PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION  1 - MAIN BUILDING 01		X3) DATE SURVEY COMPLETED	
		095034	B. WING		<del></del>	09/	09/2015	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CARROL	L MANOR NURSING &	REHAB			25 BUCHANAN ST., NE VASHINGTON, DC 20017			
(X4) ID PREFIX TAG			ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE	
K 000 K 015 SS=D	September 9, 2015 applicable provision Safety Code. The subservations of the building and include smoke detectors, finiterviews with the familiary surfaces of buildings walls, partitions, columnation of Classprinklered buildings A, Class B, or Classwithin rooms separated specific provisions of the separate surfaces of buildings walls, partitions, columnations of the separate surfaces of buildings walls, partitions, columnations of the separate surfaces of buildings walls, partitions, columnations of the separate surfaces of the separate sur	survey was conducted on to determine compliance with s of the 2000 edition of the Life urvey was conducted through interior and exterior of the d the installed sprinkler system, e panel, etc., and through		000	Carroll Manor Nursing and Rehabilitation Center makes its effort to operate in substantial compliance with both Federal a laws. Submissions of this plan of correction (POC) does not constadmission or agreement by any its officers, directors, employee agents, as the truth of the facts or validity of the conditions set the statement of deficiencies. To of correction (POC) is prepared executed because it is required State and Federal laws.  KO15 A	nd State f itute an party, s, or alleged forth on his plan and or		
	A. Based on observities were missing the The findings included It was observed at a 2:00pm on Septemble were missing in the 4th floor medication	approximately 10:00am through per 9, 2015, that ceiling tiles			<ol> <li>Missing ceiling tiles we replaced immediately.</li> <li>Visual observations we conducted of the rema ceiling tiles and were for be in place.</li> <li>Staff will be inserviced reporting protocol for missing/damaged ceiling.</li> <li>Weekly building observable conducted by the Dimediate mance or design findings will be present the quarterly QI/QA mediately.</li> </ol>	re ning und to on the g tiles. ations to rector of ee. ed at	9/9/2015 10/21/15 11/9/15 Ongoing	
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

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.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	(X3) DATE SURVEY				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING	G 01	COMPLE	:TED	
		095034	B. WING			09/09	/09/2015	
	ROVIDER OR SUPPLIER L MANOR NURSING 8	REHAB		STREET ADDRESS, CIT 725 BUCHANAN ST. WASHINGTON, DO	, NE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 015	Basement laundry r Creating a potential an event of an emer B. Based on observ were damaged. The findings include It was observed at a 2:00pm on Septemblile is damaged in the	hazard for staff and residents in regency.  ations, six (6) of 200 ceiling tiles  approximately 10:00am through our 9, 2015, the facility ceiling he following areas:  the exit sign for stair 2 access.	K 018	1. Dame replace 2. Visual conditions found found and dame 4. Weels be conditions found fou	aged ceiling tiles were aced immediately. In observations were lucted of the remaining tiles and none were d to be damaged. In will be inserviced on the protocol for mistaged ceiling tiles. It will be presented attenuance or designee. Its will be presented attenuance.	the sing ons to ottor of	9/9/15 9/9/15 11/9/15 Ongoing	
	5th floor behind the	nurse station					10/26/15	
	4th floor pantry abo 4 East nurse lounge	ve food warmer e located above escutcheon	To the state of th	repa 2. Visua cond	ng tiles and walls wer ired. al observations were lucted of ceiling tiles a s. No other penetrati	and	10/26/15	
	an event of an eme  C. Based on observobserved in three (3)	hazard for staff and residents in rgency. rations, penetrations were 8) of three ceiling/walls		were 3. Mair servi pene	e identified. Intenance staff will be iced on identifying wa etrations and proper	in-	11/9/15	
