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 _____	09/16/2014

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CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual QIS survey was conducted on September 9 through September 16, 2014. The deficiencies are based on observations, record review and staff interviews for 39 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment Reference Date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CPR - Cardiopulmonary Resuscitation D.C. - District of Columbia D/C - discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - Interdisciplinary Team INR - International Normalised Ratio L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor	F 000	Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submissions 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	TITLE	(X6) DATE
Tina Sandi	Administrator	10/31/14

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 MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act 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 RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	F 000		
	F 272 SS=D 483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		
	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			

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F 272	Continued From page 2 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; 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 39 sampled residents, it was determined that facility staff failed to accurately code a significant change and quarterly MDS (Minimum Data Sets) for a resident who was receiving dialysis. Resident #113.	F 272		

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F 272	Continued From page 3 The findings include: Facility staff failed to code Resident #113's quarterly MDS and significant change MDS Section O: Special Treatments, Procedures, and Programs for dialysis. According to the physician's discharge transfer summary note signed and dated April 5, 2014 "Recently, the patient was followed by ... with increasing BUN [Blood Urea Nitrogen] and creatinine. Today, the patient ' s last follow up with progressive increase of BUN and creatinine, and the patient was started on hemodialysis and has tolerated the procedure well. Today, the patient appears in no congestive failure. The patient appears comfortable. " A review of the quarterly MDS with an Assessment Reference Date (ARD) date of April 11, 2014 and the significant change MDS with an ARD of July 9, 2014 revealed in Section O: O0100 Special Treatments, Procedures and Programs: Item J "Dialysis" was left blank indicating that the item was not coded. Further review of the resident's care plan dated April 1, 2014 revealed that the resident is to receive dialysis three (3) times weekly on Tuesday, Thursday and Saturdays for ESRD (End Stage Renal Disease). A face-to-face interview was conducted on	F 272	**F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **1.** Resident #113's quarterly MDS and significant change MDS section 0 was coded for special treatments, procedures and programs for dialysis immediately. **2.** All MDS section 0 records were reviewed for those residents on dialysis. All records were coded correctly for dialysis. **3.** All MDS nurses were in-serviced on accurately coding section 0 special treatments, procedures and programs for dialysis. **4.** MDS Coordinator or designee will conduct random audits for accurate coding of section 0. Results will be submitted to the DON or designee for presentation at the quarterly QA/QI meeting.	9/16/14 9/18/14 11/2/14 Ongoing

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F 272	Continued From page 4 September 16, 2014 at approximately 10:30AM with Employee #18. After reviewing the MDS he/she acknowledged the findings and stated that a correction would be made. The record was reviewed on September 16, 2014.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on resident interview, record review and staff interviews for one (1) of 39 sampled residents, it was determined that facility staff	F 280		

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F 280	Continued From page 5 failed to review and revise a care plan to include goals and approaches to manage the behaviors of one (1) resident with a history of " paranoid delusions of a sexual nature. " Resident #176 The findings include: Facility staff failed to review and revise Resident #176 's care plan to include goals and approaches to address the resident's history of paranoid delusions. A face-to-face interview was conducted with Resident #176 on September 10, 2014 at approximately 9:39 AM. The resident was queried whether staff, residents or anyone else at the facility had abused him/her at any time verbally, physically and/or sexually. He/she responded, "Yes." A second query was made whether he/she had reported the alleged abuse to anyone. He/she responded, "Yes." The resident continued to state, "It happens when I am asleep, I could tell by [my genital area] being sore. " A face-to-face interview was conducted with Employee #7on September 16, 2014. A query was made regarding the resident's allegation of sexual abuse. Employee #7 stated that he/she was not aware of this current allegation of sexual abuse, but that the resident has a history of sexual delusions and was being seen by the psychiatrist. The employee added that " the resident made the same allegation in November of 2012 and it was investigated. " The resident performs [his/her] own personal hygiene. Nurses of the opposite gender are not assigned to Resident #176 and a " buddy system " is used	F 280	**F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **1.** Resident #176's care plan was updated to include a "buddy system" and same gender assignments. **2.** There were no other residents identified who needed an update of their care plans to include goals and approaches to manage behaviors of paranoid delusions of a sexual nature. **3.** Nurse Managers, Assistant Nurse Managers, and Social Workers were in-serviced on updating care plans to include goals and approaches to address resident's history of paranoid delusions of a sexual nature. **4.** Monthly audits will be conducted by the Nurse Manager or designee to monitor compliance with care plan audit. Results will be submitted to the DON or designee for presentation at the quarterly QA/QI meeting.	10/24/14 10/24/14 11/2/14 Ongoing

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F 280	Continued From page 6 during the overnight hours [two (2) nurses partner simultaneously to meet the residents needs]. A review of the resident's care plan updated May 1, 2014 revealed a care plan with a problem of " Resident has paranoid delusions of a sexual nature." The care plan was initiated November 13, 2012. However, there was no evidence that the care plan was amended to include the " buddy system " or same gender assignments outlined by Employee #7. After reviewing the aforementioned information Employee #7 acknowledged the findings.	F 280		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to meet professional standards of care as evidenced by not providing life sustaining measures for a resident who was nonresponsive and a full code. Resident #282 The findings include: Facility staff failed to implement life sustaining measures according to accepted standards of clinical practice for Resident #282.	F 281		

