Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING: ______ B. WING ______	09/16/2014

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

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L 000	Initial Comments The annual Licensure 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 MDS - Minimum Data Set	L 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.	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tina Sandri | TITLE: administrator | (X6) DATE: 10/31/14

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L 000	Continued From page 1 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	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order	L 051		

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L 051	Continued From page 2 policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute 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 the charge nurse failed to review and revise the care plan for one (1) resident with a history of sexual delusions. Resident #176 The findings include: The charge nurse failed to review and revise Resident #176 's care plan with goals and approaches to address the resident's history of sexual 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	L 051	**L051** **3210.4 Nursing Facilities** **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, 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 CP audit. Results will be submitted to the DON or designee for presentation at the quarterly QA/QI meeting	10/24/14 10/24/14 10/31/14 Ongoing

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L 051	Continued From page 3	L 051		

verbally, physically and/or sexually. He/she responded, "Yes." A second query was made whether he/she had reported the alleged abuse to any one. 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 does have a history of sexual delusions; and was being seen by the psychiatrist. The employee added that "the resident had made the same allegation in November of 2012 and it was investigated. The resident performs [his/her] own personal hygiene care, does not have a [gender identified] nurse assigned to [him/her], and no one enters [his/her] room after 8:00 PM."

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 in the resident's care plan to reflect goals and approaches stipulated by Employee #7.

After reviewing the aforementioned information Employee #7 acknowledged the findings.

The charge nurse failed to review and revise Resident #176 's care plan with goals and approaches to address the resident's history of sexual delusions.

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L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (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; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (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; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating;	L 052		

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(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:

Based on observations, record review and interviews, for one (1) of 39 sampled residents, it was determined that sufficient nursing time was not given to provide life sustaining measures for a resident who was nonresponsive and was a full code; to provide a geri-chair that was safe for resident use. Resident #282 and #66.

The findings include:

1. Sufficient nursing time was not given to implement life sustaining measures for Resident #282 who was nonresponsive and had a full code status.

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

Provider's Plan of Correction (L052):

3211.1 Nursing Facilities

(1)

Corrective action	Complete date
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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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 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 RN will remain available to assist until the resident situation has been stabilized or the resident is transferred to another setting for assistance.

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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 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. "

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" 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 after the staff was made aware and assessed the resident for responsiveness the resident ' s wishes for life sustain measures were initiated in congruence 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

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[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 " .

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.

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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 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

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[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 he/she 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

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	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 Director."		**L062 Continued**	
	Sufficient nursing time was not given 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.		**(2)** **1.** Resident #66 was provided with geri chair that was appropriate.	9/13/14
	The medical record was reviewed on September 9, 2014. Cross referenced to 483.25(h)		**2.** All residents wheel chair/geri chairs were evaluated for appropriate use. Residents identified to need appropriate wheel chair/geri chair were provided with appropriate sitting device.	11/2/14
	2. Sufficient nursing time was not given to provide a geri-chair that was safe for the resident's use. Resident #66.		**3.** Licensed staff were in-serviced to ensure that they obtain an appropriate wheel chair for any residents who are identified to need one.	11/2/14
	On September 10, 2014 at approximately 11:33AM Resident #66 was observed sitting in an upright position in his/her geri chair with legs		**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.	Ongoing

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L 052	Continued From page 13	L 052		

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 sufficient nursing time was given to implemente 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 stated, " I will order a chair with the appropriate

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	foot support. " The record was reviewed on September 12, 2014.			
	Sufficient nursing time was not given to provide a geri-chair that was safe for the residents' use. The clinical record was reviewed on September 15, 2014.		**L052 Continued**	
	3. Sufficient nursing time was not given to ensure that the status of Resident #377's sacrum, right heel and left heel were accurately assessed. This was a closed record review.		**(3)** **1.** Resident #377 was discharged from the facility at the time of this review.	6/8/14
	A review of the facility ' s " Skin Breakdown Risk Assessment Tool " Policy, dated August 1, 2009, 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. "		**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.	11/2/14
			3. Licensed staff have been in-serviced on accurately assessing the status of skin for residents with skin impairments.	11/2/14
			4. Random audits will be conducted by the wound nurse or designee. Results will be presented at the quarterly QA/QI meeting	Ongoing
	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.			

