PRINTED: 01/09/2023 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_		С	
		095034	B. WING			11/	/16/2022
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASCENSIO	N LIVING CARROLL MA	NOR			25 BUCHANAN ST., NE		
				V	VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	incidents survey was from October 26, 202. Survey activities considered from October 20, 202. Survey activities considered from October 20, 202. Survey activities and from October 20, 202. Survey activities and October 20, 202. Survey activities and October 20, 202. Survey activities and October 20, 202. Survey activities activities and October 20, 202. Survey activities a	implaint/facility reported conducted at this facility 2 to November 16, 2022. Sisted of observations, sident and staff interviews. during the survey was 162 ded 19 residents. 288, DC00010251 and illity reported incidents 10385, DC00010722, and illity reported incidents 10385, DC00010549, 10555, DC00010619, 10695, DC00010696, 10794, DC00010827, 200011009, were is survey. 28d related to the 2010310, DC00010417, 10555, DC00010619, 10829,DC00010842 and 10829,DC00010842	F	000	Preparation and execution of plan of correction does not constitute Carroll Manor's admission to or agreement withe facts alleged or conclusionset forth in the Statement of Deficiencies, and such liability specifically denied. The plan correction is prepared and executed pursuant to Carroll Manor's obligations under fed and state law.	th ns y is of	1/26/23
ABARN TOIRN F	HECTOR'S OR PROVIDER/SI	JPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Executive Director

1-23-2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
74421274101	CONTROL	IBERTIN IO/MIGITATIONIBER	A. BUILD	ING		COM	
							С
		095034	B. WING			11	/16/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASCENSIO	ON LIVING CARROLL MA	NOP			725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL WA	ANOR			WASHINGTON, DC 20017		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			N	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
F 000	Continued From page	e 1	F	000			
	AMS - Altered Me	ntal Status					
	ARD - Assessmer	nt Reference Date					
	AV- Arteriovenous	3					
	BID - Twice- a-da	ay					
	B/P - Blood Pres	ssure					
	cm - Centimet	ters					
		Federal Regulations					
	CMS - Centers fo	r Medicare and Medicaid					
	Services						
		Nurse Aide					
	_	y Residential Facility					
		Registered Nurse Practitioner					
	D.C District of 0						
		Columbia Municipal					
	Regulations						
	D/C- Discontin	nue					
	DI- Deciliter	- f N A t - 1 1 1 1th					
	DMH - Department						
	DOH- Department EKG - 12 lead Elec						
		Medical Services (911)					
	F - Fahrenheit	Medical Services (911)					
	FR French						
	G-tube- Gastrostor	my tube					
	HR- Hour	,					
		rvice Center					
		tilation/Air conditioning					
	ID - Intellectual						
	IDT - Interdiscipli						
		revention and Control					
	Program						
		ractical Nurse					
	L - Liter						
	Lbs - Pounds (u	nit of mass)					
	MAR - Medication	Administration Record					
	MD- Medical Do	octor					
	MDS - Minimum D						
	Mg - milligrams	(metric system unit of mass)					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
THE PERIOD CONCECNON	BENTH IO, MONDEIN	A. BUILDIN	G	
		5 14/11/0		С
	095034	B. WING _		11/16/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ASCENSION LIVING CARROLL MANO	ıR		725 BUCHANAN ST., NE	
			WASHINGTON, DC 20017	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
volume) mg/dl - milligrams permm/Hg - millimeters of mm/Hg - masal canula neuro - Neurological neurologic	rotection Association oner screen and Resident Endoscopic torney order sheet tor Survey ietitian se otion party kground, Assessment, Center ministration Record in aprehensive Care Plan ive Care Plans y must develop and	F 0		

	F DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			7 50.25				С
		095034	B. WING				/16/2022
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
ACCENCIO	AN LIVING CARROLL MA	MOD	725 BUCHANAN ST., NE		25 BUCHANAN ST., NE		
ASCENSIC	ON LIVING CARROLL MA	ANOR		W	ASHINGTON, DC 20017		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG		,	IAG		DEFICIENCY)		
F 656	Continued From page	3	F 6	56	F 656		
	care plan for each res	sident, consistent with the		I. Corrective action for r		dents	1/26/23
	resident rights set for	th at §483.10(c)(2) and			noted to have been affected b	y the	
	§483.10(c)(3), that in	cludes measurable			deficient practice.		
	objectives and timefra	ames to meet a resident's			A) Resident #1 was discharged on		
		d mental and psychosocial			12-25-2021.		
		fied in the comprehensive			B) Resident #5's Care plan was up	dated	
		nprehensive care plan must			on 1/3/2022 to include non-compli		
	describe the following				with maintaining her bed in the low		
		are to be furnished to attain			position by the unit manager.	vest	
		ent's highest practicable psychosocial well-being as			C) Resident # 9's fall care plan wa	c	
		24, §483.25 or §483.40; and			reviewed and revised on 1-4-2022		
	•	would otherwise be required				by	
		.25 or §483.40 but are not			the unit manager.	athan	
		esident's exercise of rights			II. How will the facility identify of		1/26/23
	•	ding the right to refuse			residents having the potential t		
	treatment under §483	3.10(c)(6).			•	icient	
		ervices or specialized			practice?		
		s the nursing facility will			The Unit Manager or designee will		
	provide as a result of				review the current resident care pla	ıns	
		a facility disagrees with the			on or before 1/26/2023 for person-		
	rationale in the reside	RR, it must indicate its			centered interventions to address fa		
		h the resident and the			and behaviors to include not calling	g for	
	resident's representa				assistance		
	(A) The resident's goa				III.The measures the facility wil		1/26/23
	desired outcomes.				or systems the facility will alt		
		eference and potential for			ensure that the problem wi	ll be	
		cilities must document			corrected and will not recur.		
	whether the resident'	s desire to return to the			The Staff education nurse or design		
	-	ssed and any referrals to			will re-educate licensed nurses on	or	
		s and/or other appropriate			before 1/26/2023 on person-center	ed	
	entities, for this purpo				Care plans.		
		n the comprehensive care			Residents with new or changed sta	atus	
		in accordance with the			will be reviewed by the		
	requirements set forti	h in paragraph (c) of this			Interdisciplinary Team during the		
		rvices provided or arranged			clinical meeting for person centere		
	3-00.21(D)(O) 1116 SE	TVICCS Provided of all alliged			care plan interventions.		
			1		•		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
		095034	B. WING_		1	C 1/16/2022
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	1/10/2022
TO HOLD THE	COVIDER OR COLL FEET			725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	ANOR				
				WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE
F 656	Continued From page by the facility, as outli care plan, must- (iii) Be culturally-composition interviews, for three (the facility's staff failed outline how staff were behavior of refusing the ambulating and transpresident had multiple resulting in a major in implement the "Falls" and #9, as evidence position while in bed sides of the bed whiled. The findings included 1. The facility's staff facility in a major in ambulating and transpresident had multiple resulting in a major in Resident #1 was adm 05/13/21. The resided diagnoses including his weakness, generalized debility, hypertension review of the medical	ned by the comprehensive petent and trauma-informed. It is not met as evidenced ans, record reviews, and staff (3) of 19 sampled residents, and to: develop a care plan to be to address Resident #1's are call for assistance with a ferring, subsequently, the falls, including a fall and	F 6	During weekly Resident at Ri meetings, the interdisciplinary will review the clinical record residents with new or changed person centered care plan inte The review will be documente Resident's clinical record. The Unit Manager or designed randomly review resident care monthly basis times 3 months that falls and behavior care plan interplemented related to beds in lowest position and not calling assistance. Findings from the residence immediately.	sk 7 Team of 1 status for rventions. ed in the e will e plans on a to ensure ans are n the g for eview will ger or Plans to e to make hieved and I care plan pleted by and I oths and	1/26/23
	that documented, "[R negative for cranial a	ident #1 previously resided desident #1's] CT was bnormalities However, face sheet documented the				