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F 281	Continued From page 7 According to the "Lippincott ' s Nursing Procedures Fifth Edition " " Code Management Page 467 ... " the goals of any code are to restore the patient's spontaneous heart beat and respirations ... " " Cardiopulmonary Resuscitation Page 474 " Cardiopulmonary Resuscitation (CPR) seeks to restore and maintain the patient's respiration and circulation after his heartbeat and breathing have stopped. Basic life support (BLS) procedures should be performed according to the 2010 American Heart Association (AHA) guidelines. CPR is a BLS procedure that ' s performed on victims of cardiac arrest. Another BLS procedure is clearing the obstructed airway .....Most adults who experience sudden cardiac arrest develop ventricular fibrillation and require defibrillation; CPR alone doesn ' t improve their chances of survival. Therefore, you must assess the victim and then contact emergency medical services (EMS) or call a code before starting CPR. Timing is critical because early access to EMS, early CPR, and early defibrillation greatly improve patient ' s chances of survival. " According to the facility's policy entitled "RN STAT Number 1279 effective date June 2000 Revised date 9/09/06" stipulates: " It is the policy of Carroll Manor and Rehabilitation Center to utilize appropriate staff with the most appropriate skill to respond to any urgent resident situation. It is for this reason that " RN STAT " will be announced to call all Clinical Registered Nurses to assist in any urgent resident situation regarding an acute change in a resident ' s health. " ... " See	F 281	**F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **1.** Resident #282 was no longer in the facility at the time of this review. 9/9/14 **2.** There were no other residents identified who were full code and required life sustaining measures. 11/2/14 **3.** Licensed staff were in-serviced on facility protocol for implementing life sustaining measures for full code residents. 9/9/14 **4.** Monthly audits will be conducted by medical records to monitor compliance. Results will be submitted to the DON or designee and presented at the quarterly QA/QI meeting. Ongoing	

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F 281	Continued From page 8 Attachment-Practice Standards. " Practice Standards 1. " RN STAT " is announced in any urgent resident situation regarding an acute change in a resident ' s health. 2. When " RN " STAT is announced all clinical Registered Nurses with-in the building will respond and assist the resident. 3. At least one RN will remain available to assist until the resident situation has been stabilized or the resident is transferred to another setting for assistance. 4. All Registered Nurses are made aware of this practice standard during their orientation and probationary period. " Clinical Record Review: According to the " Admission and Annual Physical Exam Form " dated October 2, 2013 in the section named " Advance Directive " " Full Code " was written. The resident ' s diagnoses included: Hypothyroidism, Alzheimer ' s Dementia, Osteoporosis and Hypertension A review of the resident's Physician Order Sheet dated and signed July 2, 2014 revealed the following " Code Status: Full Code: " ADM CPR " [Administer Cardiopulmonary Resuscitation] was checked. A review of the Social Services Assessment and progress note dated July 16, 2014 revealed the resident had " no advance directives " and further states " [Resident ' s Name] CODE	F 281		

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F 281	Continued From page 9 STATUS IS FULL CODE. " A review of the nursing documentation in the " Progress Notes by Resident, " dated and timed September 1, 2014 at 06:26 AM revealed the following: " Reported by assigned certified nursing assistant [CNA] while doing [his/her] rounds that [Resident ' s Name] was not breathing Nsg sup [Nursing Supervisor] made aware and is on the unit no palpable B/P [blood pressure] or pulse found PMD [Primary Medical Doctor] on call [Physician ' s Name] made aware and will make [his/her] family aware. " " At around 06:19 AM, this writer was notified that resident was unresponsive, upon arrival to [his/her] room at around 06:20 AM, resident was observed unresponsive, no pulse, no respiration, unable to obtain B/P, body was warm, Resident was a full code. [Physician ' s Name] on call doctor for [Medical Director ' s Name] was notified at around 06:22 AM; MD stated [he/she] will notify family...[Physician ' s Name] gave order that two license nurses may pronounce the body at 06:25 AM. " A review of the care plan updated July 31, 2014 revealed : Advance Directive " Resident and family has requested CPR. Resident wishes will be respected in the event of a medical emergency ". The clinical record lacked evidence that the resident ' s wishes for life sustaining measures were initiated in accordance with the advance directive of the full code status.	F 281		

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F 281	Continued From page 10 A face-to-face interview was conducted with Employee #8 on September 8, 2014 at approximately 08:00 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282, Employee #8 stated the following; " On September 1, 2014 at between 6:25AM and 6:30AM, the CNA assigned to Resident #282 approached me while I was giving medications and stated I think Resident #282 is dead. I immediately went to check the resident ' s code status which revealed[he/she]was a full code. The CNA and I both returned to Resident #282 ' s room. After checking the resident, I detected that [he/she] had no pulse, respiration or b/p [blood pressure]. I then proceeded to call the nursing supervisor assigned to the unit. Employee #11 responded immediately. I told [him/her] Resident #282 had no palpable vital signs. We both went back to the resident ' s room. The supervisor stated " The resident had already died and [he/she] was going to call the doctor and inform [him/her] about the resident ' s death. In the process of calling, the second supervisor came on the unit and was informed about what was going on with Resident # 282. The second Supervisor went to the resident ' s room and then came back and said, " Yes [he/she] has already died so don ' t call 911. They will get mad if you do " .[He/she] left the unit. The resident ' s body was warm to touch and not stiff. " When queried regarding the reason CPR was not started or EMS was not activated, [he/she] stated, " I don ' t know why. I figured [he/she] was already dead " .	F 281		

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F 281	Continued From page 11 A face-to-face interview was conducted with Employee #13 on September 8, 2014 at approximately 08:20 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282 [he/she] stated the following; " When I did my rounds at 5:00 AM, Resident #282 was still breathing. The next time I saw [him/ her] around 6:25 AM, the first thing I noticed as I entered the room was a smell like [he/she] had had a bm (bowel movement). Resident #282 was lying on [his/her] side. I touched [him/her] and called out [his/her] name. There was no response, so I checked for breathing and a pulse. There was no pulse and breathing. That ' s when I called the charge nurse, Employee #8 who came right away and told me the resident was a full code. Then [he/she] checked the residents blood pressure and for a pulse and breathing. Then Employee #8 told me to wash and clean Resident #282, and Employee #8 left the room. " A face-to-face interview was conducted with Employee #11 on September 8, 2014 at approximately 08:45 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282, [he/she] stated the following; " On September 1, 2014 at around 6:20 AM, I received a called from Employee #8 the charge nurse on the first floor unit. [He/she] stated that a resident had expired. " " Upon my arrival to the unit, I said we need to initiate CPR and call 911. The charge nurse said oh no, 911 will be upset for calling them if someone is already dead. I went into the resident ' s room. [He/she] did not have a pulse and was	F 281		