	The findings include	e: approximately 10:00am		be co Mair Resu	ng. kly building observationducted by the Direction on the Direction of th	ctor of at the	Ongoing	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCT			(X3) DATE SURVEY COMPLETED	
		095034	B. WING_				09/0	09/2015	
	ROVIDER OR SUPPLIER  L MANOR NURSING &	REHAB		72	5 BUCHAN	ESS, CITY, STATE, ZIP CODE AN ST., NE ON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG			PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 015	through 2:00pm on	September 9, 2015, the facility etrations in the following areas: torage area	K	015					
K 018 SS≑E	Doors protecting colorequired enclosures hazardous areas are those constructed of wood, or capable of minutes. Doors in sequired to resist the no impediment to the are provided with a door closed. Dutch	rridor openings in other than of vertical openings, exits, or e substantial doors, such as f 1¾ inch solid-bonded core resisting fire for at least 20 prinklered buildings are only e passage of smoke. There is e closing of the doors. Doors means suitable for keeping the doors meeting 19.3.6.3.6 are 3	K	018	K 018A				
	Roller latches are pi all health care facilit	rohibited by CMS regulations in ies.			2.	The identified door was repaired. All other doors were inspeand found to be in good operating condition.		10/26/15	
·		s not met as evidenced by:	5			Staff will be in-serviced or reporting protocol for doc repairs.  Quarterly observations to conducted by the Director Maintenance or designee.	ocol for door rvations to be the Director of	10/26/15 11/9/15	
	A. Based on observing the kitchen pantry	vation, one (1) of two (2) doors v were not operable				Results will be presented a quarterly QA/QI meeting.	at the	Ongoing	

PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION (X3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED				
		095034	B. WING		09/09/2015				
	ROVIDER OR SUPPLIER L MANOR NURSING 8	k REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
K 018	2:00pm on Septemble door hardware was potential hazard in a B. Based on observe not close and latch.  The findings include It was observed at a 2:00pm on Septemble door hardware was potential hazard in a septemble door hardware was septembl	e: approximately 10:00am through our 9, 2015, the kitchen pantry not operable. Creating a an event of an emergency.  ation, seven (7) of 200 doors did in the frame.  e: approximately 10:00am through our 9, 2015, the facility doors in did not close and latch in the	K 018	<ol> <li>K018B</li> <li>Identified doors were repaired.</li> <li>All other doors were inspected and observed to close proper.</li> <li>Staff will be in-serviced on the reporting protocol for door repairs.</li> <li>Quarterly observations will be conducted by the Director of Maintenance or designee.         Results will be presented at the quarterly QA/QI meeting.     </li> </ol>	ed 10/26/15 ne 11/9/15 oe Ongoing				
	4 West- soiled utility 3 South- activity roo 3 North- soiled utilit 3 East- Housekeep	om entry door y door		K018C  1. Magnetic hold device was repaire	d. 10/26/15				
	emergency.  C. Based on observ	hazard in an event of an vation, the magnetic hold-open f 10 doors was not working.		2. All other magnetic door devices we inspected and observed to operable.  3. Staff will be in-serviced on the reporting protocol for magnetic devices.	10/26/15				
	It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the laundry room door magnetic hold device on the 5th floor north wing was not working, posing a potential hazard.			repairs.  4. Weekly observations will be conducted by the Director of Maintenance or designee. Results wi be presented at the quarterly QI/QA meeting.	ł				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		095034	B. WING _			09	/09/2015
