up in W/C [Wheelchair] the TV room @ approx [At approximately] 0745...Call placed to covering doctor..." The physician's order signed and dated April 7, 2009 for the period of April 1, 2009 to May 31, 2009 read as follows: Acetaminophen 1 (500mg) tablet by mouth every 12 hours for pain and Acetaminophen 2 (650 mg) tablet by mouth every 6 hours as needed breakthrough pain. A review of the resident's clinical record lacked evidence that the physician was informed that the resident was administered Tylenol 650mg for breakthrough pain in addition to the routine administration of Tylenol 500mg every 12 hours before May 28, 2009. A face to face interview was conducted with Employee #6 on August 14, 2009, 2009 at approximately 10:30 AM. After reviewing the resident's clinical record, Employee #6 acknowledged the above findings. The record	F 157		

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 _____	08/14/2009

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 157	Continued From page 3 was reviewed August 14, 2009.	F 157		
F 160 SS=D	483.10(c)(6) CONVEYANCE UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on a review of the "Trial Balance" it was determined that facility staff failed to convey the personal funds of one (1) of three (3) deceased residents within 30 days of expiration. Resident F1. The findings include: A review of the "Trial Balance" dated August 10, 2009 revealed that Resident F1 expired on January 20, 2009. The current "Trial Balance" was $941.09 for Resident F1. A face-to-face interview was conducted on August 11, 2009 at 10:39 AM with Employee #28. He/she stated, " I was unable to contact the family listed on the face sheet. A letter was sent to the address on file for next of kin and it [the letter] was returned back to the facility. We will close the account out today. " The "Trial Balance" sheet was reviewed on August 11, 2009.	F 160	**F160** **483.10(c) (6) CONVEYANCE UPON DEATH** 1. Resident # F1's account was closed on August 12th, 2009. 8/12/09 2. A review of all resident accounts was conducted. No other resident was found to be affected by this practice. 9/28/08 3. An in-service was held on 9/24/09 with the Business Office on the Conveyance of Funds upon Death within 30 days. The Business Office was educated on the regulation and the time frame involved in order to remain compliant. On a weekly basis, the Resident Trust Trial balance will be generated by the Business Office Manager and reviewed to ensure accounts are closed timely. 9/28/09 4. An audit of the resident trust fund will be conducted weekly. A monthly report will be submitted to the Administrator confirming accounts have been closed timely. This information will be reported to the QA committee quarterly. 9/28/09	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		

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 _____	08/14/2009

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 253	Continued From page 4 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: During the environmental tour, it was determined that facility staff failed to maintain housekeeping and maintenance services to maintain an sanitary, orderly and comfortable environment as evidenced by: 30 of 70 dusty beds, 28 of 70 dusty blinds, 35 of 70 dusty window sills, 23 of 70 dust over bed shelves, 31 of 35 soiled accordion doors to the bathroom, 15 of 35 soiled Heating Ventilation Air Conditioning (HVAC) units on the interior of the perimeter of the unit, nine (9) of 70 rooms with damaged cove base, six (6) of 35 resident bathroom air vents not functioning, and five (5) of 35 slow draining sinks. The main laundry and the personal laundries on each floor were also included in the environmental tour. The following was observed: items stored in the lint compartment room, one (1) of one (1) ceiling tile was missing over the sheet folder, 19 of 24 interior of lights soiled with debris, one (1) of one (1) laminate wall disattached from the wall, cove base damaged by the sheet folder, one (1) of one (1) door jam to lint collector room damaged, two (2) of four (4) air vents without covers, one (1) of one (1) drain from lint compressor not positioned over drain, four (4) of four (4) dryer exteriors soiled, floor damaged in front of dryer, four (4) of four (4) washers with rusted bolts, and water leaking between washer #1 and #2 and by washer #4. 5th floor Laundry room: One (1) of one (1) light cover missing above the hand wash sink, the interior of two (2) of three (3) lights with debris,	F 253	**483.15 (h)(2) HOUSEKEEPING/ MAINTENANCE – (Section A)** 1. The soiled beds identified in item #1 have been cleaned. The soiled blinds identified in item #2 were cleaned with a power wash. Each slat of the blinds were then wiped to ensure compliance. The soiled window sills observed in item #3 have been cleaned. The soiled over bed shelves observed in item #4 have been cleaned. The Accordian doors to the bathrooms observed it item #5 have been cleaned. A corrective work order for the soiled interior perimeter of the HVAC units in item #6 was generated and all will be completed by completion date. A corrective work order was submitted for the cove base identi fied in item #7 and will be completed by completion date. A corrective work order was submitted for the bathroom air vents identified in item #8 and all will be corrected by completion date. A corrective work order was submitted for the slow draining sinks identified in item #9 and all will be corrected by completion date. 2. The bed frames in the facility were checked to ensure cleanliness. The bed frames will be cleaned and inspected on a daily basis. All blinds and window sills were inspected. All over bed shelves were inspected. All accordion doors were inspected. Additionally, an inspection of the HVAC units, cove base and sinks was conducted. Areas of concern were corrected. 3. The housekeeping staff will be inserviced on housekeeping services including the cleaning of bed frames, blinds, window sills over bed shelves, and accordion doors. The maintenance department was inserviced on cleaning the interior perimeter of the HVAC	9/28/09 9/28/09

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 _____	08/14/2009

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 253	Continued From page 5 two (2) of two (2) soiled air vents and one (1) of one (1) soiled exterior of the washer. 4th floor Laundry room: two (2) of four (4) air vents with missing covers, exterior surface and the exterior surface of one (1) washer and one (1) dryer soiled. Observations of the Rehabilitation Department, 3rd floor, included the following: One (1) of two (2) dusty air vents, two (2) of two skid strips on the shoulder flexion machine were worn, and one (1) 6-inch by 8-inch hole under the hand wash sink. Observations of the Rehabilitation Department on 5E in the main hospital, included the following: one (1) of one (1) standing table with one (1) loose right bar. The environmental tour was conducted on August 10, 2009 from 10:30 AM through 3:45 PM and on August 11, 2009 from 8:40 AM through 3:00 PM in the presence of Employees #5, 6, 7, 8, 9, 11, 15, and 16. The findings include: A. The following observations were made during the environmental tour: 1. Soiled beds were observed in the following rooms: 551, 545, 530, 456, 438, 410, 411, 407, 341, 345, 346, 341, 321, 313, 248, 246, 245, 241, 232, 230, 222, 203, 156, 142, 134, 111, 110, 109, 108 and 106. 2. Soiled blinds were observed in the following	F 253	**483.15 (h)(2) HOUSEKEEPING/ MAINTENANCE – (Section A continued)** #3 continued. units, repairs to the cove base, bathroom air vents and draining sinks. Daily rounds will be conducted by the house keeping manager to include a review of the beds, blinds, window sills, over bed shelves, and accordion doors. Additionally, environmental rounds will be conducted on the HVAC units, cove base, bathroom air vents and slow draining sinks. 4. The housekeeping manager will conduct daily room inspections. These inspections will include a review of the beds, blinds, window sills, overbed shelves, and accordion doors. The environmental team will also monitor the HVACs, cove base, bathroom air vents and drains on the sink. This information will be a component of the audit tool that is compiled on a monthly basis. This information will be reported to the QI Committee on a quarterly basis. **483.15 (h) (2) HOUSEKEEPING/ MAINTENANCE – (Section B)** 1. All items stored in the lint collector room In item #1 were removed. The ceiling tile Identified in item #2 was replaced. The interior ceiling lights identified in item#3 were cleaned. Corrective work orders were generated for the detached laminate and wall in item #4, this will be corrected by the completion date. Corrective work orders were also generated for the base board, door jam to the lint collector room and drain in the lint room which were identified in items # 5, 6 and 7, these areas will be corrected by the completion date.	9/28/09 9/28/09

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 _____	08/14/2009

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 253	Continued From page 6 rooms: 514, 512, 509, 453, 446, 438, 432, 431, 407, 405, 347, 345, 321, 326, 313, 311, 246, 241, 232, 230, 222, 203, 156, 134, 111, 110, 108 and 106. 3. Soiled window sills were observed in the following rooms: 527, 512, 456, 455, 453, 445, 438, 432, 431, 410, 407, 405, 346, 345, 333, 331, 326, 313, 311, 246, 241, 232, 230, 226, 222, 203, 156, 155, 142, 141, 138, 111, 110, 108 and 106. 4. Soiled over bed shelves were observed in the following rooms: 533, 514, 509, 456, 453, 438, 432, 411, 341, 313, 248, 246, 241, 232, 230, 222, 203, 156, 134, 111, 110, 108 and 106. 5. Accordion doors to bathrooms were observed soiled in the following rooms: 551, 545, 533, 530, 522, 509, 512, 456, 446, 445, 443, 431, 410, 346, 345, 326, 321, 313, 304, 245, 241, 226, 222, 203, 154, 143, 136, 133, 127, 110 and 103. 6. Soiled interior perimeter of the HVAC units in the following rooms: 551, 544, 530, 527, 522, 514, 446, 431, 429, 345, 326, 246, 155, 154 and 153. 7. Damaged cove base in the following areas: 552, 533, 530, 509, 429, 346, 326, 248, and 232. 8. Bathroom air vents not drawing air in the following rooms: 552, 544, 456, 453, 304 and 302. 9. Slow draining sinks in the following rooms: 552. 527. 210. 207 and 154.	F 253	**483.15 (h) (2) HOUSEKEEPING/ MAINTENANCE – (Section B continued)** #1 continued The exterior surfaces of the dryers were cleaned. Air vents in the main laundry room has been ordered as indicated in item #9. Corrective work orders were generated for floor damaged in front of the dryers, and bolts holding down the washer as indicated in items #10 and #11, these areas will be corrected by the completion date. Paper towels were placed by the hand washing sink as indicated in item #12. Corrective work orders were issued for the water accumulated between washers #1 and #2, light covers, and interior of lights as indicated in item#13 and #15. This will be completed by completion date. There were no air vents in the 5th floor laundry as indicated in item #15. There are no air vents in the 4th floor laundry room as indicated in item #16. The exterior surfaces of the washer and dryer were cleaned as indicated in item #16. 2. A detailed environmental review was Conducted in the main laundry and unit Laundry rooms. This review included: lint collection areas, lights and light fixtures, ceiling tiles, and wall surfaces. This review also include the floor surfaces, cove base, sinks and exterior surfaces of washers and dryers. There were no other areas found to be deficient. 3. The Environmental staff including, Housekeeping, laundry and maintenance have been re-educated on the cleaning and maintenance of the main laundry and unit laundry rooms.	9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 253	Continued From page 7 B. The following was observed in the main laundry and the unit laundry rooms: 1. Items stored in the lint collector room as follows: one (1) mop and bucket, two (2) ladders, one (1) package of florescent light bulbs; box of metal parts, miscellaneous machine parts, one (1) bucket of paint, one (1) gallon of motor oil stored next to the compressor, and one (1) piece of wood beam. It was noted that the handles of the mop and broom was warm to touch. 2. One (1) of one (1) ceiling tile was missing above sheet folder. 3. 19 of 24 interior ceiling lights were observed with accumulated debris in the folding and drying area. 4. The wall by the sheet folder had protective laminate that was disattached from the dry wall. 5. The base board by the disattached wall was damaged. 6. One (1) of one (1) door jam to lint collector room was damaged. 7. One (1) of one (1) drain in lint collector room was lying on its side and failed to completely empty into the floor drain causing water to accumulate on floor seeping through to sheet folding side of wall. 8. The exterior surfaces of four (4) of four (4) dryers were soiled. 9. Two (2) of four (4) air vents were observed	F 253	**483.15 (h) (2) HOUSEKEEPING/ MAINTENANCE – (Section B continued)** 4. A review/audit of the main laundry and the Unit laundry rooms will be completed monthly This information will be reported to the QA Committee quarterly. 9/28/09 **483.15 (h) (2) HOUSEKEEPING/ MAINTENANCE – (Section C)** 1. A corrective order was issued for the air vents, skid strips and hand wash sink, These items will be corrected by the completion date. 9/28/09 2. A detailed review of the environment in The rehabilitation department no other Deficient practices were noted. 9/28/09 3. The Environmental staff including, Housekeeping and maintenance have been re-educated on the cleaning and repair needs of the rehabilitation department. 9/28/09 4. An audit of the rehabilitation department Will be completed and reported to the QA Committee quarterly. 9/28/09 **483.15 (h) (2) HOUSEKEEPING/ MAINTENANCE – (Section D)** 1. A corrective order was issued for the For the 5 East standing table loose bar. This will be corrected by the completion date. 9/28/09 2. A detailed review of the environment in The rehabilitation department on 5E, no Other deficient practices were noted. 9/28/09	