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED
						С
		095034	B. WING			11/16/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	NOR		WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	resident had a new ditrauma subdural hem consciousness. A review of the Distriction of t	agnosis on 12/02/21 of atoma without loss of a complete and a patients [residents]. He ha history of fall from a many other times he fell ablood] clot is [was] older and as in the nursing home. Table 1 Risk (or similar fall gadmission and quarterly atoma without loss of atoma without loss of a completed a Hendrich fall risk evaluation) during ion.	F 6	56		
	Status summary scor	ief Interview for Mental re of "9", which suggested a moderately impaired				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED
71110 1 27111 01	CONNECTION	BENTIL IO THOMBET.	A. BUILDI	NG			
		095034	B. WING				C 4.6/2022
NAME OF P	ROVIDER OR SUPPLIER	033034	1		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	16/2022
TWAINE OF TH	COVIDEIX OIX OOI I EIEIX				725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	ANOR			WASHINGTON, DC 20017		
()(1) ID	QLIMMADV QT	TATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 6	F	656	3		
F 030	cognitive status. Under resident was not code Under section G (Fur was coded for needing assistance from one shetween surfaces and required supervision walking in his room. A (walker) for mobility. Condition) the resident any fall since admissing resident was not code occupational therapy P (Restraints and Alacoded for using any resident was not code occupational therapy P (Restraints and Alacoded for using any resident devidence completed a quarterly similar fall risk evaluations of the position in the hallway walker close by. Resident was observed position in the hallway toward fell. Resident stated to blankettripled [tripp Sustained skin tear to measured 3 cm (cent minimal bleeding, president complained	er section E (Behavior)- the ed for rejection of care. Inctional Status) the resident and extensive physical staff person for transfers doubt toilet use, the resident from one staff member for And used an assistive device Under Section J (Health and the was coded for not having ion. Under Section O, the ed for receiving physical or services, And Under Section arms) the resident was not restraints or alarms. The record lacked ethe facility's staff or Hendrich II Fall Risk (or ation). [Nursing Progress Note (1st cumented, "at about 4:30 PM and on the floor in a supine by in front of his room with his ident was observed walking is his room then tripped and		056			
		Hendrich II] had a score of dent was at a high risk for					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED
71.5 1. 271 0.	0011112011011	.52.11.10/11/01/11/01/15211	A. BUILDII	NG_			
		095034	B. WING				C 4.6/2022
NAME OF PE	ROVIDER OR SUPPLIER	03000-	1		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	16/2022
TO THE OT THE	COVIDER ON CONTRICT				725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	ANOR			WASHINGTON, DC 20017		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	÷7	F 6	656			
	09/19/21 10:49 AM [H	Hospital Discharge					
	_	ed, reason for visit- fall and					
		es - multiple closed fractures					
	of facial bone, subdu						
		l lacerationyou have been					
		ematoma. On your CT scan It and was not caused by					
		bably from another fall or					
		point in the last few weeks					
	or months						
	09/19/21 at 1:55 PM	[Nursing Progress Note]					
		t returned to the facility at					
		al hospital's name] where he					
		being observed on the floor					
		pally responsivehas					
		steri-strips noted to the ow with no active bleeding,					
	_	protrusion. Discoloration					
	•	around the right eye and					
	right lower eyelid are	a					
	09/19/21 [Hospital Af	ter Visit Summarvl					
		for visit-fall and head					
		ultiple closed fractures of					
	facial bone, subdural						
		l lacerationyou have been					
		ematoma. On your CT					
		raphy) scan it does not look aused by today's fall. It was					
		r fall or minor injury at some					
	point in the last few w						
	10/02/01 04 10:44 DM	Inurging progress sets (2nd					
		[nursing progress note (2nd 10:20 PM writer was called					
		ertified nursing assistant) to					
	report an unwitnesse						
	residents room, resid	ent was found in a sitting					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G		COMPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	what happened state [but] didn't give any or toe assessment doneinitiated neuro-checeducated to always verbalized understan 11/02/21 [Quarterly Mocumented, under SResident #1 had a Br. Status summary scorthat the resident had cognitive status. Under sident was coded for that occurred 1 to 3 of G (Functional Status) needing extensive phromatical states one staff member for used an assistive decome	n his room, when asked d, "I was trying to get up" ther informationhead to eno acute distress lksalert but oriented X1 call for assistance and ding Minimum Data Set] lection C (Cognitive Pattern) rief Interview for Mental re of "4", which suggested a severely impaired er section E (Behavior)- the or rejection of care behavior days a week. Under section the resident was coded for hysical assistance from one fers between surfaces and ant required supervision from walking in his room. And vice (walker) for mobility. Balth Condition) the resident reduce (walker) for mobility. Balth Condition) the resident reduce (and Alarms) the resident reduced for receiving services. And, Under and Alarms) the resident region and Alarms) the resident region and pressure 108/62, pulse lood pressure 108/62,	F 65	56		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER ON LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		DATE
F 656	"at 11:50 PM CNA called to this write's resident was observe lying on the floor neawas very closed (sp) assessment noted of was scrapped, reside verbally responsive, trying to get his sock 11/18/21 at 5:41 AM documented," called charge nurse at 11:5 observed lying on the foot of the bedupo in bed resting, with a (centimeter) X 2 cmresident stated, "I verbally from the dresserfor downand hit my he toe assessment compain. Neurological as no changes from res 11/20/21 at 1:39 PM documented, " the nurse informed writer [to]medical surgica on 11/18/21, and ICU there was no dischart 12/02/21 at 7:59 PM documented, "reside about 2:30 PM from being treated for subcaffer a fallhe is aleresident was re-ad diagnoses of subdurates.	attention and reported and on the floorresident was ar his bed, [resident's] head to the dresser, on the top of his head skin and the top of his head [he was] and the top of his head [he was] and the top of his head brasion measured 1 cm and the top of his head was trying to get my socks and on the dresserhead to pletedresident denied sessment implemented and	F6	56		

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		095034	B. WING_			C 11/16/2022	
	ROVIDER OR SUPPLIER	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	progresses well" 12/02/21 [Hospital Di head shows bilateral taken to the operating decompressive hemiof subdural hematom surgical intensive car bilateral SDH L > R v Radiology review det subdural hematoma questionable acute su hemorrhage versus a rightward midline shift Subdural Hemorrhage During a telephone in at 12:14 PM, the resi the resident failed to him falling. The phys control him if doesn't patients with dementi for assistance from s During a face-to-face starting a 12:20 PM, E asked, did Resident address behavior of assistance when aml Employee #2 failed to Please cross reference F689	scharge Summary]-"CT subdural hematomas. Pt g room for left craniotomy for evacuation at 11/19/21- admitted to the unit status-post fall with with left to right shift. The sails shows Bilateral (subacute/chronic with uperimposed subarachnoid artifact There is a mild fit Discharge Diagnosis et a present on admission." terview on 10/31/22 starting dent's physician stated that call for help, which led to ician stated, "How can we call for help. When we have a, they may refuse care (call taff). Interview on 10/31/22 Employee #2 (DON) was #1 have a care plan to refusing to call staff for pulating or transferring? To provide an answer. The example of the example o	F 6	56			
	"Falls" care plan for R	ailed to implement the lesidents #5 as evidence by west position while in bed;					

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		095034	B. WING			C
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA			STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		11/16/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F 656		ed in the lowest position and sides of the bed when	F 6	56		
	01/23/15. The resider diagnoses including to	admitted to the facility on nt had a history of multiple transient ischemic attack, onormalities of gait and				
	Information form #D0 documented, " [At 8:0 was observed lying o her right side with boalert, oriented to na timereported she right floor and refused hitti	olled out of the bed to the ng her head At 9:30 AM gic and difficult to arouse				
	09/20/22 documente (Cognitive) the reside Score of "11" indicatin cognitively. Under Seresident was not cod Under Section G (Fur was coded for requirifrom two or more staf Under Section J (Heavas coded for have counder Section O (Speand Programs) the receiving occupations	ent had a Brief Summary ing the resident was intact ection E (Behavior) the ed for rejection of care. Inctional Status) the resident ing extensive assistance if members for bed mobility. Ealth Condition) the resident one fall since admission. Ectial Treatment, Procedures, estident was coded for all therapy services, and straints and Alarms) the				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		COMPLETED		
		095034	B. WING _			C 11/16/2022	
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, Z 725 BUCHANAN ST., NE WASHINGTON, DC 20017	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIA		
F 656	11/10/22 revealed Reawake in a supine poat a 45-degree angle, position. Employee # bedside. The employ stated, "She is a fall rher bed elevated that left the bed elevated Please cross reference F689) 2b.Resident #9 was a 04/25/08. The resider including history of faweakness, and altered Review of District of Information #DC0001 "[Resident #9 was on amount of bloodclo to [local hospital's including history of a Quarter! 08/23/22documented Pattern) the resident problems with short/I memory, and severed decision making, Under Section G (Fur was coded for requiriform two or more stated Section J (Health Corcoded for falls history)	conducted at 10:30 AM on esident #5 was lying in bed, sition, head of bed elevated, and quarter side rails in up et 3 was called to the ree lowered the bed and isk and it's not safe to leave at high. The staff may have when she was eating." The ce (483.25 Quality of Care admitted to the facility on the had multiple diagnoses alls, generalized muscle and mental status. Columbia's Intake 0310 dated 10/15/21 stated, the floor face downsmall to be to mouthtransferred the name]" The y Minimum Data Set dated and y Under Section C (Cognitive was coded with having ong term memory, recall by impaired with daily der Section E (Behavior) the ed for rejection of care. Inctional Status) the resident ing extensive assistance and for the resident was not the sident was not set to the sident was not set of the set of the set of the resident was not set of the set of th	F6	556			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED	
		095034	B. WING_				C / 16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		72	REET ADDRESS, CITY, STATE, ZIP CODE 15 BUCHANAN ST., NE ASHINGTON, DC 20017	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Procedures, and Procedures, and Procedures, and Under Salarms) the resident restraints or alarms. Review of Resident # showed the following name] has potential fimmobility/twitching by	grams) the resident was ccupational therapy Section P (Restraints and was not coded using 9's care plan dated 10/14/21 : Problem [Resident #9's	F	656			
	review of the care plainterventions including the bed when resider. An observation was of 10/26/22 revealed Resideping in supine positive having mats on eithe #15 (RN) was called the bed and stated, "here earlier doing sof During a face-to-face 2:52 PM, Resident #1 have left her bed in the both sides of the bed take another residentials of said that they us resident's bed becautrisk.	an showed multiple g floor mats on both sides of ints is in bed. conducted at 12:55PM on esident #9 was in bed, sition, bed elevated, and not in side of the bed. Employee to the bedside, she lowered I'm not sure if staff was in					
F 684 SS=D	applies to all treatme	are Indamental principle that nt and care provided to ed on the comprehensive	F	684			

