


Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 000	<p>Initial Comments</p> <p>The Annual Licensure Survey was conducted at Carroll Manor Nursing and Rehabilitation Facility September 6, 2016 through September 9, 2016. Survey activities consisted of a review of 28 sampled residents. The following deficiencies are based on observation, record review and staff interviews.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p>Abbreviations</p> <p>AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters C. Diff - Clostridium Difficile CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal</p> <p>Regulations</p> <p>D/C Discontinue DI - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Infectious Disease ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record</p>	L 000	<p>Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and state laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, it's officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and/or executed because it is required by the State and Federal laws</p>	
-------	--	-------	--	--

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/11/16
--	------------------------	-----------------------

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	<p>Continued From page 1</p> <p>MD- Medical Doctor MDS - Minimum Data Set mcg/act - micrograms/actuation Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN - midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC - Special Care Center Sol- Solution TAR - Treatment Administration Record</p>	L 000		
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:</p>	L 052		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 2</p> <p>(c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>(j) Prompt response to an activated call bell or call for help.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on an isolated observation of one (1) of 28 Stage 2 sampled residents it was determined that facility staff failed to maintain/enhance dignity for one (1) resident as evidenced by a staff member</p>	L 052	<p>3211.1 Nursing Facilities</p> <p>1. Resident #266's dignity was maintain/enhanced immediately as staff sat down to provide feeding assistance.</p> <p>2. There was no other observation made of staff standing to feed residents.</p> <p>3. Staff have been in-service on maintaining/enhancing resident dignity during dining by sitting to provide feeding assistance at meal times.</p> <p>4. Random observations will be done by nurse manager or designee to ensure no staff is standing to feed residents. Results will be submitted to DON or designee for review and presentation at quarterly QA/QI meeting.</p>	<p>9/6/16</p> <p>10/10/16</p> <p>10/10/16</p> <p>ongoing</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	<p>Continued From page 3</p> <p>standing while feeding the resident. Resident #266.</p> <p>The findings include:</p> <p>During the initial tour conducted on September 6, 2016 at approximately 9:00 AM, Employee #12 was observed standing at a dining table next to Resident #266 feeding the resident. At this time Employee #13 came over to the employee and gestured for him/her to take a seat. Employee #12 reached for a chair to sit down.</p> <p>A face-to-face interview was conducted on September 8, 2016 at approximately 1:00 PM with Employee #12. The employee stated that he/she was standing because the resident had spilled something and [he/she] had just wiped it up.</p> <p>Facility staff failed to maintain/enhance Resident #266's dignity during dining.</p>	L 052		
L 056	<p>3211.5 Nursing Facilities</p> <p>Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.</p>	L 056		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	<p>Continued From page 4</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that the facility failed to meet 0.6 [six tenth] hour for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on six of the fourteen days and four and one tenth (4.1) hours of direct nursing care per resident per day for five of fourteen days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.</p> <p>The findings include:</p> <p>A review of Nurse Staffing was conducted on September 9, 2016 at approximately 10:50AM. fourteen days were reviewed; August 24, 2016 through September 6, 2016.</p> <p>According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.</p> <p>The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] for fourteen days reviewed as</p>	L 056	<p>3211.5 Nursing Facilities</p> <p>1.RN coverage for the day of the review met the minimum daily coverage of direct nursing care per resident per day.</p> <p>2.The facility continues to recruit qualified RN staff to meet minimum staffing requirement</p> <p>3. Staffing coordinator, managers and supervisors have been in-service on minimum staffing ratio.</p> <p>4.Staffing levels will be monitored daily. DON and administrator will be notified when staffing is below the minimum required.</p>	<p>9/9/16</p> <p>ongoing</p> <p>10/10/16</p> <p>on-going</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	<p>Continued From page 5 outlined below.</p> <p>On Saturday, August 27, 2016 it was determined that the facility provided RN coverage at a rate of 0.5 hours of direct nursing care per resident day.</p> <p>On Sunday, August 28, 2016 it was determined that the facility provided RN coverage at a rate of 0.5 hours of direct nursing care per resident day.</p> <p>On Thursday, September 1, 2016 it was determined that the facility provided RN coverage at a rate of 0.5 hours of direct nursing care per resident day.</p> <p>On Saturday, September 3, 2016 it was determined that the facility provided RN coverage at a rate of 0.4 hours of direct nursing care per resident day.</p> <p>On Sunday, September 4, 2016 it was determined that the facility provided RN coverage at a rate of 0.5 hours of direct nursing care per resident day.</p> <p>On Monday, September 5, 2016 it was determined that the facility provided RN coverage at a rate of 0.3 hours of direct nursing care per resident day.</p> <p>The facility failed to meet four and one tenth (4.1) hours of direct nursing care per resident per day</p>	L 056	<p>3211.5 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Facility staffing for the day of review met minimum daily coverage of direct nursing care per resident per day. 2. The facility continues its effort to recruit qualified staff to meet minimum staffing requirement 3. Staffing coordinator, managers and supervisors have been in-service on minimum staffing ratio. 4. Staffing levels will be mentored daily. DON and administrator will be notified when staffing is below the minimum required 	<p>9/9/16</p> <p>ongoing</p> <p>10/10/16</p> <p>on-going</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	<p>Continued From page 6</p> <p>for five of fourteen days reviewed as outlined below.</p> <p>On Saturday, August 27, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.0 hours.</p> <p>On Sunday August 28, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.9 hours.</p> <p>On Saturday, September 3, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.9 hours.</p> <p>On Sunday, September 4, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.9 hours.</p> <p>On Monday, September 5, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.7 hours.</p> <p>The review was done in the presence of Employee #10. He/she acknowledged the findings</p>	L 056		
