STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING ______ B. WING ______	09/13/2013

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F 000	INITIAL COMMENTS A recertification Quality Indicator Survey was conducted on September 9 through September 13, 2013. The deficiencies are based on observation, record review and interviews for 33 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube Gastrostomy tube EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) NP - Nurse Practitioner BID - Twice- a-day HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility EMS - Emergency Medical Services (911) DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner BID - Twice- a-day B/P - Blood Pressure L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	F 000	Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this plan of correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents, as the truth of the facts alleged or validity of the conditions set forth on the statement of deficiencies. This plan of Correction (POC) is prepared and or executed because it is required by the State and Federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE (X6) DATE 10/11/13

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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F 000	Continued From page 1 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter POS - physician ' s order sheet Prn - As needed TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia mm/Hg - millimeters of mercury PICC- Peripheral Intravenous Central Catheter APRN- Advanced Practice Nurse RN- Registered Nurse	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		

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F 272	Continued From page 2 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 33 sampled residents, it was determined that facility staff failed to accurately code the admission Minimum Data Set [MDS] under Section H, Bowel and Bladder for one (1) resident. Resident #330. The findings include: A review of Resident #330 ' s Admission MDS with an Assessment Reference Date (ARD) of March 21, 2013 revealed that under Section H [Bladder and Bowel] H0300 Resident #330 was coded as " 0 " indicative that the resident was " always continent. "	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS 1. MDS assessment for resident #330 for section H was corrected. 2. No other residents were identified who needed corrections for MDS section H. 3. MDS staff were in-serviced for proper coding of section H. 4. Random audits will be conducted by MDS coordinator. Results will be submitted to the DON or designee for presentation at the quarterly QI meeting.	9/12/13 9/16/13 10/4/13 Ongoing

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	095034	A. BUILDING ______ B. WING ______	483.35(i) FOOD 09/13/2013

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F 272	Continued From page 3 The "Bowel and Bladder Summary" sheet that the facility utilized for recording Resident #330 ' s bowel and bladder patterns was reviewed for the ARD period of March 15 through 21, 2013. It was determined that facility staff recorded thirteen (13) episodes of bowel/bladder incontinence during the seven (7) day period as follows: March 15, 2013-one (1) March 16, 2013-two (2) March 17, 2013-four (4) March 18, 2013 four (4) March 19, 2013 two (2) March 20, 2013 three (3) March 21, 2013 three (3) The Bowel and Bladder summary records lacked evidence that the resident demonstrated episodes of bowel or bladder continence. A face-to-face interview was conducted with Employee #15 on September 12, 2013 at approximately 3:15 PM. [He/she] acknowledged that the Comprehensive MDS was incorrectly coded with a zero (0) in Section H0300 of the MDS dated March 21, 2013. There was no evidence that the comprehensive MDS dated March 21, 2013 was accurately coded for bladder and bowel status. The record was reviewed on September 12, 2013.	F 272		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	483.35(i) Food Procure Store/Prepare/Serve - Sanitary	

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

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F 371	Continued From page 4 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on September 9, 2013 at approximately 9:00 AM and on September 12, 2013 at approximately 2:30 PM, it was determined that the facility failed to procure, serve, prepare and store food under sanitary conditions as evidenced by one (1) of one (1) ice scoop holder with a broken lid and with a piece of plastic debris inside the holder, five (5) of five (5) soiled muffin pans and 10 of 15 soiled and wet two-inch full hotel pans that were stored in the clean area, and a heavily soiled kitchen floor. The findings include: 1. The lid to one (1) of one (1) ice scoop holder was broken and a piece of plastic debris was found inside the holder. 2. Five (5) of five (5) muffin pans stored in the 'clean' area were soiled with food residue. 3. Five (5) of 15 two-inch hotel pans were stored wet and soiled on a shelf in the 'clean' area. 4. The entire kitchen floor was soiled and needed to be clean.	F 371	1. Ice scoop holder was replaced immediately. 2. No other broken ice scoop holder was identified. 3. Kitchen staff were in-serviced on reporting protocol for broken equipment. 4. Random audits will be conducted by kitchen management. Results will be presented at the quarterly QI meeting. 2. 1. 5 muffin pans were cleaned immediately. 2. No other soiled muffin pans were identified. 3. Kitchen staff were in-serviced on procedure for washing pans. 4. Audits will be conducted by kitchen manager or designee and results will be presented at the quarterly QI meeting.	9/9/13 9/9/13 10/10/13 Ongoing 9/12/13 9/12/13 10/4/13 Ongoing