F 684 Continued From page 14 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 19 sampled residents, the facility staff failed to: have documented evidence Resident #1, who had a recent fall with major injury PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 I.Corrective action for residents noted to have been affected by the deficient practice. A) Resident #1 was discharged on 12-25-2021. B) Resident #6 was discharged on 08-18-2022. II.How will the facility identify other residents having the potential to be affected by the same deficient		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
ASCENSION LIVING CARROLL MANOR CX4) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)			095034	B. WING		1		
F 684 Continued From page 14 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 19 sampled residents, the facility staff failed to: have documented evidence Resident #1, who had a recent fall with major injury PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 I.Corrective action for residents noted to have been affected by the deficient practice. A) Resident #1 was discharged on 12-25-2021. B) Resident #6 was discharged on 08-18-2022. II.How will the facility identify other residents having the potential to be affected by the same deficient			ANOR		725 BUCHANAN ST., NE		<u></u>	
assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 19 sampled residents, the facility staff failed to: have documented evidence Resident #1, who had a recent fall with major injury I.Corrective action for residents noted to have been affected by the deficient practice. A) Resident #1 was discharged on 12-25-2021. B) Resident #6 was discharged on 08-18-2022. II.How will the facility identify other residents having the potential to be affected by the same deficient	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE	
outlined in his care plan; apply cold compresses to Resident #6's right eye as ordered. (Residents' #1 and #6). The findings included: The unit manager or designee will review the documentation of treatment from incidents and accidents of current residents on or before 1/26/2023.	F 684	assessment of a reside that residents received accordance with profipractice, the compredicare plan, and the resident failed to: have docum #1, who had a recent (subdural hematoma outlined in his care pito Resident #6's right #1 and #6). The findings included 1. The facility staff failed to: have docum #1, who had a recent (subdural hematoma outlined in his care pito Resident #6's right #1 and #6). The findings included 1. The facility staff failevidence Resident #1 major injury (subdural hourly as outlined in Resident #1 was adn 05/13/21. The resided diagnoses including I weakness, generalized debility, hypertension review of the medical and physical (dated (home the where Resident had a new diagnoses including a review of the facility's resident had a new diagnoses. Review of the resident Review of the resident had a new diagnoses.	dent, the facility must ensure a treatment and care in desional standards of thensive person-centered sidents' choices. T is not met as evidenced diew and staff interview, for diresidents, the facility staff thented evidence Resident at fall with major injury as lan; apply cold compresses eye as ordered. (Residents' die	F 6	I.Corrective action for resito have been affected by the practice. A) Resident #1 was discharged 12-25-2021. B) Resident #6 was discharged 08-18-2022. II.How will the facility ideresidents having the potential potential feeted by the same practice? The unit manager or designer review the documentation of from incidents and accidents residents on or before 1/26/2 III.The measures the facility we ensure that the problector corrected and will not recurred the staff education nurses will re-educate the licenses on following physician or treatments as prescribed, a documenting ordered treather resident medical recorrected in the resident's person-cecare plans on or before 1/2 The Unit Manager or design review incidents and accident the clinical huddle 3x's person-cecare amonths to ensure that ordes treatment is documented in the resident in the resident medical recorrected and accident the clinical huddle 3x's person-cecare plans on or before 1/2 The Unit Manager or design review incidents and accident the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans on the surrection of the clinical huddle 3x's person-cecare plans of the clinical huddle 3x's person-cecare plans of the clini	ged on ge	1/26/23	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING				C
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			11/	16/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Resident #1 had a Br Status summary scor that the resident had cognitive status. Under resident was coded for that occurred 1 to 3 co	finimum Data Set] ection C (Cognitive Pattern) ief Interview for Mental e of "4", which suggested a severely impaired er section E (Behavior)- the or rejection of care behavior ays a week. Under section	F 6	684	F684 (Continued) Findings from the review will be corrected Unit Manager or designee immediately. IV.Quality Assurance Plans to me facility compliance to make sur corrections are achieved permanent. Monthly review of completed reviews	onitor e that and	1/26/23
	needing extensive ph staff person for transit toilet use, the resider one staff member for used an assistive dev Under Section J (Hea was coded for having since his admission. I was the resident was occupational therapy Section P (Restraints	the resident was coded for ysical assistance from one ers between surfaces and trequired supervision from walking in his room. And vice (walker) for mobility. Alth Condition) the resident one (1) fall with no injury Jnder Section 0 the resident coded for receiving services. And, Under and Alarms) the resident ng any restraints or alarms.			results and trends will be completed the Unit Manager or designee and reported to the facility's QAPI Committee for the next 3 months at then re-evaluated to determine if furnonitoring is indicated. V.Completion Date: 1/26/2023.	nd	
	56, respirations 20, bl ox 98% on room air . confused, change intransfer to hospitaltransfer t	J documented, "fall J temperature 97.1, pulse ood pressure 108/62, pulseresident was more behavior, insomnia Nursing Note] documented, (certified nursing assistant) attention and reported d on the floorresident was r his bed, [resident's] head					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			G	` '	COMPLETED		
		095034	B. WING			C 11/16/2022	
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	verbally responsive, trying to get his sock 11/18/21 at 5:41 AM documented," called charge nurse at 11:5 observed lying on the foot of the bedupo in bed resting, with a (centimeter) X 2 cmresident stated, "I versident stated," I versident stated, "I versident stated, and hit my he toe assessment compain. Neurological as no changes from res 11/20/21 at 1:39 PM documented, " the nurse informed writer [to]medical surgica on 11/18/21, and ICL there was no dischart 12/02/21 at 7:59 PM documented, "reside about 2:30 PM from being treated for subcafter a fallhe is aleresident was re-ad diagnoses of subdurated surgical site sut progresses well" 12/02/21 [Hospital D head shows bilateral taken to the operatin decompressive hemi-	[Supervisor Nursing Note] received for 2nd Floor 0 PM that resident was e floor close to dresser at the n arrival, resident observed brasion measured 1 cm not at top of his head was trying to get my socks r workthen I fell, bending ead on the dresserhead to pletedresident denied sessment implemented and ident baseline [Nursing Progress Note] ER (emergency room) That resident was admitted al ICU (intensive care unit) I nurse informed writer that age plan for resident yet." [Nursing Progress Note] Intre-admitted to facility at clocal hospital's name] after dural hematoma evacuation ort, awake, oriented to self mitted to the unit with al hemorrhageleft side of ures intact, dry and healing ischarge Summary]-"CT subdural hematomas. Pt	F 68	34			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G	` '	COMPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	bilateral SDH L > R v. Radiology review det subdural hematoma questionable acute su hemorrhage versus a rightward midline shi Subdural Hemorrhage 12/02/21 [Falls Care Falls. Further review multiple interventions check on residents. 12/02/21-12/27/21-notes, medication ad treatment administra documented evidence #1 hourly as outlined be noted that the resi hospital on 12/27/22 facility). During a face-to-face starting a 12:20 PM, 1 that if the resident was be documented in the medication administra administration record	re unit status-post fall with with left to right shift. stails showsBilateral (subacute/chronic with uperimposed subarachnoid artifactThere is a mild ftDischarge Diagnosis - the present on admission." Plan] documented, Problemof the care plan revealed including continue hourly. Review of nursing progress ministration records, and the time the care plan. (It should dent was transferred to the and did not return to the and did not return to the interview on 10/31/22. Employee #2 (DON) stated is monitored hourly it would be nursing progress notes, ation record, or treatment in the care plan. (It should dent was transferred to the and did not return to the and did not return to the sinterview on 10/31/22. Employee #2 (DON) stated is monitored hourly it would be nursing progress notes, ation record, or treatment it. The content of the fact of the f	F 6	84		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			S	(X3	COMPLETED		
		095034	B. WING			C 11/16/2022	
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Review of a District of	e 18 ss, agitation, and edema. of Columbia Intake form mented, "Resident has a	F 68	34			
	new that was identifie	ed this amdark blue t tissue swelling under right					
	Review of the resider the following:	nt's medical record showed					
	documented, Under a resident did not have Status summary scor was not able to take (Behavior) the reside care one to three time (Functional Status) to requiring extensive a member for bed mobilished.	Change Minimum Data Set] Section C (Cognitive) the Brief Interview for Mental re, indicating the resident the test. Under Section E nt was coded for rejection of es a week. Under Section G he resident was coded for ssistance from one staff ility, and Under Section M esident was not coded for sing a pressure reducing					
	documented, "Res were identified this a with soft tissue swellin (centimeters) X 3.5 c explain how she obta her advanced demen	I [Nursing Progress Note] ident has a new issue that m dark blue discolorationing under the right eye5cm m. Resident unable to ined the discoloration due to thisNP (nurse practitioner) asses application for two days					
	"Staff requested pt. (Progress Note] documented, patient) be evaluated for ingassessment/plan right					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER	095034	B. WING_	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	16/2022	
ASCENSIO	ON LIVING CARROLL MA	ANOR			25 BUCHANAN ST., NE /ASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	facial swelling, monitor compress to right fact day) until resolved.	or for now can apply ice/cold ial area BID (two-times-a	Fé	684				
	02/06/22 showed that prescribed treatment	to s medication and tion record from 02/04/22 to tresident did not receive the for cold compress four tead, she received the cold						
F 686 SS=G	approximately 3:00 P Nursing) stated that s #6's record where the compresses twice a c Treatment/Svcs to Pro	event/Heal Pressure Ulcer	F 6	686				
	resident, the facility n (i) A resident receiver professional standard pressure ulcers and dulcers unless the indidemonstrates that the (ii) A resident with pronecessary treatment with professional star promote healing, prevnew ulcers from deverthis REQUIREMENT by: Based on record revision (ii) A resident with professional star promote healing, prevnew ulcers from deverthis REQUIREMENT by:	re ulcers. hensive assessment of a nust ensure that- s care, consistent with ds of practice, to prevent loes not develop pressure vidual's clinical condition bey were unavoidable; and essure ulcers receives and services, consistent and ards of practice, to vent infection and prevent						

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED	
		095034	B. WING				C 16/2022
NAME OF P	ROVIDER OR SUPPLIER	l	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASCENSIO	ON LIVING CARROLL MA	ANOR			25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	≣	(X5) COMPLETION DATE
F 686	failed to provide care standards of practice Resident #2's Moistu (MASD). Subseque MASD declined to a	consistent with professional to promote healing of re Associated Skin Disorder ntly, Resident #2's sacrum	F	686	I. Corrective action for residence noted to have been affected by deficient practice. Resident # 2 was discharged on 6/4/2022. II. How will the facility identify or residents having the potential to	the	1/26/23
	#2 when it was deter Moisture Associated first observed on (04 accordance with the recommendation. Se disorder further decli	ed in actual harm to Resident mined that the resident's Skin Disorder to the sacrum, /20/2022) was not treated in Nurse Practitioners even days later, the skin ned, and the resident was ge III pressure ulcer/injury to			residents having the potential to affected by the same defice practice? Current residents with skin condit will be assessed by the licensed nurse or before 1/26/2023 to review curtreatment to promote healing for presulcers. III. The measures the facility will after the same deficiency of the same deficiency of the same deficiency.	tions e on rrent ssure take r to	1/26/23
	The findings included Resident #2 was adr 01/28/17 with multipl Cerebral Vascular Ad Left Side, Generalize Mellitus. Review of District of Health's Intake Inforr documented, "[Residinfected bedsore th their job, the bedsore properly" Review of the resider the following: 12/08/21 {Phuysican sacrum with soap and	nitted to the facility on e diagnoses including cident, Hemiplegia affecting ed Weakness, and Diabetes Columbia Department of nation form dated 07/07/22 lent's name] [had an] he nurses there neglected to e was not being treated nt's medical record showed order] directed, "Cleanse d water, pat dry, apply A&D imes-a-day) for protection".			ensure that the problem will corrected and will not recur. The staff education nurse or designed re-educated the licensed nurses on ski identification, evaluation and monitoring, as well as implementation of ordered treatments on or before 1/26/2023. Residents with new skin integrity issues will be reviewed for implementation of ordered treatment by the Interdisciplinary Team during daily clinical meeting for skin interventions and treatment. During weekly Resident at Risk meetings, the interdisciplinary Team will review the clinical record of residents with new skin conditions for skin evaluation, interventions an treatment. The review will be documented in the Resident's clinical record. The Unit Manager or designed	be kin on the tts g the	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		095034	B. WING		11/	/16/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	NOR		WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	02/15/22 [Significant of showed the following for Mental Status Surthe resident had a scresident had moderat Section E (Behavior) rejection of care. Section E (Behavior) rejection of totally members for toilet us on staff for bathing, a mobility device. Section and Goals) coded the incontinent of bowel at a toileting program. A Conditions) coded the for developing pressure of 10 indicating that E (Behavior) results of 10 indic	Change Minimum Data Set] Section C (Brief Interview Inmary Score) documented ore of 9 indicating that the rely impaired cognition. did not code the resident for tion G (Functional Status) is requiring extensive (2) staff members for bed dependent on two staff (e, being totally dependent as a on GG (Functional Abilities is resident as always being and bladder and not being on and Section M (Skin is resident for being at risk in the resident for being at risk in the resident for being at risk in the resident had a score resident #2 was at risk for fulcers/injuries. [Treatment Administration in nursing staff was providing in order [start date of acrum with soap and water, interest three-times-a-day (6 M). I [Skin Evaluation] form the effective interest in the standard interest in the set with the se	F 68	will randomly review wound evalute forms for 3 months for treatment the promotes healing. Findings from the review will be corrected by the United Manager or designee immediately. IV.Quality Assurance Plans monitor facility compliance to sure that corrections are achieved permanent. Monthly review of completed audit results and trends will be completed the United Manager or designee and reported to the facility's QAPI Committee for the next 3 months at then re-evaluated to determine if furnonitoring is indicated. V.Completion: 1/26/2023	nat ne it s to make d and t d by	1/26/23