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 _____	08/14/2009

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 253	Continued From page 8 without covers above dryers. 10. The floor was damaged in front of the dryers. 11. Bolts holding down four (4) of four (4) washers were observed with accumulated debris on sides of washers, and with rusted bolts. 12. One (1) of one (1) hand wash sink by the washing machines had no paper towels. 13. Water was observed accumulating between washers #1 and #2, and towards the back of #2. A puddle of water was observed to side of washer #4. 15. 5th floor Laundry room: One (1) of one (1) light cover missing above the hand wash sink. The interior of two (2) of three (3) lights soiled with debris. Two (2) of two (2) air vents were soiled with dust. The exterior of one (1) of one (1) washer was soiled with debris. 16. 4th floor Laundry room: Two (2) of four (4) air vents were observed with missing covers. The exterior surface of one (1) washer and one (1) dryer soiled were soiled with debris C. Observations of the Rehabilitation Department, 3rd floor, included the following: One (1) of two (2) air vents was dusty. Two (2) of two skid strips on the shoulder flexion machine were worn. One (1) 6-inch by 8-inch hole was observed under the hand wash sink around the pipe.	F 253	**483.15 (h) (2) HOUSEKEEPING/ MAINTENANCE – (Section D continued)** 3. The Environmental staff including, Housekeeping and maintenance have been re-educated on the cleaning and repair needs of the rehabilitation department. 4. An audit of the rehabilitation department Will be completed and reported to the QA Committee quarterly.	9/28/09 9/28/09

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 _____	08/14/2009

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 SHOUL OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 9 D. Observations of the Rehabilitation Department on 5E of the main hospital included the following: One (1) of one (1) standing table with one (1) loose right bar. Employees #5, 6, 7, 8, 9, 11, 15, and 16 acknowledged these findings at the time of the observations.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to review and revise the care	F 280	**1.) 483.20 (d) (3), 483.10 (k) (2) C COMPREHENSIVE CARE PLANS** 1. Resident #14's care plan was updated to include each episode of wandering. 8/13/09 2. All residents with episodes of wandering care plans were reviewed to ensure all episodes were addressed. 9/28/09 3. The care plan protocol was reviewed with the licensed staff. 9/28/09 4. The Nurse Managers will conduct monthly care plan audits to ensure completeness and submit their finding to the DON for present-ation at the QA/QI quarterly meeting. 9/28/09 **2.) 483.20 (d) (3), 483.10 (k) (2) C COMPREHENSIVE CARE PLANS** 1. Resident #JH1's care plan was updated For Remeron and Megace usage. 8/13/09 2. All residents on Remeron and Megace care plans were reviewed and update. 9/18/09 3. The care plan protocol was reviewed with all licensed staff. 9/28/09 4. Nurse Managers will conduct monthly care plan audits to ensure completeness and submit to the DON for presentation at the QA/QI quarterly meeting. 9/28/09	

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 _____	08/14/2009

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 280	Continued From page 10 plan for wandering for one (1) resident and for the use of Remeron and Megace for one (1) resident. Residents #14 and JH1. The findings include: 1. Facility staff failed to revise and review Resident #14's wandering care plan. A review of Resident #14's record revealed that the resident had wandered off the unit on March 6, April 4 and August 6, 2009. The resident did not wander out of the building. A review of the resident's care plan, last reviewed and revised on May 21, 2009, documented the following: "Wandering - goals - Staff will assist resident by helping to orient to self and current surroundings. Resident's position on unit will be monitored by staff. Resident will be included in activities so that [he/she] can be off nursing unit supervised." There was no evidence that the care plan was revised or reviewed after the resident's wandering off the unit on August 6, 2009. A face-to-face interview was conducted with Employee #5 on August 12, 2009 at 2:30 PM. He/she stated, "[Resident #14] has a watch mate bracelet on, a picture at the front desk, the safety officer (an appointed Certified Nurse Aide) does hourly checks and activities have engaged Resident #14 in more diversional activities." The record was reviewed August 12, 2009. 2. Facility staff failed to review and revise Resident JH1's care plan for the use of Remeron and Megace.	F 280		

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 _____	08/14/2009

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 280	Continued From page 11 On August 12, 2009, at approximately 9:00 AM during the reconciliation of the medication pass. The care plan dated April 28, 2009, documented, " Psychotropic Drug Use, " Resident receives Remeron for insomnia and appetite " A review of the physician ' s orders dated and signed on August 7, 2009, directed , " Megace 400 mg po [by mouth] daily for appetite stimulant. " A face-to face interview was conducted at approximately 10:00 AM with Employee # 9 . He/she acknowledged that the care plan was not reviewed or reviewed for Remeron and Megace.	F 280		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for two (2) of 30 sampled residents and five (5) of 18 supplemental residents, it was determined that facility staff failed to: initiate neurological assessments after one (1) resident hit/her head, follow-up on weight gain for one (1) resident, administer medication in accordance with the physician ' s orders for five (5) residents, write a complete order for medications and differentiate between the use of pain medication for one (1) resident. Residents #20, 28, JH2, S1,	F 309	**1.) 483.25 QUALITY OF CARE** 1. Neuro checks were initiated on Resident #20 before and after his/her emergency room visit. 8/10/09 2. All residents with R/O Head Trauma were reviewed to ensure neuro checks were done. 8/18/09 3. Neurological assessment/check Competency/in-service will be done on all licensed staff. 8/28/09 4. Nurse Managers will conduct monthly audits to ensure neuro checks were completed on all R/O Head Trauma and submit to DON for presentation at the QA/QI quarterly meeting. 9/28/09	

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 _____	08/14/2009

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 309	Continued From page 12 S2, SK4, and FS7. The findings include: 1. Facility staff failed to follow up on neurological checks after Resident #20 sustained a laceration and a raised area to the left outer aspect of his/her eye. A face-to-face interview was conducted on August 11, 2009 at 9:30 AM with Employee #27. He/she stated, " It was around 6:30 AM ... [Resident #20] said, ' I hit my head. ' [Resident #20] allowed me to check out his/her head. I put a cold compress on his/her head. I went to my charge nurse after the incident around 7:30 AM [to report the incident] ... The CNA [day shift] must have called the day shift nurse to come to the room. The charge nurse came back [to the nurse ' s station] and stated did you see the cut on [Resident #20 ' s] face? I said yes [this was around 7:30 AM]. I filled out the incident report and I tried to make the phone call to the grandson. That was around 8:00 AM. I didn't do any neurochecks; I applied the cold compress to the left temple area." The Physician's Interim Orders Dated August 10, 2009 at 0830 revealed, " ...Left head trauma Tx [treatment]: give cold compress every 15 minutes to raised area until transported to [name ER] for evaluation of left temple raised area. " A review of the progress notes revealed the following: "August 10, 2009 at 0630 ... Resident sustained a cut to left side of forehead. Measures 0.5 cm x 0.1 cm. [Responsible party] made aware via phone ...this AM ... "	F 309	**B.) 483.25 QUALITY OF CARE** 1. Resident #20 was re-weighed on 8/14/09. A dietary consult was done and he/she is currently on weekly weights. 2. All residents weight will be reviewed to Identify any significant weight loss or gain. 3. Staff will be re-inserviced on weight loss/ gain protocol. Nurse Manager and Dieticians will review all residents weights monthly and submit their findings to the Nutrition and Hydration monthly meeting to develop a plan of care. 4. Nurse Managers will conduct monthly weight audits to ensure all variances were addressed and submit their results to the DON for presentation to the quarterly QA/QI meeting. **2.) 483.25 QUALITY OF CARE** 1. Resident #28 was discharged on June 29, 2009. 2. All residents on PRN pain medications were reviewed to ensure the transcription and dosage administered were given per physician's orders. 3. Staff will be in-serviced on following Physician's orders when administering Medications. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit to the DON for presentation at the quarterly QA/QI meeting.	8/14/09 9/10/09 9/28/09 9/28/09 6/29/09 9/18/09 9/28/09 9/28/09