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F 281	Continued From page 12	F 281		

not breathing. There was no blood pressure and the body was stiff. The second supervisor on duty arrived and I informed [him/her] the resident who was a full code had expired. "

" The supervisor went in the resident ' s room. When [he/she] came out, [he/she] saw me on the phone and said, I hope you ' re not calling 911 because we don ' t call 911 for situations like this. [He/she] is already dead. I was on the phone notifying Employee #21 that the resident who was a full code was observed with no respirations, pulse or blood pressure, and that the body was stiff. I requested an order for two[2] nurses to pronounce the resident. I provided the family members phone number. Employee #21 called the unit again after, speaking to Resident #282 ' s family to give the charge nurse an order for two[2] nurses to pronounce the resident. "

When further queried regarding the reason CPR was not initiated or EMS activated [he/she] stated " I don ' t know why I didn ' t call. I knew it should have been done but everyone said [he/she] was already dead and EMS would be mad if I called for someone that is already dead, so I didn ' t call."

A face-to-face interview was conducted with Employee #12 on September 8, 2014 at approximately 10:30 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282 [she/he] stated the following; " Between 6:30AM and 6:40AM, I went to the first floor unit to collect the twenty four (24) hour report. In the charting room, I met Employee ' s #8 and #11. They informed me that a resident who was a full code had just expired. I

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CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 went to the room and looked at the resident. The CNA was there. Afterward I picked up the 24 hour report and left the unit. " When further queried regarding the reason CPR was not initiated or EMS activated [he/she] stated, " They said [he/she] was already dead and I did not question it. " A telephone interview was conducted with Employee #21 at approximately 10:00 AM on September 18, 2014. When queried about the events that occurred on September 1, 2014 regarding Resident #282, [he/she] stated the following; " At approximately 6:40 AM on September 1, 2014, the nursing supervisor called to inform me that Resident #282 had expired, and the family needed to be notified. The supervisor also requested an order for two [2] licensed nurses to pronounce the resident. After obtaining the contact information, I notified the family and called back to the unit to inform the nurses that the family would be coming in to view the resident. At that time I gave an order for two [2] nurses to pronounce the resident. " When queried regarding the resident ' s code status, Employee #21 stated; " They did inform me that the resident had expired, but there was no discussion about the resident ' s code status. I was not familiar with Resident #282, as I was serving in an on call capacity for the Medical Director." There was no evidence the facility staff followed acceptable standards of clinical practice by implementing life sustaining measures in accordance with the advance directive of the full	F 281		

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F 281	Continued From page 14 code status when Resident # 282 was nonresponsive. Facility staff failed to implement life sustaining interventions for Resident #282 whose status was designated as a full code. The findings were acknowledged by Employee #2 on September 9, 2014. The medical record was reviewed September 9, 2014. Cross referenced to 483.25(h)	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, for one (1) of 39 sampled residents, it was determined that facility staff failed to provide life sustaining measures for a resident who was nonresponsive and was a full code. Resident #282. The findings include: Facility staff failed to implement life sustaining measures for Resident #282 who was nonresponsive and had a full code status.	F 309	**F309** **483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **1.** Resident #282 was no longer in the facility at the time of this review. **2.** There were no other residents identified who were full code and required life sustaining measures. **3.** Licensed staff were in-serviced on facility protocol for implementing life sustaining measures for full code residents. **4.** Monthly audits will be conducted by medical records to monitor compliance. Results will be submitted to the DON or designee and presented at the quarterly QA/QI meeting.	9/9/14 11/2/14 9/9/14 Ongoing

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F 309	Continued From page 15 According to the "Lippincott ' s Nursing Procedures Fifth Edition " " Code Management Page 467 ... " the goals of any code are to restore the patient's spontaneous heart beat and respirations ... " " Cardiopulmonary Resuscitation Page 474 " Cardiopulmonary Resuscitation (CPR) seeks to restore and maintain the patient's respiration and circulation after his heartbeat and breathing have stopped. Basic life support (BLS) procedures should be performed according to the 2010 American Heart Association (AHA) guidelines. CPR is a BLS procedure that ' s performed on victims of cardiac arrest. Another BLS procedure is clearing the obstructed airway .....Most adults who experience sudden cardiac arrest develop ventricular fibrillation and require defibrillation; CPR alone doesn ' t improve their chances of survival. Therefore, you must assess the victim and then contact emergency medical services (EMS) or call a code before starting CPR. Timing is critical because early access to EMS, early CPR, and early defibrillation greatly improve patient ' s chances of survival. " According to the facility policy entitled "RN STAT Number 1279 effective date June 2000 Revised date 9/09/06" stipulates: " It is the policy of Carroll Manor and Rehabilitation Center to utilize appropriate staff with the most appropriate skill to respond to any urgent resident situation. It is for this reason that " RN STAT " will be announced to call all Clinical Registered Nurses to assist in any urgent resident situation regarding an acute change in a	F 309		

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F 309	Continued From page 16 resident ' s health. " ... " See Attachment-Practice Standards. " Practice Standards 1. " RN STAT " is announced in any urgent resident situation regarding an acute change in a resident ' s health. 2. When " RN " STAT is announced all clinical Registered Nurses with-in the building will respond and assist the resident. 3. At least one [1] RN will remain available to assist until the resident situation has been stabilized or the resident is transferred to another setting for assistance. 4. All Registered Nurses are made aware of this practice standard during their orientation and probationary period. " Clinical Record Review: According to the " Admission and Annual Physical Exam Form " dated October 2, 2013 in the section named " Advance Directive " " Full Code " was written. The resident ' s diagnoses included: Hypothyroidism, Alzheimer ' s Dementia, Osteoporosis and Hypertension. A review of the resident's Physician Order Sheet dated and signed July 2, 2014 directed the following " Code Status: Full Code: " ADM CPR " [Administer Cardiopulmonary Resuscitation] was checked. A review of the Social Services Assessment and progress note dated July 16, 2014 revealed the resident had " no advance directives"and further states " [Resident ' s Name] CODE STATUS IS	F 309		