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			S		COMPLETED		
		095034	B. WING			C 11/16/2022	
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 686	foul smell,Treatmer [and] A&D ointment to needed Nurses Nowith opening on sacridaily living) care by a Nurse Aide)Reside assessment. NP (Nuaware, new order recent A&D ointment tid and (Zguard is indicated to associated with diapowetness. Also protect or cracked skin. https://www.woundsohytoplex-z-guard-skin. Review of the physic from 04/20/22 to 04/2 evidence that Z guard treat the resident's Mod/20/22 to 04/26/22 Record] showed, the care per the following 12/08/21], "Cleanse's pat dry, apply A&D oin AM, 2 PM, and 10 PM documented evidence Z-guard. 04/26/22 at 9:00 AM eating 25-50 %no's weakness and contral to skin breakdown, it is not skin breakdown.	ent - Z guard cream plus hree-times-a-day and as tes: Resident was observed um during ADL (activities of assigned CNA (certified ent denies pain on arse Practitioner made eived for Z guard plus [and] diprn" o protect minor skin irritation er rash and to help seal out as and helps relieve chapped eurce.com/product/remedy-pa-protectant-paste) ian's orders and the TAR 26/22 lacked documented dicream plus was ordered to ASD. [Treatment Administration nursing staff was providing gorder [start date of accrum with soap and water, antment three-times-a-day (6 M)". However, there was not e that nursing staff applied [Physician Progress Note]-skin breakdownleft sided	F 68	36			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		COMPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	documented - Sacruic centimeters (length), 40% slough, pink gramild serous drainage Na cream plus Santy and as needed cover dressing), [resident raware 04/27/22 at 20:40 (8: Record] documented 4.2 X 4.8 cm (centime granulation 60 %, micellulites. Recommer (two-times-a-day) and with bordered dressing) and with bordered dressing output directed, "Cleanse sa saline, pat dry, apply cover with Allevyn lifenceded" There was no evident the treatment as presin the "Skin Evaluation Review of Resident # 08/30/21 revealed the pressure injury second mobility, incont [incorderself. Goal - [resident's nate of the same and th	M [Nursing Progress Note] m Stage 3 measured 4X2 4X8 centimeters (width), anulating 60%, no cellulitis, New order received for Sal ordinament two-times-a-day r with Allevyn Life (foam representative name] made 40 PM) [Physician Consult , "Report- Sacrum Stage 3, reters), slough 40 %, pink ld serious drainage) andations - Salna +Santyl bid ord prn (as needed), cover ng." 10:00 PM) [Physician Order] acrum wound with normal Sarna cream and Santyl), e, twice a day [and] as 10:00 PM (as needed) (as a cream and Santyl), 10:00 PM (as need	F 6	86		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	095034	B. WING		11/16/2022	
	NOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
next review period.		F 68	66		
including observe ski breakdown during rou treatment as ordered	n for redness and tine care, and [provide] when needed				
approximately 9:00 A stated that she was n had MASD wound. H by the nursing staff th III sacral wound on 0-	M, the resident's physician ot aware that Resident #2 owever, she was informed at the resident had a Stage 4/27/22 at which time she				
approximately 10:30 of Nursing) stated she	AM, Employee #2 (Director e did not see where the staff				
implemented the comintervention, "[provide when needed" when the physician's order that the physician's order that the physician's order that the physician when the physician order to a Stage III pressure to a Stage III pressure the physician order that the physician order to be provided that the physician order that the physician order to be provided to the physician order to be physician order to be provided to the physician order to be physician o	prehensive care plan e] treatment as ordered en they failed to transcribe to apply Z guard to Resident when it was first identified on uently, within seven days #2's sacrum MASD declined e ulcer/injury. ards/Supervision/Devices	F 68	99		
The facility must ensu §483.25(d)(1) The res as free of accident ha	re that - ident environment remains azards as is possible; and				
	Continued From page next review period. The care plan outlined including observe skil breakdown during routreatment as ordered During a face-to-face approximately 9:00 A stated that she was nhad MASD wound. Hby the nursing staff th III sacral wound on 0 assessed and gave to During a face-to-face approximately 10:30 of Nursing) stated she had provided the treatment as no evidentimplemented the comintervention, "[provide when needed" whe the physician's order the physician's	CONTINUED CARROLL MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 next review period. The care plan outlined multiple interventions including observe skin for redness and breakdown during routine care, and [provide] treatment as ordered when needed During a face-to-face interview on 11/07/22 at approximately 9:00 AM, the resident's physician stated that she was not aware that Resident #2 had MASD wound. However, she was informed by the nursing staff that the resident had a Stage III sacral wound on 04/27/22 at which time she assessed and gave treatment orders. During a face-to-face interview on 11/08/22 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated she did not see where the staff had provided the treatment for Z guard. There was no evidence that facility staff implemented the comprehensive care plan intervention, "[provide] treatment as ordered when needed" when they failed to transcribe the physician's order to apply Z guard to Resident #2's sacrum MASD when it was first identified on 04/20/2022. Subsequently, within seven days (04/27/22), Resident #2's sacrum MASD declined to a Stage III pressure ulcer/injury. Free of Accident Hazards/Supervision/Devices	Continued From page 24 next review period. The care plan outlined multiple interventions including observe skin for redness and breakdown during routine care, and [provide] treatment as ordered when needed During a face-to-face interview on 11/07/22 at approximately 9:00 AM, the resident had a Stage III sacral wound on 04/27/22 at which time she assessed and gave treatment orders. During a face-to-face interview on 11/08/22 at approximately 9:00 AM, the resident had a Stage III sacral wound on 04/27/22 at which time she assessed and gave treatment orders. During a face-to-face interview on 11/08/22 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated she did not see where the staff had provided the treatment for Z guard. There was no evidence that facility staff implemented the comprehensive care plan intervention, "[provide] treatment as ordered when needed" when they failed to transcribe the physician's order to apply Z guard to Resident #2's sacrum MASD when it was first identified on 04/20/2022. Subsequently, within seven days (04/27/22), Resident #2's sacrum MASD declined to a Stage III pressure ulcer/injury. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d) (1) (2) §483.25(d) Accidents. The facility must ensure that - §483.25(d) (1) The resident environment remains as free of accident hazards as is possible; and	IN LIVING CARROLL MANOR SUMMANY STATEMENT OF DEFICIENCIES (EACH DEPOSITION NUMBER) (EACH DEPOSITION NUMBER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 24 next review period. The care plan outlined multiple interventions including observe skin for redness and breakdown during routine care, and [provide] treatment as ordered when needed During a face-to-face interview on 11/07/22 at approximately 9:00 AM, the resident's physician stated that she was not aware that Resident #2 had MASD wound. However, she was informed by the nursing staff that the resident had a Stage III sacral wound on 04/27/22 at which time she assessed and gave treatment orders. During a face-to-face interview on 11/08/22 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated she did not see where the staff had provided the treatment for Z guard. There was no evidence that facility staff implemented the comprehensive care plan intervention, "[provide] treatment as ordered when needed "when they failed to transcribe the physician's order to apply Z guard to Resident #2's sacrum MASD when it was first identified on 04/20/2022. Subsequently, within seven days (04/27/22), Resident #2's sacrum MASD declined to a Stage III pressure ulcer/finity. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d) (1) (1) [The resident environment remains as free of accident hazards as is possible; and	

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (X3) DATE (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) DATE (X		ESURVEY PLETED				
						С	
		095034	B. WING_				/16/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
				72	25 BUCHANAN ST., NE		
ASCENSIC	ON LIVING CARROLL MA	ANOR		W	VASHINGTON, DC 20017		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	NEGOE WORT ON E	SO ISENTI TINO IN GRAMMATION	170		DEFICIENCY)		
F 000							
F 689	1 0		F 6	689	F689		
	•	tance devices to prevent			I.Corrective action for residents	noted	
	accidents.	- :			to have been affected by the def		1/26/23
	by:	is not met as evidenced			practice.	ICICIII	
	•	ns, that record reviews and			A) Resident #1 was discharged on		
		of 19 sampled residents,			12-25-2021		
		d to ensure that Resident #1					
	received adequate su	pervision to prevent a fall			B) Resident #3's wanderguard was replaced on 3/9/2022. The access code		
		nematoma) on 11/18/21.			for the memory care door was also	Juc	
		ng the fall, the resident			changed on 3/9/2022.		
	required surgery repa				C) Resident #4 has had no further		
	hemi-craniotomy for e	evaluation of subdural of subd			incidence of concern regarding		
	•	pervision to prevent an			transfers.		
	· · · · · · · · · · · · · · · · · · ·	22; Resident #4 was secure			D) Resident #5 Care plan was upda	ited	
	· · · · · · · · ·	ng a transfer which led to			on 1/3/2022 to include non-complia		
		n assisted fall with minor			with maintaining her bed in the low		
		/22; and Resident #5 was			position. Resident #5's bed enabler		
		nich led to fall without injury			checked on 12/30/2022 and is	was	
	on 09/30/22. (Resider	nts' #1, #3, #4 and #5)			functioning.		
	Those failures results	ed in actual harm to Resident			II.How will the facility identify	other	
	#1	d in actual nami to Resident			residents having the potential		1/26/23
	<i>IT</i> 1				2 •	icient	
	The findings included	:			practice?		
	· ·				The Unit Manager or designee will		
		ailed to ensure Resident #1			review the current resident care pla		
		pervision to prevent a fall			for fall interventions on or before		
		nematoma) on 11/18/21.			1/26/2023. The unit manager or		
		ng the fall, the resident			designee also reviewed current		
	hemi-craniotomy for e	nir (left decompressive			residents, who are at risk for eloper	nent.	
	hematoma).	valuation of subdulat			There are no residents who require		
	nomatomaj.				supervision.		4/00/00
	Resident #1 was adm	nitted to the facility on			III.The measures the facility will	take	1/26/23
		nt had a history of multiple			or systems the facility will alt		
	diagnoses including h				ensure that the problem wi		
		ed osteoarthritis, age-related			corrected and will not recur.		
	debility, hypertension	and epilepsy.			corrected that will not recur.		