	ROVIDER OR SUPPLIER  L MANOR NURSING 8	REHAB		72	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE (ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 047 SS=E	Exit and directional accordance with ser illumination also ser system. 19.2.10.7  This STANDARD is Based on observat were obstructed.  The findings include It was observed at a	s not met as evidenced by:  ion, three (3) of 50 exit signs  e:  approximately 10:00am through oer 9, 2015, the facility exit signs the following areas:	K	047	<ol> <li>Identified item was avoid obstruction of immediately.</li> <li>Visual observations conducted and all elements were found to be frobstruction.</li> <li>Staff will be in-service keeping exit and evisigns free of obstruction conducted by the Dimensional Maintenance or designate will be president to the president will be president to the presid</li></ol>	f exit signs were xit signs ee from feed on vacuation ctions. as to be irector of signee. ented at the	9/9/15 9/9/15 11/9/15 Ongoing
	4 North wing exit ac	cess			K050		
		cess hazard for staff and residents an event of an emergency.	To the state of th		<ol> <li>Facility conducted faccording to regula</li> <li>Desired modification fire drill documentate will be updated as a</li> </ol>	tions. ons to the otion form	10/29/15 11/9/15
K 050 SS=F	Fire drills are held a varying conditions, The staff is familiar that drills are part o Responsibility for plassigned only to co qualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. It is is a mpetent persons who are the leadership. Where drills are to 9 PM and 6 AM a coded or be used instead of audible	K	)50	3. Staff will be in-serv completion of the completion of the confidence of the confi	iced on updated fire of form.  I be ch fire drill designee, ented at the	11/9/15 Ongoing

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		AIN BUILDING 01	COMPLETED		
		095034	B. WING_			09/	09/2015	
	ROVIDER OR SUPPLIER  L MANOR NURSING 8	k REHAB		725 B	T ADDRESS, CITY, STATE, ZIP CODE UCHANAN ST., NE HINGTON, DC 20017		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	<b>X</b>	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
K 050 K 051 SS=F	Based on observation proper documentation been performed quarter and review through 2:00pm on failed to show properite drills have been NFPA 101 LIFE SA A fire alarm system devices or equipme 72, National Fire Alwarning of fire in an of the complete fire alarm initiation, aut system operation, areas may be omitted.	ion, the facility failed to provide on that shows the fire drills have arterly or monthly.  at approximately 10:00am September 9, 2015, the facility or documentation that shows the performed quarterly or monthly.  FETY CODE STANDARD  with approved components, ent is installed according to NFPA arm Code, to provide effective my part of the building. Activation alarm system is by manual fire omatic detection or extinguishing Pull stations in patient sleeping ed provided that manual pull	K		1. The facility obtained a control the 2014 and 2015 and Alarm and Detection Synthesis Inspection Report from third-party inspector. Regulatory agency.  2. Third-party inspector has directed to send all inspector to Carroll Manco.  3. Inspection report(s) will maintained in the Main	ual Fire estem the eports e as been pection or.	10/30/15	
	stations are located Electronic or writter A reliable second s alarm systems are NFPA 72 and recor readily available. T	200 feet of nurse's stations. Pull in the path of egress. In records of tests are available, ource of power is provided. Fire maintained in accordance with rids of maintenance are kept There is remote annunciation of m to an approved central station.	000000		Department.  4. Quarterly observations by Director of Maintenance designee will be presente quarterly QA/QI meeting.	or d at the	Ongoing	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUC - MAIN BL	TION JILDING 01	(X3) DATE SURVEY COMPLETED	
		095034	B. WING _				09/0	9/2015
	ROVIDER OR SUPPLIER  L MANOR NURSING 8	к РЕНАВ		72	5 BUCHAN	ESS, CITY, STATE, ZIP CODE IAN ST., NE ON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	<		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 051	Continued From pag	ge 6	Κű	)51				
	This STANDARD is	s not met as evidenced by:			K062A			