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 _____	08/14/2009

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 309	Continued From page 13 "August 10, 2009 at 0830 ... Writer called to assess resident with small cut about his/her left/side of left eye 0.5 x 1 cm. Resident also has raised area over eye lid ... Resident denies pain, Resident denies discomfort. Area is soft to touch. Small amount of blood from laceration. Resident is being transferred to the ER for evaluation. Will continue to monitor. " The record lacked evidence that neurological assessments were completed after the resident stated he/she hit his/her head and sustained a laceration and a raised area on the left outer aspect of Resident #20 ' s eye from 0630 to 0730. B. Facility staff failed to follow up on weight gain for Resident #20. A review of the "Monthly Record of V/S [vital signs] and Weights" revealed, "June 1, 2009 weight - 108.60, July 1, 2009 weight - 120.4, and August 1, 2009 weight - 116.8. According to the "Nutrition of Resident" Policy, revised 8/1/09, stipulated, "...2....Weights are re-done if there is a deviation of the last recorded weight...3. The Nursing Department Nutritional Assessment Tool will be completed if triggered for interdisciplinary management of hydration/nutrition when there is any deviation (plus or minus) from the last recorded weight. 5% weight loss in 1 month or 10% weight loss in 6 months..." A review of Resident #20's clinical record lacked evidence that facility staff re-weighed and addressed the weight gain after the July 1, 2009 weight of 120.4 pounds.	F 309	**3.) 483.25 QUALITY OF CARE** 1. Resident #JH2's medication order was reviewed and she/he was given an additional tablet of calcium carbonate with vitamin D to equal 2 tablets as ordered. 2. Residents were monitored during med-ication pass to ensure administration per physician's orders. 3. Staff will be in-serviced on following physicians orders when administering medications. 4. Nurse Managers will conduct monthly Medication Pass audits to ensure compliance and submit the results to the DON for presentation to the quarterly QA/QI meeting. **4.) 483.25 QUALITY OF CARE** 1. The Nitrodur patch was removed from Resident # S1. 2. All residents on Nitrodur patches were assessed to ensure compliance with physicians orders. 3. Staff will be in serviced on following physicians orders when administering medications. 4. Nurse Managers will conduct random medication pass audits to ensure physician medication administration compliance and submit the results to the DON for presentation to the QA/QI quarterly meetings.	8/13/09 9/18/09 9/28/09 9/28/09 8/13/09 9/18/09 9/28/09 9/28/09

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 _____	08/14/2009

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 309	Continued From page 14 A face-to-face interview was conducted on August 14, 2009 at 2:15 PM with Employee #7. He/she acknowledged that the resident was not re-weighed and that the weight gain was not addressed by the facility staff. The record was reviewed on August 14, 2009. 2. Facility staff failed to administer Oxy IR to Resident #28 in accordance with the physician's order. A review of the physician's orders dated June 15, 2009 directed, "Oxy IR 5 mg 1 tab Q 4 hrs PO prn mild pain; Oxy IR 5 mg 2 tabs Q 4 hrs PO prn mod [moderate]-severe pain " . A review of the MAR June 2009 revealed, " Oxy IR 5 mg; Oxy IR 5 mg two tabs PO Q 4 hrs PRN, mod-severe pain " A review of the " Pain Management " flow sheet revealed, " June 16, 2009 at 0900 Pain location-left hip pain ...Pain Rating-7 [which is severe according to the pain scale used by the facility] ...Intervention-one OXY IR was administered ... " The record lacked evidence that Oxy IR 5 mg 2 tabs Q 4 hrs PO prn for moderate to severe pain was administered to Resident #28 when the pain rating was moderate to severe as directed by the physician. A face-to-face interview was conducted on August 13, 2009 at 11:15 AM with Employee #7. He/she acknowledged that the Oxy IR 5 mg 1 tab prn for mild pain was not entered/transcribed as ordered by the physician.	F 309	**5.) 483.25 QUALITY OF CARE** 1. Resident # S2's laxative was administered in the correct amount of water as the next medication administration. 2. All residents receiving medications to be diluted in water was reviewed and staff monitored to ensure accuracy in the preparation. 3. Staff will be in serviced on following physicians orders when administering medication. 4. Nurse managers will conduct monthly med pass audits to ensure compliance and submit their results to the DON for presentation at the QA/QI meeting. **6.) 483.25 QUALITY OF CARE** 1. Resident #SK4 received the Volturen Cream and it were applied as ordered. 2. All residents with Volturen Cream orders were assessed to ensure the cream was available. 3. Staff was in serviced on the protocol for obtaining medication from the pharmacy. 4. Nurse Managers will conduct monthly med pass audits to ensure compliance and submit their results to the DON for presentation at the monthly QA/QI meeting.	8/14/09 8/18/09 9/28/09 9/28/09 8/13/09 8/18/09 9/28/09 9/28/09

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 _____	08/14/2009

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 309	Continued From page 15 A telephone interview was conducted on August 13, 2009 at 3:25 PM with the Consultant Pharmacist. He/she acknowledged that the Oxy IR 5 mg 1 tab prn for mild pain was not entered/transcribed as ordered by the physician. The closed record was reviewed on August 13, 2009. 3. Facility staff failed to administer medication as per physician's orders for Resident JH2. A physician's order dated July 13, 2009 directed, "Calcium Carbonate Vitamin D 500 mg/200 mg II (two) tabs daily via G-tube (Gastrostomy)." During a medication administration observation on August 11, 2009 at approximately 10:30 AM, the nurse administered one (1) Calcium carbonate tablet. During reconciliation of the medication pass observation with the resident's record, it was determined that two (2) Calcium Carbonate tablets should have been administered in accordance with physician's orders for August 2009. A face-to-face interview with Employee #32 was conducted on August 11, 2009 at 1:20 PM. He/she acknowledged that two (2) tablets of Calcium Carbonate should have been administered. The record was reviewed August 11, 2009. 4. Facility staff failed to remove and apply a Nitrodur Patch as per physician's orders for Resident S1. During medication pass conducted on August 13,	F 309	**7A.) 483.25 QUALITY OF CARE** 1. Resident # JH1's medication reconciliation was completed and an order was obtained for nebulizations. 2. All residents were assessed to ensure medication reconciliations were completed. 3. Staff will be in serviced on Medication Reconciliations policy. 4. Nurse Managers will conduct monthly medication reconciliation audits on all residents returning from/or readmitted to the facility to ensure compliance and submit their results to the DON for presentation at the QA/QI meeting. **7B.) 483.25 QUALITY OF CARE** 1. Resident # FS7 was discharged. 2. All residents on PRN pain medication reconciliation were reviewed to ensure indication-mild, moderate, severe was noted for number of tablets to be administered. 3. Pain management competency will be reviewed with all licensed staff. 4. Nurse managers will conduct monthly audits physicians orders, MAR and med pass to ensure compliance and submit their findings in the QA/QI quarterly meeting.	8.14/09 8/18/09 9/28/09 9/28/09 8/17/09 8/18/09 9/28/09 9/28/09

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 _____	08/14/2009

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 309	Continued From page 16 2009 at 10:00 AM, facility staff was observed administering a Nitrodur Patch. He/she checked to see where best to place the Nitrodur Patch and the old patch from the day before was still on resident's right side of chest. This was removed and the area cleansed with alcohol. The new patch was applied to the left chest area. A review of Physician Order Sheet revealed medication order written on March 14, 2007 that reads, " Nitroglycerin 0.2 Milligram/hr daily for Cardiovascular Disease " . A review of the August 2009 Medication Administration Record [MAR] a physician order reads, " Nitroglycerin 0.2 Milligram per hour, apply (1) one patch topically every morning and remove at bedtime for Cardiovascular Disease " . A face-to-face interview was conducted with Employee #7 on August 14, 2009 at 11:20 AM. He/she acknowledged that the Nitrodur Patch was to be removed at 2100 (11:00 PM) as scheduled and voiced that the evening and night shift will be educated on this subject. The record was reviewed on August 14, 2009. 5. Facility staff failed to administer a laxative in (8) eight ounces of water to Resident S2 During medication pass conducted on August 13, 2009 at 10:30 AM, facility staff was observed administering Polyethylene Glycol 3350 Powder. One scoop was dissolved in (4) four ounces of water. A review of Physician Order Sheet revealed medication order on November 11, 2008 that reads, " Miralax (1) One scoop dissolved in (8)	F 309		

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 _____	08/14/2009

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 309	Continued From page 17 eight ounces of water by mouth daily for Constipation " . A review of the August 2009 Medication Administration Record [MAR] a physician order reads, " One scoop dissolved in eight (8) ounces of water by mouth daily for Constipation " . A face-to-face interview was conducted with Employee #7 on August 14, 2009 at 11:20 AM. He/she read the physician's order and voiced that the cups on the medication cart are 4 ounces. He/she acknowledged that the order reads one scoop of Polyethylene Glycol 3350 Powder dissolved in eight (8) ounces of water and that all shifts will be educated. The record was reviewed on August 14, 2009. 6. Facility staff failed to apply an analgesic cream to Resident SK4's knees as per physician's orders. A physician's order dated August 12, 2009 directed, "Volturen 1% to knees QID (four times daily)." The facility identified 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM as the time the Volturen was to be applied to the resident' s knees. During a medication pass observation conducted on August 13, 2009 at 1:20 PM, the Volturen was not administered. Employee #26 stated that the cream was not available, that it had not arrived from the pharmacy. He/she acknowledged that the medication was not available at 9:00 AM either, and thus the resident missed two (2) applications. Employee #9 immediately contacted the pharmacy and it was noted that the prescription	F 309		

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 _____	08/14/2009

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 309	Continued From page 18 was entered into the " Treatment " area and thus the medication was not ordered by the pharmacy. A "stat" delivery was requested and the medication arrived within two (2) hours and applied to the resident's knees. 7. Facility staff failed to write a complete order for a nebulizer treatment and differentiate between the use of pain medication for Resident JH1. A. Facility staff failed to write a complete order for a nebulizer treatment. A review of Resident FS7's record revealed a admission orders dated August 4, 2009 and signed by the physician on August 5, 2009 that directed, "Xoponex inhaler 2 puffs q 4 to 6 hours prn sob; Xoponex 1.25 mg plus." A face-to-face interview was conducted with Employee #24 at 7:25 AM on August 14, 2009. He/she stated, "The Xoponex 1.25 is what goes into the inhaler. If the patient has shortness of breath [he/she] can have the inhaler every 4 hours or 6 hours as needed." When queried as who determined the frequency of the inhaler, Employee #24 stated, "The nurse decides if the patient needs the inhaler every 4 hours or every 6 hours." There was no evidence that facility staff clarified that the Xoponex 1.25 mg was to be inserted into the inhaler. Additionally, facility staff failed to clarify the parameters of when to administer the nebulizer every four (4) hours or every six (6) hours. B. Facility staff failed to differentiate between the	F 309		

