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 _____	10/20/2006

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 PRECEEDED 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 An annual recertification survey was conducted October 16 through 20, 2006. The following deficiencies were based on observations, staff interviews and record review. The survey included 30 sampled residents based on a census of 247 the first day of survey and one (1) supplemental resident.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: damaged walls, corners and separated wallpapers borders, marred accordion doors jams, worn draperies, marred, scarred and splintered entrance and bathroom doors, leaking washers, soiled venetian blinds, marred furnishings, chemicals spilled on counters in the dental clinic, a soiled plastic drain cover around the pool and a damaged concrete floor. These findings were observed in the presence of maintenance, housekeeping and nursing staff. The findings include: 1. Walls and corners were damaged and marred and wallpaper was separated from the wall in residents' rooms and common areas:	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Carole Pearce Acting Administrator 11/6/06

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.

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 _____	10/20/2006

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 PRECEEDED 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 253	Continued From page 1 First Floor Rooms 102, 109, 131, 134, 153, soiled utility room and personal laundry room in seven (7) of 10 observations between 9:50 AM and 4:00 PM on October 16, 2006. Second Floor Rooms 226, 227, 236, 248 and dayroom in five (5) of 14 observations between 4: 10 PM and 4:45 PM on October 16, 2006 and 9: 45 AM and 11:00 AM on October 17, 2006. Third Floor Rooms 302, 324, 336 and 348 in four (4) of 14 observations between 1:15 PM and 4:30 PM on October 17, 2006. Fourth Floor Rooms 428, 447, dayroom, dining room and bathing room in five (5) of 13 observations between 8:56 AM and 11:30 AM on October 18, 2006. Fifth Floor Rooms 505, 509, 512, 545 and 550 in five (5) of 13 observations between 11:39 AM and 1:45 PM on October 18, 2006. 2. The lower surfaces of accordion door jams were marred and scarred in residents' rooms. Second Floor Rooms 241 and 255 in two (2) of 10 observations between 4:10 PM and 4:45 PM on October 16, 2006 and 9:45 AM and 11:00 AM on October 17, 2006. Third Floor Rooms 314 and 326 in two (2) of 12 observations between 1:15 PM and 4:30 PM on October 17, 2006. Fourth Floor Rooms 421, 428 and 443 in three (3) of 13 observations between 8:56 AM and 11:30	F 253	**F253** **1. 483.15(h)(2) HOUSEKEEPING / MAINTENANCE** 1.) Repair and paint a. first floor rooms 102, 109, 131, 153, soiled utility and laundry b. second floor rooms 226, 227, 236, 248, dayroom c. third floor rooms 302, 324, 336, 348 d. fourth floor rooms 428, 447, dayroom, dining room and bathing room. e. firth floor rooms 505, 509, 512, 545, 550 2.) We will survey remaining areas and repair as needed. 3.) We will continue to monitor conditions daily, log issues and repair as warranted. 4.) The housekeeping and maintenance Manager will inspect one floor per month and report the findings to the QI committee meeting. **2. 483.15(h)(2) HOUSEKEEPING / MAINTENANCE** 1.) Repair a. second floor rooms 241, 255 b. third floor rooms 314, 326 c, fourth floor rooms 421, 428, 443 d. fifth floor rooms 509, 512, 526, 530 2.) We will survey remaining doors and repair as necessary. 3.) We will continue to monitor weekly, log issues and repair as warranted. 4.) The housekeeping and maintenance manager will inspect one floor per month and report findings to the QI Committee.	11/30/06 11/30/06