	documentation that been maintain in ac authority having juri. The findings include Record and review through 2:00pm on failed to provide documents alarm system has be				2.	The facility obtained a copthe 2014 and 2015 quarte automatic fire sprinkler sy inspection report from the third-party inspector. Repowill be forwarded to the regulatory agency. Third-party inspector has directed to send the inspector (s) to Carroll Manor Inspection report(s) will be maintained in the mainter	rly stem e orts oeen ection	10/30/15 10/26/15
K 062 SS=F	Required automatic continuously mainta condition and are in	FETY CODE STANDARD sprinkler systems are ined in reliable operating spected and tested periodically. A 13, NFPA 25, 9.7.5	Κ¢	062	4.	department. Quarterly observations by th Director of Maintenance or designee will be presented a quarterly QA/QI meeting.		Ongoing
	A. Based on obser provide documenta system has been m	s not met as evidenced by:  vation, the facility failed to  ion that shows the sprinkler  aintained in accordance with  ity having jurisdiction.		Volenter :				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION  1 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		095034	B. WING		· 	09/	09/2015
	ROVIDER OR SUPPLIER  L MANOR NURSING 8	REHAB		72	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
K 062	through 2:00pm on failed to provide doc sprinkler system has accordance with NF jurisdiction.  B. Based on observineads one (1) of 25  The findings included it was observed at a 2:00pm on Septemble head in the pantry of repositioning. Creat event of an emergent	at approximately 10:00am September 9, 2015, the facility cumentation that shows the s been maintained in PA or the authority having ation, one (1) of 250 sprinkler oneeded repositioning.  Exproximately 10:00am through per 9, 2015, the facility sprinkler on the 5th floor needed ing a potential hazard in an ancy.  ation, twenty-one (21) of 250	K	062	Identified sprinkler head was instand repositioned.  1. Visual observations were conducted of the remains sprinkler heads. And all found to be properly positioned.  2. Maintenance staff will be serviced on visual obsetof sprinkler heads to enterproper positioning.  3. Monthly inspections to conducted by the Direct Maintenance or designed findings will be presented quarterly QA/ QI meeting K062C	e ning were e in- vation sure oe or of ee. All	10/28/15 10/28/15 11/9/15 Ongoing
	The findings include  It was observed at a 2:00pm on Septemb	e: approximately 10:00am through oer 9, 2015, the facility sprinkler og areas were dust laden:			1. Identified sprinkler heads replaced by a third party v. 2. All remaining sprinkler her visually observed and four free of dust. 3. Maintenance staff will be serviced on observing the heads to ensure they are v. 4. Monthly observations to be conducted by the Director Maintenance. All findings presented at the quarte QA/QI meeting.	endor.  ads were ad to be  n- sprinkler dust free. e of will be	11/5/15 11/9/15 11/9/15 Ongoing

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCT	TION JILDING 01	(X3) DATE COMPI	
		095034	B. WING			<u> </u>	09/0	9/2015
	ROVIDER OR SUPPLIER  L MANOR NURSING 8	ι REHAB		72	5 BUCHAN	ESS, CITY, STATE, ZIP CODE IAN ST., NE ON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 062	Continued From page Room 449 4 West day room 3rd floor kitchen 3rd floor soiled liner 3 North soiled liner 1st floor dinning are Gift shop 1st floor lobby waitin Basement kitchen a Basement houseker Maintenance shop Cart wash area Resident storage ro 2nd floor living room 2nd floor dining room Room 102	ge 8  chute room a  ng area and dining area eping  om	K	062	2.	The identified missing escutcheon plates were replaced. Remaining escutcheon plates were observed by the maintenance staff and fout be in place. Maintenance staff will be serviced on the reporting protocol for missing escut plates. Weekly observations to be conducted by the Director Maintenance. All findings be presented at the quart QA/QI meeting.	ind to in- cheon e of will	10/29/15 10/29/15 11/9/15 Ongoing
	emergency.	hazard in an event of an ration, three (3) of 250 were missing.						