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 _____	08/14/2009

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 309	Continued From page 19 use of pain medication. A review of Resident FS7's record revealed an admission order dated August 4, 2009 and signed by the physician August 5, 2009, that directed, "Tylox 1 - 2 tabs po (orally) every 4-6 hours." A face-to-face interview was conducted with Employee #24 on August 14, 2009 at 7:40 AM. When queried as to who determines how much medication (one (1) or two (2) tabs) and how frequently (every four (4) or six (6) hours) the resident received the medication, he/she replied, "The patient tells us how much medication he wants." There was no evidence that facility staff clarified the physician's order to differentiate between the levels of severity of pain (mild, moderate or severe) or the amount of medication to be administered for each level of pain. The record was reviewed August 14, 2009.	F 309		
F 313 SS=D	483.25(b) VISION AND HEARING To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 30 sampled residents, it was	F 313		

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 _____	08/14/2009

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 313	Continued From page 20 determined that facility staff failed to follow up with the physician's order for an eye (follow up) appointment for one resident. Resident #16 The findings include: Facility staff failed to follow up with the physician's order for an eye appointment that was due in June 2009 for Resident # 16. According to a Consultation Record in the resident ' s clinical record, the resident was seen for an eye examination on June 19, 2008 with recommendations that included follow up in one year. A review of the resident ' s clinical record revealed a Physician ' s Order Sheet dated October 7, 2008 and renewed December 11, 2008, and June 2, 2009 that directed " To obtain new glasses and follow up with Dr ...in one year. Follow up due June 2009. " A further review of the resident ' s clinical record lacked evidence that facility staff followed up with the physician ' s order for a follow-up eye appointment. A face-to-face interview was conducted on August 13, 2009 at approximately 1:40 PM with Employee # 5. He/she acknowledged the aforementioned findings. The record was reviewed August 13, 2009.	F 313	**1. 483.25(b) VISION AND HEARING** 1. Resident # 16 was seen by his/her eye doctor in the facility on June 24, 2009 and then again on 9/2/09 in his office. 2. All residents medical records will be reviewed to ensure all scheduled appointments are adhered to. 3. The consult policy will be reviewed with the licensed staff. 4. Nurse Managers will conduct monthly audits to ensure all consults are follow-up and submit the results to the DON for presentation in the quarterly QA/QI meeting. .	6/24/09 9/18/09 9/28/09 9/28/09
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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 _____	08/14/2009

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 314	Continued From page 21 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations for one (1) of four (4) wound care treatments, it was determined that facility staff failed to maintain clean technique for Resident SK7 ' s sacral and shoulder wound. The findings include: A wound treatment observation was conducted on August 14, 2009 at 10:05 AM to Resident SK7's sacrum and right shoulder. Employee #21 placed a towel under the resident's sacrum and removed the soiled dressing. A Certified Nurse Aide (CNA) was assisting the resident to remain on his/her left side. The rectal area was soiled with stool, which was cleaned by Employee #21 with a wet towel. Employee #21 directed the CNA to leave the resident and dispose of the soiled towel. When the CNA left the resident, he/she rolled onto his/her back with the exposed sacral wound resting on the towel. Employee #21 cleansed the wound and the resident again rolled back on the towel. The towel had areas of bloody drainage on it from the sacral wound. The treatment was completed as per physician's orders. Employee #21 completed the wound treatment to the right shoulder as per physician's orders.	F 314	**1.) 483.25(c) PRESSURE SORES** 1. Resident # SK7's wound care treatment was completed using clean techniques for all subsequence dressing changes. 8/14/09 2. Observations were done on all residents receiving wound care treatments to ensure a clean technique was adhered to. 8/31/09 3. Wound Care competencies/inservices will be conducted on all licensed staff by 9/28/09. Annual competencies will be conducted by the Wound Care Specialist. 9/28/09 4. Monthly wound care audits will be done by the Wound Care Specialist and results will be submitted to the DON for presentation at the QA/QI meeting. 9/28/09	

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 _____	08/14/2009

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 314	Continued From page 22 A face-to-face interview was conducted with Employee #21 at the time of the wound treatment observation. He/she acknowledged that the sacral wound was re-contaminated when it came into contact with the towel. Employee #21 re-cleaned the wound and completed the wound treatment. This deficiency was cross referenced to CFR 483. 65, F441.	F 314		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview during the environmental tour and the tour of the main kitchen , it was determined that facility staff failed to maintain an accident free environment as evidence by: four (4) of six (6) oxygen tank stored without a holder, one (1) of one (1) fan in the wash area of the main laundry with an extension cord stretched among chemical barrels, one (1) of one (1) frayed cord to the tilt grill and screws protruding from the base of the entrance door to the dining room. The environmental tour was conducted on August 10, 2009 from 10:30 AM through 3:45 PM and on August 11, 2009 from 8:40 AM through 3:00 PM	F 323	**483.25 (h) ACCIDENTS AND SUPERVISION** 1. All oxygen tanks identified in item #1 were secured immediately. A corrective work order was generated and issued for the extension cord stretched among the chemical barrels, frayed cord on the tilt grill, and the screws protruding from the door. All items will be corrected as indicated in the Completion date. 2. Environmental Rounds were conducted on all floors and all rooms to ensure there were no further oxygen tanks without holders. Additionally, an environmental tour was conducted to review for any safety related concerns, no other areas were identified. 3. The staff will be re-inserviced regarding Accidents and supervision particularly as it pertains oxygen tanks, fans, extension cords, chemical barrels and the frayed cords and screws. 4. The nursing management team will conduct monthly audits as it pertains to the oxygen tanks. Environemental rounds/audits will be conducted to review safety concerns. Both audits will be reported to the QA/QI Committee quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 323	Continued From page 23 in the presence of Employees #5, 6, 7, 8, 9, 11, 15, and 16. The tour of the main kitchen and pantries was conducted on August 8, 2009 from 8:40 AM through 3:45 PM in the presence of Employees #11 and 12. The findings include: 1. Oxygen tanks were not secured in holders to prevent accidental tip over in the following areas: 4 East storage room, four (4) of six (6) oxygen containers stored on the floor without a holder. 3 North supply room, two (2) of five (5) containers stored on the counter without a holder. 2. One (1) of one (1) fan with soiled interior and exterior surfaces was observed with an extension cord stretched among chemical barrels. 3. The cord to one (1) of one (1) tilt grill was frayed. This was identified on weekly rounds on August 3, 2009 and not repaired at time of this observation. 4. Screws were protruding from the door to the dining room at the base of the door on the first floor. A metal cover was missing over the screws.	F 323	**1.) 483.25(l) UNNECESSARY DRUGS** 1. Resident # 3's medical record was updated to address the effectiveness of the Ambien and the Mirtazaphine.	8/12/09
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	2. All residents' records were reviewed to ensure documentation of the effectiveness of psychotropic and hypnotics after administration. 3. Staff will be in serviced on follow up documentation related to anti-hypnotics and psychotropic medication usage. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit the results to the DON for presentation to the QA/QI meeting.	8/18/09 9/28/09 9/28/09

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 _____	08/14/2009

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 329	Continued From page 24 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: monitor the effects of an antipsychotic medication for two (2) residents and administered Amoxicillin to one (1) resident with an allergy to Penicillin. Residents #3, 7 and SK1. The findings include: 1. Facility staff failed to document evidence and consistently monitor for the use of Ambien for insomnia, Mirtazapine for depression and sleep, Resident #3. A physician's order signed and dated June 3, 2009 directed, "Ambien 5 mg PO Q HS " and " Remeron 7.5mg by mouth Q HS x7 days for depression, appetite and sleep. "	F 329	**2.) 483.25(l) UNNECESSARY DRUGS** 1. Resident #7's medical record was updated to address the effectiveness of Zolpidem for sleep and Sertraline for depression. 2. All residents' medical records were reviewed to ensure documentation of the effectiveness of hypnotics and psychotropic medication usage. 3. Staff will be in serviced on follow up documentation related to anti-hypnotic and psychotropic medication usage. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit the results to the DON for presentation in the QA/QI meeting. **3.) 483.25(l) UNNECESSARY DRUGS** 1. Resident # SK1 was discharged from the facility. 2. All residents medical records were reviewed to ensure allergies were noted and no residents were receiving foods or medication where allergies were noted. 3. Staff will be in serviced on adverse reactions by checking allergies when excepting telephone orders. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit results to the DON for presentation in the QA/QI meeting.	8/12/09 8/24/09 9/28/09 9/28/09 7/13/09 9/1/09 9/28/09 9/28/09

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 _____	08/14/2009

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 329	Continued From page 25 According to the Medication Administration Record (MAR) for the months for June 2009 through August 9, 2009, Resident #3 was administered " Ambien 5 mg P.O. QHS for sleep " , and Remeron 7.5mg for depression, appetite and sleep as evidenced by the initials on the MAR on the aforementioned dates. The Remeron was increased to 15mg on June 5, 2009. A further review of the resident's "Interdisciplinary Progress Notes" lacked consistent documented evidence for monitoring for the use of Ambien for sleep and Remeron for sleep and depression. A face-to-face interview was conducted with Employee #8 on August 11, 2009 at approximately 10:30 AM. He/She acknowledged that the resident's clinical record including the progress notes lacked consistent documented evidence of monitoring for the use of Ambien for insomnia and Remeron for depression and sleep. Employee # 8, further stated " We monitor weekly on the flow sheet and document only when the resident have sleep problem. " The record was reviewed August 12, 2009. 2. Facility staff failed to document evidence and consistently monitor for the use of Zolpidem for insomnia and Sertraline for depression for Resident #7. A physician's order signed and dated August 10, 2009 directed, "Zolpidem 10mg PO Q HS for insomnia and Sertraline 100mg PO every morning for depression. " According to the Medication Administration Record (MAR) for the months of July 1, 2009	F 329		

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 _____	08/14/2009

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 329	Continued From page 26	F 329		

through August 9, 2009, Resident # 3 was administered " Zolpidem 10mg P.O. QHS for insomnia " and was administered Sertraline 50mg PO every morning for depression. July 1, to July 21, 2009. The Sertraline was increased to 100mg every morning on July 22, 2009. as evidenced by the initials on the MAR on the aforementioned dates.

A further review of the resident's "Interdisciplinary Progress Notes" lacked documented evidence for monitoring for the use of Zolpidem and Setraline.

A face-to-face interview was conducted with Employee #6 on August 12, 2009, at approximately 12:15 PM. He/She acknowledged that the resident's clinical record including the " Interdisciplinary Progress Notes " lacked documented evidence of monitoring for the use of Ambien for sleep. Employee # 8 further stated: " We document only if there is problem including sleep problem. We do weekly flow sheet that is used to monitor the sleep. " The record was reviewed August 12, 2009.