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 _____	10/20/2006

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 PRECEEDED 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 253	Continued From page 2 AM on October 18, 2006. Fifth Floor Rooms 509, 512, 526 and 530 in four (4) of 13 observations between 11:39 AM and 1:45 PM on October 18, 2006. 3. Draperies were observed to have separated seams and pleats in dayrooms, dining rooms and common areas. Second Floor dayroom in one (1) of one (1) observation at 10:55 AM on October 16, 2006. Third Floor dayroom in one (1) of one (1) observation at approximately 2:55 PM on October 17, 2006. Fourth Floor dayroom and dining room in two (2) of two (2) observations between 8:56 AM and 11: 30 AM on October 18, 2006. Fifth Floor dayroom and dining room in two (2) of two (2) observations between 11:39 AM and 1:45 PM on October 18, 2006. Rehabilitation services in the basement in one (1) of one (1) observation at 8:30 AM on October 19 , 2006. 4. Residents' entrance and bathroom doors were damaged, marred, and splintered on edges. First Floor Rooms 103, 109, 131, dayroom, unit entrance and dining room doors in six (6) of 10 observations between 9:30 AM and 4:00 PM on October 16, 2006. Second Floor Rooms 216, 236, east side bathing	F 253	**3.) F253 483.15(h)(2) Housekeeping** 1. Draperies observed with separated seams/pleats in the day rooms, dining rooms and common areas will be removed and stitched. 2. We will inspect and repair draperies for separated seams/pleats after completion of bi-annual cleaning. 3. The Housekeeping Manager/Supervisor will inspect draperies during daily rounds. 4. Daily observation by Housekeeping Manager/Supervisor during rounds. Housekeeping Manager will report repairs of separated drapery seams to the QI committee.	11/15/06

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 _____	10/20/2006

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 PRECEEDED 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 253	Continued From page 3 room, soiled utility room and west side bathing room in five (5) of 10 observations between 9:50 AM and 4:00 PM on October 16, 2006. Third Floor Rooms 302, 306, 312 and 326 in four (4) of 12 observations between 1:45 PM and 4:30 PM on October 17, 2006. Fourth Floor Rooms 412, 421, 424, 433, 447, 453 , clean utility room and storage room in eight (8) of 13 observations between 8:30 AM and 11:30 AM on October 18, 2006. Fifth Floor Rooms 530, 550 and soiled utility room in three (3) of 12 observations between 8:30 AM on 1:45 PM on October 17, 2006. Five East Rooms 562, 563 and 566 in three (3) of six (6) observations between 3:09 and approximately 4:00 PM on October 18, 2006. 5. Washers in the personal laundry rooms were leaking from the front with towels placed on the floor to absorb the water and detergent barrels were soiled with dust on units One, Two, Four and Five in four (4) of five (5) observations between 9:50 AM and 4:00 PM on October 16, 2006, 9:45 AM and 4:30 PM on October 17 and between 8:56 AM and 1:45 PM on October 18, 2006. 6. The slat surfaces of venetian blinds were soiled with dust and debris in residents' rooms and common areas. First Floor dayroom in one (1) of 10 observations between 9:50 AM and 4:00 PM on October 16, 2006.	F 253	**4. 483.15(h)(2) HOUSEKEEPING / MAINTENANCE** 1.) Repair and paint doors a. first floor rooms 103, 109, 131, dayroom unit entrance , dining room b. second floor soiled utility, bathing room c. third floor rooms 302, 306, 312, 326 d. fourth floor rooms 412, 421, 424, 433, 447, 453 e. firth floor rooms 562, 563, 566 2.) We will survey remaining doors and repair/refinish as necessary. 3.) We will continue to monitor conditions weekly, log issues and repair/refinish as necessary. 4.) Housekeeping and maintenance manager will inspect one floor per month and report findings to the QI **5. 483.15(h)(2) HOUSEKEEPING / MAINTENANCE** 1. Leaking washer repaired and detergent barrels cleaned. 2. We will inspect all personal laundry washers and make repairs as needed. 3. We will continue to monitor conditions weekly, log issues and make repairs as warranted. 4. The housekeeping and maintenance manager will inspect one floor per month and report findings to the quarterly QI.	11/30/06 10/19/2006