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L 052	Continued From page 15 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 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	L 052		

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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.

Sufficient nursing time was not given to accurately conduct an assessment of Resident #377's risk for 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 [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

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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 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,

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L 052	Continued From page 18 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 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	L 052		

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L 052	Continued From page 19 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 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	L 052		

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	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; Co-Morbidities, End-Stage Disease, Decreased mobility, Inactivity, Decreased Blood Flow.		**L052 Continued**	
	Sufficient nursing time was not given to address Resident #377 ' s left and right heel skin impairment.		1. Resident #377 was discharged from the facility at the time of this review.	6/8/14
			2. All new residents admission assessments for the risk of developing pressure ulcers have been reviewed. All assessments have been accurately conducted.	11/2/14
	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. "		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
	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,			

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L 052	Continued From page 21 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. 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	L 052	**L052 Continued** **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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L 052	Continued From page 22 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 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. Sufficient nursing time was not given to ensure that the status of Resident #377's sacrum, right heel and left heel were accurately assessed. This was a closed record review.	L 052	**L052 Continued** 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
L 099	3219.1 Nursing Facilities 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: A. 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	L 099		

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L 099	Continued From page 23 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. 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 made in the presence of Employee #24 who acknowledged the findings. 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	L 099	**3219.1 Nursing Facilities L099** **(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. **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 10/1/14 Ongoing 9/10/14 9/10/14 10/1/14 Ongoing

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L 099	Continued From page 24 the main kitchen. 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.	L 099	**L099 Continued** **(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.	9/12/14 912/14 10/31/14 Ongoing
L 233	3236.2 Nursing Facilities There shall be no cross-connection between the potable safe water supply and each water supply that is non-potable, or any source of pollution through which a safe supply might become contaminated. This Statute is not met as evidenced by: 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: 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.	L 233	**3236.2 Nursing Facilities L233** **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.	9/9/14 9/13/14 9/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING: ______ B. WING ______	09/16/2014

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

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L 233	Continued From page 25 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.	L 233	**4.** Random audits will be conducted by maintenance staff to ensure compliance and the results will be presented at the Quarterly QA/QI meeting.	Ongoing
L 235	3236.4 Nursing Facilities The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, it was determined that facility staff failed to ensure that the resident environment remained free of accident hazards as evidenced by: hot water temperatures that exceeded acceptable ranges in 6 of 15 resident rooms. The findings include: Facility staff failed to ensure that hot water temperatures were maintained in acceptable ranges as to not pose a burn hazard in 5 of 15 resident rooms observed. Water temperature readings were obtained from	L 235	**3236.4 Nursing Facilities L235** **1.** The temperatures of the observed rooms were adjusted immediately. **2.** Water temperatures were taken at all resident sinks and adjusted when needed. **3.** Environmental auditors were educated on the required water temperature ranges. **4.** Resident sink temperatures will be randomly monitored and the results will be presented at the monthly safety meeting and the quarterly QA/QI meeting.	9/9/14 10/30/14 10/31/14 Ongoing

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L 235	Continued From page 26 the sink in resident rooms located on the east wing of all 5 floors. The water temperature readings were made in the presence of Employee #9 on September 9, 2014 at approximately 3:30 PM. Employee #9 used the facility ' s thermometer to assess for the temperatures. The water temperatures readings were as follows: Rooms #253 sink 112.1 F (degrees Fahrenheit) Room #255 sink 112.7 F Room #256 sink 110.5 F Room #355 sink 114.3 F Room #356 sink 111.6 F After the above observations, Employee #9 acknowledged the findings and made adjustments to the temperatures at the time of the observation.	L 235		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute 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 of five 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.	L 442		

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L 442	Continued From page 27 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. 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.	L 442	**3258.13 Nursing Facilities L442** **(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. **(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.	11/15/14 11/2/14 11/2/14 Ongoing 9/16/14 9/13/14 9/13/14 Ongoing