3. Facility staff administered Amoxicillin to Resident SK1 who had an allergy to Penicillin.

A telephone order dated July 2, 2009 at 2:30 PM, signed by the physician the same day, and directed, " Amoxicillin 500 mg po q 8 hours x 2 weeks for Otitis of R (right) ear ... "

A review of Resident SK1 ' s record documented on the " Admission & Annual Physical Exam Form " completed by the physician on July 13, 2009, under " Allergies - Penicillin (PCN). "

Hand written on each " Physician ' s Interim

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 _____	08/14/2009

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 329	Continued From page 27 Orders " (telephone order sheets) at the bottom of the sheet was, " Allergies: PCN. " " PCN " was identified as an allergy on the June and July 2009 Medication Administration Record. A 24 hour chart check was completed on July 3, 2009. The nurse failed to identify that the resident was allergic to Amoxicillin. According to the manufacturer, " Amoxicillin belongs to a group of antibiotics called Penicillins. " (www.dsm.com <http://www.dsm.com>). The resident received 32 doses while in the facility. The resident was discharged home on July 13, 2009 with directions to complete the antibiotic. There was no evidence in the record that the resident had any untoward effects from the Amoxicillin. A face-to-face interview was conducted on August 13, 2009 at 2:30 PM, with Employee #27, who processed the Amoxicillin order. He/she stated, " The pharmacy will alert us if the resident has an allergy and then we call the doctor. I don't know why they didn't let us know that the resident was getting the wrong medication. I don ' t know how the resident got the wrong medication. " The record was reviewed August 13, 2009.	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332		

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 _____	08/14/2009

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 332	Continued From page 28 Based on observation, record review and staff interview, it was determined that the medication error rate was 7.35 % with five (5) non-significant errors in 68 opportunities. The findings include: On August 10, 11 and 13, 2009, medication pass was observed on five (5) of five (5) nursing units. 68 opportunities were observed with five (5) non-significant errors. The non-significant errors were as follows: 1. Facility staff failed to administer medication as per physician's orders for Resident JH2. A physician's order dated July 13, 2009 directed, "Calcium Carbonate Vitamin D 500 mg/200 mg II (two) tabs daily via G-tube (Gastrostomy)." During a medication administration observation on August 11, 2009 at approximately 10:30 AM, the nurse administered one (1) Calcium carbonate tablet. During reconciliation of the medication pass observation with the resident's record, it was determined that two (2) Calcium Carbonate tablets should have been administered. A face-to-face interview with Employee #32 was conducted on August 11, 2009 at 1:20 PM. He/she acknowledged that two (2) tablets of Calcium Carbonate should have been administered. The record was reviewed August 11, 2009. 2. Facility staff failed to remove a nitroglycerin	F 332	**483.25 (m) (1) MEDICATION ERRORS** 1. Resident #JH 2's medication order was reviewed and he/she was given an additional tablet of calcium carbonate with Vitamin D to equal 2 tablets as ordered. The nitroglycerin patch was removed from Resident #S1. the area was properly cleaned and the nitro patch was properly applied. Resident #S2's laxative was administered in The correct amount of water during the next Medication administration. Resident #SK4 received the Volturem Cream and it was applied as ordered. 2. Residents were monitored during Medication pass to ensure they were administered as per physician's orders. All residents on nitro glycerin patches were assessed to ensure compliance with physician's orders and to ensure proper application. All residents with Volturem cream orders were assessed to ensure the cream was available. 3. The nursing staff will be in-serviced on following physicians orders when administering medications, on proper applications of nitro glycerin patch, and on the protocol for obtaining medication from the pharmacy. 4. The Nurse Managers will conduct monthly audits to ensure physician medication administration compliance and submit the results to the DON for presentation to the QA/QI quarterly meeting.	8/11/09 8/13/09 8/13/09 8/13/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 332	Continued From page 29 patch (nitro patch) as per physician's orders. Resident S1. A physician's order dated October 10, 2007 directed, "Nitroglycerin 0.2 MG/HR Patch, Apply 1 (one) patch topically every morning and remove at bedtime." According to the August 2009 Medication Administration Record, the facility identified 2100 (9:00 PM) as the time the nitro patch was to be removed During a medication pass observation conducted on August 13, 2009 at 10:20 AM, the nurse administering the nitro patch found that the resident had a nitro patch on the right side of his/her chest dated August 12, 2009. The nitro patch was not removed as per the physician's orders. Employee #20 acknowledged that the patch dated August 12, 2009 should have been removed by the evening nurse at 2100 PM. The nurse immediately removed the Nitro patch. A face-to-face interview was conducted at the time of the observation with Employees #7 and 20. They acknowledged that the nitro patch was not removed as order per physician's order. The record was reviewed August 13, 2009. 3. Facility staff failed to appropriately apply a nitroglycerin patch (nitro patch) to Resident S1. A physician's order dated October 10, 2007 directed, "Nitroglycerin 0.2 MG/HR Patch, Apply 1 (one) patch topically every morning and remove at bedtime." The facility identified 9: 00 AM as the time the Nitro patch was to be applied.	F 332		

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 _____	08/14/2009

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 332	Continued From page 30 During a medication pass observation conducted on August 13, 2009 at 1020 AM, the nurse administering the nitro patch did not apply the patch evenly. The middle portion of the patch was stuck together, causing a crease in the patch. The entire surface of the patch was not applied to the resident's chest. Employee # 20 acknowledged that the nitro patch was not applied patch evenly on left side of resident chest. According to the manufacturer's recommendations, the patch must be smoothly placed on the designated area to ensure proper absorption of the medication (www.herconlabs.com). A face-to-face interview was conducted at the time of the observation with Employees #7 and 20. They acknowledged that the nitro patch was not applied patch evenly on left side of resident's chest. The record was reviewed August 13, 2009. 4. Facility staff failed to administer laxative as per physician's orders. Resident S2 The physician's orders dated November 11, 2008, directed, "Miralax 1 (one) scoop dissolved in 8 (eight) ounces of water by mouth daily for Constipation". During a medication pass observation conducted on August 13, 2009 at 10:00 AM, the nurse administered Miralax 1 (one) scoop dissolved in 4 (four) ounces of water instead of 8 (eight) ounces of water.	F 332		

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 _____	08/14/2009

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 332	Continued From page 31 A face-to-face interview was conduct on August 13, 2009 at approximately 10:25 AM with Employees #7 and 20. He/she acknowledged that the Miralax should have been mixed 1 (one) scoop dissolved in 8 (eight) ounces of water instead of 4 (four) ounces of water. The record was reviewed August 13, 2009. 5. Facility staff failed to apply an analgesic cream to Resident SK4's knees as per physician's orders. A physician's order dated August 12, 2009 directed, "Volturen 1% to knees QID (four times daily)." The facility identified 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM as the time the Volturen was to be applied to the resident' s knees. During a medication pass observation conducted on August 13, 2009 at 1:20 PM, the Volturen was not administered. Employee #26 stated that the cream was not available, that it had not arrived from the pharmacy. He/she acknowledged that the medication was not available at 9:00 AM either, and thus the resident missed two (2) applications. Employee #9 immediately contacted the pharmacy and it was noted that the prescription was entered into the " Treatment " area and thus the medication was not ordered by the pharmacy. A "stat" delivery was requested and the medication arrived within two (2) hours and applied to the resident's knees.	F 332		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	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 _____	08/14/2009

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 32 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on the tour of the main kitchen and pantries on each floor, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidence by: one (1) of one (1) ice scoop and one (1) of one (1) paddle for the ice machine stored uncovered, one (1) of one (1) observation of chicken being thawed in standing water, soiled floor and grout, two (2) of two (2) soiled deep fryers, one (1) of one (1) observation of water leaking behind the steamer and combo ovens, 17 of 17 hotel pans store wet and ready for reuse, one (1) of one (1) soiled tilt grill, two (2) of two (2) soiled convection ovens, two (2) of two (2) leaking hand sinks, one (1) of one (1) hand sink without paper towels, one (1) of one (1) back splash to the pot and pan sink area soiled, 10 of 14 soiled cooking hood filters, one (1) of one (1) floor to walk-in refrigerator and freezer slippery, items unlabeled and undated in the walk-in refrigerator, food and paper/plastic trash in the same container, no air gap for one (1) of one (1) back flow pipe, one (1) of one (1) soiled air vent in pot and pan wash area, no sanitizer available during the food preparation time, one (1) of one (1) rusty can opener, and two (2) of two (2) vegetable mixtures and one (1) of one (1) batch of mashed potatoes prepared without recipes.	F 371	**483.35(i) SANITARY CONDITION** **1.** 1.The ice scoop was cleaned immediately and placed in the proper holder. 2.The Chicken parts were removed immediately. 3.The floor in the main kitchen was cleaned. 4. The two deep fryers and gas and electrical equipment underneath were cleaned. 5. A corrective water was generated and Issued for water leaking behind the steamer this was corrected prior to the date in the completion date. 6. The wet pans were re-cleaned and re-stored after drying. 7. The interior and exterior of the convection and tilt oven was cleaned. 8. The leaking hand sinks were repaired. 9. The back splash to the pot and pan wash sink was cleaned. 10. The two cans propping the storage door Were removed immediately 11.The hood filters were taken down and cleaned. 12. The walk in refrigerator and freezer floors were cleaned. 13. All food items placed in the refrigerator And freezer were labeled and dated. Items identified to have any soft areas or changes in color were discarded. 14. All food items in the freezer were labeled and dated. 15. The lettuce and chicken parts were sorted and disposed of separately. 16. A corrective work order was generated for the backflow prevention pipe, and will be corrected by the plan of correction date. 17. A corrective work order was generated for the three compartment sink and will be corrected by the plan of correction date.	