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F 309	Continued From page 17 FULL CODE. " A review of the nursing documentation in the " Progress Notes by Resident, " dated and timed September 1, 2014 at 06:26 AM revealed the following: " Reported by assigned certified nursing assistant [CNA] while doing [his/her] rounds that [Resident ' s Name] was not breathing Nsg sup [Nursing Supervisor] made aware and is on the unit no palpable B/P [blood pressure] or pulse found PMD [Primary Medical Doctor] on call [Physician ' s Name] made aware and will make [his/her] family aware. " " At around 06:19 AM, this writer was notified that resident was unresponsive, upon arrival to [his/her] room at around 06:20 AM, resident was observed unresponsive, no pulse, no respiration, unable to obtain B/P, body was warm, Resident was a full code. [Physician ' s Name] on call doctor for [Medical Director's Name] was notified at around 06:22 AM; MD stated [he/she] will notify family...[Physician ' s Name] gave order that two [2] license nurses may pronounce the body at 06:25 AM. " A review of the care plan updated July 31, 2014 revealed; Advance Directive " Resident and family has requested CPR. Resident wishes will be respected in the event of a medical emergency. " The clinical record lacked evidence that after the staff was made aware and assessed the resident for responsiveness the resident ' s wishes for life sustain measures were initiated in congruence	F 309		

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F 309	Continued From page 18 with the advance directive of Full Code status. Additionally, the record lacked evidence that CPR (Cardiopulmonary Resuscitation) was initialed and the EMS (Emergency Medical System) was activated. A face-to-face interview was conducted with Employee #8 on September 8, 2014 at approximately 08:00 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282, Employee #8 stated the following; " On September 1, 2014 at between 6:25AM and 6:30AM, the CNA assigned to Resident #282 approached me while I was giving medications and stated I think Resident #282 is dead. I immediately went to check the resident ' s code status which revealed [he/she]was a full code. The CNA and I both returned to Resident #282 ' s room. After checking the resident, I detected that [he/she] had no pulse, respiration or b/p [blood pressure]. I then proceeded to call the nursing supervisor assigned to the unit. Employee #11 responded immediately. I told [him/her] Resident #282 had no palpable vital signs. We both went back to the resident ' s room. The supervisor stated " The resident had already died and [he/she] was going to call the doctor and inform [him/her] about the resident ' s death. In the process of calling, the second supervisor came on the unit and was informed about what was going on with Resident # 282. The second Supervisor went to the resident ' s room and then came back and said, " Yes [he/she] has already died so don ' t call 911. They will get mad if you do " .[He/she] left the unit. The resident ' s body was warm to touch and not stiff. "	F 309		

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F 309	Continued From page 19 When queried regarding the reason CPR was not started or EMS was not activated, [he/she] stated, " I don ' t know why. I figured [he/she] was already dead " . A face-to-face interview was conducted with Employee #13 on September 8, 2014 at approximately 08:20 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282 he/she stated the following; " When I did my rounds at 5:00 AM, Resident #282 was still breathing. The next time I saw [him/ her] around 6:25 AM, the first thing I noticed as I entered the room was a smell like [he/she] had had a bm (bowel movement). Resident #282 was lying on [his/her] side. I touched [him/her] and called out [his/her] name. There was no response, so I checked for breathing and a pulse. There was no pulse and breathing. That ' s when I called the charge nurse, Employee #8 who came right away and told me the resident was a full code. Then [he/she] checked the residents blood pressure and for a pulse and breathing. Then Employee #8 told me to wash and clean Resident #282, and Employee #8 left the room. " A face-to-face interview was conducted with Employee #11 on September 8, 2014 at approximately 08:45 AM. When queried about the events that occurred on September 1, 2014 regarding Resident #282, he/she stated the following; " On September 1, 2014 at around 6:20 AM, I received a called from Employee #8 the charge nurse on the first floor unit. [He/she] stated that a resident had expired. "	F 309		

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F 309	Continued From page 20 " Upon my arrival to the unit, I said we need to initiate CPR and call 911. The charge nurse said oh no, 911 will be upset for calling them if someone is already dead. I went into the resident ' s room. [He/she] did not have a pulse and was not breathing. There was no blood pressure and the body was stiff. The second supervisor on duty arrived and I informed [him/her] the resident who was a full code had expired. " " The supervisor went in the resident ' s room. When [he/she] came out, [he/she] saw me on the phone and said, I hope you ' re not calling 911 because we don ' t call 911 for situations like this. [He/she] is already dead. I was on the phone notifying Employee #21 that the resident who was a full code was observed with no respirations, pulse or blood pressure, and that the body was stiff. I requested an order for two [2] nurses to pronounce the resident. I provided the family members phone number. Employee #21 called the unit again after, speaking to Resident #282 ' s family to give the charge nurse an order for two [2] nurses to pronounce the resident. " When further queried regarding the reason CPR was not initiated or EMS activated [he/she] stated " I don ' t know why I didn't call. I knew it should have been done but everyone said [he/she] was already dead and EMS would be mad if I called for someone that is already dead, so I didn't call." A face-to-face interview was conducted with Employee #12 on September 8, 2014 at approximately 10:30 AM. When queried about the events that occurred on September 1, 2014	F 309		