PRINTED: 01/09/2023 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 095034 11/16/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 BUCHANAN ST., NE ASCENSION LIVING CARROLL MANOR WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) document F 689 Continued From page 26 F 689 F689 ed, under (Continued) Section C Review of Resident #1's medical history prior to (Cognitive The staff admission to the facility revealed a computed Pattern) education tomography scan (CT scan of the resident's Resident head) which showed no cranial abnormalities. nurse #1 had a designee will Brief A review of the District of Columbia's complaint re-educate Interview intake #DC00010417 documented. Did the for Mental and observe [resident] suffer any physical injuries? Yes, brain the current clot surgery [local hospital's name] 11/19/21 ... nursing staff Complaint: 09/18/21- first fall ... explanation of on utilizing injury didn't match what I expected when I saw the him [Resident #1] in a video chat. 10/23/21- he mechanical [Resident #1] fell again not going to hospital lift safely and ...11/18/21 he fell again doctor wants him to go to fall the hospital ...admitted and had surgery [left decompressive hemi-craniotomy] on 11/19/21 brevention. ...three falls are two too many should have had a The social better safety plan for patients [residents]. He workers will came their [there] with a history of fall from be 1/2021 ...not sure how many other times he fell educated not witnessed [brain blood] clot is [was] older and discharge during the time he was in the nursing home." planning f**o**r residents Review of the policy tilted, Fall Policy with a last approval date of 01/2022 instructed staff who require complete the Hendrich II Fall Risk (or similar fall 1:1 or before risk evaluation) during admission and quarterly ... 1/26/2023. The staff Review of medical record showed the following: education nurse 05/13/21 - The record lacked documented designee evidence the facility's staff completed a Henrich II educated Fall Risk (or similar fall risk evaluation) during the current staff resident's admission. on elopement 08/10/21- [Quarterly Minimum Data Set]

and reporting

maintena ons for wander guard placement, nce needs mechanical lift transfers, placement of bed to enablers and fall interventions weekly for 3 facilities months. Findings from the review will be maintena corrected immediately by the Unit manger nce on or designee.

before IV.Quality Assurance Plans to monitor 1/26/202 facility compliance to make sure that 3. During corrections are achieved and permanent. Monthly review of completed care plan weekly results and trends will be completed by the Resident Risk Unit Manager or designee and reported to at the facility's QAPI Committee for the next meetings. 3 months and then re-evaluated to determine the if further interdisci

1/26/23

record of residents with new or changed fall or elopemen t risk for safety interventi ons. The

review will

documen ted in the Resident's clinical record. The unit

be

plinary Team will review the clinical

manager or designee

will complete

Compiete

random

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3	B) DATE SURVEY COMPLETED
		005004	D WING			С
		095034	B. WING			11/16/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASCENSIO	ON LIVING CARROLL MA	NOR		725 BUCHANAN ST., NE		
7100211011	,			WASHINGTON, DC 20017		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO		VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 689	that the resident had cognitive status. Under section G (Fur was coded for needing assistance from one setween surfaces and required supervision walking in his room. A (walker) for mobility. Condition) the reside any fall since admissing resident was not code occupational therapy P (Restraints and Alacoded for using any resident was not coded	re of "9", which suggested a moderately impaired er section E (Behavior)- the ed for rejection of care. Inctional Status) the resident and extensive physical staff person for transfers doublet use, the resident from one staff member for and used an assistive device under Section J (Health and used an assistive device under Section J (Health and used for not having ion. Under Section O, the ed for receiving physical or services, And Under Section arms) the resident was not restraints or alarms. The record lacked enthe facility's staff of Hendrich II Fall Risk (or action). The care plans showed the Resident #1's name] with related to pain, assion with an initial date of eview of the care plan erventions including need with transfers, keep lutter free and provide personal items within reach, arterly and as indicated. Falls with an initial date of	F6	F 689 (Continued)		1/26/2023
	occupational therapy	ns included physical and consult as needed				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION G	COMP	COMPLETED		
	095034	B. WING			C /16/2022		
NAME OF PROVIDER OR SUPPLIER ASCENSION LIVING CARROLL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017				
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN'	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
O9/18/21 at 4:46 PM [Nursin documented fall)] documenter resident was observed on the position in the hallway in from walker close by. Resident win the hallway towards his refell. Resident stated that he blankettripled [tripped] on Sustained skin tear to right umeasured 3 cm (centimeter) minimal bleeding, pressure a Resident complained of pain notifiedtransfer to ER (enfurther evaluation and treatm Review of the Hendrich II shog/18/21 at 5:37 PM the resident resident minimal bleeding. T" indicating he was a high of facial bone, subdural hem hematoma, and facial lacera seen for a subdural hematom it does not look recent and word today's fall. It was probably minor injury at some point in or months O9/19/21 at 1:55 PM [Nursin documented, resident return 12:00 noon from [local hospi was transferred after being ofHe is alert and verbally resperiods of confusionsterilateral area of right brow with no swelling, no bone protrus	ed, "at about 4:30 PM le floor in a supine let of his room with his les observed walking loom then tripped and let went to get a let his walker and fell. In one right eyelid. Dr let her had a score of let had a score of le	F 68	9				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095034	B. WING_				C /16/2022	
NAME OF PROVIDER OR SU		ANOR		725	REET ADDRESS, CITY, STATE, ZIP CODE 5 BUCHANAN ST., NE ASHINGTON, DC 20017			
PREFIX (EACH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACTION SHOULD B	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
right lower 09/19/21 [Indocumente in injury. Diagonal bone hematoma seen for a soit does not today's fall minor injury or months 10/23/21 and documente by assigne report an unresidents reposition by what happy [but] didn't toe assess initiated rowerbalized Care Plant 10/23/21. In physical/or resident with before any dry floor, and 11/02/21 [Condocumente state of the composition of th	especially eyelid are dospital Ard, "Reason noses - m, subdural hook receil to always and facility at some and facility at some and fall)] - at d CNA (convitnesses oom, residenced states give any coment done are dospitally and erstare and low be Quarterly I d, under Squarterly I d, und	refer Visit Summary] on for visit- fall and head nultiple closed fractures of I hematoma, facial al laceration you have been nematoma. On your CT scan not and was not caused by obably from another fall or point in the last few weeks I [nursing progress note (2nd at 10:20 PM writer was called pertified nursing assistant) to ed fall, upon arrival to dent was found in a sitting in his room, when asked ed, "I was trying to get up" other informationhead to be no acute distress cks alert but oriented X1 as call for assistance and anding Falls with an initial date of the included all therapy screen post fall, ing to always call for help and keep room clutter free,	F	689				

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED		
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	that the resident had cognitive status. Und resident was coded for that occurred 1 to 3 of G (Functional Status) needing extensive phystaff person for trans toilet use, the resider one staff member for used an assistive desunder Section J (Heawas coded for having since his admission. It was the resident was occupational therapy Section P (Restraints was not coded for used to 11/102/21 is in a section J as the resid look back period. 11/17/22 at 11:50 PN Communication Form documented, "fall temperature 97.1, pupressure 108/62, pulsresident was more behavior, insomnia 11/18/21 at 3:08 AM "at 11:50 PM CNA called to this write's resident was observed lying on the floor neawas very closed (sp) assessment noted or	a severely impaired er section E (Behavior)- the or rejection of care behavior lays a week. Under section the resident was coded for sysical assistance from one fers between surfaces and trequired supervision from walking in his room. And vice (walker) for mobility. Walth Condition) the resident gone (1) fall with no injury Under Section 0 the resident coded for receiving services. And, Under and Alarms) the resident ing any restraints or alarms. At Section J of the MDS ccurately coded under ent had two falls within this At [Professional in (3rd documented fall)] resident hit his head lase 56, respirations 20, blood as ox 98% on room air confused, change in transfer to hospital Nursing Note] documented, (certified nursing assistant) attention and reported d on the floor resident was r his bed, [resident's] head	F 6	89		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(COMPLETED	
		095034	B. WING _			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR	•	STREET ADDRESS, CITY, STATE, ZIP COL 725 BUCHANAN ST., NE WASHINGTON, DC 20017	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATI	(X5) COMPLETION DATE
F 689	trying to get his sock 11/18/21 at 5:41 AM documented," called charge nurse at 11:5 observed lying on the foot of the bedupo in bed resting, with a (centimeter) X 2 cm iresident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain. Neurological as no changes from resident stated "I w from the dresserfo downand hit my he toe assessment compain."	Resident #1] stated [he was] s. [Supervisor Nursing Note] received for 2nd Floor 0 PM that resident was a floor close to dresser at the marrival, resident observed brasion measured 1 cm and at top of his head as trying to get my socks ar workthen I fell, bending ad on the dresserhead to pletedresident denied sessment implemented and adent baseline Fall with an initial date of the included transfer resident repartment) for further leep pattern X 1 week, the included to edges of	F6	89		
	documented, " the nurse informed writer [to]medical surgica on 11/18/21, and ICU	[Nursing Progress Note] ER (emergency room) that resident was admitted al ICU (intensive care unit) I nurse informed writer that ge plan for resident yet."				
	documented, "resider about 2:30 PM from [being treated for subd	[Nursing Progress Note] ntre-admitted to facility at local hospital's name] after dural hematoma evacuation rt, awake, oriented to self				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X:	COMPLETED	
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL M.	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	diagnoses of subdur- head surgical site sur- progresses well" 12/02/21 [Hospital D head shows bilateral taken to the operatin decompressive hem of subdural hematon surgical intensive ca bilateral SDH (subdu- to right shift. Radiolo Bilateral subdural h with questionable ac subarachnoid hemor- is a mild rightward m	mitted to the unit with all hemorrhageleft side of tures intact, dry and healing ischarge Summary]-"CT subdural hematomas. Pt g room for left l-craniotomy for evacuation na. 11/19/21- admitted to re unit status-post fall with ral hematoma) L > R with left gy review details shows nematoma (subacute/chronic	F 6	89		
	occupational therapisummary note dated the resident started of 11/18/22Indoor more needed partial assist complete activities stand [the resident re(close enough to rean needed)precaution unexpectantly dischar	ted during a telephone 2 at approximately 2:30 PM, icient care of my dad complaint stated that the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` '	IPLE CONSTRUCTION NG	(X	COMPLETED	
		095034	B. WING_			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP COE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	Þ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	According to the comber conflicting explar fall because her dad nurses described. She looked horrible, with fractured nose, and a staff called her an information suffered a second fair require a hospital transaid, Her father had remove a brain blood 11/18/22." During a face-to-face starting at 2:31 PM, I Director) stated that stand by assist (beer away from resident for staff should have becaway from Resident Employee #3 stated, employee said that a Resident #1 was not independently in his required the assistant complete the activity nursing staff made at for rehab, Employee weekly during utilizate employee was asked review notes at the tild however, the notes we surveyor for review. During a face-to-face 5:00 PM, Employee was asked how was that the resident required.	plainant, the staff kept giving nations about the (09/18/21) didn't look like what the ne said that Resident #1 a black and blue face, a an eye fracture. Also, the formed that Resident #1 ll on 10/23/21, but he did not nsfer. The complainant also to have an operation to diclot after his third fall on diclot after his third fall on 10/28/22 Employee #3 (Rehab staff should have provided in no more than an arm length or safety). When asked, if en at least an arm length #1 with the fall on 10/23/22, "yes". Additionally, the coording to the therapy notes safe to ambulate room on 11/18/21. He are from another person to when asked, how is ware of the recommendation #3 stated they are discussed the for copies of the utilization	F6	589		

PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			COMPLETED		
	095034	B. WING			C 11/16/2022
ROVIDER OR SUPPLIER	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		1110/2022
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE
ambulation? The emnursing staff aware of required during a care Employee #4 also staimpulsive. During a telephone in at 12:14 PM, the resi Resident #1's daught the nursing home be home. According to tailed to call for help, physician stated, "Ho doesn't call for help. I dementia, they may assistance from staff one-to-one care for hold me that they don Additionally, the physician stated and the previously mention the resident physicial was present doing the the previously mention the resident physicial was right when he sa one-to-one services for was then asked how safe from falls? The ohim closer to the nurs was then asked how as recommended by to provide an answer	ployee said that he made if the assistance the resident eplan meeting on 09/23/21. The plan meeting on 09/23/21 atted that Resident #1 was atterview on 10/31/22 starting dent's physician stated that the brought the resident to cause he was falling at the physician, the resident which led to him falling. The low can we control him if When we have patients with refuse care (call for a limit of least one of the resident which led to him falling. The low can we control him if When we have patients with refuse care (call for a limit of least one of least one of the resident with the sident with the sident with the sident with the resident. It interview on 10/31/22 to the resident with the resident. It interview on 10/31/22 to the resident with the resident with the physician with the facility does not offer for residents. The employee did you keep Resident #1 to employee was that an arm length away rehab. The employee failed in the resident with the move of the remaining that an arm length away rehab. The employee failed in the resident with the move of the remaining that an arm length away rehab. The employee failed in the resident with the residen	F 6	89		
	Continued From page ambulation? The employee #4 also stainpulsive. During a telephone in at 12:14 PM, the resi Resident #1's daught the nursing home behome. According to tailed to call for help, physician stated, "Hodoesn't call for help, physician stated, "Hodoesn't call for help. I dementia, they may assistance from staff one-to-one care for hold me that they don Additionally, the physician stated in the previously mention the resident physician stated was right when he saone-to-one services for the physician stated in the previously mention the resident physician was right when he saone-to-one services for the nursual state in the physician was right when he saone-to-one services for the nursual state in the previously mention the resident physician was then asked how safe from falls? The facility staff facility sta	ON LIVING CARROLL MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 ambulation? The employee said that he made nursing staff aware of the assistance the resident required during a care plan meeting on 09/23/21. Employee #4 also stated that Resident #1 was	ON LIVING CARROLL MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 ambulation? The employee said that he made nursing staff aware of the assistance the resident required during a care plan meeting on 09/23/21. Employee #4 also stated that Resident #1 was impulsive. During a telephone interview on 10/31/22 starting at 12:14 PM, the resident's physician stated that Resident #1's daughter brought the resident to the nursing home because he was falling at home. According to the physician, the resident failed to call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help. When we have patients with dementia, they may refuse care (call for assistance from staff). I asked nursing staff for one-to-one care for him [Resident #1], but they told me that they don't have one-to-one services. Additionally, the physician, stated that he could not remember what nurse he talked to about one-to-one services for the resident. During a face-to-face interview on 10/31/22 starting a 12:20 PM, Employee #2 (DON) who was present doing the telephone interview with the resident physician, said that the physician was right when he said the facility does not offer one-to-one services for residents. The employee was then asked how did you keep Resident #1 safe from falls? The employee said we moved him closer to the nursing station. The employee was then asked how was that an arm length away as recommended by rehab. The employee failed to provide an answer.	ROVIDER OR SUPPLIER ON LIVING CARROLL MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPTICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION). Continued From page 34 ambulation? The employee said that he made nursing staff aware of the assistance the resident required during a care plan meeting on 09/23/21. Employee #4 also stated that Resident #1 was impulsive. During a telephone interview on 10/31/22 starting at 12:14 PM, the resident's physician stated that Resident #1's daughter brought the resident to the nursing bhome because he was falling at home. According to the physician, the resident failed to call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated, "How can we control him if doesn't call for help, which led to him falling. The physician stated that the could not remember what nurse he talked to about one-to-one services for the resident. During a face-to-face interview on 10/31/22 starting a 12:20 PM, Employee %2 (DON) who was present doing the telephone interview with the previously mentioned telephone interview with the resident physician, said that the physician was right when he said the facility does not offer one-to-one services for residents. The employee was then asked how did you keep Resident #1 safe from falls? The employee said we moved him closer to the nursing station. The employee was then asked how was that an arm length away as recommended by rehab. The employee lailed to	NUMBER OF SUPPLIER NEW ASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES BUCHANAN ST., NE WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES CARDIFICIATION IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 ambulation? The employee said that he made nursing staff aware of the assistance the resident required during a care plan meeting on 09/23/21. Employee 44 also stated that Resident #1 was impulsive. During a telephone interview on 10/31/22 starting at 12:14 PM, the resident's physician stated that Resident #1's daughter brought the resident to the nursing home because he was falling at home. According to the physician, the resident to failed to call for help. When we have patients with dementia, they may refuse care (call for assistance from staff). I asked nursing staff for one-to-one care for him [Resident #1], but they told me that they don't have one-to-one services. Additionally, the physician, stated that he could not remember what nurse he talked to about one-to-one services for the resident. During a face-to-face interview on 10/31/22 starting a 12:20 PM, Employee #2 (DON) who was present doing the telephone interview with the resident physician, said that the physician was right when he said the facility does not offer one-to-one services for tre scilents. The employee was then asked how was that an arm length way as recommended by rehab. The employee tailed to provide an answer.

	F CORRECTION	IDENTIFICATION NUMBER:		G	(X3	COMPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		11,13,2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	resident eloped from Resident #3 was adn 04/29/21 with multipl Alzheimer's Disease Review of a District of #DC00010619 docur missing from the unit from the activity depa to the unit at 5:30 PM Allison Street NE (at of the facility). Reside bruises, discomfort, of could walk outside to own During an observation approximately 10:00/a around the talking an residents. The reside wander/elopement at She was oriented to be recall the incident wh the facility on 03/09/2 showed the unit was monitors and alarms and exiting the unit. Review of the resider the following: 07/15/21 [Physician of monitoring- check pla 01/31/22 [Quarterly M Under Section C (Co a Brief Interview of M	nitted to the facility on e diagnoses including and Dementia. of Columbia Intake form mented, "the resident was at 5:15 PMAnother staff artment brought the residentthe resident [was] on 12th the entrance of the campus ent was assessedno skin distressShe thought she oget some fresh air on her	F 68	89		