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 _____	10/20/2006

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 PRECEEDED 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 253	Continued From page 4 Second Floor Rooms 236, 241, 248, dayroom and activity dayroom in five (5) of 14 observations between 4:10 PM and 4:55 AM on October 17, 2006. Third Floor Rooms 343, rehabilitation room and dayroom in two (2) of 10 observations between 1: 15 PM and 4:30 PM on October 17, 2006. Fourth Floor Room 412 and dayroom in two (2) of five (5) observations between 8:56 AM and 11:30 AM on October 18, 2006. Fifth Floor Room 521 and dayroom in two (2) of 13 observations between 11:39 AM and 1:45 AM on October 18, 2006. 7. The armrest and legs of straight back chairs and closets, chest and tables were marred and scarred in the following areas: First Floor Room 131 chest and closet and dayroom chairs and tables in two (2) of 10 observations between 9:50 AM and 4:00 PM on October 16, 2006. Second Floor Rooms 209, 216, 235, 241, 248, 253 chests and closets and dayroom chairs and tables in seven (7) of 14 observations between 4: 00 PM and 4:45 PM on October 17, 2006. Third Floor Rooms 306, 312, 314 chests and closets and dayroom chairs and tables in four (4) of 13 observations between 1:15 PM and 4:30 PM on October 17, 2006. Fourth Floor Rooms 421, 428 chests and closets	F 253	**6.) F253 483.15(h)(2)** **Housekeeping** 1. Remove venetian blinds from windows identified during survey. Power wash blinds and wipe each slat to insure compliance. Cleaning of blinds will be completed twice a year. 2. Inspect window blinds and clean as needed. 3. Continue to remove and power wash identified dusty blinds. 4. Daily observation by Housekeeping Manager and Supervisor during rounds. Report blinds that have been removed and power washed to the QI committee. **7.) F253 483.15(h)(2)** **Housekeeping** 1. Straight back chairs with marred/scarred arm rest and legs identified during survey, will be refinished by an outside contractor. 2. Housekeeping Manager and Supervisor will identify and remove chairs with marred/scarred arm rest and legs during daily rounds. 3. Housekeeping Manager and Supervisor will prepare a work order request for maintenance immediate attention. 4. Report to the QI committee, number of refinished chairs by maintenance and outside contractor,	11/15/06 11/30/06

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 _____	10/20/2006

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 PRECEEDED 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 253	Continued From page 5 and dayroom chairs and tables in three (3) of 13 observations between 8:56 AM and 11:30 AM on October 18, 2006. Fifth Floor Room 513 chest and closet and dayroom chairs and tables in two (2) of 13 observations between 11:39 AM and 1:45 PM on October 18, 2006. 8. Chemicals were spilled on the counter top in the darkroom area of the dental clinic in one (1) of one (1) observation at approximately 11:00 AM on October 17, 2006. 9. A plastic drain cover around the perimeter of the pool in the Rehabilitation Department was soiled with debris in one (1) of one (1) observation at approximately 10:45 AM on October 19, 2006. 10. The lower concrete floor was separated from the elevated washer platform in front of washers in the main laundry room in one (1) of one (1) observation at approximately 11:45 AM on October 19, 2006.	F 253	**8.) F253 483.15(h)(2) Housekeeping** 1.) Chemical spill on dentist office dark room counter top was cleaned immediately when observed by surveyor. 2.) Housekeeping Manager will monitor dentist office daily for chemical spill. 3.) Daily observation by Housekeeping Manager during routine cleaning. 4.) Daily observation by Housekeeping Manager/Supervisor during rounds. Report findings to QI committee quarterly. **9.) F253 483.15(h)(2) Housekeeping** 1. Plastic drains in Rehab/Pool perimeter will be machine scrubbed weekly by Housekeeping associate. 2. All drains in Rehab/Pool areas will be cleaned during daily routine cleaning. 3. Soiled drain covers will be identified by Housekeeping Supervisor. Housekeeping associate will machine scrub drain surfaces to ensure compliance. 4. Daily observation by Housekeeping Supervisor during rounds. Report drain cleaning routine to QI committee quarterly.	11/15/06