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 095034 B. WING 09/09/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 725 BUCHANAN ST., NE **CARROLL MANOR NURSING & REHAB** WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K062E K 062 Continued From page 9 K 062 The findings include: Identified corroded escutcheon plate was replaced. 10/26/15 It was observed at approximately 10:00am through Remaining escutcheon plates were 2:00pm on September 9, 2015, the facility observed and were found to be 10/30/15 escutcheon plates were missing in the following free of corrosion. areas: Maintenance staff will be inserviced on the reporting protocol 5th floor pantry 11/9/15 for corroded escutcheon plates. 5th floor center core day room Weekly observations to be conducted by the Director of Room 114 Maintenance or designee. All Ongoing findings will be presented at the Posing a potential hazard in an event of an quarterly QA/QI meeting. emergency. K062F E. Based on observation, two (2) of 250 escutcheon Identified standpipe caps were plates were corroded in the following areas: 9/9/15 loosened immediately. Pool area 10/29/15 Maintenance staff inspected and adjusted each stairwell standpipe 1st floor activity room cap as necessary. Maintenance staff will be in-11/9/15 F. Based on observation, three (3) of 14 standpipe serviced on standpipe protocols. caps were tight. Quarterly observations by the Director of Maintenance or The findings include: Ongoing designee will be presented at the It was observed at approximately 10:00am through quarterly QA/QI meeting. 2:00pm on September 9, 2015, the facility standpipe caps were too tight in the following areas: Penthouse stair 2 roof access 4th floor stair 2 level 4 3rd floor stair 2 level 3

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			DATE SURVEY COMPLETED	
		095034	B. WING		09/	09/2015	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<del>*</del>		
CARROL	L MANOR NURSING 8	k REHAB	ľ	725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID	SHMMARYST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ORRECTION (VS)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 062	Continued From page	ge 10	K 062	2			
	emergency.	hazard in an event of an		K073			
K 073	NFPA 101 LIFE SA	FETY CODE STANDARD	K 07	3			
SS=D	No furnishings or de character are used.	ecorations of highly flammable 19.7.5.2, 19.7.5.3, 19.7.5.4		1. All highly flammable decora observed hanging from the ceiling the 5 <sup>th</sup> floor were immediately removed.	on	9/9/15	
	This STANDARD is	s not met as evidenced by:		2. All units were inspected to	,	9/9/15	
		ion, decorations were observed eiling in three (3) of 3 e 5th floor.		ensure compliance and no highly flammable decorations were obse 3. Staff will be in serviced on	use of	·	
	The findings include	<b>9</b> :		proper decorations within the faci 4. Monthly rounds and audit	ts will	11/9/15	
	2:00pm on Septemb	approximately 10:00am through ber 9, 2015, the facility has g from the ceiling in the following		be conducted by the Activity Man or designee to ensure compliance regulations. All findings will be rep to the quarterly QI/QA meeting.	with	Ongoing	
	5th west exit corrido	or					
	5th floor stair 3 exit	door					
	5th floor 507 and 50	08			ļ		
	Creating a potential emergency.	l hazard in an event of an					
K 130 SS≂E	NFPA 101 MISCEL	LANEOUS	K 13	ס			
33∞€	OTHER LSC DEFIC	CIENCY NOT ON 2786					
	This STANDARD is	s not met as evidenced by:					

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 01 - MAIN BUILDING 01 095034 B. WING 09/09/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE **CARROLL MANOR NURSING & REHAB** WASHINGTON, DC 20017 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K130A K 130 | Continued From page 11 K 130 A. Based on observation, six (6) of six surge Identified surge protectors protectors observed were not mounted. were mounted. 9/9/15 2. Maintenance staff will conduct The findings include: 11/9/15 observations to ensure that all It was observed at approximately 10:00am through surge protectors are properly 2:00pm on September 9, 2015, surge protectors mounted. were not mounted in the following areas: 11/9/15 Staff will be in-serviced on proper surge protector 5th floor nurses main office mounting protocol. 4th South activity room Weekly observations will be conducted by department 4th floor charting room Ongoing heads or designees. Results will be presented at the quarterly 3 South social worker office QA/QI meeting. 3rd floor manager office 3rd floor charted area K130B Posing as a potential hazard in an event of an 1. The identified dryer was emergency. 9/9/15 cleaned immediately. B. Based on observation, one (1) of 1 laundry room 2. All facility dryers were observed 9/9/15 dryer had dust build up. and found to be dust free. 11/9/15 3. Staff will be in-serviced on The findings include: identifying dust build up and It was observed at approximately 10:00am through cleaning procedures. 2:00pm on September 9, 2015, the facility dryer has 4. Monthly observations will be Ongoing dust build up behind it. Creating a potential hazard conducted by the Director of in an event of an emergency. Maintenance or designee. C. Based on observation, the facility has storage Results will be presented at the greater than 18 inches from the sprinkler head in quarterly QA/QI meeting. two (2) of 2 locations observed.