	F CORRECTION	IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	COME	
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	cognitively. Under Seresident was not cod Under Section G (Furwas coded for activit locomotion off the unone staff member whand needing set-up funder Section O- the receiving psychologic (Alarms) the resident wander/elopement a 03/01/22 to 03/09/22 Record] showed that the placement of the every shift. 03/09/22 at 10:26 PM documented, "At 4:3 resident was in her responsive with her rebut non-compliant in writer notice resident searched for the resident. She reporte and Allison Street Calm, no distress not alert (wander/elopemalert was immediatel working properly" 03/09/22 [5 Working documented, "Sun Brown left the memoheld the door open for are in place to preversent to RR (resident in the control of the	ection E (Behavior)- the led for refusal behavior. Inctional Status)- the resident ly did not occur for lit, needing supervision of the walking in the corridor, or walking in her room. It resident was not coded for local therapy. Under Section Pet was coded for using a larm daily. [Medication Administration nursing staff was checking wander/elopement alarm M [Nursing Progress Note] O PM this writer noted loom alert and verbally loom alert on her right wrist keeping it on. At 5PM this is was not in her room We dent within the unit. While loersonnel show up with led that the resident on 12th lon assessment [resident] is led and without her room lent device). A new room ly place on resident and its	F 6	89		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S	SURVEY
			A. BUILDI	NG _		l .	0
		095034	B. WING				C / 16/2022
NAME OF PE	ROVIDER OR SUPPLIER	555551	1	ç	STREET ADDRESS, CITY, STATE, ZIP CODE	11/	10/2022
TO HOLD OF TH	COVIDER ON COLL FIELD				725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	ANOR	WASHINGTON, DC 20017		·		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES			·		2/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	37	F	689			
	the elopement preven	ntion process.					
	documented, "Reside member outside the b outside the unit with s	Physician Progress Note] ent was found by staff building on the street, left some other family member PT (patient) to keep roam ent alarm).					
	documented, "A care 3/14/22 to address [ro on 03/09/22. In attended members names]. However, and the managed to get off the was unintentionally leby another resident's returned to the unit be another to the unit be another elopement. In order elopement, the securic changed and will not visitors. All visitors to escorted onto and off	Social Work Progress Note] plan meeting was held esident's name] elopement dance virtually[two family ow [resident's name] ne unit was explained: she et out of the unit at 5:13 PM family member, she was y staff at 5:27 PM. Family ty footage (video) of the to prevent any future risk of ity code for the floor has ben be disturbed to family or the unit will need to be the unit by staff[resident's g a roam alert bracelet.					
	following:	t's care plan showed the					
	forelopement. Inter	[Resident's name] is at risk rvention included follow t evaluation and monitoring					
	from the facility second dementia/verbalized facility. Interventions	Potential for elopement ndary to dx (diagnosis of intentions to leave the included apply roam mate accessfor potential to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE (COMP	
		095034	B. WING_			C 11/16/2022
	ROVIDER OR SUPPLIER	ANOR		STREET ADDRESS, CITY, STATE, ZIP (725 BUCHANAN ST., NE WASHINGTON, DC 20017	CODE	111102022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B	DATE
F 689	to surroundings" 01/07/22 -"Problem [impaired behavior rel hovering around the e onInterventions in resident when standi During a face-to-face approximately 3:00 F Assistant) stated that for the day, she saw the hospital (located e nursing home). She e the nursing home. During a face-to-face approximately 4:30 F (Administrator) state security video and sa resident's family men the unit. When asked resident went through stated no because sh wander/elopement al removed the alarm. V	Resident's name] has lated to exit seeking, exit doors (with a start dated cluded nursing to re-directing at the exit door" In interview on 11/03/22 at exit when she was going home Resident #3 at the back of on the same grounds as the excepted the resident back to the interview on 11/03/22 at exit when she was going home as the excepted the resident back to the excepted the resident back to the interview on 11/03/22 at exit with the same grounds as the excepted the resident back to the excepted the resident back to the excepted the same grounds as the excepted the resident back to the excepted the resident back to the excepted the same grounds at the excepted	F 6	889		
	was secure in a mecl	uiled to ensure Resident #4 hanical lift during transfer lent having an assisted fall n).				
		Columbia Intake form 06/22/22 documented, "				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	l	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	2 staffin an attempt pad left underneath he wheelchair, suddenly wheelchair to the floo of her wheelchairs on touch and by node noted, and skin warm. During an observation showed Resident #4 dependent on staff for When asked about the resident hunched her she did not know about the following: Review of the resident #following: Review of Resident #following: 08/19/21 - "Problemassistance with daily Interventions include with mobilityneed mobilityuse wheeld 08/19/21 - "Problempotential for falls related activity. Interventions transfers and mobility transfers and mobility transfers and mobility	erred with a full body to the bed to wheelchair with to adjust the mechanical ther for comfort while in the tresident slide off the trin a sitting position in front the reported pain to left hip ding her head, no swelling the and dry to touch. In on 11/10/22 at 8:45 AM alert, non-verbal, totally tractivities of daily living. The fall on 06/22/22, the shoulders indicating that but the fall. It's medical record showed 4's care plans showed the [Resident's name] needs activities of daily living care. If all on total assistance the person staff support thair device for mobility " [Resident's name] has a tend to hx (history) of seizure to included assist with all try prn (as needed)	F 68	39		
	following: Under Sec	imum Data Set] showed the tion C (Cognitive) Brief Status summary score of				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	(X3	COMPLETED
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Under Section G (Fu was coded for extens staff member for trans and uses a wheelchat J (Health Condition) for fall since her adm Section O (Special T Programs) the reside	e 40 esident intact cognitively. nctional Status) the resident sive assistance from one nsferring between surfaces air for mobility. Under Section the resident was not coded hission to the facility. Under reatments, Procedures and ent was not coded for al/physical therapy services.	F 68	39		
	documented, "Nurse resident's assigned (assistant) at 11:30 A sitting on the floor in legs stretched out identified that she is hip. Tylenol 500 mg	[Nursing Progress Note] was called to the hallway by CNA (certified nursing Mresident was observed front of her wheelchair with about1:00 PMresident feeling pain now on her left (milligrams) po (by mouth) order received for x-ray of left				
	pain post fall." 06/23/22 [Physician F " Transferred from be mechanical lift] but si WNL (within normal adduction Xray of back pain on exam. post fall, LT (left) low (three-times-a-day), (milligrams) BID (two X-ray of lower back."	-times-a-day) for 10 days.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
						С
		095034	B. WING _			11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	ANOR		STREET ADDRESS, CITY, STATE, ZIF 725 BUCHANAN ST., NE WASHINGTON, DC 20017	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE
F 689	documented, "Verteb	ral bodies are normal o-moderate degenerative	F6	589		
	Review of the facility's the following:	s investigative notes showed				
	assigned certified nur "We were transferring her wheelchair. While	tness Statement Form] from sing assistant, documented, g the incident [resident] in e we were adjusting the padable. She started sliding, so e floor in front of her				
	approximately 1:00 F Assistant) stated, "St resident in her wheeld (used with mechanica resident properly, she slide forward. When s	interview on 11/10/22 at M, Employee #7 (Activity aff was trying to put the chair. Because the blue sling al lift) was not under the e (Resident #4) started to she started sliding forward, I members assist her down to er wheelchair."				
	I =	ailed to ensure Resident #5 h led to a fall without injury				
	07/15/20 with multiple	nitted to the facility on e diagnoses including eakness, and need for onal care.				
		of Columbia's Intake 00011009 documented, "				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	COV	
		095034	B. WING			C 11/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL M	ANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	[At 8:00 AMReside lying on the floor beswith both of her legs oriented to name and out of the bed to the headAt 9:30 AM redifficult to arousetr name]" An observation was 11/10/22 revealed Ron her back and the (from the floor). The 45-degree angle, an position. The resider of the observation. E Practical Nurse) was employee lowered the fall risk and it's not set that high. The staff relevated when she was the following: Review of the reside the following: Review of the reside the following: Review of the reside the following: O9/20/22 [Quarterly documented, Under revealed multiple into bed in lowest position of the reside under Section E (Becoded for rejection of the rejection of the reside under Section E (Becoded for rejection of the rejection of the rejection of the rejection of the reside under Section E (Becoded for rejection of the reje	ent #5's name was observed ide her bed on her right side stretched outalert, diplacereported she rolled floor and refused hitting her esident noted lethargic and ransferred to [local hospital's conducted at 10:30 AM on esident #5 was lying in bed, bed was in high position head of bed elevated at a diplace quarter side rails in up in the was not eating at the time imployee #13 (LPN/Licensed is called to the bedside. The ine bed and stated, "She is a lafe to leave her bed elevated in any have left the bed was eating." In this medical record showed in the care plan greventions including place in while in bed"	F 6	89		

NAME OF PROVIDER OR SUPPLIER ASCENSION LIVING CARROLL MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPLETON DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 43 requiring extensive assistance from two or more staff members for bed mobility. Under Section J (Health Condition) the resident was coded for have one fall since admission. Under Section O (Special Treatment, Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded for using physical restraints or alarms. O9/27/2022 [Hendrix II Fall Risk] documented that the resident was a high Risk for falls. PREFIX TAGE TA		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
ASCENSION LIVING CARROLL MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREETX REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 43 requiring extensive assistance from two or more staff members for bed mobility. Under Section J (Health Condition) the resident was coded for have one fall since admission. Under Section O (Special Treatment, Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded for using physical restraints or alarms. 09/27/2022 [Hendrix II Fall Risk] documented that the resident has a score of "11" indicating that the							С
ASCENSION LIVING CARROLL MANOR T25 BUCHANAN ST., NE WASHINGTON, DC 20017			095034	B. WING_			11/16/2022
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 43 requiring extensive assistance from two or more staff members for bed mobility. Under Section J (Health Condition) the resident was coded for have one fall since admission. Under Section O (Special Treatment, Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded for using physical restraints or alarms. 09/27/2022 [Hendrix II Fall Risk] documented that the resident has a score of "11" indicating that the			ANOR		725 BUCHANAN ST., NE		
requiring extensive assistance from two or more staff members for bed mobility. Under Section J (Health Condition) the resident was coded for have one fall since admission. Under Section O (Special Treatment, Procedures, and Programs) the resident was coded for receiving occupational therapy services, and Under Section P (Restraints and Alarms) the resident was not coded for using physical restraints or alarms. O9/27/2022 [Hendrix II Fall Risk] documented that the resident has a score of "11" indicating that the	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	COMPLETION
09/30/22 at 11:08 AM [Nursing Progress Note] documented, "At 8:00 AM[Resident #5] was observed lying on the floor beside her bed on her right side with both of her legs stretched outalert, oriented to name and place reported she rolled out of the bed to the floor and refused hitting her head. Denies pain or discomfort. Resident bed in low positionassisted from the floor by 3 staff to bed via full body mechanical lift denies dizziness no apparent injury noted/s (vital signs) 117774 (blood pressure), 78 (pulse), 20 (respirations), 97.5 (temperature) At 9:30 AM resident noted lethargic and difficult to arouse transferred to [local hospital's name]. 09/30/22 at 8:08 PM [Nursing Progress Note] documented, "writer placed call to [local hospital's name] nurse stated [Resident #5] was admitted" 09/30/22 [hospital discharge summary] documented, "Active problems principal urinary tract infection ED (emergency department) course UA (urinary analysis) consistent with	F 689	requiring extensive a staff members for be (Health Condition) th have one fall since as (Special Treatment, If the resident was code therapy services, and (Restraints and Alarm coded for using phys 09/27/2022 [Hendrix the resident has a sc resident was a high If 09/30/22 at 11:08 AM documented, "At 8:00 observed lying on the right side with both oalert, oriented to na she rolled out of the bhitting her head. Den Resident bed in low p floor by 3 staff to bed denies dizziness /s (vital signs) 117 (pulse), 20 (respiration At 9:30 AM resident narouse transferred 09/30/22 at 8:08 PM documented, "writer prame] nurse stated"	ssistance from two or more d mobility. Under Section J e resident was coded for dmission. Under Section O Procedures, and Programs) ed for receiving occupational d Under Section P ins) the resident was not ical restraints or alarms. II Fall Risk] documented that ore of "11" indicating that the Risk for falls. If [Nursing Progress Note] O AM[Resident #5] was a floor beside her bed on her of her legs stretched out ime and place reported bed to the floor and refused ies pain or discomfort. Ositionassisted from the via full body mechanical lift in no apparent injury noted (774 (blood pressure), 78 ons), 97.5 (temperature) in the control of the local hospital's name]. [Nursing Progress Note] Diaced call to [local hospital's laced call to [local hospital's laced call to [local hospital's laced scharge summary] problems principal urinary emergency department)	Fé	89		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		SURVEY PLETED
			A. BUILDI	NG		
		095034	B. WING_		11	C /16/2022
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		110/2022
				725 BUCHANAN ST., NE		
ASCENSIO	ON LIVING CARROLL MA	ANOR		WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	acute intracranial hem UTI confirmed in a complete course of (c) Other medical issues During a face-to-face 12:10 PM, Employee resident's assigned n stated, "The resident herself in the bed, and the left side of her be position. When ask w up? The employee sa	ction), CT of the head no norrhageHospital course- urine culture patient will oral) antibiotics X 2 days are stable at this time" Interview on 11/10/22 at #13 (LPN), who was the urse on the day of the fall was trying to reposition d she rolled onto the floor on d. The bed was in low are the resident's side rail aid, "The side rail was not lit was up against the wall. I	F	689		
F 812 SS=D	CFR(s): 483.60(i)(1)(§483.60(i) Food safety The facility must - §483.60(i)(1) - Procurapproved or consider state or local authorit (i) This may include f from local producers, and local laws or regulation of the consider (ii) This provision does facilities from using p gardens, subject to consider growing and fool	ore/Prepare/Serve-Sanitary 2) y requirements. re food from sources ed satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable	F	312		