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F 309	Continued From page 21 regarding Resident #282 [she/he] stated the following; " Between 6:30AM and 6:40AM, I went to the first floor unit to collect the twenty four (24) hour report. In the charting room, I met Employee ' s #8 and #11. They informed me that a resident who was a full code had just expired. I went to the room and looked at the resident. The CNA was there. Afterward I picked up the 24 hour report and left the unit. " When further queried regarding the reason CPR was not initiated or EMS activated [he/she] stated, " That [he/she] was already dead and I did not question it. " A telephone interview was conducted with Employee #21 at approximately 10:00 AM on September 18, 2014. When queried about the events that occurred on September 1, 2014 regarding Resident #282, he/she stated the following; " At approximately 6:40 AM on September 1, 2014, the nursing supervisor called to inform [him/her] that Resident #282 had expired, and the family needed to be notified. The supervisor also requested an order for two [2] licensed nurses to pronounce the resident. After obtaining the contact information, I notified the family and called back to the unit to inform the nurses that the family would be coming in to view the resident. At that time I gave an order for two [2] nurses to pronounce the resident. " When queried regarding the resident ' s code status, Employee #21 stated; " They did inform me that the resident had expired, but there was no discussion about the resident ' s code status. I was not familiar with Resident #282, as I was serving in an on call capacity for the Medical	F 309		

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F 309	Continued From page 22 Director." Facility staff failed to implement life sustaining interventions for Resident #282 whose status was designated as a full code. The findings were acknowledged by Employee #2 on September 9, 2014. The medical record was reviewed on September 9, 2014. Cross referenced to 483.25(h)	F 309	**F309** **483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **1**. Resident #282 was no longer in the facility at the time of this review. **2.** There were no other residents identified who were full code and required life sustaining measures. **3.** Licensed staff were in-serviced on facility protocol for implementing life sustaining measures for full code residents. **4.** Monthly audits will be conducted by medical records to monitor compliance. Results will be submitted to the DON or designee and presented at the quarterly QA/QI meeting.	9/9/14 11/2/14 9/9/14 Ongoing
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to accurately assess the status of skin impairment for Resident #377 ' s sacrum, right heel and left heel. This was a closed record review. The findings include: A review of the facility ' s " Skin Breakdown Risk Assessment Tool " Policy, dated August 1, 2009,	F 314		

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F 314	Continued From page 23 stipulated ... " Purpose: To ensure that residents are assessed and maintained at their highest level of functioning. Policy: It is the policy of this facility that each resident is assessed on Admission/Readmission, every week for the first month post admission, quarterly and PRN (as needed) for risk of skin breakdown using the Braden Scale Pressure Ulcer Risk Assessment Tool. " Resident #377 was admitted to the facility on June 25, 2014 for Physical Therapy and Occupational Therapy for generalized weakness status post an Acute Myocardial Infarction. The resident diagnoses on admission included: Congestive Heart Failure, Hypertension, Diabetes Mellitus, Gout, Anemia and Acute Kidney Disease. According to an admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of July 2, 2014, Resident #377 was coded under Section G (Functional Status) as requiring extensive assistance with toileting ,bed mobility and transfer(s). Section C- Cognitive Patterns- BIMS (Brief Interview for Mental Status) - Scored-11 (Moderately impaired). A review of the admission physician ' s order sheet dated June 26, 2014 directed; " Furosemide (therapeutic class: diuretic, antihypertensive) 40 mg po[by mouth] daily for congestive heart failure, Hydralazine (therapeutic class: antihypertensive) 20mg- one (1) tab po	F 314	**F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **1**. Resident #377 was discharged from the facility at the time of this review. **2**. Resident assessments and records for residents with skin impairment were reviewed. There were no other residents identified who needed accurate assessment of status of skin impairment. **3.** Licensed staff have been in-serviced on accurately assessing the status of skin for residents with skin impairments. **4**. Random audits will be conducted by the wound nurse or designee. Results will be presented at the quarterly QA/QI meeting..	6/8/14 11/2/14 11/2/14 Ongoing

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F 314	Continued From page 24 daily [for] hypertension, Aldactoone (therapeutic class: potassium-sparing diuretic) 25mg - one (1) tablet daily for blood pressure, Ferrous Sulfate (therapeutic class: iron supplement) 325mg- one (1) tab (tablet) po daily for anemia, Apply in house moisture barrier ointment every shift with each incontinence care 3 (three) times per day during day, evening, night and elevate heels off mattress supported by pillows under the legs while in bed 3 (three) times per day during day, evening, night. " The care plan entitled, " Problem: At risk for skin breakdown due to decreased mobility, decreased ability to turn self in bed, poor appetite- Approaches- Assess resident for pressure ulcer risk using Braden scale skin assessment on admission and weekly, Assess skin for bogginess, induration, coolness or increased warmth and skin sensation, Turn and reposition every 2 hours as tolerated, Elevate/float heels, Apply house moisture barrier to bilateral buttocks and perineal area after each incontinent care or daily as needed ... " Braden Scale for " Predicting Pressure Sore Risk " dated June 25, 2014 revealed a score of 16 (low risk) and July 3, 2014 was 11 (high risk). His/her sensory perception on the Braden scale form June 25, 2014 was coded as a " 4 - No impairment " and " 3 - slightly limited " on July 3, 2014. Facility staff failed to accurately conduct an assessment of Resident #377's risk for	F 314		

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F 314	Continued From page 25 developing pressure ulcers. A review of the physician ' s interim orders revealed the following: July 1, 2014 at 2100 (9:00 PM) directed: " ... Cleanse left buttock open area with NS [Normal Saline], apply bacitracin ointment BID (twice a day) until healed. July 1, 2014 - 12:00 (12 Noon)- (1) Cleanse sacral area Stage III wound, with wound cleanser , pat dry, then apply santyl daily and PRN (as needed). (2). Apply betadine solution to bilateral heels daily and prn, (3) Apply float boots on bilateral feet while in bed. July 3, 2014- 1400 (2:00 PM) - Give multivitamins with minerals -one tablet po daily for nutritional supplement. Zinc sulfate 220mg - 1 tablet po daily for 14 days, Give Ensure Plus- one can po TID (three times a day) as snacks. A review of the electronic progress notes revealed the following: Admissions Observation " sheet dated June 25, 2014 (page 4 of 11) under " Skin Condition " revealed: " right top 2nd toe had a dry scab and the right elbow had a scar " . No other skin or wound abnormalities were depicted on the	F 314	**F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **1.** Resident #377 was discharged from the facility at the time of this review.	6/8/14
			2. All new residents' assessments for the risk of developing pressure ulcers have been reviewed. All assessments have been accurately conducted.	11/2/14
			3. Licensed staff were in-serviced on accurately conducting assessments for risk for developing pressure ulcers on admission.	11/2/14
			4. Random audits will be conducted by the wound nurse or designee. Results of audits will be presented at the quarterly QA/QI meeting.	Ongoing