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 _____	08/14/2009

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 33 The following observations were made in the facility ' s pantries: 1st floor Pantry: Wrong scoop size for pureed turkey plated for the lunch meal for August 10, 2009, one (1) of one (1) damaged area behind spray nozzle, one (1) of one (1) damaged counter, damaged cove base, and one (1) of one (1) soiled transport cart. 2nd floor Pantry: Wrong scoop size for turkey and squash plated for the lunch meal for August 10, 2009, one (1) of one (1) damaged dining room threshold, one (1) of one (1) piece of side cabinet missing, one (1) of one (1) soiled transport cart with damaged gasket, two (2) of two (2) blue drain tube and copper pipe from ice machine secured into drain with no air gap to prevent backflow, one (1) of one (1) soiled cup low rater and bent front, one (2) of one (1) soiled floor in pantry, one (1) of one (1) soiled back splash by sink, two (2) of two (2) ceiling tiles soiled, and one (1) of one (1) rusty air vent. 3rd floor Pantry: Wrong scoop size for stuffing, pureed turkey and squash, and no purred potatoes for lunch meal for August 10, 2009, damaged cove base, one (1) of one (1) backflow drain from ice machine in dining room positioned so that water hit side of drain and not centered over drain, one (1) of one (1) marred chair rail, one (1) of one (1) refrigerator with soiled interior and exterior, one (1) of one (1) outside of sanitizer container soiled with built-up thick white substance, and one (1) of one (1) back splash soiled with caulking above sink noted with black spots. 4th floor Pantry: Corners at entrance to dining	F 371	**483.35 (i) SANITARY CONDITON Continued** **#1 continued** 18. Sanitizer solution was make available. 19. The can opener was replaced. 20. The cooks were instructed to follow recipes as directed on the package/Geri menu recipes. **2.** A comprehensive inspection was conducted in the main kitchen. This included ensuring items correctly stored such as ice scoops and pans. The items were also checked for cleanliness. The environmental checks included all equipment, wall and floor surfaces, appliances and supplies. All food items stored in the refrigerators and freezers were inspected thoroughly for spoilage and expiration dates. All food items that showed signs of spoilage were discarded. Recipes were posted and staff were instructed to use recipes. **3.** The Food Service staff will be re-educated on The storage, preparation and distribution of Food. The Sanitation Check list was revised to include items identified in survey. The supervisors were re-educated on the sanitation of the kitchen. The Maintenance staff have modified preventive maintenance program to include the main kitchen.	9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 34 room by nurse ' s station soiled, one (1) of one (1) ceiling tile falling out of ceiling over resident ' s table, one (1) of one (1) broken handle on palate and dish low rater, one (1) of one (1) soiled fan in the refrigerator, and one (1) of one (1) soiled interior and exterior of the refrigerator. 5th floor Pantry: Wrong scoop size for squash and pureed turkey for lunch meal of August 10, 2009, three (3) of five (5) rusty air vents in dining room, one (1) of one (1) soiled exterior transport cart, one (1) of one (1) cabinet door off track, soiled corners, one (1) of one (1) damaged electric plug, and one (1) of one (1) soiled interior and exterior refrigerator. The following observations were made in the kitchen on 5E of the main hospital: One (1) of five (5) knobs missing off the stove, one (1) on one (1) bag of unlabeled and undated food items, one (1) of one (1) vegetable platter with "Best used by" date of August 8, 2009, one (1) of one (1) bag of Kentucky Fried Chicken undated and unlabeled, two (2) of two (2) plastic containers undated and unlabeled, and one (1) of one (1) package of bagels with expiration date of June 13, 2009. The tour of the main kitchen and pantries was conducted on August 8, 2009 from 8:40 AM through 3:45 PM in the presence of Employees #11 and 12. The findings include: 1. One (1) of one (1) ice scoop and one (1) of one (1) paddle used for the ice machine was stored on top of the ice machine uncovered. 2. Chicken parts were being thawed in standing	F 371	**483.35 (i) SANITARY CONDITON Continued** **4.** The Dietary manager and/or designee will increase the Monitoring and surveillance of the kitchen. This surveillance will be included on a Dietary sanitation audit tool. This tool will be completed monthly and reported to the QA/QI committee quarterly. **483.35(i) SANITARY CONDITION** **1ST Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the area behind the spray nozzle, The counter pulled away from the wall, and the cove base. These areas will be corrected as indicated in the completion date. The transport cart exterior was cleaned. 2. A comprehensive review of the first floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The use of appropriate scoop size was also reviewed. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 35 water in the cook ' s preparation area. 3. The floor of the main kitchen was observed soiled and the grout between the tiles of the main kitchen floor was observed discolored. 4. Two (2) of two (2) deep fryers and gas and electrical equipment underneath observed soiled with grease and other debris. 5. Water was leaking behind the steamer and combo ovens. 6. 17 of 17 hotel pans were stored wet and ready for reuse: four (4) of four (4) one quarter inch hotel pan, seven (7) of seven (7) one-half hotel pan and six 9^) of six (6) one quarter hotel pans. 7. The interior and exterior of one (1) of one (1) tilt grill and one (1) of one (1) convection ovens were observed soiled with grease and debris. 8. The hand sink by the pot and pan wash area leaked from underneath the bowel when the water was turned on. This was identified during rounds on July 13, 2009 and August 3, 2009 and was not repaired at time of observation. The hand sink in dish room leaked from underneath the bowel. 9. The back splash to pot and pan wash sink soiled with grease and debris. 10. The dry storage fire door was propped open with two (2) cans. 11. 10 of 14 cooking hood filters were soiled with grease and debris. The filters were cleaned on June 6, 2009. 12. The walk in refrigerator and freezer floors were slippery. Employee #11 stated that there were rubber mats to place on the floor which is made of aluminum. 13. Items not dated or labeled in walk-in refrigerator: Yellow and green jello in a hotel pan 32 of 32 containers of pudding 10 of 10 containers of applesauce	F 371	**483.35(i) SANITARY CONDITION Continued** **2nd Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the threshold, blue drain tube with air gap, ceiling tiles and air vents. These areas will be corrected as indicated in the completion date. The transport cart exterior cleaned. The cup lower rater was cleaned and a work order was created for the bent front panel. The floor in the pantry and the back splash were cleaned. 2. A comprehensive review of the second Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The use of appropriate scoop size was also reviewed. Drainage tubes, air vents and low raters Were also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 36 Three (3) packages of open American cheese One (1) package tortilla wraps One (1) container sliced tomatoes not wrapped securely One (1) package broccoli parts Two (2) plastic bags of radishes One (1) plastic bag of lettuce Four (4) heads of wilted lettuce Two (2) of four (4) tomatoes with brown spots and soft 12 cherry tomatoes in large bin of cherry tomatoes with soft and brown spots One (1) of three (3) watermelons split and brown 14. Items not dated in the freezer: One (1) of one (1) package of bagels One (1) of one (1) loaf of French bread One (1) of one (1) package of waffles One (1) of one (1) package of muffins 15. Lettuce and chicken parts in the same trash can with paper. 16. A backflow prevention pipe was observed in the drain with no air gap by the three (3) compartment sink. 17. One (1) of one (1) air vent soiled above three (3) compartment sink. 18. No sanitizer was available during food preparation time. 19. One (1) of one (1) can opener with rusty surfaces. 20. Employee #13 stated that he/she did not use a recipe to make the vegetable mixture for the lunch meal. He/she stated, "I just put it in the steamer and add butter and salt." Employee #14 stated that he/she did not use a recipe for the winter vegetable mixture being prepared for the dinner meal. He/she stated, "The veggies are steamed and I add butter and salt. We don't have a recipe."	F 371	**483.35(i) SANITARY CONDITION Continued** **3rd Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the cove base, drainage pipe, and chair rail These items will be corrected by the completion date. The interior and exterior surfaces of the refrigerator, sanitizer and back splash were cleaned. 2. A comprehensive review of the third Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters, appliances and equipments. The use of appropriate scoop size was also reviewed. Drainage tubes, air vents and chair rails were also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 37 Employee #14 stated, "We make the mashed potatoes in the big silver bowel. I use 7 gallons of boiling water, six packages of mashed potato mix, three sticks of butter and one quart of milk." Directions on the back of the package of potato mix directed to mix one gallon of water with the contents of the package. An interview was conducted with Employee #4 on August 10, 2009 at 3:30 PM. He/she stated, "We are trying to enhance the food and use less supplements. We are just starting this and haven't really discussed or documented this information about the potatoes." 1st floor Pantry 1. Observation of the lunch meal for August 10, 2009 included the wrong scoop size was used for the pureed turkey. 2. A 4 oz (ounce) scoop was used and according to the meal ticket the serving portion was 3 oz. 3. Plaster was damaged behind spray nozzle on the sink. 4. The counter was observed with the back of counter pulled away from wall. This was identified on round on February 18, 2009 and not repaired at time of observation. 5. Cove base was observed soiled and damaged in the pantry. 6. The transport cart exterior was soiled. 2nd floor Pantry 1. Observation of the lunch meal for August 10, 2009 included the wrong scoop size for stuffing. A 3 oz scoop was used and according to the meal ticket the serving should have been ½ cup and for	F 371	**483.35(i) SANITARY CONDITION Continued** **4th Floor Pantry** 1. The corners and entrances to the dining Room nurse station was cleaned. A corrective work order was ceiling tile. These areas will be corrected as indicated in the completion date. The broken handle was removed. The fan in the refrigerator and the interior and exterior surfaces of the refrigerator were cleaned. 2. A comprehensive review of the fourth Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The refrigerators were also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 38 the squash, a 6 oz scoop was used and the serving size should have been ½ cup. 2. The threshold to the dining room was damaged. 3. The exterior of the transport cart was soiled with a damaged gasket. 4. A blue drain tube and a copper pipe from ice machine were secured into a drain with no air gap to prevent backflow. 5. The cup low rater was soiled with a bent front panel. 6. The floor in the pantry was soiled. 7. The back splash by the sink was soiled. 8. Two (2) ceiling tiles were soiled above the sink with one (1) tile bowing downward over the sink area. 9. One (1) of one (1) air vent was rusty. 3rd floor Pantry 1. Observation of the lunch meal for August 10, 2009, included the wrong scoop size for the stuffing. A 3 oz scoop was used and the meal ticket directed the portion should have been ½ cup; 4 oz scoop was used for the pureed turkey and should have been 3 oz; a 2 oz scoop was used for the pureed squash and it should have been ½ cup. There were no pureed potatoes for 3 pureed diets on the 3rd floor. 2. The cove base behind the equipment in the dining room was damaged. 3. The drainage pipe from the ice machine in the dining room was not centered over the drain and caused water to pool behind the equipment. 4. The chair rail in the back of the dining room was marred with chipped paint. 5. The interior and exterior surfaces of the refrigerator were soiled with accumulated debris. 6. The outside of the sanitizer container was	F 371	**483.35(i) SANITARY CONDITION Continued** **5th Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the air vents, cabinet doors, and plugs were completed. These areas will be corrected as indicated in the completion date. The exterior transport cart, corners and the interior and exterior of the refrigerator were cleaned. 2. A comprehensive review of the fifth Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The use of appropriate scoop size was also reviewed. Cabinets, air vents and electrical plugs were Also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 39 soiled with a thick white substance. 7. The back splash of the sink was soiled with debris and the caulking above sink was noted with black spots. 4th floor Pantry 1. The corners at entrance to dining room by nurse ' s station were soiled. 2. One (1) ceiling tile was falling out of the ceiling over a resident ' s table. 3. A broken handle was observed on the palate and dish low rater. 4. The fan in the refrigerator was soiled with accumulated debris. 5. The interior and exterior of the refrigerator was soiled. 5th floor 1. Observation of the lunch meal on August 10, 2009 included the wrong scoop size was used for the squash. A 6oz scoop was used and the meal ticket noted the serving should have been ½ cup and a 4 oz scoop was used for pureed turkey and should and have been 3 oz. 2. Three (3) of five (5) air vents in the dining room were rusty. 3. The exterior transport cart was soiled. 4. The cabinet door was off track in the dining room. 5. Corners were soiled in the dining room. 6. An electric plug where the palate and plate warmer plugged into was damaged. 7. The interior and exterior of the refrigerator was soiled. The following observations were made in the kitchen on 5E of the main hospital:	F 371	**483.35(i) SANITARY CONDITION Continued** **5 East** 1. The knobs missing off the stove were Replaced. The undated and unlabeled food Items were discarded. 8/10/09 2. All areas in the Center that have stoves Were checked, and those areas that needed Replacement were replaced. All refrigerators were checked for undated and unlabeled food items. 8/10/09 3. Staff was in serviced on the importance of Appliances being properly maintained and on refrigerator log protocol for checking for undated and unlabeled food items. 9/28/09 4. The Dietary Manager and/or designee will Monitor the stoves on a monthly basis. The night charge nurse will conduct refrigerator audits daily and complete refrigerator cleaning log to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meeting. 9/28/09	