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F 371	Continued From page 5 These observations were made in the presence of Employee #14 who acknowledged the findings.	F 371	3. 1. 5 2" hotel pans were cleaned and dried immediately.	9/12/13
			2. No other soiled or wet hotel pans were identified.	9/12/13
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	3. Kitchen staff were in-serviced on protocol for washing and drying pans.	10/4/13
			4. Audits will be conducted by kitchen manager or designee and results will be presented at the quarterly QI meeting.	Ongoing
			4. 1. Entire kitchen floor was cleaned immediately.	9/9/13
			2. No other soiled kitchen floor was identified.	9/9/13
			3. Kitchen staff were in-serviced on increased frequency for floor cleaning.	10/4/13
			4. Audits will be conducted by kitchen manager or designee and results will be presented at the quarterly QI meeting.	Ongoing

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F 441	Continued From page 6 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on an isolated observation of a sterile dressing treatment and staff interview , it was determined that facility staff failed to practice in a manner as to prevent the spread of infection as evidenced by the preparation of a sterile field and placement of dressing treatment materials on an unclean table. Resident #242. The findings include: During an observation of a " sterile " PICC Line [peripheral intravenous catheter] dressing change, it was determined that Employee #18 prepared a sterile field and placed dressing treatment materials on a table that was later determined to be unclean. On September 13, 2013 at 12:40 PM, Employee #18 was observed performing a PICC line dressing change. The employee stated that the technique utilized for the treatment was " sterile. " At the time of the observation, the sterile field including the treatment materials was observed previously prepared atop a bedside table proximal to Resident #242' s bed. After completing the dressing change, Employee #18 removed the treatment materials from the table and bagged them for disposal. Fragments of food [e.g. crumbs], dust particles and grease spots were observed on the surface of the table	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Resident #242 's table for dressing treatment was cleaned for the next treatment. 2. No other residents were identified who need clean tables for dressing treatment. 3. Licensed staff were in-serviced on cleaning treatment tables prior to preparation of sterile field and placement of dressing materials. 4. Random audits will be conducted by wound nurse or designee. Results will submitted to the DON or designee for presentation at the quarterly QI meeting.	9/13/13 9/13/13 10/11/13 Ongoing

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F 441	Continued From page 7 that was used for the sterile field. Employee #18 was queried whether or not he/she cleaned the table prior to establishing the sterile field. He/she responded, " I did clean it. " The table surface was reviewed with Employee #18 and after visualizing the soiled surface he/she stated, " I am sorry, I will clean it now. " A face-to-face interview was conducted with Employee #8 at approximately 1:00 PM on September 13, 2013. He/she stated, " [Employee #18 named] is a new employee and was taught correctly. I don ' t know what happened. " Facility staff failed to practice in a manner as to prevent the spread of infection as evidenced by the establishment of a sterile field and placement of dressing treatment materials on an unclean table.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenths] hours	F 492	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD 1. RN coverage for the next day met minimum daily average of direct nursing care per resident per day. 2. Facility continues to recruit qualified RN staff to meet minimum daily nursing care per resident per day. 3. Staffing Coordinator and Supervisors have been in-serviced on minimum staffing requirements.	9/9/13 Ongoing 10/10/13

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F 492	Continued From page 8 for Registered Nurses/APRN [Advanced Practice Registered Nurse] and 4.1 [four and one tenth] hours for Direct Nursing Care on one (1) of the seven (7) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on September 13, 2013 at approximately 3:30 PM. According 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 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. Of the seven (7) days reviewed, one (1) of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] and Direct Nursing Care Hours 4.1 [four and one tenth] as follows: On September 8, 2013 it was determined that the facility provided direct nursing care at a rate of 4.0 hours and RN coverage at a rate of 0.56 hours. The findings were determined on September 13, 2013 at approximately 3:30 PM during a concurrent review of records with Employee #3.	F 492	4. Staffing levels will be monitored. The DON and Administrator will be notified when staffing levels are below the minimum required.	Ongoing

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F 492	Continued From page 9 Employee #3 acknowledged the findings and stated that the staffing was reflective of weekend coverage and the facility made every effort to supplement staffing coverage, but was unsuccessful.	F 492		