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F 314	Continued From page 26 anatomical diagram. [Responsiveness: Slow Mentation and communication/hearing-Minimal Difficulty. [Name of registered nurse]. June 25, 2014- 19:39 (10:39 PM) - ... [male/female] admitted from [acute hospital]. Admitting diagnose[as] are Congestive Heart Failure, Coronary Artery Disease, Diabetes Mellitus, Gout, and Hypertension ... Bilateral elbow protruding lump with dark and pinkish dry scabs. Left arm swelling with decreased range of motion noted, painful with movement, bilateral lower extremities edema, pitting +2. Hyper pigmentation and dry scaly skin between all toes and dry scab on right 2nd toe noted... [Registered nurse] June 26, 2014- [Dietary] - ... Special Dietary Programs Comments- 73 year old [male/female] admitted from [acute hospital]. Admitting [diagnoses]: CHF (Congestive Heart Failure, CAD (Coronary Artery Disease), DM (Diabetes Mellitus), Gout, [and] HTN (Hypertension). Medications: ... Bidil (vasodilator for heart failure), Furosemide (dehydration risk) ...Spirolactone ([potassium -sparing diuretic)... Labs (hospital): elevated BUN/CR (blood urea nitrogen/creatinine) (dehydration risk) and low H/H. Skin Condition Comments = Intact. General Dietary Comments- ... Promote intact skin. Interventions: (1) Continue current diet, (2) Add mighty shake TID (three times a day) as snacks. (Receives 21 g protein from mighty shake) (3) Encourage adequate po and dehydration, (4) Monitor [weights], labs and meal	F 314		

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F 314	Continued From page 27 intake. A review of the electronic June and July 2014 Treatment Administration Record (TAR) revealed nurses' initials in the allotted spaces which indicated that the resident received snacks at 10:00 AM, 1:00 PM and 8:00 PM. June 27, 2014 06:30 AM - Registered Nurse- Resident is status post admit day 2. ... Bilateral lower extremity and Left arm elevated on pillow to reduce [swelling]. Turning and repositioning every 2 hours to [relieve] pressure from bony prominence areas. June 28, 2014- 04:30 AM- Licensed Practical Nurse- " ... Both lower extremities elevated on pillow ..." June 29, 2014 22:53 (10:53 PM) - Registered Nurse- " ... PO (by mouth) fluids encouraged. Resident consumed 50% of dinner with staff assistance. No complain of pain/discomfort on assessment at this time. ADL (Activities of daily living) care provided with extensive assistance as needed, turned and repositioned [every] two hours for comfort and pressure relief. Left arm elevated with pillow, BLE (bilateral lower extremities) elevated to relief edema and heels floated to offload pressure." June 30, 2014- 13:52 (1:52 PM) - Registered	F 314		

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F 314	Continued From page 28 Nurse- Resident is alert and oriented x 2 and given all due medications for the day shift and tolerated well. Resident is up and out of bed during the day and ate breakfast and lunch in [his/her] room. Resident also attended therapy during the day and tolerated well with no pain noted. Resident has no complaints of pain, discomfort or distress noted at this time. July 1, 2014 23:51 (11:51 PM) - Licensed Practical Nurse- Resident was noted with open are on left buttock, no drainage noted. MD (Medical Doctor) made aware with [treatment] order. Will have wound nurse evaluate in am. " A review of the " Skin Condition Report with Images " sheets revealed the following: " July1, 2014- 7:09 PM- New (1st recording) for Site 352- Present on the coccyx is a blister (open). The following findings were documented, Staging, Stage 2, and Length in cm = 5, Width in cm= 5, Skin is blanchable, no odor is apparent, drainage consistency is thin, scan drainage is present, and color is red-tinged ... MD notified of the present status of this site. .. Wound base is not visible, Red wound base = 40%, Black Brown base = 60%, Granulation tissue type = 100%... Pressure reducing or relieving devices (s) are in place, devices used on the bed surface, devices used on the chair surface, extremity device or shoe used, turning and repositioning program being implemented, Likelihood of heading due to overall condition; Fair Risk Factors;	F 314		

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F 314	Continued From page 29 Co-Morbidities, End-Stage Disease, Decreased mobility, Inactivity, Decreased Blood Flow. Facility staff failed to address Resident #377 ' s left and right heel skin impairment. July 2, 2014- 1:28 PM- Skin and Wound Update to Site- 352. Present on the Coccyx is a Blister (open). The following findings were documented, Staging, Stage 2 [Error: 07/03/2014 08:13, name of registered nurse] ... Length in cm = 4, Width in cm = 6, no odor is apparent, no drainage is apparent. Wound base is visible, Granulation tissue type = 70%, slough tissue type = 30%, surrounding tissue is normal ...Revision History: 07/03/2014 08:13 [registered nurse], Coccyx wound is Stage 3. " July 2, 2014- 1:35 PM- New (1st recording) for Site -408- Present on the Left Heel is a Deep Tissue injury. The following findings were documented, Unable to accurately stage- Suspected Deep Tissue Injury in Evolution, Length in cm= 5, Width in cm= 5.5, no drainage is apparent. July 2, 2014- 1:39 PM- New (1st) recording) for Site-488. Present on the Right heel is a pressure ulcer. The following findings were documented, Unable to accurately stage- Suspected Deep Tissue injury in evolution [Error: 07/07/2014 11:25- Registered Nurse]... Revision History: 07/07/2014- ... Stage 1- Refer to [wound consultant] note.	F 314	**F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **1.** Resident #377 was discharged from the facility at the time of this review. **2.** Resident assessments and records of residents with skin impairment were reviewed. There were no other residents identified who needed skin impairment to be addressed. **3.** Licensed staff were in-serviced on addressing skin impairments for residents. **4.** Random audits will be conducted by the wound nurse or designee. Results of audits will be presented at the quarterly QA/QI meeting.	6/8/14 11/2/14 11/2/14 Ongoing