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 095034 B. WING 09/09/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE **CARROLL MANOR NURSING & REHAB** WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K130C Continued From page 12 K 130 9/9/15 The findings include: Identified storage was placed 18" below the sprinkler head. It was observed at approximately 10:00am through 2. Observations will be conducted 2:00pm on September 9, 2015, the facility has 11/5/15 of storage areas and contents storage greater than 18 inches from the sprinkler head in the following areas: were found to be 18" below the sprinkler heads. 5 west corridor Staff will be in-serviced on regulatory guidelines for 3 west storage room 11/9/15 storage. Creating a potential hazard in an event of an Random observations to be emergency. conducted by the Director of Ongoing Maintenance or designee. All D. Based on observation, the facility has storage less than 6 inches off the floor in eight (8) of 8 findings will be presented at the locations observed. quarterly QA/QI meeting. K130D The findings include: 1. Identified boxes were removed It was observed at approximately 10:00am through immediately and stored 2:00pm on September 9, 2015, the facility has 9/9/15 storage less than 6 inches off the floor in the appropriately. following areas: Observations will be conducted to ensure all boxes are properly 3rd floor social worker office 11/5/15 stored off of the floor. 5 West corridor Staff will be in-serviced on regulatory guidelines for 11/9/15 5 North corridor storage. 4. Random observations to be Laundry room storage room 2 conducted by the Director of Ongoing Laundry room storage room 1 Maintenance or designee. All findings will be presented at the Kitchen office area quarterly QA/QI meeting. Business office

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 095034 B. WING 09/09/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE CARROLL MANOR NURSING & REHAB WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K130E K 130 Continued From page 13 K 130 9/9/15 Staff education room Identified tank was removed. No other tanks were found to 2 9/9/15 Creating a potential hazard in an event of an be improperly stored. emergency. 11/9/15 3. Staff will be in-serviced on the E. Based on observation, one (1) of 1 oxygen tank proper storage of tanks. was stored unsecured. Monthly random observations Ongoing to be conducted by the shift The findings include: managers or designees. All It was observed at approximately 10:00am through findings will be presented at the 2:00pm on September 9, 2015, one (1) of 1 oxygen quarterly QA/QI meeting. tank in the storage room was unsecured. Creating a potential hazard in an event of an emergency. 2000 Life Safety Code-LSC 8.3.6.2 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. K130F Openings occurring at points where floors or smoke 9/9/15 Identified floor penetration was barriers meet the outside walls, other smoke sealed immediately. barriers, or fire barriers of a building shall meet one 9/9/15 2. No other floor penetrations of the following conditions: were identified. (1) It shall be filled with a material that is capable of Maintenance staff will be inmaintaining the smoke resistance of the floor or 11/9/15 serviced on identifying floor smoke barrier. penetrations and proper (2) It shall be protected by an approved device that sealing. Ongoing is designed for the specific purpose. Random monthly observations will be conducted by the F. Based on observation, one (1) of 1 penetration Director of Maintenance or was observed in the floor surface. designee. Results will be The findings include: presented at the quarterly QA/QI meeting. It was observed at approximately 10:00am through 2:00pm on September 9, 2015, that the

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	penthouse had a pe hand corner opposi mechanical room.	netration in the floor on the left te the roof access door storage						
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