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 _____	10/20/2006

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 PRECEEDED 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 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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 observation, staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to update a care plan for a resident with a pressure sore. Resident # 26. The findings included: On October 18, 2006 at 10:25 AM, a wound treatment to the left heel was observed on Resident #26. During the review of resident's record, a nurse's note dated April 25, 2006 at 1500 [3:00 PM] indicated that the resident was observed with	F 280	**10.) F253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE** **10.** 1. Concrete separation from building settlement was caulked and sealed. 2. All washer platforms will be inspected and repaired as needed. 3. We will continue to monitor conditions daily, log issues and repair as needed. 4. The Laundry manager will report findings to the quarterly QI meeting **F280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Resident #26 right heel was healed. Her Care Plan and progress notes reflected such. Her left heel was assessed. Her treatment order remains the same. Her care Plan was updated. 2. Care Plan will be reviewed and updated on all Residents with pressure ulcers. 3. All Managers and Asst. Nurse Managers were inserviced on the care planning process. 4. Care Plan audits will be done monthly and submitted to the DON for review by the QA Committee quarterly	11/3/2006 10/30/2006 11/3/2006 10/30/2006 11/3/2006

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 _____	10/20/2006

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 PRECEEDED 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 280	Continued From page 7 bilateral heel blisters. According to the "Weekly Skin Sheets", the wound was initially observed on April 25, 2006 as a fluid filled blister-black to the left heel. Further review of the "Weekly Skin Sheet" dated October 9, 2006 described the left heel pressure sore as Stage III, measuring 0.8 x 1.5 x 0.5 cm with a pale and pink appearance. There was no evidence that the care plan initiated April 7, 2006 was updated or amended to include the left heel pressure sore. A face-to-face interview was conducted on October 20, 2006 at 11:00 AM with Nursing Administration. They acknowledged that the care plan was not updated to address the resident's skin condition. The record was reviewed October 18, 2006.	F 280		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period in two (2) of seven (7) rooms, it was determined that boilers and mixing valves were not adjusted to maintain hot water temperatures at or below 110 degrees Fahrenheit (F) on 5 East, the subacute unit located in the main hospital. These findings were observed in the presence of the	F 323	F 232 483.25(h) 1 Accidents 1. The water temperatures were adjusted to acceptable levels on 10/19/06 for rooms 563 and 564. 2. All remaining rooms were tested for acceptable heat temperatures. 3. Water risers at these locations are slated for replacement in a future renovation project. The supervisor will monitor the temperatures on a daily basis with adjustments made as needed. 4. Findings will be reported to the Safety Committee and the department director for review on a monthly basis.	10/19/2006

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 _____	10/20/2006

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 PRECEEDED 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 323	Continued From page 8 Housekeeping and Maintenance Directors. The findings include: Temperatures of the sink water in rooms 564-114 degrees F and 563-116 degrees F in two (2) of seven (7) observations between 3:09 and 3:40 PM on October 18, 2006. The boiler was adjusted and sink water temperatures remained elevated in room 563 at 114 degrees F at 6:15 PM, 116 degrees F at 6:17 PM, 118 degrees F at 6:20 PM and 116 degrees F at 6:37 PM in four (4) of four (4) observations on October 18, 2006. Facility staff placed a sign above the sink, "Do not use." On October 19, 2006 at 1:30 PM the sink water temperature was 100 degrees F.	F 323		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 30 sampled residents, it was determined that the dietician failed to re-assess and initiate interventions for Resident #7 who subsequently sustained a 16 pound weight loss in two (2) months.	F 325	**F325** **483.25(i)(1) NUTRITION** 1. Resident #7 will continue on weekly weights. A dietary, speech, psychiatric and pharmacy consults were requested. 10/30/2006 2. All residents weights will be reviewed for ~~+/- 5lbs, A re-~~ weight loss + or - minus 5lbs weight change. Re-weight will be requested for these residents. The Nurse Manager or the Asst. Nurse Manager will review the meal consumption log of the identified Residents and request consults by Dietary, Speech, Psychiatric and Pharmacy and place the Resident on weekly weights. 11/8/2006	