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F 314	Continued From page 30 July 2, 2014- 1:45 PM- Skin and Wound Update to Site-488. Present on the Right Heel is a Pressure Ulcer. The following findings were documented, Staging, Stage 1, and Length in cm = 2, width in cm = 2, Skin is not blanchable, no odor is apparent, no drainage is apparent ... " A review of the clinical record revealed that the nursing assessments of Resident #377 ' s skin impairment revealed inconsistent documentation of the characteristic of his/her wound. A review of the consultation record revealed the following: " A review of the [wound nurse] consultation dated July 2, 2014 at 10:30 AM revealed: " Report: [Left heel] = 5 x 5.5 cm. Dark purple blister intact. Suspected deep tissue injury. [Right lateral heel] 2 cm x 2cm- nonblancable- Stage I, Sacrum towards lt (left)- 4 x 6 cm; slough 30%- Stage 3. Recommendations: Both heel betadine daily and PRN. Float. Sacrum- Santyl daily and PRN. " A face-to- face interview was conducted with Employee # 2 on September 12, 2014 at approximately 11:00 AM. After reviewing the clinical record, [he/she] acknowledged the aforementioned findings. He/she further stated, " The resident was admitted with a lot of co-morbidities, the Braden scale score should have reflected [he/she] was high risk for developing pressure ulcer (s). We had measures	F 314	**F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **1.** Resident #377 was discharged from the facility at the time of this review. **2.** Resident assessments and records of residents with skin impairment were reviewed. There were no other residents identified who needed consistent documentation of characteristics of their wound. **3.** Licensed staff were in-serviced on consistent documentation of characteristics of wounds. **4.** Random audits will be conducted by the wound nurse or designee. Results of audits will be presented at the quarterly QA/QI meeting.	6/8/14 11/2/14 11/2/14 Ongoing

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F 314	Continued From page 31 in place for prevention of any skin alteration. We have been having problems with the nurses ' scoring the Braden scale accurately and we are in the process of conducting in-services are in progress. " The clinical record was reviewed on September 12, 2014. Facility staff failed to accurately assess the status of skin impairment for Resident #377 ' s sacrum, right heel and left heel.	F 314	**F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **1.** Resident #377 was discharged from the facility at the time of this review. **2.** Resident assessments and records for residents with skin impairment were reviewed. There were no other residents identified who needed accurate assessment of status of skin impairment. **3.** Licensed staff have been in-serviced on accurately assessing the status of skin for residents with skin impairments. **4.** Random audits will be conducted by the wound nurse or designee. Results will be presented at the quarterly QA/QI meeting.	6/8/14 11/2/14 11/2/14 Ongoing
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for an isolated observation it was determined that facility staff failed to properly maintain an assistive device [recliner chair] as to prevent accidents and ensure adequate seating as evidenced by the use of a recliner chair that lacked leg and foot rests. Resident #66 The findings include: On September 10, 2014 at approximately 11:33AM Resident #66 was observed sitting in	F 323		

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F 323	Continued From page 32 an upright position in his/her geri chair with legs and feet dangling as a result of missing leg and foot rests. A review of Resident #66's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of July 9, 2014 revealed that the resident was coded in Section G: Functional Status, G0110 ADL (Activities of Daily Living) for assistance as totally dependent; G0400 Functional limitation in range of motion Section B: impairment of both lower extremities and under Section G0600 "Mobility Devices" Section C Wheel chair. A review of the "In-Patient Podiatric Services Form" dated May 29, 2014 revealed that an examination was conducted on September 12, 2014 which revealed "Muscle Strength as Gross: atrophy right and left foot; Extremity Range of Motion: Right foot limited, left foot limited and rigid was checked off. Foot drop was WNL (within normal limit)." There was no evidence that facility staff implemented measures to provide Resident #66, with a Gerri - Chair that was safe for his/her use. A face -to- face interview was conducted on September 12, 2014 at approximately11:40AM with Employee #16 who was present at the time of the observation. A query was made regarding the aforementioned condition of Resident #66 geri-chair. After the observation, Employee #16	F 323	**F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **1.** Resident #66 was provided with geri chair that was appropriate. **2.** All residents' wheel chair/geri chairs were evaluated for safe use. Residents identified to need an appropriate wheel chair/geri chair were provided with appropriate sitting device. **3.** Licensed staff were in-serviced to ensure that they obtain an appropriate wheel chair for any residents who are identified to need one. **4.** Random audits will be conducted by the Nurse manager or designee. Results will be submitted to the DON or designee for presentation at the quarterly QA/QI meeting.	9/13/14 11/2/14 11/2/14 Ongoing