L 091	<p>3217.6 Nursing Facilities</p> <p>The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control,</p>	L 091		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 091	<p>Continued From page 7</p> <p>laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on a review of the facility ' s Infection Control Program and staff interview, it was determined that the facility failed to ensure the implementation of an Infection Control Program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility.</p> <p>The findings include:</p> <p>A review of the facility ' s infection control surveillance documentation, " Infection Control Log " for the period of October 2015 to September 2016 revealed that the documents lacked evidence of a methodology to consistently collect, analyze, interpret and disseminate data related to infections in the facility. The facility ' s documentation on the " Infection Control Log " was inconsistent for the following items: organism type, culture date, treatment start date, and resolved date.</p> <p>In response to a request for copies of the facility's line listing (list of infections) for the period of October 2015 through September 2016 the Infection Preventionist (IP) presented an incomplete listing of infections for the month of September, 2016. The listing identified two (2) residents who were treated for UTI (Urinary Tract Infections). Seven (7) other residents were identified on the form but the form lacked consistent documentation of the onset of symptoms and/or treatment; whether the infections were acquired within the facility or from the community or whether the infections were resolved and/or the date of resolution.</p>	L 091	<p>3217.6 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Facility infection control program has been revised to include a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. 2. No residents were identified with untreated infections or episode of infectious outbreak in the facility. 3. Infection control nurse has been in-serviced on the importance of maintaining consistent and systematic collection, analysis and interpretation of data to identify infections and infection risk in the facility. 4. Monthly infection control logs will be given to QI director and DON or designee for review and presentation at quarterly QA/QI meeting 	<p>9/9/16</p> <p>10/10/16</p> <p>10/10/16</p> <p>ongoing</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 091	<p>Continued From page 8</p> <p>There was no evidence that the facility's Infection Control Program included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility.</p> <p>The IP (Infection Preventionist) was queried regarding the surveillance logs for October 2015 through September 2016. He/she responded " This is all I have. " Further stated, [he/she]was in the process of implementing a new surveillance sheet that will have consistent tracking and treading such as: "Type of Infections, Organism, Symptoms, Treatments (Antibiotics), and if Infection was facility or community acquired; also resolution dates.</p> <p>A face-to-face interview was conducted with Employee's #1, #2 and the IP at approximately 3:00 PM on September 9, 2016. All acknowledged that the " Line Listings" of the facility 's infections were incomplete, lacked inclusion of all of the aforementioned information and did not accurately track the infections within the facility.</p>	L 091		
L 099	<p>3219.1 Nursing Facilities</p> <p>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:</p> <p>Based on observations made on September 8, 2016 at approximately 3:45 PM, it was determined that facility staff failed to store and prepare foods under sanitary conditions as</p>	L 099		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	<p>Continued From page 9</p> <p>evidenced by 5 of 20 fruit bowls of strawberries prepared to be served were observed stored in third floor pantry uncovered and two (2) of two (2) partially consumed bottles of water were observed on the counter of the third floor pantry.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Five (5) of 20 fruit bowls of strawberries stored in the third floor pantry were observed uncovered on a serving cart. Two (2) of two partially consumed bottles of water were observed on the counter of the third floor pantry. <p>These observations were made in the presence of Employee #8 who acknowledged the findings.</p>	L 099	<p>3219.1 Nursing Facilities 1</p> <ol style="list-style-type: none"> Five uncovered bowls of strawberries were discarded immediately. There were no other uncovered bowls of food items identified. Dietary staff have been in-service to ensure all food items are covered. Dietary manager or designee will conduct random inspection of food items to ensure all items are covered. Results will be presented at quarterly QA/QI meeting for review 	<p>9/8/16</p> <p>9/8/2016</p> <p>10/10/16</p> <p>on-going</p>
L 201	<p>3231.12 Nursing Facilities</p> <p>Each medical record shall include the following information:</p> <ol style="list-style-type: none"> The resident's name, age, sex, date of birth, race, marital status home address, telephone number, and religion; Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; Medicaid, Medicare and health insurance numbers; Social security and other entitlement numbers; 	L 201		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 201	<p>Continued From page 10</p> <p>(e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;</p> <p>(f)Date of discharge, and condition on discharge;</p> <p>(g)Hospital discharge summaries or a transfer form from the attending physician;</p> <p>(h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation;</p> <p>(i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease;</p> <p>(j)Current status of resident's condition;</p> <p>(k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition;</p> <p>(l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;</p> <p>(m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing</p>	L 201	<p>3219.1 Nursing Facilities</p> <p>2</p> <p>1. Partially consumed bottles of water were removed and discarded immediately.</p> <p>2.No other partially consumed bottles of water were observed on the counter of any other pantry.</p> <p>3.Dietary staff have been in-serviced Not to leave personal items in pantry.</p> <p>4. Dietary manager or designee will conduct random audits of pantries. Results will be presented at quarterly QA/QI Meeting for review.</p>	<p>9/8/16</p> <p>9/8/16</p> <p>10/10/16</p> <p>ongoing</p>