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 _____	08/14/2009

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 40 One (1) of five (5) knobs missing off the stove. One (1) on one (1) bag of unlabeled and undated food items in the refrigerator. One (1) of one (1) vegetable platter with "Best used by" date of August 8, 2009 in the refrigerator. One (1) of one (1) bag of Kentucky Fried Chicken undated and unlabeled in the refrigerator. Two (2) of two (2) plastic containers filled with food undated and unlabeled in the refrigerator. One (1) of one (1) package of bagels in the refrigerator with "Sell by" date of June 13, 2009. Employees #11 and 12 acknowledged the findings at the time of the observations.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**483.60(a),(b) PHARMACY SERVICES** 1. 5th Floor Xalatan was discarded; a new bottle was ordered and obtained from the pharmacy. 3rd Floor Lidocaine, Tuberculin, Pneumococcal vials and Clonidine tablets were all discarded. New vials and tablets were ordered and received from the pharmacy. 2. All residents medications were reviewed to ensure no expired. medications were being administered. 3. Staff will be in serviced on pharmacy policies on dating and discarding expired medications. 4. Nurse Managers will conduct monthly audits on pharmaceutical services to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meeting.	8/10/09 8/10/09 9/28/09 9/28/09

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 _____	08/14/2009

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 425	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that in two (2) of seven (7) medication carts observed, the facility staff failed in seven (7) of 10 multi-dose vials to initial or date the vials when first opened and removed expired medication from currently date medication. The findings include: On August 10, 2009, between 12:00 PM and 3:30 PM, during the inspection of the medication carts on the 3rd, 4th, and 5th the following medications were observed opened, not dated or initialed and expired. 5th Floor (4) Xalatan ophthalmic drops undated or initialed when opened 3rd Floor (2) Lidocaine HCl 1% 30ml vial undated or initialed when opened Tuberculin 5TU/0.1ml vial undated or initialed when opened Pneumococcal vaccine (Pneumovax 23) vial undated when opened (19) Clonidine 0.1 mg tab - expired September 18, 2008 (9) Clonidine 0.1 mg tab - expired August 10, 2008 (22) Clonidine 0.1 mg tab - expired December 5, 2008 A face-to-face interview was conducted at the time of the observation. Employee #7 acknowledged that the vial was not initialed or dated when first opened or expired.	F 425		

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 _____	08/14/2009

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 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined during the inspection of the	F 431	**483.60(b), (d), (e) PHARMACY SERVICES** 1. All discontinued and unlabeled medications were removed from the medication carts on the 3rd and 5th floors. 2. All medication carts were inspected and all discontinued and unlabeled medications were removed. 3. Staff will be in serviced on the facility policy on labeling and discontinued medications. 4. Nurse Managers will conduct monthly audits on pharmaceutical services to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meeting.	8/12/09 8/13/09 9/28/09 9/28/09

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 _____	08/14/2009

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 431	Continued From page 43 medication storage areas that the facility staff failed in three (3) of nine (9) medication carts to remove unlabelled and discontinued medication from the medication carts. The findings include: On August 12, 2009, between 12: 00 PM and 3:30 PM, the following unlabelled (medication without a patient name) and discontinued (patient no longer using medication) medication was observed stored in the medication carts on the 3rd and 5th floors: Unlabelled medication (5) Spironolactone 25 mg tablets (1) Ciprofloxacin 250 mg tablet (1) Metopropol 25 mg tablet (1) Hydralazine 50 mg tablet Discontinued medication Ciprofloxacin 250 mg tablet, discontinued July 24, 2009 Robitussin DM cough syrup (generic brand), discontinued July 7, 2009 Pred Forte 1% Ophthalmic drops, discontinued July 30, 2009 Robitussin cough syrup (generic brand) , discontinued August 1, 2009 Diabetic Tussin syrup, discontinued July 24, 2009 Robitussin cough syrup (generic brand), discontinued July 9, 2009 Pepto Bismol (generic brand), discontinued April 20, 2009 A face-to-face interview was conducted at the same time of the observation with Employees #7	F 431		

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 _____	08/14/2009

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 431	Continued From page 44 and 9. They acknowledged that the medications should have been removed from the medication carts.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on an observation of a dressing change for two (2) of four (4) dressing changes, it was determined that facility staff failed to wash his/her hands after the procedure to prevent the spread of infection and facility staff failed to maintain clean technique during one (1) resident's wound dressing change. Residents P1 and SK7. The findings include: 1. On August 12, 2009 at 11:30 AM a wound dressing change was observed to the right heel of Resident P1. Immediately after the dressing change, Employee #23 removed his/her gloves and returned the equipment required for the wound dressing change to the treatment cart outside of the resident's room which included open bottles of	F 441	**1.) 483.65(a) INFECTION CONTROL** 1. Resident # P1's wound care treatments treatments were done using a clean technique. The nurse washed his/her hands per protocol. 2. Observations were done on all residents receiving wound care treatments to ensure the facility Hand Washing Policy was adhered to. 3. Staff will be in serviced on the Wound Care Policy which includes Hand washing. 4. The Infection Control Nurse will conduct monthly audits to ensure compliance and submit the results to the DON for presentation at the quarterly infection control QA/QI meeting.	8/13/09 8/14/09 9/28/09 9/28/09

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 _____	08/14/2009

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 45 Povidone Solution and Normal Sterile Saline and 10 unopened packages of 4 x 4 gauze pads. The soiled dressings were then removed and disposed of in the soiled utility room. Employee #23 returned to the treatment cart and stored the above cited items in the designated drawers. There was no evidence that Employee #23 washed his/her hands after completing the wound care treatment. A face-to-face interview was conducted with Employee #23 at approximately 12:00 PM on august 12, 2009. Employee #23 acknowledged that he/she had failed to wash his/her hands after completing the wound dressing change and discarding the soiled dressings. He/she added, "You are right. I didn't wash my hands." 2. Facility staff failed to maintain clean technique for Resident SK7's sacral and shoulder wound. A wound treatment observation was conducted on August 14, 2009 at 10:05 AM to Resident SK7's sacrum and right shoulder. Employee #21 placed a towel under the resident's sacrum and removed the soiled dressing. A Certified Nurse Aide (CNA) was assisting the resident to remain on his/her left side. The rectal area was soiled with stool, which was cleaned by Employee #21 with a wet towel. Employee #21 directed the CNA the leave the resident and dispose of the soiled towel. When the CNA left the resident, he/she rolled onto his/her back with the exposed sacral wound resting on the towel. Employee #21 cleansed the	F 441	**2.)483.65(a) INFECTION CONTROL Continued** 1. Resident # SK7's wound care treatment was completed using clean techniques for all subsequence dressing changes. 2. Observations were done on all residents receiving wound care treatments to ensure a clean technique was adhered to. 3. Wound care competencies/inservices will be conducted on all licensed staff by 9/28/09. Annual competencies will be conducted by the Wound Care Specialist. 4. Monthly wound care audits will be done by the Wound Care Specialist and the results will be submitted to the DON for presentation at the QA/QI meeting.	8/14/09 8/31/09 9/28/09 9/28/09

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 _____	08/14/2009

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 46 wound and the resident again rolled back on the towel. The towel had areas of bloody drainage on it from the sacral wound. The treatment was completed as per physician's orders. Employee #21 completed the wound treatment to the right shoulder as per physician's orders. A face-to-face interview was conducted with Employee #21 at the time of the wound treatment observation. He/she acknowledged that the sacral wound was re-contaminated when it came into contact with the towel. Employee #21 re-cleaned the wound and completed the wound treatment. This deficiency was cross referenced to CFR 483. 25, F314.	F 441		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that one (1) physician failed to maintain a current District of Columbia Controlled Substance License. The findings include: According to 22DCMR 1300.3, "A prescription shall only be issued by a practitioner who holds a	F 492	**483.75 (b) ADMINISTRATION** 1. Practioner in question was contacted Immediately. The ability to prescribe Narcotics was immediately suspended by VPMA; Pharmacy Director, MD and Medical Director of Carroll Manor. DEA renewal application was hand delievered to DOH on day expiration identified. The Medical Director at Carroll Manor countersigned all existing narcotic orders for Carroll Manor residents. The Practioner received renewal within 24 hours of the identification of the issue. 2. The remaining Carroll Manor Practioner Files were reviewed for compliance, There Were no other Practioners found to be Affected.	8/31/09 8/31/09