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F 323	Continued From page 33 stated, " I will order a chair with the appropriate foot support. " The record was reviewed on September 12, 2014. Facility staff failed to provide a geri-chair that was safe for the residents' use. The clinical record was reviewed on September 15, 2014.	F 323		
F 371 SS=D	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 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 10, 2014 at approximately 11:30 AM and on September 12, 2014 at approximately 12:15 PM, it was determined that facility staff failed to store, serve and distribute food under sanitary conditions as evidenced by unidentified foods from a lunch bag that were not labeled or dated in the reach-in refrigerator, a half-gallon of ice cream that was not labeled or dated in the walk-in freezer and water filter housings from one (1) of one (1) ice machine on the second floor and one (1) of one (1) ice machine on the third floor that were soiled with accumulated dust particles.	F 371	**F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** **(1)** **1.** Unauthorized item stored in reach in refrigerator was immediately removed. **2.** No other unauthorized items were identified as being stored in reach in refrigerator. **3.** Kitchen staff were in-serviced on proper storage of personal items. **4.** Random audits will be conducted by the kitchen manager or designee and the results will be presented by the Director of Dining Services or designee at the quarterly QA/QI meeting. **(2)** **1.** Ice Cream was discarded immediately. **2.** No other undated/unlabeled ice cream was identified. **3.** Kitchen staff was in-serviced on proper storage/labeling/dating of products.	9/10/14 9/10/14 10/1/14 Ongoing 9/10/14 9/10/14 10/1/14

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F 371	Continued From page 34 The findings include: 1. A purple lunch bag containing unidentified food items that were not labeled or dated was stored in one (1) of one (1) reach-in refrigerator in the main kitchen. 2. A half-gallon container of butter pecan ice cream was stored in the walk-in freezer and was not labeled or dated. 3. Water filter housings from one (1) of one (1) ice machine located in the second floor dining room and from one (1) of one (1) ice machine located in the third floor dining room were soiled with accumulated dust particles. These observations were acknowledged by Employees #24 and 25.	F 371	**F371 Continued** **4.** Random audits will be conducted by the kitchen manager or designee and the results will be presented by the Director of Dining Services or designee at the quarterly QA/QI meeting. **(3)** **1.** Water filters were changed immediately. **2.** All water filters on ice machines were checked and no other dirty filters identified. **3.** Maintenance staff were in-serviced on the proper preventive maintenance of ice machine filters. **4.** Radom audits will be conducted by the maintenance supervisor and the results will be presented at the quarterly QA/QI meeting.	Ongoing 9/12/14 9/12/14 10/31/14 Ongoing
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	F 441		

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F 441	Continued From page 35 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 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on observation, inspection and staff interview for one (1) of one (1) unit inspected, it was determined that facility staff failed to ensure the decrease of the spread of infection as evidenced by a pipe and tube from the unit ice machine extending down into a wall drain. The findings include:	F 441	**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS (A)** **1.** Pipe and tube from the unit ice machine was removed from the drain and a 2 inch air gap was established immediately. **2.** All ice machines were inspected. There were no other identified pipes or tube from ice machines extending down into a wall drain. **3.** Maintenance staff were in-serviced on properly securing pipes or tubes from ice machines. **4.** Random audits will be conducted by maintenance staff to ensure compliance and the results will be presented at the quarterly QA/QI meeting.	9/9/14 9/12/14 10/31/14 Ongoing

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F 441	Continued From page 36 During the inspection of the 5 East Unit conducted on September 9, 2014 at approximately 11:00 AM, the following was observed: ice machine located in the residents' common area was noted to have a pipe and tube extending from the rear of the machine down into a wall drain pipe. The observation was made in the presence of Employee #20. A-face-to-face interview was conducted on September 9, 2014 at approximately 12:00 PM with Employees #20, #22, and #23. After inspection of the ice machine all employees acknowledged that the pipe and tube extending down into the wall drain, therefore leaving no air gap between the pipe, tube and wall drain. Facility staff failed to ensure the decrease of the spread of infection as evidenced by a pipe and tube from the unit ice machine extended down into a wall drain. B. Based on observations made on September 12, 2014 at approximately 12:30 PM, it was determined that the facility failed to provide a safe and sanitary environment as evidenced by unidentified, personal food item (s) that were stored in a lunch bag in a reach-in refrigerator in the main kitchen.	F 441	**F441 Continued** **(B)** **1.** Unauthorized item stored in reach in refrigerator was immediately removed. **2.** No other unauthorized items were identified as being stored in reach in refrigerator. **3.** Kitchen staff were in-serviced on proper storage of personal items. **4.** Random audits will be conducted by the kitchen manager or designee and the results will be presented by the Director of Dining Services or designee at the quarterly QA/QI meeting	9/10/14 9/10/14 10/31/14 Ongoing

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F 441	Continued From page 37 The findings include: 1. Unidentified, personal food items were stored in a purple lunch bag in a reach-in refrigerator located in the main kitchen. This observation was made in the presence of Employee #24 who acknowledged the finding.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to ensure essential equipment was in safe operating condition, as evidenced by two (2) of five (5) freezers that were inoperative since June 2014 and one (1) of one (1) hand washing sink in the fifth floor dining room that continuously leaked water from the bottom. The findings include: 1. One (1) of one (1) freezer located in the first floor dining room and one (1) of one (1) freezer located in the fifth floor dining room have been out of order since June 9, 2014.	F 456	**F456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION** **(1)** **1.** Two inoperable freezers were replaced. **2.** All other pantry freezers were inspected and were found operable. **3.** Dietary managers were in-serviced regarding proper reporting and monitoring of inoperable equipment. **4.** Random audits of the freezers will be conducted by the kitchen manager or designee and presented by the Director of Dining Services at the quarterly QA/QI meeting.	10/30/14 11/2/14 11/2/14 Ongoing

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 38 2. One (1) of one (1) hand washing sink located in the fifth floor dining room was leaking from a pipe located under the sink. These observations were made in the presence of Employee #24 who acknowledged the findings.	F 456	(2) **1.** Leaking pipe under the sink was repaired. **2.** Pantry hand sinks were inspected. No other hand sink was identified as needing repair. **3.** Dining services staff were in-serviced on reporting leaking hand sinks to the maintenance department. **4.** Random audits of the hand sinks will be conducted by the kitchen manager or designee and presented by the Director of Dining Services at the quarterly QA/QI meeting.	9/16/14 9/13/14 9/13/14 Ongoing