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 _____	10/20/2006

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 PRECEEDED 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 325	Continued From page 9 The findings include: A review of Resident #7's record revealed that the resident was admitted to the facility on August 14, 2006. The resident's weights as listed on the "Monthly Record of V/S [vital signs] and Weights" were 180 pounds (lbs) on August 14, 2006, 168 lbs on September 1, 2006 and 163.6 lbs on October 2, 2006. According to the Treatment Administration Record for August 2006, the resident weighed 176.6 lbs on August 21, 2006 and 168.5 lbs on August 28, 2006. The admission Minimum Data Set completed August 27, 2006, coded the resident in Section J (Problem Conditions) with edema. According to the facility's policy, "Obtaining Height and Weight of Residents" , policy #1265, page 2 of 4, "The dietician and nurse manager will review the weights of +/- 5 lbs. from their previous month's weight and submit to nursing for re-weigh ...II. Weight Loss, Procedure: 2. The dietician/nurse manager will: a) Assess whether or not the weight loss was desirable and document accordingly ..." There was no evidence in the record that the dietician/nurse manager requested a re-weight and re-assessed the resident's weight loss. The dietician completed an initial assessment on August 24, 2006. The next entry was dated September 13, 2006, "Resident seen regarding [his/her] food preferences/complaints. Changes made. Will continue to monitor." No weight was	F 325	**F325** **483.25(i)(1) NUTRITION** **(con't from page 9 of 15)** 3. All staff was in-serviced on proper use of the bed scale. 4. Nurse Managers will audit admission weekly and monthly weights. Findings will be submitted to the DON at monthly nutrition and hydration meeting and a summary report will be presented to the quarterly QA Committee meeting.	10/27/2006 11/8/2006

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 _____	10/20/2006

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 PRECEEDED 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 325	Continued From page 10 recorded in the dietician's note. A face-to-face interview was conducted with the dietician on October 18, 2006 at 10:30 AM. He/ she acknowledged that the resident should have been re-assessed because of the weight loss. A face-to-face interview was conducted with the nurse manager on October 18, 2006 at 11:00 AM. He/she acknowledged that the resident's weight loss should have been followed up on. The record was reviewed October 18, 2006.	F 325		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by : Based on observation, record review and staff interview, it was determined that one (1) significant error and one (1) nonsignificant error occurred during the morning medication pass on October 18, 2006 for Resident #J1. The findings include: At approximately 9:35 AM on Wednesday, October 18, 2006, the medication nurse prepared medication for Resident #J1. The surveyor asked the nurse to set the medication to be administered to the side of the medication cart. The surveyor observed the following medications: Calcarb 600 w/vitamin D tablet, one (1) tablet; Colchicine 0.6 mg tablet, one (1) tablet;	F 333	**483.25(m)(2) MEDICATION ERRORS** 1.) A review of Resident J1 medication administration record was done. Ferrous sulfate was re-written on the MAR, Resident #51 B/P was monitored. There were no changes. 2.) All Resident medication administration records will be reviewed for evidence of potential errors. 3.) An inservice will be done for all licensed staff on 5 Rights to Safe Medication Administration and review of common look alike drugs and sound alike drugs. 4.) Medication pass competencies will be done on all licensed staff every 6 months and submit to the DON for review at the quarterly QA Committee meeting.	10/30/2006 11/1/2006 11/4/2006 11/3/2006

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 _____	10/20/2006

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 PRECEEDED 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 333	Continued From page 11 Felodipine ER 2.5 mg, two (2) tablets; Tylenol 650 mg, (1) tablet, Potassium Chloride 20 meq, one (1) tablet; Prevacid 15 mg, one (1) capsule; and Tab-A-Vite, one (1) tablet. The physician's order for Felodipine ER 2.5 mg tablet, one (1) tablet by mouth daily for (Hypertension) and Ferrous Sulfate 325 mg, one (1) tablet by mouth daily for Anemia was written on August 10, 2006 and renewed on subsequent 30 day orders. The nurse administered two (2) Felodipine ER 2.5 mg tablets instead of one (1) and failed to administer Ferrous Sulfate 325 mg to the resident. A face-to-face interview was conducted on October 18, 2006, at 3:00 PM with the medication nurse after review of the physician's orders. The nurse stated, "I might have made a mistake because both of the tablets are green."	F 333		
F 371 SS=E	483.35(i)(2) SANITATION CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that food was prepared and served in a safe and sanitary manner as evidenced by hotel pans that were not thoroughly	F 371	**F371** **483.35(i)(2) SANITATION CONDITIONS – FOOD PREP & SERVICE** 1. All identified hotel pans were thoroughly washed/cleaned and allowed to dry before storing for reuse. 2. All remaining pans were pulled off the rack and rewashed and allowed to air dry. 3. An in service was given to staff the October 20, 20006 on proper washing and storing of pots and pans. Supervisors are to inspect on a daily basis all pots and pans.	