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COMF	PLETED
		095034	B. WING_				C /16/2022
	ROVIDER OR SUPPLIER			72	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on an observa record review, the fact food in accordance w for food service safety insect observed craw was stored. The findings included On 10/26/22 at appro observation of the fact residents, staff, and the crawling on the perim foods including salad cheese was stored. A Employee #10 (Cash insect, she used a pa insect and wiped off the with a Oxivir TB wipe on proprietary hydrog cleaning performance non-food contact so https://www.diverseyte TbOneStepDisinfecta pes6x7160ea12count Review of Pest Contr	prepare, distribute and ince with professional rvice safety. Tis not met as evidenced ation, staff interviews and sility's staff failed to store ith professional standards as evidence by a crawling ling on ice chest where food the public revealed a eter of the ice chest where s, sandwiches, muffins and after the surveyor made sier) aware of the crawling per towel to kill the crawling per towel to kill the crawling per perimeter of the ice chest (disinfectant cleaner based en peroxide effective e. Disinfects in 60 seconds anitizer).	F	812	I.Corrective action for residents to have been affected by the definanctice. No residents were affected. Pest services was contacted and the can was treated and sanitized on 10/26/II.How will the facility identify oresidents having the potential traffected by the same definanctice? The Chef made rounds in the canter and no additional pest sightings were observed on 10/26/2022. III.The measures the facility will alternate that the problem wire corrected and will not recur. The Chef or designee re-educated the kitchen staff on process for contact pest services; food safety and clear procedures. Pest Services will controus make weekly visits. The Chef or Designee will randomly observe measure that food is served in a sanitary manner. Finding from the review will be corrected by the Unit Manager or designee immediately. IV.Quality Assurance Plans to monitor facility compliance to measure that corrections are achieved permanent.	teen (2022 ther o be icient en ere I take er to II be the ing inue eal onths it	1/26/23 1/26/23
	During a face-to-face	interview on 10/26/22 at					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
						С
		095034	B. WING		11/	/16/2022
	ROVIDER OR SUPPLIER DN LIVING CARROLL MA	NOR		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	12:05 PM, Employee should not have happ	#11 (Chef) stated that ened and he discarded the st and instructed staff to	F 812	F812 (continued) Monthly review of completed audi results and trends will be complete the Chef or designee and reported t facility's QAPI Committee for the months and then re-evaluated to determine if further monitoring is indicated V. Completion: 1/26/2023	d by o the	1/26/23
F 842 SS=D	3:58 PM, Employee # Director) stated that the pest control maintenanceded. The employer company had been of (10/26/22) to treat the	ontact and will be in today e cafeteria. lentifiable Information	F 842			
	(i) A facility may not re resident-identifiable t (ii) The facility may re resident-identifiable t accordance with a co- agrees not to use or except to the extent t to do so.	elease information that is o an agent only in ntract under which the agent disclose the information he facility itself is permitted				
		rdance with accepted ds and practices, the facility al records on each resident ented; e; and				

FORM APPROVED OMB NO. 0938-0391

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION G	COMPLETED	
					С	
		095034	B. WING		11/16/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASCENSIO	N LIVING CARROLL MA	ANOR		725 BUCHANAN ST., NE		
				WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 842	(ii) Required by Law;(iii) For treatment, pay	release is- or their resident permitted by applicable law;	F 84	I.Corrective action for residents to have been affected by the del practice. A) Resident #2 was discharged on 6-4-2022		
	with 45 CFR 164.506; (iv) For public health a neglect, or domestic vactivities, judicial and law enforcement purp purposes, research p medical examiners, for a serious threat to health and in compliance			B) Resident #7's Hendrich II Fall was completed on 12/1/2022. II.How will the facility identify oresidents having the potential to affected by the same deficient practice? Current residents with skin condition will be assessed by the licensed number on or before 1/26/2023. The license nurse will review the current residents.	ther be 1/26/23 ons arse ed	
	record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The medical properties of the period of time.	records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches e law. dical record must contain- on to identify the resident;		Hendrich II Fall Risk assessments before 1/26/2023 for completion. III.The measures the facility will or systems the facility will alter tensure that the problem will be corrected and will not recur. The staff education nurse or design educated the current licensed nurse skin identification, evaluation monitoring and the completion of Hendrich Fall Risk assess following a fall. Resident's fall	take 1/26/23 ee reses on and of the ssment ll risk	
FORM CMS-2567	(iii) The comprehension provided;	ve plan of care and services preadmission screening	l F	assessment will be reviewed completion by the Interdiscip	l for	

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and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and

Team during the daily clinical meeting for completion. Residents with new skin integrity issues will be reviewed by the Interdisciplinary Team during the daily clinical meeting for skin interventions

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING		C 11/16/2022	
NAME OF PROVIDER OR SUPPLIER ASCENSION LIVING CARROLL MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
PREFIX (EAC	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(X5) COMPLETION DATE

F 842 Continued From page 48 F842 (continued) F 842 (vi) Laboratory, radiology and other diagnostic and treatment. services reports as required under §483.50. This REQUIREMENT is not met as evidenced During weekly Resident at Risk meetings, the interdisciplinary Team Based on record reviews and staff interviews, for will review the clinical record of two (2) of 19 sampled residents, the facility's staff residents with new or changes in skin failed to ensure: Resident #2's medical record conditions, as well as residents with contained accurate information related to Stage new falls, to include their assessments, III pressure ulcer; And Resident #7's fall interventions and treatment. assessment dated 02/02/22 contained accurate The Unit Manager or designee will information. randomly review wound evaluation forms and Hendrich II Fall risk The finding included: assessments weekly of residents for 3 1.Resident #2 was admitted to the facility on months for accuracy. 01/28/17 with multiple diagnoses including **IV.Ouality** Assurance Plans 1/26/23 Cerebral Vascular Accident, Hemiplegia affecting monitor facility compliance to make Left Side, Generalized Weakness, and Diabetes sure that corrections are achieved and Mellitus. permanent. Monthly review of completed audit Review of the resident's medical record showed results and trends will be completed by the following: the Unit Manager or designee and reported to the facility's QAPI 04/27/22 at 12:28 PM [Skin Evaluation Form] documented, Type- Moisture Associated Skin Committee for the next 3 months and Damage ... Description-slough 40%, 60% pink then re-evaluated to determine if further granulating tissue, mild serous drainage, no monitoring is indicated. cellulitis ... **V.Completion:** 1/26/2023 04/27/22 at 12:31 PM [Nursing Progress Note] documented - Sacrum Stage 3 measured 4X2 centimeters (length), 4X8 centimeters (width), 40% slough, pink granulating 60%, no cellulitis, mild serous drainage. New order received for SalNa cream plus Santyl ointment two-times-a-day and as needed cover with Allevyn Life. [resident representative name] made aware ... STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 095034 B. WING 11/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE ASCENSION LIVING CARROLL MANOR WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

F 842	documented, Report- cm (centimeters), slo 60 %, mild serous dra Recommendations - \$	[Physician Consult Record] Sacrum Stage 3, 4.2 X 4.8 ugh 40 %, pink granulation ainage,) cellulites. Salna +Santyl bid d prn (as needed), cover	F8	42		
	documented, Type- M DamageDescription	[Skin Evaluation Form] loisture Associated Skin n-slough 40%, 60% pink ild serous drainage, no				
	approximately 10:30 A of Nursing) stated tha III sacral wound not a Evaluation Forms dat	interview on 11/08/22 at AM, Employee #2 (Director at the resident had a Stage a MASD wound. The Skin led 04/27/22 and 04/28/22 are resident had a MASD t.				
		dmitted to the facility on a diagnoses including history alking, and muscle				
	showed that staff wer	titled, "Falls," dated 01/22, e to complete Henrich II Fall sk evaluation)after every				
	Resident #7 sitting in common area of the u	AM, observation showed a reclined geri-chair in the unit listening to music. When ame? The resident just				
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3)	DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
095034		B. WING			C 11/16/2022	
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	IP CODE	,,
ASCENSIO	ACCENCION LIVING CARROLL MANOR			725 BUCHANAN ST., NE		
ASCENSION LIVING CARROLL MANOR				WASHINGTON, DC 20017		

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F 842	Continued From page	50	F 842			
	Review of the resident's medical record showed the following:					
	the resident was code recalling memories to long memories, curre staff names/faces, an Also, the resident was impaired with daily de Section H (Bladder at	dinimum Data Set] Section C (Cognitive Pattern) ed for having problem with a include after 5 minutes, nt season, location of room, ad being in a nursing home. Is coded for being severely ecision making. And Under and Bowel) the resident ys incontinent of urine and				
	"Resident noted to be housekeeping staff at lying on her left side	ogress Note] documented, e lying on floor by t 11:00 AM on 02/02/22 e with feet stretched out and oor bedside her bed"				
	02/02/22 [Hendrix II Fall Risk] documented that Resident #7 was oriented to person, place, and time. Also, the resident was continent of both bowel and bladder.					
	12:00 PM, Employee Nurse) stated that shoon the day of fall on 02					
	During a face-to-face interview on 11/08/22 at 12:30 PM, Employee #8 (Unit Manager) stated that the Hendrix II Fall Risk dated 02/02/22 was inaccurate.					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	CONSTRUCTION		PLETED	
		095034	B. WING		C 11/16/2022	

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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ASCENSION LIVING CARROLL MANOR			WASHINGTON, DC 20017		
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