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

L 201	<p>Continued From page 11</p> <p>service;</p> <p>(n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services;</p> <p>(o)The plan of care;</p> <p>(p)Consent forms and advance directives; and</p> <p>(q)A current inventory of the resident's personal clothing, belongings and valuables.</p> <p>This Statute is not met as evidenced by:</p> <p>A. Based on record review and staff interview for one (1) of 28 Stage 2 sampled residents, it was determined that the facility failed to maintain quarterly inventory of personal clothing belongings and valuable in the medical record. Resident #106.</p> <p>The findings include:</p> <p>A review of the clinical record revealed Resident #106 was admitted to the facility on September 2, 2008. The personal property inventory form dated July 12, 2015 indicated the last date the resident's inventory was recorded in the medical record.</p> <p>There was no evidence the medical record included a quarterly inventory of the resident's personal clothing, belongings, and valuables.</p>	L 201	<p>3231.12 Nursing Facilities</p> <p>1. Inventory record for resident #106 was updated immediately.</p> <p>2. Inventory record for all other residents have been updated.</p> <p>3. Staff were in-service on updating inventory records quarterly.</p> <p>4. Monthly audits will be conducted by nurse manger or designee. Results will be submitted to DON or designee for presentation at quarterly QA/QI meeting.</p>	<p>9/8/16</p> <p>10/10/16</p> <p>10/10/16</p> <p>ongoing</p>
-------	--	-------	--	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 201	<p>Continued From page 12</p> <p>A face-to-face interview was conducted with Employee #2 and #3 on September 8, 2016 at approximately 1:00 PM regarding the aforementioned findings. After reviewing the clinical record, both acknowledged quarterly inventories were not conducted. The clinical record was reviewed on September 8, 2016.</p> <p>B. Based on record review and staff interview for one (1) of 28 Stage 2 sampled residents, it was determined that facility staff failed to ensure that the resident's clinical record was inclusive of Hospice documents. Resident #149.</p> <p>The findings include:</p> <p>A Physician 's Order dated August 10, 2016 -1740 [5:40] pm directed: "Initiate Hospice Care for End Stage Dementia".</p> <p>A review of the clinical record lacked evidence that Resident #149's "Initial Hospice Nursing Assessment" was included in the current clinical record.</p> <p>A face-to-face interview was conducted on September 8, 2016 with Employees #3. After review of the aforementioned the employee acknowledged the finding and had the document faxed to the facility.</p>	L 201	<p>3231.12 Nursing Facilities</p> <p>1.Hospice document was obtained immediately.</p> <p>2.No other hospice residents were identified who needed hospice documents.</p> <p>3.Staff have been in-serviced to ensure all hospice documents are in place for hospice residents.</p> <p>4.Monthly audits will be completed by hospice nurse and nurse manager. Results will be submitted to DON for review and presentation at quarterly QA/QI meeting.</p>	<p>9/8/16</p> <p>9/8/16</p> <p>10/10/16</p> <p>ongoing</p>