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 _____	10/20/2006

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 PRECEEDED 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 371	Continued From page 12 cleaned and allowed to dry before storing for reuse. The findings include: 10 of 10 hotel pans 6 x 10 x 8 inch and 10 of 13 hotel pans 12 x 14 x 10 inch were not thoroughly cleaned after washing in the pot and pan wash area and not allowed to dry before storage between 2:45 PM and 3:00 PM on October 16, 2006.	F 371	**F371** **483.35(i)(2) SANITATION CONDITIONS – FOOD PREP & SERVICE** **(con't from page 12 of 15)** 4. The Monitoring of pots/pans has been added to the Quality Assurance/Improvement Indicators for Food and Nutrition and will be reported monthly to the Department Director and Quarterly to Administration	11/15/2006
F 430 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 30 sampled residents, it was determined that the physician failed to act upon the pharmacist's reports for Resident #23. The findings include: A review of Resident #23's record revealed three (3) "Consultant Pharmacist Communication" forms dated September 22, 2006. The pharmacist requested the physician to clarify the use of Ascorbic Acid, to consider increasing the dosage of Vitamin D to a dosage that is effective for fracture prevention as determined by research, and to consider obtaining a blood value for low density lipoprotein as recommended by the American Dietetic Association for a resident	F 430	**F430** **483.60©(2) DRUG REGIMEN REVIEW** 11/20/06 1. Attending Physician of Resident #23 reviewed the medical record for pharmacy recommendations and responded as needed. 10/19/2006 2. Nurse Managers reviewed other pharmacy recommendations on their units and found no other missing actions on pharmacy reports. 3. The individual physician was counseled on 11/3/2006 and the medical staff will be educated at the Carroll Manor Medical Staff meeting on 11/16/2006.	

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 _____	10/20/2006

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 PRECEEDED 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 430	Continued From page 13 with the diagnosis of hypercholesteremia. The physician progress notes were present in the record for September 23, October 3 and October 5, 2006. There was no evidence that the physician acted upon the pharmacist's communications. A face-to-face interview was conducted with the unit manager on October 18, 2006 at 11:30 AM. He/she stated, " I reminded [physician] the last two times [he/she] was here to address those forms." The record was reviewed October 18, 2006.	F 430	**F430** **483.60©(2) DRUG REGIMEN REVIEW** **(con't from page 13 of 15)** 4. The Nurse Managers will continue to monitor physicians compliance with pharmacy recommendations. Recommendations that are not acted upon timely will be referred to the Medical Director for implementation. The findings will be reported at the Quarterly QI meetings. Ongoing	11/16/2006
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that oxygen concentrators were soiled with dust and debris. The findings include:	F 441		

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 _____	10/20/2006

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 PRECEEDED 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 441	Continued From page 14 Oxygen concentrators were not cleaned as evidenced by accumulated dust and debris behind the filter on the interior of the machine in room 224 at 9:50 AM on October 16, 2006 and one (1) concentrator being used by a resident in the third floor dining room at 4:00 PM on October 17, 2006 in two (2) of 15 observations.	F 441	**F441 483.65(a) INFECTION CONTROL** 1.) Concentrators in room 224 and in 3rd floor dining room were cleaned thoroughly. 2.) A thorough inspection was made of all other concentrators in the facility and all were found to be clean. 3.) All oxygen concentrators shall be inspected and cleaned by RT staff on Mondays when other respiratory equipment is changed. 4.) The Senior Practitioner for Carroll Manor shall monitor equipment cleaning compliance on a weekly basis and report to the QI committee quarterly.	10/23/2006 10/23/2006 11/9/2006 On-going