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 _____	08/14/2009

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 492	Continued From page 47 valid license issued by the District of Columbia ...to prescribe drugs or medical devices. If the prescription is for a controlled substance, the practitioner must also have a valid federal Drug Enforcement Agency (DEA) registration number and if applicable, a valid District of Columbia controlled substance registration ... " A review of Physician #1's credentials revealed that the District of Columbia controlled substance registration expired May 31, 2009. The following orders for controlled substances were signed by Physician #1 after his/her District of Columbia Controlled Substance Registration expired: 1. A review of Resident FS1 ' s record revealed that Physician #1 signed the following orders on August 10, 2009: " Fentyl 75 mcg/ hr patch. Apply 1 patch every 3 days & remove old patch for pain ... Lorazepam 0.5 mg tablet -Ativan 0.5 mg QHS (bedtime) for anxiety. " 2. A review of Resident FS2 ' s record revealed that Physician #1 signed the following order on August 7, 2009: " Tylox 1 cap po (by mouth) q (every) 4 hrs prn (as needed) pain. " 3. A review of Resident FS3 ' s record revealed that Physician #1 signed the following order on July 17, 2009: " Tylox 1 cap po q 4 hrs prn mild pain. " 4. A review of Resident FS4 ' s record revealed that Physician #1 signed the following order on August 8 and 10, 2009:	F 492	**483.75 (b) Administration Continued** 3. Medical Affairs will re-educate Practioners regarding the importance of Ensuring that timely renewal of the controlled Substance registration. A Monitoring system will provide 30 day Notification to practitioners for pending DEA and other licenses as required. Physicians will be suspended at day 30 for non-compliance. 4. An audit of the Practioners Licensure and Registration requirements will be conducted Monthly. The results will be reported to the QI committee quarterly.	9/28/09 9/28/09

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 _____	08/14/2009

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 492	Continued From page 48 " Oxycontin 10 mg po q 12 hrs - pain. " 5. A review of Resident FS5 ' s record revealed that Physician #1 signed the following order on August 1, 2009: " Haldol 2.5 mg by mouth every 6 hours as needed. " 6. A review of Resident FS6 ' s record revealed that Physician #1 signed the following order on August 12, 2009: " Tylenol #3 1 po q 4 hrs prn pain. " 7. A review of Resident FS7 ' s record revealed that Physician #1 signed the following order on August 5, 2009: " Tylox 1 tab po every 4 hrs prn pain. Tylox 2 tabs po every 6 hrs prn pain. " A face-to-face interview was conducted with Employee #2 on August 13, 2009 at 1:30 PM. He/she stated, "I just talked to (Physician #1) who said [he/she] forgot to send in the renewal." The records were reviewed August 13 and 14, 2009.	F 492		
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to promptly notify the physician that the ordered laboratory reports were unavailable for two residents. Resident #16 and 21.	F 505		

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 _____	08/14/2009

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 505	Continued From page 49 The findings include: 1. Facility staff failed to promptly notify the physician that the ordered laboratory reports for Depakote level and HGBA1C [Glycated Hemoglobin] were unavailable for Resident # 16 A review of Resident # 16's clinical record revealed "Physicians' Order Sheet " signed and dated December 11, 2008, and renewed February 5, and April 10, 2009 that directed the following: "Depakote level Q [Every] 6 months October/April, and HGBA1C Q [Every] 6 months October/April. " A further review of the resident's clinical record lacked evidence of laboratory reports for Q 6 months Depakote level and HGBA1C and that the physician was promptly notified that the reports were unavailable. A face-to-face interview was conducted with Employee #5 on August 13, 2009 approximately 10:30 AM. After reviewing the resident's clinical record, Employee # 5 acknowledged the aforementioned findings. He/she stated: " The blood level for Depakote and HGBA1C was last done in December, 2008 and an order has now been obtained and the blood drawn for the required blood levels. " The record was reviewed August 13, 2009. 2. Facility staff failed to promptly notify the physician that the ordered laboratory reports for BMP [Basic metabolic panel] and Lipid panel were unavailable. Resident # 21. A review of Resident # 21's clinical record	F 505	**1.) 483.75(j)(2)(ii) LABORATORY SERVICES** 1. Depakote level and HGBA1C was drawn on resident # 16 on August 14, 2008. 2. All residents medical records were reviewed to ensure all medication driven labs were drawn. 3. Staff will be in serviced on the lab policy regarding medication administration. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit the results to the DON for presentation in the QA/QI quarterly meeting. **2.) 483.75(j)(2)(ii) LABORATORY SERVICES** 1. Resident #21 had BMP drawn on 1/14/09 ,6/12/09 and 9/10/09. Lipid panel was done on 3/5/09 and 8/19/09, another will be due 2/2010. 2. All residents medical records were reviewed to ensure all medication driven labs were drawn. 3. Staff will be in serviced on the lab policy regarding medication administration. 4. Nurse managers will conduct monthly comprehensive medical record audits to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meetings.	8/14/08 8/19/09 9/28/09 9/28/09 9/10/09 8/19/09 9/28/09 9/28/09

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 _____	08/14/2009

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 505	Continued From page 50 revealed "Physicians' Order Sheets " signed and dated December 9, 2008, April 7, 2009 that directed "BMP Q 3 months, July/Oct/Jan/April"and Lipid panel Q6 months Jan/July. " A further review of the resident's clinical record lacked evidence of laboratory reports for Q 3 months BMP and Q 6 months lipid panel and that the physician was promptly notified that the reports were unavailable. A face-to-face interview was conducted with Employee # 6 on August 13, 2009 approximately 10:30 AM. After reviewing the resident's clinical record, Employee # 6 acknowledged the aforementioned findings. The record was reviewed August 13, 2009.	F 505		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 30 sampled residents, it was determined that facility staff failed to ensure	F 514	**1.) 483.75(l)(1) CLINICAL RECORDS** 1. Resident # 27's completed Dialysis Flow Sheet was delivered from the dialysis center on 8/13/09. 2. Review of the other dialysis record was done to ensure completeness of the flow sheets from dialysis. 3. Staff was in serviced on the dialysis flow sheets for completeness upon return to the facility. 4. Nurse Managers will conduct monthly audits of residents on dialysis to ensure completion of dialysis flow sheet and submit the results to the DON for presentation in the QA/QI quarterly meeting.	8/13/09 8/13/09 8/14/09 9/28/09

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 _____	08/14/2009

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 514	Continued From page 51 consistent documentation for one (1) resident's condition/status while at the dialysis center, physician failed to accurately document one (1) resident's allergies on the Admission & Annual Physical Exam Form and facility staff failed to enter/document the indication for the use of pain medication on the Medication Administration Record [MAR] for one (1) resident. Residents #27, 28, and 29. The findings include: 1. Facility staff failed to ensure consistent documentation of resident ' s status at the dialysis center. Resident # 27. A review of the resident ' s clinical record revealed a " History and Physical " / annual examination completed on February 6, 2009 that listed the resident ' s diagnosis as including End Stage Renal. According to the Physician Order Form for August 2009, the resident attends dialysis on Tuesdays, Thursdays and Saturdays. A further review of the resident ' s treatment sheets at the dialysis facility for August 4, 6, 8, and 11, 2009 revealed a section of the treatment sheet that require that the dialysis facility assess the resident ' s status during dialysis. Specifically " New complaints or new observations which developed during dialysis and if the complaints improve by the end of dialysis. " The dialysis facility failed to consistently complete the treatment sheets devised to communicate the resident ' s status while at the dialysis facility to the nursing facility.	F 514	**483.75(l)(1) CLINICAL RECORDS Continued** 1. Resident # 28 was discharged on June 29, 2009. 2. All residents on PRN pain medications were reviewed to ensure the transcription and dosage administered were given per physicians orders. 3. Staff will be in serviced on following physicians orders when administering medications. 4. Nurse Managers will conduct monthly pain management competency audits audits to ensure compliance and submit to the DON for presentation at the quarterly QA/QI meeting. **3.) 483.75(l)(1) CLINICAL RECORDS** 1. The history and physical reads no known drug allergies (AKDA). The physician was notified that food allergies need to be included in the history and physical. 2. The physician's other residents history and physicals will be reviewed for compliance. 3. Medical Affairs will re-educate The Practioners regarding the allergy/ Documentation requirements. 4. The Medical Records department audits the clinical record for accuracy. This information will be reported to the QI Committee quarterly.	6/29/09 9/18/09 9/28/09 9/28/09 9/28/09 9/28/09 9/28/09

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 _____	08/14/2009

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 514	Continued From page 52 According to Employee #8 the treatment sheet serves as a communication tool between the dialysis facility and the nursing facility, communicating the resident ' s status while at the dialysis facility to the nursing facility. Facility staff failed to ensure that the dialysis facility consistently complete the resident's treatment sheets. A face-to-face interview was conducted with Employee #8 on august 13, 2009 at approximately 3:30 PM. After reviewing the resident ' s dialysis " Treatment sheet for facility " for August 4, 6, 8 and 11, he/she acknowledged the aforementioned findings. The record was reviewed August 13, 2009. 2. Facility staff failed to completely enter/document the directions for use of Oxy IR on the MAR for Resident #28. A review of the physician's orders dated June 15, 2009 directed, "Oxy IR 5 mg 1 tab Q 4 hrs PO [by mouth] prn mild pain; Oxy IR 5 mg 2 tabs Q 4 hrs PO prn mod [moderate]-severe pain." A review of the MAR June 2009 revealed, "Oxy IR 5 mg; Oxy IR 5 mg two tabs PO Q 4 hrs PRN, mod-severe pain." The June 2009 MAR lacked evidence that Oxy IR 5 mg 1 tab Q 4 hrs PO prn mild pain was entered/transcribed to the MAR as ordered by the physician. A face-to-face interview was conducted on August 13, 2009 at 11:15 AM with Employee #7.	F 514		

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 _____	08/14/2009

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 514	Continued From page 53 He/she acknowledged that the Oxy IR 5 mg 1 tab prn for mild pain was not entered/transcribed as ordered by the physician. A telephone interview was conducted on August 13, 2009 at 3:25 PM with the Consultant Pharmacist. He/she acknowledged that the Oxy IR 5 mg 1 tab prn for mild pain was not entered/transcribed as ordered by the physician. The closed record review was conducted on August 13, 2009. 3. Physician failed to list the allergies on the Admission & Annual Physical Exam Form for Resident #29. A review of the Admission & Annual Physical Exam Form dated May 28, 2009 revealed, "Allergies: NKDA [no known diagnosed allergies] " A review of the Physician order sheet dated and signed June 1, 2009 revealed, " Drug Allergies: Iodine; Other Allergies: Shellfish, Tomato, Peanuts, and Citrus Fruits " A face-to-face interview was conducted on August 13, 2009 at 11:30 AM with Employee # 29. He/she acknowledged that the allergies were not listed on the Admission & Annual Physical Exam Form for Resident #29. The closed record review was conducted on August 13, 2009.	F 514		